

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Gene McCaskill, Commissioner
Avery B. Wilkerson, Jr., Commissioner
R. Michael Campbell, II, Commissioner

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APPELLATE CASE NO.: 2018-000359

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SC Court of Appeals

Vickie Rummage, Employee, ...Appellant,

vs.

BGF Industries, Employer, and Great American Alliance Insurance Co., Carrier,
.....Respondents.

RECORD ON APPEAL

VOLUME II

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Palmetto Center of Psychiatry

September 1, 2015

Mr. Andrew N. Safran
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Re: Vickie Rummage (DOB [REDACTED] 1959)

Dear Mr. Safran,

Following your request, I evaluated Vickie Rummage on April 27, 2015. Prior to this evaluation, Mrs. Rummage was informed of the limits of confidentiality. She was informed that a report of my findings would be made available to you, and perhaps shared with other participants in her worker's compensation case. She was informed that this evaluation was a forensic psychiatric evaluation, meaning the nature of this interview did not establish a doctor-patient relationship but instead was an independent psychiatric evaluation as part of the process related to her worker's compensation case. Mrs. Rummage verbalized understanding of this information, and, of her own free will, agreed to participate in the evaluation.

As part of this evaluation, I have reviewed records from Sandhills Regional Medical Center, McQueen Medical Center, Wright Rehabilitation Services, Tora L. Brawley, Ph.D., Chesterfield General Hospital, Grand Strand Specialty Associates (Jeff A. Benjamin, DO), Florence Rehabilitation Medicine (Daniel L. Collins, MD), Florence Neurosurgery & Spine, Carolinas Center for Advanced Mgmt of Pain (Justin K. Hutcheson, MD), and NCNeuropsychiatry (C. Thomas Gualtieri, MD). In addition, I interviewed Mrs. Rummage for almost one hour and 45 minutes, and obtained collateral history from her husband.

Mrs. Rummage is a 55 year-old married, Caucasian female who suffered a job related injury on May 18, 2012 while working as a weaver at BGF Industries in Cheraw, S.C. While performing her job duties at her workstation, she stepped backwards onto a doff truck and fell to the ground. She struck her head and sustained open wounds to her head bilaterally. She denied loss of consciousness at the time of the injury. She was assessed at the first aid room where the medical provider wanted her to go to the emergency department for evaluation. Mrs. Rummage declined this referral. Instead, she went home. She reported having a headache that was unlike her migraine headaches. Her hair was torn out. She said she chipped her teeth. She had neck pain. She also reported having had pain in her buttocks and back. It was over the passage of time that she developed memory problems and depressive mood symptoms.

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Mrs. Rummage said that following the accident she did not miss work. She reported that she feared she would lose her job if she missed work. Thus, she returned to her next shift as scheduled on the following Sunday. She worked her regular schedule for one week before her supervisor sent her to the plant physician who referred her to Chesterfield Hospital for evaluation. She has since been diagnosed with closed-head injury and post-concussive syndrome related to the compensable injury.

Her history of treatment following evaluation at Chesterfield Hospital was first with Dr. McLeod. Later she entered treatment with Dr. Benjamin who diagnosed a closed head injury and took her out of work. She is now in treatment with Dr. Collins who has diagnosed "post work injury, 5-18-12, with post-concussive symptoms persisting." Dr. Collins' notes indicate that he does "not think [Mrs. Rummage] will be able to return to her regular job now or in the foreseeable future." According to notes from Wright Rehabilitation Services, Dr. Collins rated Mrs. Rummage at maximum medical improvement as of July 2014.

Mrs. Rummage presented as an honest and forthcoming individual. She described herself as "the determined type." Her social history, including educational efforts and work history, is congruent with this self-description. She did not present as overly dramatic or exaggerated. Her given history was congruent with that documented in her extensive medical records. She was noted to have difficulties with dates (usually gave years to approximate best estimates). She would auto-correct herself when she thought she had misrepresented a given date. She expressed much frustration with the loss of several certificates that she has not been able to maintain following the injuries sustained in the worker's compensation accident.

Mrs. Rummage reported that since the accident, she is quite forgetful, anxious, and depressed. She finds her forgetfulness to be quite frustrating for her as she experiences this on a daily basis and it impairs her from accomplishing what would otherwise be a simple and straightforward task. She forgets what she is doing when she is in the middle of a task. She reported that she almost burned down the house because she forgot to take a pot of boiling chicken off the stove. In addition, she has accidentally melted plastic bowls because she put them in a hot oven that was still on. In addition, she has low energy and gets frustrated because she is not able to keep up with daily household tasks to keep her home in order. In addition, she described having developed problems with her speech. This symptom has led to an increase in her anxiety as she feels others "look at [her] funny." Since the development of her speech problem, she has found she doesn't want to be around crowds and tends to isolate at home. Although she will drive less than a mile to a convenience store, in general she does not drive or go shopping. She relies on her husband or a friend to handle these tasks.

Mrs. Rummage noted having bouts of depression prior to the injury, but "nothing they couldn't give me a little something and [I would] overcome" these bouts with

depression. She recalled some of the events that triggered these depressive spells to include when each of her parents died and when her husband was deployed. As she said, "Sure I got depressed, [but] not like now." She recalled positive effect with fluoxetine (Prozac) from these previous episodes of depression. Medical records document a history of treatment with fluoxetine (Prozac), escitalopram (Lexapro), bupropion (Wellbutrin XL), duloxetine (Cymbalta), amitriptyline (Elavil), and nefazodone (Serzone), trazodone (Desryl), and zolpidem (Ambien). She has also been prescribed anti-anxiety medications, lorazepam (Ativan) and alprazolam (Xanax). She denied a history of evaluation or treatment by a mental health professional prior to the worker's compensation injury. She has no prior history of inpatient psychiatric treatment. She denied a history of suicide attempts.

Mrs. Rummage reported that her sleep became disrupted after the worker's compensation injury, that her sleep has worsened, and she has not experienced improved sleep despite limited treatment. Some, but not all, of this relates to her pain. There is a delayed onset to falling asleep, middle of the night awakening, and waking up early in the morning. Overall, she estimates she gets about two to three hours of sleep per night. However, she offered another concern that there are times in which she wakes from sleep with ringing in her ears, nausea (no vomiting) and dizziness. As far as her appetite, Mrs. Rummage said, "I'm fat as a pig so I guess it's good." She estimated an approximate 20-pound weight gain since the injury.

Additional depressive symptoms that were endorsed included crying spells, anhedonia (loss of interest in previously enjoyed activities), and feeling depressed. She described her problems as being extremely difficult for her to do things that she otherwise intends to do. She has had thoughts of being better off dead, but denied being suicidal or having a plan or desire to kill herself.

The above symptoms are in contrast to her pre-injury functional capacity in which she considered herself the "backbone of [my] family." She was able to work two to three jobs and care for sick and ailing family members. Her history of employment has included being a jailer (1 year), a 911 dispatcher (2 years), bus driver (several years), and technician assembler at Cooper Tools (over 20 years).

Mrs. Rummage reported a history of high blood pressure and hypothyroidism that was present prior to this worker's compensation injury. She is also diagnosed with osteoarthritis and has a history of being treated for cervical cancer. She reported she has chronic pain in her back and buttocks but has "never asked [worker's compensation] for any treatment about that." She has headaches on a regular basis. She gets car sick and experiences dizziness and ringing in her ears (present regardless of her medications or not). She has a hard time getting a full night of sleep. Her reported history of surgeries includes a partial hysterectomy, cholecystectomy, surgical repair of her right shoulder and left leg.

Mrs. Rummage said she has no known drug allergies. However, several records document an allergy to penicillin and IV dye. She is currently prescribed the following medications:

1. venlafaxine (Effexor XR) 75mg daily;
2. duloxetine (Cymbalta) 30mg daily;
3. promethazine (Phenergan) 25mg three times a day;
4. pregabalin (Lyrica) 50mg twice a day;
5. oxycodone/acetaminophen (Percocet) 10/325mg, one to two tablets three times daily as needed;
6. alprazolam (Xanax) 0.5mg three times a day as needed;
7. cyclobenzaprine (Flexeril) 5mg, one tablet twice a day and two tablets every night;
8. butalbital/acetaminophen/caffeine (Fioricet) 50/325/40mg, one table three times a day as needed;
9. levothyroxine (Synthroid) 75mcg daily; and,
10. lisinopril/hydrochlorothiazide (Zestoretic) 20/12.5mg daily.

Mrs. Rummage denied a history of severe depression, treatment for mood or anxiety problems, or suicides in her family members. Dr. Brawley's notes reveal that her son tried to commit suicide by overdose at age 27. She denied a history of dementia in her family. Her father died from a stroke at age 68.

Mrs. Rummage is the only child of her parents. She was born in Cordova, N.C., but moved to Wallace, S.C. when she was approximately age 12 or 13. She dropped out of school in the ninth grade and married her husband, Darryl Rummage, at age 15. Her eldest child was born within the first year of marriage and her second son was born just over ten years later. Mrs. Rummage's history of employment in her teenage years included work at local plants and cleaning houses. According to her husband, she obtained her high school diploma (age 18) by attending night school classes. He reported she has accomplished several other licensures to include physical therapy, certified nursing assistant, phlebotomy, home health care, emergency medical technician, and her CDL driver's license.

On exam, Mrs. Rummage presented appropriately dressed and made adequate eye contact. She was noted to have patches of red blotchy skin on the exposed parts of her arms that were reported to be itchy despite taking Benadryl the night before. She reported having similar patches on her legs as well. Mrs. Rummage had increased tearfulness and distress when asked to provide dates for landmark events (such as one child's year of birth and the year her father died). She was able to maintain her composure with limited verbal support. She did not present overly dramatic or hysterical. Her speech was fluent but with word-finding difficulties. Her reported mood was depressed. She noted she finds herself easily frustrated and overwhelmed, feelings that are outside her normal character. Her affect was congruent with her stated mood. Her thought processes were linear. She demonstrated concreteness of thought (limited ability for abstract thinking). She is

not suicidal, homicidal or psychotic. There was no evidence of bizarre thoughts that would rise to the level of a delusional system.

She was alert and oriented to person, place, date, and event. Her immediate memory was intact as demonstrated by her ability to register three words. She had difficulty recalling these words after a brief delay (recalled one spontaneously and the other two when a cue was provided). Her attention was impaired as evidenced by extreme difficulty when asked to spell the word "world" backwards. She scored a 24 on the mini-mental status examination. Her insight into her current difficulties is intact. Her judgment is adequate for continuing her active involvement in the informed decision-making processes inherent for making treatment decisions about her health.

Additional information and history was obtained from Mrs. Rummage's husband, Darryl Rummage. He reported concerns congruent with the symptoms endorsed by Mrs. Rummage. Mr. Rummage reported that the day of this evaluation was a "better day" than the one before which he described as "rough." Mr. Rummage said that on the day preceding this evaluation, Mrs. Rummage was thinking people were against her, that she had "done something wrong", or that her family "didn't care" because she had not received a phone call from her son or grandson. He reported times in which she has seen a shadow when nothing was present. He stated that there were times when driving that Mrs. Rummage would forget knowing where she was even though she was in familiar territory. Mr. Rummage said that she has frequent, but not daily, crying spells. He, too, was concerned with the mood and cognitive changes she has experienced subsequent to the sustained head injury.

Dr. Gualtieri offers the opinion that Mrs. Rummages' "most likely diagnosis is somatoform pain disorder" and that she "is at maximal medical improvement." I respectfully disagree. In doing so, I challenge his methodology and will document my concerns that lead to my dissent from his offered opinion. Please note that I have consulted with Dr. Tora Brawley and have identified the following concerns about the methodology Dr. Gualtieri utilized for his evaluation of Mrs. Rummage.

In reviewing Dr. Gualtieri's report, there are several areas that rise to a level of concern. The first is the date for which the service is alleged to have been provided. The report documents a date of service for December 11, 2014. However, Mrs. Rummage told me she went for evaluation by Dr. Gualtieri in April 2015. You confirmed the evaluation as being done in April 2015. It is not clear whether there is a mistake in the documented date, or if Dr. Gualtieri's report reflects a level of carelessness or neglect to the level of attention and/or effort put forth in the evaluation itself.

Second, Dr. Gualtieri performed multiple psychological instruments and rating scales. Without additional training and experience, a physician trained in medicine should not be administering or interpreting psychological testing. Instead, medical doctors should work in conjunction with neuropsychologists and/or psychologists

who are adequately trained and experienced in the selection, administration, and interpretation of such tests. In doing so, one would recognize that in April 2015, Mrs. Rummage was too severely depressed to participate in psychological testing expected to produce valid results. Such severe depression precludes the ability for accurate and reliable testing. In fact, this is the reason why Dr. Brawley has been unable to complete appropriate neuropsychiatric testing that would lend itself to meaningful interpretation. Given the severity of Mrs. Rummage's depression surrounding the time of Dr. Gualtieri's testing, she should not have been exposed to the testing done at that point in time. A clinical evaluation and history alone would have identified the active and severe depressive state in which she suffers. If a suspicion of faking the depression rose to a level of concern, then a brief test of malingering would have been sufficient to clarify as to whether or not her presentation was genuine or not.

In addition, it appears that Dr. Gualtieri is biased by the selection of tests he elected to perform on Mrs. Rummage. The fact that he administered and appears to have relied on the Pediatric Neurocognitive Test, a test designed for a pediatric population, is concerning. Mrs. Rummage is not a child or adolescent, and should not be administered tests designed for youth. Use of such instrument is not appropriate for her. There are alternate neurocognitive tests designed and normalized to an adult population that can assess attention, processing, and cognitive functions in someone like Mrs. Rummage.

The Neuropsych Questionnaire (NPQ) is an internet-based computerized symptom checklist developed by Dr. Gualtieri himself. By his own publication, the NPQ "was not developed as a diagnostic test." Instead, "its purpose is to inquire after the presence and intensity of symptoms of a wide range of neuropsychiatric disorders, to score patient responses and to collect them in the appropriate clinical scales, to generate a report, and to save the results to a central database." My research yields no peer-reviewed evidence-based medicine to link the administration of the NPQ to the clinical correlation of its use in general psychiatric practice, or to the assessment of mental health claims in the world of worker's compensation.

Furthermore, Dr. Gualtieri gives conflicting descriptions of Mrs. Rummage. In his mental status examination, he documents "she appeared his/her stated age, and was neatly dressed and well groomed." (Of note, I find it interesting that his exam does not specify Mrs. Rummage's gender specific possessive pronoun when describing her appearance.) Later he says she "was alert, neither sedated nor irritable....Her affect was intermittently tearful. She was not agitated, disorganized or paranoid." He described her as "very concerned about her condition. She was pleasant, well related, cooperative and compliant." Aside from his description that "her responses had prolonged latency and were under-detailed," these observations and descriptions are incongruent with his summary and impressions offered in which he opines her evaluation to demonstrate a "non-credible clinical presentation, with dramatic inconsistencies" with "clear evidence of symptom exaggeration."

Dr. Gualtieri did document an adequate neurological examination that reflects an overall slowing of motor activity (psychomotor retardation) that is typical of severe depression. It is not likely that Mrs. Rummage would know the relevance of faking such symptom of depression. The summary of his report fails to acknowledge or offer explanation as to why he dismissed this information from being a valid part of his assessment and interpretation.

There is no material presented or documentation to explain the differences of record, or the connection Dr. Gualtieri made between the history he obtained, his recorded mental status and neurological examinations, and his summary of offered opinions. Dr. Gualtieri's opinions offered are lacking in detail and inconsistent with his own record of material reviewed and observations recorded for which he provides no explanation to account for such discrepancies.

Thus, I am alarmed by his selection of instruments as being deviant from the standard of care and concerned that he performed tests on a client for whom such tests are not currently appropriate (selection bias). Dr. Gualtieri's heavy reliance on a test he developed (and publishes data to support its usefulness although it is not a test with mainstream use), when considered in light of his neglect to reference or explain sources with conflicting information, leaves one contemplating whether Dr. Gualtieri's report reflects his desire to promote his personally developed instrument as opposed to being a valid assessment of Mrs. Rummage. In considering all the currently available information, Dr. Gualtieri stands alone in his opinion that "there is no reason to believe that her current problems are related to a head injury, for example in the slip and fall in May 2012." There are multiple medical providers (Dr. McQueen, Dr. Benjamin, and Dr. Collins) who have seen Mrs. Rummage over a significant period of time and offer opinions to the contrary. In short, his report stands out in such a divergent perspective in comparison to the other available records, that it leaves me perplexed as to how one is to find any validity in his offered opinion.

It is my professional opinion, offered to a reasonable degree of medical certainty, that Mrs. Rummage meets diagnostic criteria for Major Depressive Disorder. Based on her score of 23 on the PHQ-9 (Patient Health Questionnaire-9), her current depression is severe. Although she has a history of depressive mood symptoms, her past documented and reported depressive episodes have not risen to the level of severity she is currently experiencing. She described neurovegetative symptoms of depression (changes in her sleep and appetite) that are congruent with an episode of severe, persisting depression. She has frequent crying spells, feelings of helplessness, and little interest in previously enjoyed activities. Her overall mood state is depressed and frustrated. Furthermore, she described a state dependent style of thinking that is typical of one who is severely depressed. Her constellation of symptoms as verified by collateral information, current mental status examination, and personal history of depression are indeed congruent with a major depressive episode, severe in nature, that is most likely related to her work injury.

Furthermore, her depressive mood symptoms are likely to worsen and become more resistant to treatment if treatment is delayed and stressors persist.

It is my professional opinion that Mrs. Rummage is not at maximum medical improvement in regards to her mood symptoms and memory impairments. She has not had adequate treatment for her depression. Her current medication regimen of antidepressant use is under-dosed for what she is likely to need in terms of antidepressant treatment. Mrs. Rummage would benefit from evaluation and treatment with a board-certified psychiatrist and a licensed therapist with experience in mood problems subsequent to head trauma. Treatment of depression is at least two-fold: 1) psychotherapy to help one move to a healthy means of thinking, interpreting, responding to life experiences while developing healthy coping skills; and 2) psychopharmacological treatment to target the underlying symptoms of depression. As Mrs. Rummage has a history of responding positively to the antidepressant fluoxetine (Prozac), it would be reasonable to think she would gain benefit from this medication again. However, as she has severe symptoms of a major mood disturbance, and a complicated presentation that includes cognitive deficits and problems with her memory that are likely a result of a severe head trauma, she needs to be under the medical treatment of a provider who has specialized training in the assessment and treatment of such complex cases. And, she will need regular follow-up with such care providers.

Mrs. Rummage's cognitive impairments could be impacted by either or both her documented head trauma and/or her current depression. Once she is psychiatrically stabilized in terms of her current mood symptoms, she should be re-evaluated by a neuropsychologist to explore the source(s) of her cognitive losses.

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October 18, 2016

Mr. Andrew N. Safran
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Re: Vickie Rummage (DOB [REDACTED] 1959)

Dear Mr. Safran,

On September 20, 2016, I conducted a follow-up examination lasting approximately 45 minutes of your client, Vickie Rummage. Prior to this evaluation, Mrs. Rummage was reminded of the limits of confidentiality as relevant to this evaluation. Furthermore, she was reminded that the nature of this interview was an independent psychiatric evaluation and thus did not establish a doctor-patient relationship. Mrs. Rummage verbalized understanding of this information, and, of her own free will, voluntarily agreed to participate in the evaluation. This letter is supplemental to my previous evaluation of Mrs. Rummage as recorded in a letter to you dated September 1, 2015.

In addition to the above, I have reviewed medical records from Dr. Daniel Collins dated April 24, 2015 through January 4, 2016; a questionnaire Dr. Collins returned to you dated January 14, 2016; and, medical records from Dr. Paul Singh dated May 17, 2016 through October 13, 2016.

Mrs. Rummage reported that she continues to have "a lot of problems" subsequent to her job related injury that was sustained on May 18, 2012. She reported ongoing problems with ringing in her ears, headaches associated with vomiting, dizziness, nausea, and difficulty thinking clearly. These reported symptoms are congruent with the symptoms she has reported on numerous occasions to Dr. Collins. She has reported similar symptoms pertaining to her headaches to Dr. Singh who is not addressing these complaints in his diagnoses or treatment recommendations. Mrs. Rummage said that she continued in treatment with Dr. Collins through January 2016 when she went in for a scheduled appointment and learned that he would no longer be available to provide her treatment. Per Mrs. Rummage's recollection, Dr. Collins told her that he dreaded telling her about his departure from practice because, as he said to her, "I was the only one he couldn't help getting the help that they needed." She said that Dr. Collins provided her a one-month supply of medication prescriptions. When this medication supply ran out, she had no one else to turn to for refills, and subsequently went without medication from February until May 2016 when she started seeing Dr. Singh (Carolina Spine Center, Rockingham, NC).

Mrs. Rummage reported that she has established medical care at Care South where she sees a nurse practitioner for primary care. Her reported current medications are:

1. Lisinopril/Hydrochlorothiazide 20/12.5mg, one oral daily (blood pressure medicine);
2. Levothyroxine 75mcg oral daily (for thyroid);
3. Vitamin D 2000 units weekly (vitamin replacement);
4. Alprazolam (Xanax) 0.5mg oral twice a day (anxiolytic);
5. Venlafaxine XR 150mg oral daily (antidepressant, anxiolytic);
6. Cyclobenzaprine 5mg, one tablet po q 8 hours;

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7. Percocet 10/325, one tablet po q 8 hours as needed (for pain); and,
8. Butalbital Compound 50/325/40, one tablet po daily as needed (for headaches).

On October 13, 2016, Dr. Singh prescribed Trazodone, a sleep aid, at a dose of 100mg every night for treatment of insomnia.

Mrs. Rummage reported that she has not yet received approval or referral for mental health care. Dr. Collins' note dated December 2, 2015 states, "She did have an evaluation with an independent medical physician in Charlotte who had completely opposing evaluation compared to myself and the psychologist and psychiatrist that she is seen locally [sic]. I still feel that she is in desperate need of continued psychiatric/psychological care for her depression which only [sic] is exacerbating her pain." On several documents, Dr. Collins emphasized his medical opinion that Mrs. Rummage was in need of psychological care for severe depression. In a questionnaire he returned to you he offered the medical opinion that Mrs. Rummage is not malingering or feigning symptoms of mental illness and does have genuine symptoms of depression and anxiety. Dr. Singh's notes document that she "seems to be depressed. She is sad and despaired." Mrs. Rummage's current antidepressant medication regimen is monitored by her primary care provider, a nurse practitioner, at Care South. Her dose of venlafaxine was recently increased to 150mg per day (approximately one month prior to the face-to-face interview conducted for the current evaluation).

Mrs. Rummage described ongoing symptoms of depression to include anhedonia (loss of interest in previously enjoyed activities), low energy, poor focus and impaired concentration, social isolation, fluctuating moods, and thoughts of being better off dead. She denied desire or plan to actively kill herself or suicide. She described neurovegetative symptoms of depression, particularly related to disrupted sleep patterns. It is noted that some of her sleep disruption is attributed to ongoing chronic pain associated with injuries sustained in the accident. She scored a 24 on the PHQ-9 (Patient Health Questionnaire-9). This score is congruent with a severe depressive episode.

She said that she cries a lot of days noting, "I cry when I should be laughing and I laugh when I should be crying." She reported having "really, really bad mood swings." Her moods have been unchanged despite the recent increase in her antidepressant medication. Again, Mrs. Rummage described low energy levels and inability to do for herself what she was accustomed to being able to accomplish prior to injury. Through tears, Mrs. Rummage described wearing herself out trying to do tasks around the house due to her tendencies towards distraction and difficulties maintaining focus. She gave a specific example of times in which she has been in process of washing clothes, but then found herself cleaning the refrigerator because she forgot what she was doing in the first place. She recollected a previously reported experience in which she melted plastic containers that remained in the oven when she forgot to turn off the oven.

Mrs. Rummage described symptoms of social isolation, particularly noting that she tends to avoid going out in public. She reported that she avoids people because she gets embarrassed when she cannot keep track of their conversation and has found herself repeating already asked questions or getting confused in the midst of the conversation. Mrs. Rummage reported she has preference to stay home and limit her contacts to close family in order to avoid such embarrassing interactions, noting her forgetfulness is "something I can't help." She also reported her forgetfulness has led to unpaid bills, and that

her poor concentration precludes her ability to watch television and keep up with the story line.

Mrs. Rummage did tell me that she participated in speech therapy and that "it helped." She recalled doing online brain games and said, "I still try with that," even though she is no longer going for speech therapy. However, in regards to her day-to-day functional capacity, she said, "It's like everything is taken away."

Mrs. Rummage presented to the evaluation casually dressed. She engaged in a calm and cooperative manner. She presented as an honest and forthcoming self-reporter with internal consistency noted between the current and previous evaluation (April 2015). Eye contact was adequate. She demonstrated mild psychomotor retardation. Her speech patterns were slow and meticulous, mostly monotone with altered prosody. At times, there was a slight increased latency to onset of speech (responses were delayed) that appeared to be a derivative of impoverishment of thought processes. Her moods have been depressed and laden with frustration. Her affect tended to be constricted, at times tearful, but she was able to console herself with verbal support. Mrs. Rummage's thought processes were mostly linear with some poverty of thought content noted. She demonstrated concreteness of thought (limited ability for abstract thinking). Although Mrs. Rummage described having frequent thoughts of being better off dead, she is not suicidal. She denied homicidal thoughts or plan. She denied symptoms of hallucinations or active psychosis. There was no evidence of bizarre thoughts that would rise to the level of a delusional system.

Mrs. Rummage was alert and oriented to person, place, date, and event. She was able to register two out of three words immediately, three out of three with a subsequent presentation. She had mild difficulty recalling these same words after a brief delay (recalled two words spontaneously and the other when a cue was provided). When asked to provide her personal cell phone number, she had to reference her cellular mobile device in order to ensure accuracy of the numbers provided. Her attention was impaired as evidenced by extreme difficulty when asked to spell the word "world" backwards. However, she was able to do so very slowly and with accuracy. She scored a 27 on the mini-mental status examination. Her insight into her current difficulties is intact. Her judgment is adequate for continuing her active involvement in the informed decision-making processes inherent for making treatment decisions about her health.

It is noted that Mrs. Rummage has been diagnosed with closed-head injury and post-concussive syndrome related to the injury she sustained at work in May 2012. It is my professional opinion, offered to a reasonable degree of medical certainty, that she continues to meet diagnostic criteria for Major Depressive Disorder, current episode severe. Mrs. Rummage continues to present in a credible fashion and does not appear to be magnifying or feigning her reported symptoms. It is my professional opinion that Mrs. Rummage is not at maximum medical improvement in regards to her mood symptoms and memory impairments. It appears that over the course of the last one plus years, she has not had adequate treatment for her depression. Thus, not surprisingly, she continues to struggle daily with symptoms of her severe depression.

As previously stated, it is my professional opinion that Mrs. Rummage would benefit from evaluation and treatment with a board-certified psychiatrist and a licensed therapist with experience in mood problems subsequent to head trauma. Treatment of depression is at least two-fold: 1) psychotherapy to help one move to a healthy means of thinking,

interpreting, responding to life experiences while developing healthy coping skills; and 2) psychopharmacological treatment to target the underlying symptoms of depression. As she has severe symptoms of a major mood disturbance, and a complicated presentation that includes cognitive deficits and problems with her memory that are likely a result of a severe head trauma, she needs to be under the medical treatment of a provider who has specialized training in the assessment and treatment of such complex cases. And, she will need regular follow-up with such care providers.

Mrs. Rummage's cognitive impairments could be impacted by either or both her documented head trauma and/or her current depression. Once she is psychiatrically stabilized in terms of her current mood symptoms, she should be re-evaluated by a neuropsychologist to explore the source(s) of her cognitive losses.

Please contact me directly should you need additional information.

Amanda B. Salas MD.

Amanda B. Salas, MD
Consulting Forensic Psychiatrist
Board Certified in Adult, Child and Adolescent, and Forensic Psychiatry

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Post Office Box 12089
COLUMBIA, SOUTH CAROLINA 29211

October 20, 2016

Amanda B. Salas, M.D.
26 Hayek Street
Beaufort, South Carolina 29907

RE: Vickie Rummage

Dear Dr. Salas:

Thank you for your October 18, 2016 updated report relative to Mrs. Vickie Rummage. Based upon my review of this report, it is my understanding you believe: (a) "she continues to meet diagnostic criteria for Major Depressive Disorder, current episode severe; (b) "Mrs. Rummage continues to present in a credible fashion and does not appear to be magnifying or feigning her reported symptoms"; (c) she "is not at maximum medical improvement in regards to her mood symptoms and memory impairments; (d) "she has not had adequate treatment for her depression . . . [and] would benefit from evaluation and treatment with a board-certified psychiatrist and a licensed therapist with experience in mood problems subsequent to head trauma"; and (e) Mrs. Rummage's "severe symptoms of a major mood disturbance . . . [and] cognitive deficits and problems with her memory that are likely a result of severe head trauma"

In this regard, you have reviewed various reports and questionnaire responses of Dr. Daniel L. Collins, M.D., Mrs. Rummage's previous treating psychiatrist, as well as reports generated by Drs. Thomas Gualtieri, Donna Schwartz Watts (Maddox) and Tora L. Brawley. I also understand you have considered Dr. Brawley's deposition testimony.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mrs. Rummage's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that Mrs. Rummage has exhibited any evidence of malingering, symptom magnification or secondary gain during your evaluations?

Yes _____ No ☒



Amanda B. Salas, M.D.

October 20, 2016

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2) Do you believe, to a reasonable degree of medical certainty, that Mrs. Rummage continues to exhibit symptoms reflective of Major Depression and cognitive impairment?

Yes ☒ No ☐

3) Do you believe, to a reasonable degree of medical certainty, that Mrs. Rummage's current Major Depression and cognitive impairment most probably result from the consequences (direct cause and/or aggravation) of her May 18, 2012 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Mrs. Rummage requires treatment of the nature identified in your respective reports?

Yes ☒ No ☐

5) Do you believe, to a reasonable degree of medical certainty, that Mrs. Rummage's receipt of the psychological/psychiatric treatment modalities you have identified/recommended is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by the consequences of her May 18, 2012 compensable accident?

Yes ☒ No ☐

6) Do you believe, to a reasonable degree of medical certainty, that Drs. Watts' (Maddox's) and Brawley's observations/opinions/conclusions as to the legitimacy of Mrs. Rummage's presentation, the source of her psychological/psychiatric symptoms and cognitive impairments, as well as her current treatment needs, are consistent with your own?

Yes ☒ No ☐

7) Do you believe, to a reasonable degree of medical certainty, that the nature/degree of Mrs. Rummage's casually related Major Depression and cognitive impairment most probably prohibits from currently engaging in/sustaining any forms of work activities?

Yes ☒ No ☐

AS

Amanda B. Salas, M.D.

October 20, 2016

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I, Amanda B. Salas, M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.

Amanda B. Salas, M.D.

Amanda B. Salas, M.D.

10/21/16.

Date

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,

Andrew N. Safran

Andrew N. Safran

ANS/as

TORA L. BRAWLEY, PH.D.
CLINICAL PSYCHOLOGY — NEUROPSYCHOLOGY
803-361-1659 803-497-3526 (FAX)

NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Vickie Rummage
Date of Birth: [REDACTED] 1959
Referral Source: Andrew Safran, JD
Date of Evaluation: 05/15/2014

Per the request of Mr. Andrew Safran, a clinical interview and neuropsychological evaluation were attempted with Vickie Rummage on May 15, 2014. Mrs. Rummage was involved in an accident at work on May 18, 2012 where she fell and struck her head. She received a laceration to the right occipital region, as well as an abrasion on the left side of her neck.

Upon clinical interview, Mrs. Rummage reports that following the accident she was nauseous, and by the time she reached home, had developed a headache. Her symptoms persisted for several days so she went to the plant manager and asked to be evaluated. She was reportedly sent to a physician who diagnosed her with whiplash and a concussion.

Currently, Mrs. Rummage reports continued problems with headaches for which she is being treated with Botox. She states that the Botox does help but that it wears off before it is time for the next injection.

Mrs. Rummage is also reporting cognitive problems which she first noticed approximately one week after the accident. She states "routine things are a struggle." She reveals that she will forget to turn off the oven, loses track of what she is watching on TV, gets lost while driving (so she has stopped driving), has word finding problems, loses track of what she is doing mid-task and will repeat the same question several times. Upon direct questioning she endorses decreased concentration, inability to multi-task and losing track of what she is saying midsentence.

Additional current difficulties include problems sleeping, not feeling rested in the morning, low energy level, loss of interest in "everything", daily feelings of depression, suicidal thoughts, crying spells, increased anxiety, increased irritability and decreased frustration tolerance. She went on to say "I never feel excited about anything anymore, I don't have a life."

In addition to the headaches, current physical symptoms include ringing in the ears, dizziness, decreased balance, blurred and double vision. She states that she has had several falls.

Current psychosocial stressors include being terminated from her job, feeling like she is unable to do any of her previous activities and her son attempting suicide this past November. She states that her son is 27 years old and lives with her and her husband. She states that he attempted to overdose on medications. She tearfully reported that she believed this was her fault because "his mom is different now."

Mrs. Rummage states that she does have a prior history of depression but that she felt she had it under good control until the accident. She states, "I was always everybody's caretaker."

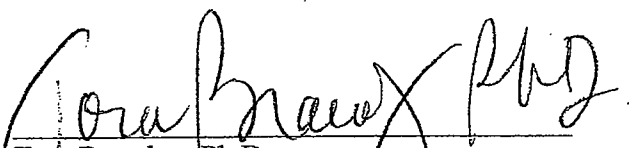
Behavioral observations revealed Mrs. Rummage to have a flat affect and multiple crying spells during the interview. She was fully cooperative and answered all questions, but exhibited slowed response time. An initial screen of attention and concentration revealed severely impaired speed and accuracy. Forced choice testing (TOMM) was then administered and Mrs. Rummage's scores did not indicate malingering of cognitive symptoms.

It was believed however, that her psychiatric symptoms were significantly interfering with cognition and therefore invalidating the test results. Neuropsychological testing was discontinued at that time. It is recommended that the tests be re-attempted when Mrs. Rummage's psychiatric symptoms have been more effectively managed. She should be evaluated by a psychiatrist to assess the efficacy of her antidepressant and anti-anxiety medications. It is also recommended that she receive counseling to help her cope more effectively with her current symptoms.

While Mrs. Rummage does have a previous history of depression, it is clear that her symptoms worsened significantly following the accident and should be aggressively treated at this time. Formal assessment of effort did not reveal attempts to malingering.

I would be happy to re-attempt a cognitive assessment once she has been more effectively treated for her depression and anxiety.

Thank you for asking me to participate in the evaluation of this patient. Please do not hesitate to contact me should you have further questions.


Tora Brawley, Ph.D.
Clinical Psychology-Neuropsychology

TORA L. BRAWLEY, PH.D.
CLINICAL PSYCHOLOGY — NEUROPSYCHOLOGY
803-361-1659 803-497-3526 (FAX)

September 16, 2015

Andrew Safran, LLC
Attorney at Law
Post Office Box 12089
Columbia, SC 29211

RE: Vickie Rummage

Dear Mr. Safran,

As you are aware, I attempted a clinical interview and neuropsychological evaluation with Vickie Rummage on May 15, 2014. Mrs. Rummage was involved in an accident at work on May 18, 2012 where she fell and struck her head. She received a laceration to the right occipital region, as well as an abrasion on the left side of her neck.

At the time of the attempted evaluation, behavioral observations revealed Mrs. Rummage to have a flat affect and multiple crying spells during the interview. She was fully cooperative and answered all questions, but exhibited slowed response time. During the clinical interview she reported significant cognitive difficulties as well as problems sleeping, not feeling rested in the morning, low energy level, loss of interest in "everything", daily feelings of depression, suicidal thoughts, crying spells, increased anxiety, increased irritability and decreased frustration tolerance.

It was my opinion at that time that her psychiatric symptoms were significantly interfering with cognition and would therefore invalidate any test results. Neuropsychological testing was discontinued at that time. I recommended that the tests be re-attempted when Mrs. Rummage's psychiatric symptoms had been more effectively managed, and that she should be evaluated by a psychiatrist to assess the efficacy of her antidepressant and anti-anxiety medications. I also recommended that she receive counseling to help her cope more effectively with her current symptoms.

While Mrs. Rummage does have a previous history of depression, it was clear that her symptoms worsened significantly following the accident and needed to be aggressively treated. Formal assessment of effort did not reveal attempts to malingering.

At this time, I have been asked to review an Independent Medical Evaluation by C. Thomas Gualtieri, MD that includes some neuropsychological testing. I asked to also be provided with

the raw data from any testing conducted. It is standard procedure for raw data to be provided directly to other psychologists qualified to interpret them, and who are mandated to maintain test security. In an email from your office dated May 7, 2015, I was informed that Dr. Gualtieri's office sent the raw data directly to your law office. This is a concerning breach of test security. In a position paper from the National Academy of Neuropsychology regarding test security, they state, "Copying test protocols, video and/or audio taping a psychological or neuropsychological evaluation for release to a non-psychologist potentially violates the Ethical Principles of Psychologists and Code of Conduct (APA, 1992; APA, 2002), by placing confidential test procedures in the public domain 2.10), and by making tests available to persons unqualified to interpret them (APA, 1992; Codes 2.02, 2.06 and 2.10; APA, 2002; Codes 9.04 and 9.11)".

The report of the IME lists the date of service as 12/11/14, yet when reviewing the raw data it was noted that the testing was conducted almost 4 months later on 4/9/15. It is unclear who administered and interpreted these tests as this should be done only by a qualified psychologist, or by a trained psychometrician under the supervision of a qualified psychologist. This is also stated in the APA Ethical Principles of Psychologists and Code of Conduct (APA, 1992; Code 2.1, and APA, 2002; Code 9.11, Maintaining Test Security), which specify that these procedures are to be used only by psychologists trained in the use and interpretation of test instruments (APA, 1992; Codes 2.01, 2.06; Unqualified Persons; and APA, 2002; Code 9.04; Release of Test Data).

Only Dr. Gualtieri's signature was on the report and it was noted that he was assisted by a physician's assistant. Upon review of the raw data there are concerns about the accuracy of scoring and interpretation. For example, the scoring and interpretation of the copy of a complex figure were both incorrect. Additionally, simply because someone cannot recall any details on a delayed recall does not render the test "invalid". It is also curious why Mrs. Rummage was administered the Pediatric Neurocognitive Test at the age of 55 years.

In his report, Dr. Gualtieri states that Mrs. Rummage was "intermittently tearful". He also notes that she reported "headaches, unpleasant thoughts, lack of appetite, crying easily, trembling, difficulty falling asleep, feeling a lack of interest in things, worrying that something is wrong with her mind, feeling self-conscious". Additionally, he reports motor slowing and slowed response times. On the Personality Assessment Inventory administered by his office, the number one diagnostic consideration listed in the interpretive report is Major Depressive Disorder. It is clear, based on his report, that Mrs. Rummage was experiencing significant psychiatric symptoms at the time of his evaluation. These symptoms can certainly affect test results, as well as energy and motivational levels.

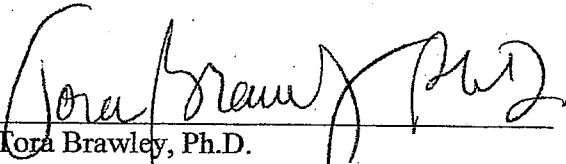
Additionally, it is Dr. Gualtieri's opinion that Mrs. Rummage "would be more appropriately treated with medications that are less sedating and less addictive". Given this, medication effects should also be taken into account when interpreting her clinical presentation.

I respectfully disagree with Dr. Gualtieri's opinion that Mrs. Rummage is at maximal medical improvement. She needs to be treated immediately and aggressively for her psychiatric symptoms. The presence and extent of any residual cognitive deficits related to the accident cannot be definitely determined until this has been accomplished. I also disagree with his

statement, "There was clear evidence of symptom exaggeration." Given Mrs. Rummage's psychiatric symptoms, sedating medication and other factors, to make this definitive of a statement is misleading at best.

It continues to be my opinion that her psychiatric symptoms were significantly interfering with cognition and therefore interfering with test results. I recommended that the tests be re-attempted when Mrs. Rummage's psychiatric symptoms have been more effectively managed. As stated in my prior report, she should be evaluated by a psychiatrist to assess the efficacy of her antidepressant and anti-anxiety medications. It is also recommended that she receive counseling to help her cope more effectively with her current symptoms.

Thank you for asking me to participate in the evaluation of this patient. Please do not hesitate to contact me should you have further questions.


Tora Brawley, Ph.D.
Clinical Psychology-Neuropsychology

Psychiatric Evaluation
Vickie Webb Rummage
Date of Birth: [REDACTED] 59
Date of Injury: 5/18/12
Date of Interview: 6/10/14
Date of Report: 4/10/16

Identifying Information: Vickie Rummage is a 56-year-old married female evaluated pursuant to a request by her attorney, Andrew Safran.

Statement of Nonconfidentiality: Ms. Rummage understood a written report of this evaluation would be sent to her attorney and possibly used in her Worker's Compensation case.

Qualifications of Examiner: Donna Schwartz-Watts, MD is a Board Certified Psychiatrist with Added Qualifications in Forensic Psychiatry.

Sources of Information:

1. Florence Rehabilitation Medicine Evaluation 12/17/12, 1/11/13, 2/11/13, 3/11/13, 4/10/13, 5/13/13, 6/18/13, 8/19/13, 9/20/13, 10/17/13, 11/14/13, 1/17/14, 2/19/14, 3/13/14, 4/11/14, 5/8/14, 6/17/14, 7/17/14, 8/15/14, 9/24/14, 9/26/14, 10/24/14, 11/24/14, 12/23/14, 12/30/14, 1/20/15, 2/20/15, Daniel Collins, M.D.
2. Neuropsychological Testing Tora Brawley, Ph.D. 5/15/14
3. McQueen Medical Center records 6/1/12, 7/19/12, 8/23/12, 9/18/12, 10/22/12, Fred McQueen, M.D.,
4. Letter to Dr. McQueen from Andrew Safran 1/13/14
5. Grand Strand Specialty Associates Records 9/5/12, 10/10/12, 10/12/12, 11/14/12, Jeff Benjamin, D.O.
6. Records John McLeod, III, 5/30/12, 6/6/12
7. Chesterfield General Hospital Imaging Report 6/6/12
8. InMed MRI report 9/17/12
9. Sandhills Regional Medical Center Rehab Services, Speech Therapy (cognitive linguistic treatment from 1/13-10/13
10. Carolinas Center for Advanced management of pain records 9/8/13, Kevin Hutcheson, MD
11. Palmetto Pain Management 9/13/13 Ezra Riber, M.D.
12. McQueen records 3/7/91, 3/18/91, 2/11/92, 5/12/92, 12/28/92, 1/11/93, 3/4/94, 3/21/95, 6/1/95, 5/7/96, 5/23/97, 2/23/98, 5/12/98, 7/27/98, 7/12/99, 8/3/00, 7/5/02, 12/3/02, 7/28/03, 5/7/04, 5/10/05, 9/12/05, 1/10/06, 4/10/06, 7/10/06, 9/11/06, 12/8/06, 2/16/07, 5/11/07, 8/9/07, 11/26/07, 11/27/07, 4/21/08, 7/22/08, 10/21/08, 1/21/09, 5/15/09, 8/17/09, 11/17/09, 2/12/10, 5/13/10, 8/24/10, 11/22/10, 1/25/11, 3/25/11, 5/9/11, 6/30/11, 9/30/11, 10/13/11, 12/13/11, 1/13/12, 2/13/12, 3/13/12, 5/14/12,
13. NC Neuropsychiatry 12/11/14, C. Thomas Gualtieri, M.D.
14. Report Tora Brawley, Ph.D. 5/5/14, 9/16/15

15. Report of Amanda Salas, M.D. 9/1/15
16. Letter/Questionnaire of Daniel Collins, M.D. 1/22/16
17. Deposition Tora Brawley, Ph.D. 11/20/15

Pertinent Statements:

Ms. Rummage was injured while working on 5/18/12. She sustained a laceration to her head. She was diagnosed with a probable concussion and continues to complain of headaches and pain. She had a pre-existing history of migraine headaches, cervical and lumbar pain. She had extensive treatment with Dr. Collins post-injury.

She had extensive treatment with Dr. McQueen pre-injury. Dr. Tora Brawley previously attempted to assess her cognitive deficits on 5/5/14 but noted her psychiatric symptoms were preventing her from giving maximum effort. She did not malingering memory deficits during that assessment. Dr. Brawley requested a forensic psychiatric evaluation,

Initial record review included numerous records from treatment by Dr. McQueen and reports from treatment following her accident. She underwent an evaluation in April, 2015 by Dr. Gualtieri who opined she was faking cognitive deficits. She also underwent a forensic psychiatric evaluation by Dr. Salas in April, 2015. She concluded Ms. Rummage was exhibiting Major Depression that was the result of her work related injury. She did not believe Ms. Rummage was malingering and questioned Dr. Gualtieri's test results and conclusion. Dr. Brawley also reviewed Dr. Gualtieri's report and also disagreed with several aspects of his testing and his conclusion that Ms. Rummage was malingering. She also felt Ms. Rummage needed treatment for her psychiatric symptoms before completing neuropsychological testing

At the time I examined her, she was residing near Cheraw, South Carolina with her husband and 27-year-old son. She reported her husband is disabled due to "Iraq." She noted he was a truck driver and has heart problems and "nerves." She noted her 27-year-old is "mentally retarded." Her oldest son worked for the Highway Patrol. She notes that he was injured on the job. She states he was tased.

She reported that her medications were: Cymbalta®, Lyrica®, Percocet®, Xanax®, Antivert®, Imitrex®, Flexeril® and Botox® injections. She reported she is allergic to penicillin. She reported prior inpatient hospitalization with childbirth and her partial hysterectomy. She denied a history of prior head injury. She reported she had surgery on her shoulder. She reported she has hypertension and takes Lisinopril®. She also reported she is treated for hypothyroidism with Synthroid®. She reported she is post menopausal. "I had it early."

Psychiatrically, she denied that she has been treated by a psychiatrist. She noted receiving psychotropic medication from Dr. McQueen before her head injury.

She reported she was born in Raleigh, NC. She noted her mother had COPD (chronic obstructive pulmonary disease) and her father had a CVA (cerebrovascular accident). She reported her son has Bipolar Disorder. She denied a family history of psychiatric disorder.

Her chief complaint remains memory impairment. She reports she "takes things one week at a time." She states her memory has gotten worse since her accident. She stated that WCC "stopped me from seeing my doctor in Cheraw and makes me drive to Myrtle Beach." She also complained of trouble sleeping. She reported she has difficulty talking with people and often asks for things to be repeated twice. She also reported she is unable to maintain daily functioning. She stated she "cannot keep the house up." She reported she loses track of tasks while performing them. She also reported frequent crying "when I can't do something." She stated she "laughs" when she is supposed to cry. She reported suicidal ideation at times. "I get so far down. I can't do the things I used to do. I thought about shooting myself." She reported she stopped going to church. She also reported financial difficulties. "My son stays with me to help me out." She reported a prior history of depression when her parents died. She reported her depressed mood lasted six months and she did not develop suicidal ideation. She reported her husband is not well. "He is very dependent on me. Now, I am dependent on him. I feel guilty because I can't protect him." She also reported her son is sick with kidney problems and Bipolar Disorder. She reported she has been engaging in various strategies to assist her in cognitive function. She stated she was using *Luminous*, crosswords and plays *Candy Crush*.

She denies any drug or alcohol use. She reports prior legal involvement. "I can't remember. My rotator cuff. My husband's insurance. I had a fracture in my left leg."

On mental status examination, she was tearful. She had a depressed mood and constricted affect. She did exhibit pseudobulbar affect during the examination. When asked for three wishes she replied: "to be the same person I was before the accident. That's all." She was alert and oriented times four. She was concrete when abstracting similarities between objects. She was able to register three items. She recalled two correctly after five minutes. She failed prompting and forced choice testing when attempting to recall the third item. She recalled all three after ten minutes but required prompting to recall the second object.

I found no evidence that Mrs. Rummage was exaggerating or feigning symptoms. She gave a good effort on the cognitive portion of her mental status examination and did not over endorse symptoms. Her pseudobulbar affect is difficult to feign.

Diagnoses:

Major Depression, recurrent
Cognitive Disorder, Not Otherwise Specified
Hypothyroidism
Hypertension
Headaches by history

Back and neck pain by History

Conclusions and Recommendations:

1. Ms. Rummage had a pre-existing history of depression which was worsened by her work related injury.
2. Her cognitive impairment is worsened by her untreated depression.
3. It is my opinion that her depression is related to her work related injury. It is also my opinion that she is not exhibiting any evidence of malingering.
4. She needs to be treated by a psychiatrist as she requires medication for her depression. She also needs psychotherapy. She has not reached maximum medical improvement for the worsened depression caused by her work related injury.
5. She needs laboratory tests including a thiamine level, folate and B12 level. She also needs an RPR and recent TSH level.
6. I agree with Dr. Brawley that any neuropsychological testing should be deferred until after Ms. Rummage's depression have been treated and reached a stable level.
7. Ms. Rummage's Major Depression and cognitive impairment prevent her from working.
8. All opinions are given to a reasonable degree of medical certainty.

John A. Nicks, MD

4/11/18

Psychiatric Evaluation
Vickie Webb Rummage
Date of Birth: [REDACTED] 59
Date of Injury: 5/18/12
Date of Evaluation: 6/10/14, 9/16/16
Date of Report: 4/10/16
Date of Addendum: 10/14/16

Identifying Information: Vickie Rummage is a 56-year-old married female evaluated pursuant to a request by her attorney, Andrew Safran.

Statement of Nonconfidentiality: Ms. Rummage understood a written report of this evaluation would be sent to her attorney and possibly used in her Worker's Compensation case.

Qualifications of Examiner: Donna Schwartz Maddox, MD is a General and Forensic Psychiatrist.

Sources of Information:

1. Florence Rehabilitation Medicine Evaluation 12/17/12, 1/11/13, 2/11/13, 3/11/13, 4/10/13, 5/13/13, 6/18/13, 8/19/13, 9/20/13, 10/17/13, 11/14/13, 1/17/14, 2/19/14, 3/13/14, 4/11/14, 5/8/14, 6/17/14, 7/17/14, 8/15/14, 9/24/14, 9/26/14, 10/24/14, 11/24/14, 12/23/14, 12/30/14, 1/20/15, 2/20/15, Daniel Collins, M.D.
2. Neuropsychological Testing Tora Brawley, Ph.D. 5/15/14
3. McQueen Medical Center records 6/1/12, 7/19/12, 8/23/12, 9/18/12, 10/22/12, Fred McQueen, M.D.,
4. Letter to Dr. McQueen from Andrew Safran 1/13/14
5. Grand Strand Specialty Associates Records 9/5/12, 10/10/12, 10/12/12, 11/14/12, Jeff Benjamin, D.O.
6. Records John McLeod, III, 5/30/12, 6/6/12
7. Chesterfield General Hospital Imaging Report 6/6/12
8. InMed MRI report 9/17/12
9. Sandhills Regional Medical Center Rehab Services, Speech Therapy (cognitive linguistic treatment from 1/13-10/13
10. Carolinas Center for Advanced management of pain records 9/8/13, Kevin Hutcheson, MD
11. Palmetto Pain Management 9/13/13 Ezra Riber, M.D.
12. McQueen records 3/7/91, 3/18/91, 2/11/92, 5/12/92, 12/28/92, 1/11/93, 3/4/94, 3/21/95, 6/1/95, 5/7/96, 5/23/97, 2/23/98, 5/12/98, 7/27/98, 7/12/99, 8/3/00, 7/5/02, 12/3/02, 7/28/03, 5/7/04, 5/10/05, 9/12/05, 1/10/06, 4/10/06, 7/10/06, 9/11/06, 12/8/06, 2/16/07, 5/11/07, 8/9/07, 11/26/07, 11/27/07, 4/21/08, 7/22/08, 10/21/08, 1/21/09, 5/15/09, 8/17/09, 11/17/09, 2/12/10, 5/13/10, 8/24/10, 11/22/10, 1/25/11, 3/25/11, 5/9/11, 6/30/11, 9/30/11, 10/13/11, 12/13/11, 1/13/12, 2/13/12, 3/13/12, 5/14/12
13. NC Neuropsychiatry 12/11/14, C. Thomas Gaultieri, M.D.

14. Report Tora Brawley, Ph.D., 9/16/15
15. Report of Amanda Salas, M.D., 9/1/15
16. Letter/questionnaire of Daniel Collins, M.D., 1/22/16
17. Deposition Tora Brawley, Ph.D. 11/20/15
18. Update Florence Rehabilitation Records 4/25/15, 5/26/15, 6/18/15, 7/30/15, 8/27/15, 9/25/15, 11/17/15, 12/2/15, 1/4/16
19. Carolina Spine Records 5/17/16, 6/14/16, 7/12/16, 8/19/16, 10/13/16

Pertinent Statements:

Ms. Rummage was injured while working on 5/18/12. She sustained a laceration to her head. She was diagnosed with a probable concussion and continues to complain of headaches and pain. She had a pre-existing history of migraine headaches, cervical and lumbar pain. She had extensive treatment with Dr. Collins post-injury. Unfortunately, he has left the practice.

Review of her recent updated records indicate her headaches were improved with Botox® injections from Dr. Collins. During her most recent evaluation, she reported she is no longer seeing Dr. Collins and has not received her injections. "Dr. Collins left."

She had extensive treatment with Dr. McQueen pre-injury. She underwent an independent evaluation by Dr. Gaultieri on 12/11/14 who opined she was faking cognitive deficits. Dr. Tora Brawley attempted to assess her cognitive deficits on 5/5/14 but noted her psychiatric symptoms were preventing her from giving maximum effort. She did not malingering memory deficits during that assessment.

At the time I examined her in 2014, she was residing near Cheraw, South Carolina with her husband and 27-year-old son. She reports her husband is disabled due to "Iraq." She noted he was a truck driver and has heart problems and "nerves." She notes her 27-year-old is mentally retarded. Her oldest son worked for the Highway Patrol. She notes that he was injured on the job. She states he was tased.

She reported that her medications while treating with Dr. Collins were Cymbalta®, Lyrica®, Percocet®, Xanax®, Antivert®, Imitrex®, Flexeril® and Botox® injections. She reports she is allergic to penicillin. She reports prior inpatient hospitalization with childbirth and her partial hysterectomy. She denies a history of prior head injury. She reports she had surgery on her shoulder. She reports she has hypertension and takes Lisinopril®. She also reports she is treated for hypothyroidism with Synthroid®. She reports she is postmenopausal. "I had it early."

Review of her updated records indicate she did not respond to Cymbalta® and remained on Effexor XR® 75mg which is a suboptimal dose for her and her level of depression. In her most recent evaluation, she reported her dosage has been increased to 150mg. The maximum dosage is 300mg. Dosages over 150mg can elevate blood pressure. She has also been prescribed Vitamin D.

Psychiatrically, she denied that she has been treated. She noted that after Dr. Collins left the practice she didn't receive the same medications. She states it took several months for her to be sent to Dr. Singh for treatment. He has performed epidural injections and has not repeated the Botox injections that found more helpful for her headaches. He has not prescribed many of the medications she previously received from Dr. Collins. Review of updated notes from Dr. Singh indicates her depression is still present and has not been treated. He also noted her usage of pain medications was 240 Percocet® per month, and he was not comfortable with the dosage. She did report he prescribed Fioricet®, which does help her headaches. She reported she had been prescribed Topiramate in the past, which worsened her depression.

During her second evaluation, she reported her mood remained "down and out." She reported her sleep remained poor. When I lay down at night, I have ringing in my ears...I dread the nights and I dread the days." She reported that she has mood swings. She now reports that she becomes irritable with her husband and worries he will leave her. Her husband was interviewed briefly and remains supportive.

Her chief complaint in 2014 was memory impairment. She reports she "takes things one week at a time." She states her memory has gotten worse since her accident. She states that WCC "stopped me from seeing my doctor in Cheraw and made me drive to Myrtle Beach." She also complains of trouble sleeping. She reports she has difficulty talking with people and often asks for things to be repeated twice. She also reports she is unable to maintain daily functioning. She states she "cannot keep the house up." She reports she loses track of tasks while performing them. She also reports frequent crying, "when I can't do something." She states she "laughs" when she is supposed to cry. She reports suicidal ideation at times. "I get so far down. I can't do the things I used to do. I thought about shooting myself." She reports she stopped going to church. She also reports financial difficulties. "My son stays with me to help me out." She reports a prior history of depression when her parents died but did not develop suicidal ideation. She reports her husband is not well. "He was very dependent on me. Now, I am dependent on him. I feel guilty because I can't protect him." She also reports her son is sick with kidney problems and Bipolar Disorder. She reports she has been engaging in various strategies to assist her in cognitive function. She states she uses *Luminous*, crosswords and plays *Candy Crush*.

On mental status examination in 2014, she was tearful. She had a depressed mood and constricted affect. She did not exhibit pseudobulbar affect during the examination. When asked for three wishes she replied: "to be the same person I was before the accident. That's all." She was alert and oriented times four. She was concrete when abstracting similarities between objects. She was able to register three items. She recalled two correctly after five minutes. She failed prompting and forced choice testing when attempting to recall the third item. She recalled all three after ten minutes but required prompting to recall the second object.

During her most recent evaluation, she remains depressed with a flat and tearful affect.

Diagnoses:

Major Depression, recurrent, moderate

Neurocognitive Impairment secondary to multiple etiologies (partially treated depression, chronic pain; closed head injury)

Hypothyroidism

Hypertension

Headaches by history

Back and neck pain by History

Recommendations:

1. Mrs. Rummage had a pre-existing history of depression, which was worsened by her work related injury. Her depression contributes to her cognitive impairment which also likely results from her chronic pain and closed head injury. She appears to have some mild paranoia, which was not previously present and would benefit from a low dosage of antipsychotic medication. Her presentation remains consistent with the updated records and she does not exhibit any evidence of malingering.
2. She has obtained partial treatment of her depression through medication that was previously prescribed by Dr. Collins and now her primary care provider but still needs to be treated by a psychiatrist. She also needs psychotherapy, which has never been obtained. The laboratory tests are also necessary. Once her depression has been treated and stabilized, she can pursue neuropsychological testing.
3. Mrs. Rummage has not reached maximum medical impairment for the worsened depression caused by her work related injury. Her Major Depression and cognitive impairment also continue to prevent her from working.
4. All opinions are given to a reasonable degree of medical certainty.



Donna Schwartz Maddox M.D.
Consulting Forensic Psychiatrist

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COLUMBIA, SOUTH CAROLINA 29211

October 18, 2016

Donna Schwartz Maddox, M.D.
115 Carter Woods Drive
Anderson, South Carolina 29621

RE: Vicki Webb Rummage

Dear Dr. Maddox:

Thank you for your October 14, 2016 Addendum report relative to Ms. Vickie Webb Rummage. Based upon my review of this report, it is my understanding you continue to believe: (a) Ms. Rummage's psychological/psychiatric symptoms result from the aggravation of preexisting depression by the consequences of her May 18, 2012 compensable accident; (b) she requires treatment for these causally related psychological/psychiatric symptoms; (c) her persistent cognitive impairment likely results, to some extent, from her May 18, 2012 closed head injury; (d) further delineation of her cognitive impairments should be pursued through neuropsychological testing following treatment and stabilization of her causally related psychological/psychiatric symptoms; and (e) Ms. Rummage remains incapable of resuming work activities in view of the nature/degree of her causally related psychological/psychiatric injury component.

In this regard, you have reviewed various reports and questionnaire responses of Dr. Daniel L. Collins, M.D., Ms. Rummage's treating psychiatrist for three (3) years, as well as reports generated by Drs. Thomas Gualtieri, Amanda B. Salas and Tora L. Brawley. I also understand you have considered Dr. Brawley's deposition testimony.

At this time, I would greatly appreciate your answering the following questions so that the parties to Ms. Rummage's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage has exhibited any evidence of malingering, symptom magnification or secondary gain during your evaluations?

Yes _____ No ☒

Donna Schwartz Maddox, M.D.

October 19, 2016

Page 2

2) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage continues to exhibit symptoms reflective of Major Depression and cognitive impairment?

Yes ☒ No ☐

3) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage's current Major Depression and cognitive impairment most probably result from the consequences (direct cause and/or aggravation) of her May 18, 2012 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage requires treatment of the nature identified in your respective reports?

Yes ☒ No ☐

5) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage's receipt of the psychological/psychiatric treatment modalities you have identified/recommended is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by the consequences of her May 18, 2012 compensable accident?

Yes ☒ No ☐

6) Do you believe, to a reasonable degree of medical certainty, that Drs. Salas' and Brawley's observations/opinions/conclusions as to the legitimacy of Ms. Rummage's presentation, the source of her psychological/psychiatric symptoms and current treatment needs are consistent with your own?

Yes ☒ No ☐

I, Donna Schwartz Maddox, M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.


Donna Schwartz Maddox, M.D.

10/19/16
Date

SANDHILLS REGIONAL MEDICAL CENTER REHAB SERVICES

Mild Cognitive deficit Therapy Addendum

331.83

☒ Evaluation ☐ Progress Report ☐ Discharge

☐ Occupational ☐ Physical ☒ Speech

Patient: Rummage, Vickie MR# _____ DOB: [REDACTED]/59

Mrs. Vickie Rummage was referred for cognitive assessment and treatment as a result of a CHI on 5/18/12 in which she fell lacerating her Right Occipital area of the brain. She stated that "I'm not myself and cannot do things I used to do." She has gotten lost several times in familiar areas which increase her anxiety and frustration. Her goal is to return to work as a weaver and resume her responsibilities as an EMT. She described her job which requires sequencing multiple tasks and lifting at least fifty lbs. Currently, she is restricted from lifting anything greater than 5 lbs. Her medications are listed in Dr. Collins report. Patient reported usual pain level at a 5-6 and sometimes a 10. This documented pain is an important aspect of decreased attention and memory because of the constant need to guard and protect self from activities/positions that increase pain. Other symptoms included blurred vision, headaches, decreased balance, tinnitus, and preoccupation with the inability to complete simple ADL's.

Subtests of the CLQT, Cookie theft picture, trials utilizing memory strategies and patient education were used during the assessment. The visual subtests were omitted as a result of decreased vision. Auditory comprehension and recall of short paragraph was 61%, Delayed recall < 50% without cue, Naming 10/10 without delay (c/o word finding deficits), Clock Drawing 100% (numbers slanted to left), Generative Naming /Word fluency reduced 15/60sec.(difficulty with flexible thinking), and Personal information 100%. Phone numbers could not be recalled immediately; only prefix. Auditory rehearsal improved her ability to repeat the number and dial the phone in 3 trials. Visual recall of numbers was successful in 3 trials. Her awareness of time was reduced as indicated by her estimation of the evaluation. She reported .5 hr. vs. 1.25 hrs. which was indicative of a decreased temporal relationship for task completion. She has been avoiding reading because of her blurred vision. She confirmed decreased visual perception when reaching for an object and dizziness from stooping or sitting to upright position. A composite score could not be determined due to omission of the visual subtests. Based on her personal account of deficits and the above subtests she has mild impairment of attention, memory, executive function, and visuospatial skills (Cookie theft written description). These deficits would interfere with her ability to process,



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SPEECH THERAPY

RUMMAGE, VICKIE
Acct#3012904 MR#0000098479 0000 OP
COLLINS, DANIE
Adm:01/02/2013 DOB:12/09/1959 053 F
SANDHILLS REGIONAL MED CENTER
[REDACTED]

SANDHILLS REGIONAL MEDICAL CENTER REHAB SERVICES
Therapy Addendum

☒ Evaluation ☐ Progress Report ☐ Discharge
☐ Occupational ☐ Physical ☒ Speech

Patient: Rummage, Vickie MR# _____ DOB: 1/2/59

retain, recall and utilize the information for executive function. Fatigue and or preoccupation would increase deficits to a moderate level. Examples of tasks requiring various levels of attention and memory were given for patient's understanding. Blurred vision has persisted for 7 months. A Neuro-Optomologist evaluation may be needed to maximize her visual processing and facilitate increased functional abilities.

Cognitive-linguistic treatment was recommended for 2 x week x 8 weeks. Certification is from 1/2/13- 2/22/13. Prognosis for stated goals is good.

STG: 1. Maintain visual/auditory attention necessary to complete various timed tasks without cuing; 80% of attempts. 2. Utilize memory strategies (auditory/visual) for recall of 4-7# sequences, related/unrelated items, facts, directives, picture detail and other tasks requiring attention and memory for immediate and delayed recall. 3. Recall of treatment tasks after 10, 15, 20, and 30 minute increments up to 45 min. again using strategies as needed; 80% of attempts. 4. Demonstrate doing +2 tasks simultaneously i. e., talking on the phone while taking a message and various other tasks in a timely, functional manner. 5. Demonstrate solutions to moderately complex problems in a timely manner; 80% of attempts. 6. Initiate higher cognitive thinking for planning, scheduling and executing tasks.

LTC: Demonstrate ability to manage ADL/IADL tasks safely, timely and independently.

Martha Williams
Therapist Name (typed or printed)

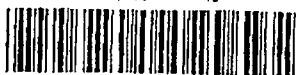
Martha Williams cc/1/13
Therapist Signature

1/2/13
Date
1/7/13

DANIEL L. COLLINS
Physician Name (typed or printed)

Physician Sig RUMMAGE, VICKIE

Acct# _____ 0000- RP
COLLINS, DANIE
Adm:01/02/2013 DOB: _____ 1959 053 F
SANDHILLS REGIONAL MED CENTER



8752250



Therapy Addendum

RUMMAGE, VICKIE

Acc# [REDACTED] 0000- RP

COLLINS, DANIE

Adm:01/02/2013 DOB: [REDACTED] 1959 053 F

SANDHILLS REGIONAL MED CENTER

[REDACTED]

valuation

☒ Progress Report☐ Discharge☐ Occupational☐ Physical☒ SpeechPatient: Rummage, Vickie MR#DOB: 11/59

Mrs. Rummage has attended 10 total treatments (2 cancellations) with measureable progress within structured treatment. Goals 1-3 are partially met; 4&5 not met. Patient has demonstrated increased ability to recall information (in quiet) up to 40 min. Tasks had to be alternated between visual and auditory every 15 min. as a result of increased blurred vision/fatigue. Her ability to generate simple lists and recall up to 6 related items was 4/4 trials. Matching a set of 16 pictures was 1.38 after 3 trials (app). Recall of phone message containing 3 critical elements, following multi-step directives during card sorting activities, and re-telling short story with and without visual cues were successful. Patient and family consultation was conducted to improve their understanding of CHI symptoms/behaviors and how to respond during those moments. The use of visual imagery during recall of previous events was her primary strategy. It should be noted that these tasks are completed in quiet; no distractions. As a result of her persistent tinnitus, pleasant sounds or instrumental music was recommended to ease the discomfort. A log each day was initiated one week ago for tracking the # of headaches/tinnitus and the technique to manage. The use of pleasant sounds significantly reduced the tinnitus. Patient reported several events of forgetting "what" she was doing, getting lost, and relentless headache and tinnitus which interfered with sleep and appetite. She reported having a "very bad" week starting on the 4th which spiraled down resulting in muscular pain, severe headache, blurred vision, tinnitus, loss of sleep and appetite. She confirmed feeling discouraged and depressed. She was assured that all of these symptoms could be managed. The duration of this situation certainly has reduced her ability to complete her daily tasks/routine. She reported going to get ice for a drink but refilled the tray and put it in the freezer without getting ice. This of course resulted in an emotional meltdown. These persistent symptoms reduce attention/memory for task resulting in increased frustration and discouragement.

Patient has demonstrated significant improvement (50%) in attention and memory during quiet structured treatment. Her recall of specific detail during subjective updates each treatment is inconsistent re: day, time and situation. Hopefully, the log will reduce some of the frustration and show improvement when reviewed in the future. Based on my weekly observation patient appears to be developing depression as a result of the unending situation which has completely changed her life. Her account of her personal life prior to this indicated that she has always been the "ROCK" in her family. She was caregiver for her parents and single parent while her husband was deployed. Recommend treatment to continue per previous goals.

Martha Williams
Therapist Name (typed or printed)

Martha Williams ecc SP
Therapist Signature

2/11/13
Date

Daniel L. Collins
Physician Name (typed or printed)

[Signature]
Physician Signature

2/11/13
Date



8752250

SPEECH THERAPY

RUMMAGE, VICKIE

Acc# [REDACTED] 0000- RP

COLLINS, DANIE

Adm:01/02/2013 DOB: [REDACTED] 1959 053 F

SANDHILLS REGIONAL MED CENTER



SANDHILLS REGIONAL MEDICAL CENTER REHAB SERVICES
Therapy Addendum

☐ Evaluation ☒ Progress Report ☐ Discharge
☐ Occupational ☐ Physical ☒ Speech

Patient: Rummage, Vickie MR# _____ DOB: _____

Mrs. Rummage completed the remaining pre-authorized treatment sessions but goals 4 & 5 were not met. On 3/4/13 we reviewed the outcome of utilizing the learned strategies for managing and improving her ability to initiate and execute daily tasks. As result of reducing some of the medications, increased alertness, response time and recall were noted during this session. We reviewed frequency and severity of tinnitus, headaches, double vision, and loss of concentration for task completion. All of these have improved except for the vision which has not been reevaluated since the fall. She was encouraged to have a vision assessment from an opthamologist who specializes in managing neurologic vision changes. A CHI list of symptoms was provided for patient to give a severity rating which showed reduction in the frequency and severity but of course dependent on the situation. She was assured that these would continue to improve which would increase her cognition and emotional/behavioral control. All of these symptoms continue to interfere in her initiation and execution of IADL's.

Recommend continued treatment for cognitive re-training utilizing various tasks for recall of sequential (3-4) step directive with cuing as needed. Goal is to return demonstrate in quiet and with added sound/visual distractions. She was instructed to continue all of her cooking, cleaning, gardening tasks, in an organized preplanned manner repeatedly for increased success and accuracy. Also, continue with daily log for review and comparison of improvement. Role play was used to reduce "reaction" vs. "response" to unsuccessful /loss of thought during task initiation/execution. This has reduced "destructive self talk" i.e. "I'm no good" "I'm never...." and etc. Prognosis for stated goals and continued recovery is good.

STG: 1. Return demonstration of various sequential tasks in quiet and noise with cuing as needed 80% accuracy 4/5 consecutive sessions. 2. Provide (verbally) how and when strategies are utilized and the outcome of different tasks 5/5 treatment sessions. 3.

Completion of vision exam. LTG: Improve executive function or IADLs. Recommend 12 additional treatment sessions.

Thank you for your support in patient's continued recovery to maximize cognition.

Martha Williams
Therapist Name (typed or printed)



8752250

SPEECH THERAPY

Martha Williams ccc/sdp
Therapist Signature

3/6/13
Date

Physician Signature

RUMMAGE, VICKIE
Acct# _____ 0000 RP
COLLINS, DANIE
Adm: 03/01/2013 DOB: _____ 063 F
SANDHILLS REGIONAL MED CENTER

P359

MRN: 8750000098479 Encounter: 3015746

Page 1 of 1

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SANDHILLS REGIONAL MEDICAL CENTER REHAB SERVICES
Therapy Addendum

☐ Evaluation ☒ Progress Report ☐ Discharge
☐ Occupational ☐ Physical ☒ Speech

Patient: Rummage, Vickie MR# _____ DOB: _____

Mrs. Rummage had 3 treatment sessions as a result of 3 cancellations and clinic closed for Easter 2 days. She has obtained a smart phone which has improved and larger graphics resulting in better visual accuracy. However, her visual deficits continue to be the primary barrier to utilizing schedules, notes and reminders on the phone or 7.0 tablet. When asked to complete a task using a 10.1 tablet, the following were observed: squinting eyes trying to focus with a 14 font double spaced paragraph resulting in blurred vision reducing visual acuity/focus, moving her head left-right and forward-backward from device, repeated efforts to get the correct information relative to the specific search. Bold and/or color contrast improved her ability to focus and track information with reduced squinting/effort. Due to the dependence on written reminders, notes, and understanding visual information, the visual deficit is preventing maximum benefit of the strategy. She commented that while reading, the blurred vision becomes double vision creating headache and tinnitus. Return demonstration x 1 using phone schedule, setting alarm, and entering notes for ADLs was completed in a slow unsure manner requiring supervision-min. assist. The screen was enlarged and brightness increased for better visual accuracy. Noticeable difficulty focusing was observed repeatedly. A vision exam with corrective lenses/intervention would hopefully improve this modality and decrease headaches and other physical symptoms.

The only major event which created a safety issue was placing a plastic bowl in a preheated oven instead of the chicken. A costly oversight of 2 bills was reported because she is responsible for the monthly bills. She stated that she keeps a calendar with the due dates but missed the dates. Her pain and fatigue significantly increased after her FCE which reduced her ADL functional level. (patient report) Significant improvement was observed in patient's detailed recall of events without delay or doubt increasing her communicative effectiveness. Log/journal has shown improvement albeit very slow with inconsistencies. She stated concern about her continued inability to safely and accurately clean/organize her home in a timely manner without pain/fatigue. The major improvement noted during this treatment period was increased short term memory with more accurate and detailed descriptions of events/ situations. Visual deficits are the principal barrier for delayed inaccurate execution of the eye-hand tasks utilizing devices and/or picking up small objects items or choosing the correct make up brush. Recommend vision exam and continued therapy. Thank you for your support in her recovery.

Martha Williams
Therapist Name (typed or printed)

Martha Williams ecc SDP
Therapist Signature

4/9/13
Date

Physician Name (typed or printed)

Physician Signature

Date

Sandhills Regional Medical Center Rehabilitation Services
Speech Pathology

Evaluation

✓ Progress Report

Discharge

Mrs. Rummage attended 8/12 treatment sessions with significant progress in organization and planned tasks reducing her frustration and increasing efficiency. She used a step by step procedure (written reference) with organization of items needed for task completion rather than moving from task to task, i.e. cleaning the house while doing the laundry based on timed tasks. This reference allowed her to continue even after distracted from the task. She was very pleased and encouraged by this strategy. Again, bright paper/background on tablet was used for contrast and increased visual attention. Template envelopes (addressee) were made for bill paying in addition to adding "check bills" to her weekly scheduled tasks. Patient demonstrated increased verbal problem solving (rehearsal) during these cognitive retraining activities. Development of listed items with prices, allowable amount, total \$, written check entered in register was completed 3 times in an efficient accurate manner independently. Patient's confidence increased markedly with these IADL's. However, when questioned about community activities, she indicated that crowds and noise have deterred her from shopping. She sends her son to get groceries and etc. She described an event that was so unpleasant that she withdrew from additional trials. She indicated that she used to enjoy these activities but not now. She was asked to follow a plan to get items on a Wal-Mart list during early morning or evening when it was least busy to practice organized movement through the store obtaining the 10 items on her list. This has not been reported on due to her vision exam 5/10/13. Intermittent headaches, pain, and tinnitus continue but with decreased frequency and severity. Measureable progress continues to be observed with all the cognitive retraining strategies which improved her confidence and efficiency in all household tasks including her bill payments. The use of her tablet or written information for reference was useful and effective in reducing disorganization and frustration. Recommend continued treatment to improve her ability to use strategies as needed for resuming grocery/personal/home item shopping to increase her independence for daily community tasks. Thank you for your support in Mrs. Rummage's BI recovery.

Martha Williams
Therapist Name

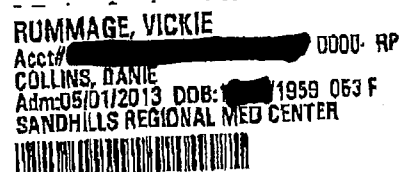
Martha Williams ccc SLP
Signature

5/10/13
Date

Physician Name

Signature

Date



Sandhills Regional Medical Center Rehabilitation Services
Speech Pathology

 Evaluation X Progress Report Discharge

Patient continues to make significant progress (6 treatments) in organization, planning, and problem solving as indicated by her ability in executing several tasks including calling 911 after witnessing a MVA in her rearview mirror involving a family member. Reasoning, insight and problem solving skills were well utilized with a successful outcome. She developed personal short term goals with timelines which primarily focused on regaining her confidence and composure during family gatherings and being more functional in crowds and noise. Cognitive retraining tasks included setting up G-mail, finding and down loading functional apps for IADL's, and utilizing these for improved recall and organization for daily tasks/events. Several trips to Wal- Mart were completed successfully increasing her confidence in shopping as needed without dependence on her son. The barriers interfering with consistency are Headaches, Neck pain, and tinnitus which are triggered by more stressful situations involving emotion (puppy died), noise/crowds and personal stress associated with the recovery process. Pt. called today and stated that "I forgot my appointment....it was the 10th". She was very upset and required assurance that everything would be fine. She was to notify M. Estep her case worker via phone. Pt. had to drive her husband to the VA today so treatment was rescheduled to Wed. 19th.

Currently, IADL's are being managed with strategies/systems for recall, organization, planning and execution of tasks. Household cleaning, cooking, and etc. are being done without major incident. Mrs. Rummage's measureable progress has improved her overall functional abilities and confidence. Recommend treatment to continue for formal re-assessment utilizing the CLQT (cognitive-language quick test) to determine level of recovery. Thank you for your support in her recovery.

Martha Williams
Therapist Name

M. Williams ccc/slp
Signature

4/14/13
Date

Physician Name

Signature

Date



8752250

SPEECH THERAPY

ENCLOSURE (THIS SHOULD BE ATTACHED TO THE REPORT)

RUMMAGE, VICKIE

Acct#

COLLINS, DANIE

Adm: 08/03/2013 DOB: 1959 053 F

SANDHILLS REGIONAL MED CENTER

PHYSICIAN (THIS SHOULD BE ATTACHED TO THE REPORT)

0000- RP

Sandhills Regional Medical Center Rehabilitation Services Speech Pathology

 Evaluation X Progress Report Discharge

Vickie Rummage attended 7/12 treatment sessions due to illness 1 week and 1 additional sick day. The focus of treatment was increasing word fluency using generative naming tasks for abstract and concrete categorical information. She continues to have difficulty transitioning topics/sub-categories as was demonstrated in the generative naming task in the CLQT which was administered on 7/17/13. Results of the assessment showed the following profile: **Attention WNL, Memory Moderate, Executive Functions WNL, Language Mild, Visuospatial skills WNL, Composite Score Mildly Impaired.** As indicated by story retelling task, her immediate and short term memory continue to be impaired without cuing. The generative naming and recall of auditory information is imperative for initiating and maintaining mental search for nouns (content) and working memory is essential for processing new information in daily situations. However, the overall improvement in the other domains since initial evaluation has improved measurably.

Her ability to complete daily tasks in the community i.e., shopping, running errands and etc. is functional but is interrupted by distraction and noise. She still cannot accomplish this task in large crowds and/or loud extraneous noise which is typical for CHI patients. Continued difficulty with communication during family gatherings has been reported frequently. One of her goals is to resume "normal" interaction with family during larger gatherings. Additional goal is to resume employment as possible in the future. Mrs. Rummage is motivated to continue treatment as indicated to achieve the skills needed to meet a job's requirement for multitasking and maintaining focus on needed information to succeed in new employment. She is not capable of resuming former job safely due to the nature of the work. Recommend continued treatment for improved memory and language skills which are needed for acquisition of new information. Goals to include list generation, following multi-step directives presented visual/auditory with 80% accuracy, written correspondence, and recalling moderate complex information verbally/written with 80% accuracy; 12 additional sessions. Thank you for your continued support in Mrs. Rummage's recovery.

Martha Williams
Therapist Name

Martha Williams
Signature

Date 7/17/13
Date

Physician Name

Signature



8752250

SPEECH THERAPY

HUMMAGE, VICKIE

Acct#3021384 MR#0000088479 0000- RP

COLLINS, DANIE

Adm:07/12/2013 DOB:12/09/1959 053 F

SANDHILLS REGIONAL MED CENTER



Sandhills Regional Medical Center Rehabilitation Services
Speech Pathology

 Evaluation

 ✓ Progress Report

 Discharge

Mrs. Rummage attended 5/12 treatment sessions due to illness and fall resulting in lack of consistency which is needed for BI patients. She has had increased headache, dizziness, and tinnitus which contributed to her fall.

Treatment centered on increasing organization in retrieval of information and the strategies needed to increase accuracy. Auditory and visual strategies were used in the recall of numbers, and sequential color, shape of timed presentation of images. Pt. had difficulty with all of these timed visual tasks requiring replay and additional trials 50% of the attempts. Fatigued occurred rapidly resulting in frequent rest periods. Visual exclusion tasks in a timed presentation were 0%. Generative naming skills are improving as indicated by 11/60secs x2 trials. Her ability to transition sub groups continues to be a challenge. Pt. has a noticeable increase in spelling errors which were not evident initially.

When asked about her personal progress, she stated "yes, I am making progress but it's difficult not to compare to before the fall." Daily activities at home such as cleaning, have become well organized and timely. Pt. practices various word find games (apps) for increased visual-linguistic skills which continue to be difficult. As previously reported, patient's goal is to resume employment as possible. Recommend continued treatment for improved cognitive-linguistic skills necessary for her to process and use new information while learning a new job skill. Thank you for your support in Mrs. Rummage's perseverance for recovery.

Martha Williams

Therapist Name

Martha Williams ccc/SLP

Signature

8/14/13

Date

Physician Name

Signature

Date



8752250

SPEECH THERAPY



RUMMAGE, VICKIE

Acct# [REDACTED] 0000- RP

COLLINS, DANIE

Adm:08/15/2013 DOB: [REDACTED] 1959 053 F

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Sandhills Regional Medical Center Rehabilitation Services
Speech Pathology

 Evaluation

 X Progress Report

 Discharge

Pt. has had 6 treatment sessions since the last authorization. Focus on use of her learning strategies has been emphasized utilizing various auditory and visual tasks. Her use of visual imagery is very effective in recalling information as well as sequential steps for daily tasks. Auditory rehearsal has required cuing to use but she has been successful with repetition of numbers, attributes and words during sentence formulation tasks. However, her ability to maintain a given task is approximately 15 minutes with a 5 minute rest period to prevent blurred vision resulting in frustration and loss of concentration. As previously stated, she watches TV or uses the computer only 20 minutes which creates frustration because of the impaired informational processing resulting in reduced recall of the plot and/or topic specific facts. Her ability to learn new information requires repetition using her learning/memory strategies but fatigues after 15-18 minutes and is less tolerant of errors. She uses her external memory aides successfully and has demonstrated good self-awareness and correction of misnomers during conversation. She has difficulty recalling a sequential auditory presentation of information such as an automated phone system because of absent visuals. Pt. reported avoiding this because of the complexity and length of the recording. When asked about her current status, she stated "feelings of regression" due to the physical symptoms which are manifested in the cognitive domain. As expected, the persistent pain and headaches with intermittent blurred vision further complicates her total recovery. Continue treatment as previously authorized for 16 sessions. Thank you for supporting Mrs. Rummage in her BI recovery.

Martha Williams

Therapist Name

Martha Williams csp

Signature

9/18/13

Date

Physician Name



8752250

SPEECH THERAPY

Signature

Date

RUMMAGE, VICKIE

Acct# [REDACTED] 0000- RP

COLLINS, DANIE

Adm: 09/18/2013 DOB: [REDACTED] 1959 053 F

SANDHILLS REGIONAL MED CENTER



P365

Sandhills Regional Medical Center Rehabilitation Services
Speech Pathology

 Evaluation Progress Report X Discharge

Vickie Rummage has received cognitive-linguistic treatment since January 2013 and has made excellent progress. As a result, she is able to manage her household with strategies and communicate effectively 80% of the time. She has extreme difficulty with more than one task and cannot manage tasks in competing background noise or speech. Auditory tasks without any visual prompts are very difficult such as an automated phone system. The main disruption in her daily life is the persistent physical symptoms which she reports at least 1-3 times per week. The headaches, tinnitus, visual disturbances and dizziness result in decreased ability to maintain her daily schedule. The chronic neck pain also contributes to her reduced concentration and inconsistency with daily tasks. Dizziness has been observed several times as pt. stood and stretched after 60-75 minutes. When asked about the dizziness relative to changing positions she confirmed the frequent episodic dizziness with decreased balance. Could she be suffering from Benign Paroxysmal Positional Vertigo and/or Cervical Vertigo? An audiology evaluation would determine her vestibular function. The disequilibrium associated with TBI is 40-60%. The Rivermead post-concussion questionnaire was given to rate her level of severity for 16 symptoms within the last 24 hrs. She rated headaches, dizziness, sleep disturbances, fatigue, feeling depressed, blurred vision, poor concentration, light and noise sensitivity, and irritability/frustration as severe. The combined physical symptoms seem to be the primary interference with her IADLs and the main reason for bed rest and limited ability to carry out her tasks. She has maximized her structured therapy in a clinic setting. Carryover of her learned strategies would be generalized to community setting i.e. bank, grocery store, pharmacy, and etc. A neuropsychology evaluation is recommended to assess her strengths and weaknesses, help her determine skills for possible employment, make additional professional referrals as indicated, provide ways to better cope with situation, and help family with recovery.

Summary of treatment and rationale for discharge from speech was reviewed and pt. agreed with plan to discontinue at this time. Thank you for allowing me to participate in Mrs. Rummage's recovery. Please contact me if there are any questions or concerns.

Martha Williams, CCC-SLP

Martha Williams-CC-SLP

10/16/13

Daniel L. Collins

Physician's Name

[Signature]

Signature

10/16/13

Date



8752250

SPEECH THERAPY

RUMMAGE, VICKIE
Acc: [redacted] 0000 RP
COLLINS, DANIEL
Acc: 10/14/2013 DOB: [redacted] 1959 083F
SANDHILLS REGIONAL MED CENTER
NOT RECENTLY TO BE RE-ENTERED

Acc: [redacted]

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKY DOB: [REDACTED]/1959

DATE: 06/01/2012

DICTATING: Fred McQueen, MD

ATTENDING:

We are going to go ahead today and place her on Neurontin. The insurance does not cover the Lyrica. We had written for Lyrica on her last admission. She fell on the job about 2 weeks ago and hit her head. She had to use glue to hold the laceration back together again. It is healing up real good. She did an excellent job. She was concerned about internal hemorrhage subdural, but she is beyond the timeframe now, and she has no focal neurological deficits. Her pupils are equal and round; reactive to light and accommodation. The patient has been advised I want her to stay on her Percocet 10/650 1 q. 8 h. as needed for pain along with Neurontin. These two drugs should definitely ease off her neuropathic-type pain that she has in her back. The patient has been advised to pick up her Percocet when due. I am writing her for Neurontin today. I am going to reassure that she is okay from her fall for any internal head injuries. She has a history of chronic pain. She is to stay on her Percocet and her Xanax. I am also going to write her for the Voltaren gel, the 5-2 pack, to have her husband rub her neck and shoulders down at least twice a day and it will give her great relief. She has a lot of problem with the muscles that were damaged when she fell.

The patient states her legs are cramping. I feel that maybe it is because she is not on potassium. I am writing her for K-tab 10 mEq to take 1 a day now. She is on lisinopril 20-12.5. On the 12.5 I thought she may be able to correct her potassium with diet, but I am also going to get a BMP so that I can check her electrolytes. In the meantime, will go ahead and place her on Neurontin along with K-tab 10 mEq. I have advised the patient she can take the Lodine which is what she was given by Dr. Mc Cloud, and she can take it 1 twice a day after meals. It is the same as Motrin, ibuprofen, and it will ease up a lot of the soreness and the stiffness.

I am also writing her for Nasonex for her sinuses. The patient has been advised to stay away from cigarette smoke, stay away from dust and pollen.

Fred McQueen, MD

CC:

6/24/12: 2-PAC #1 2 refills script given to Pt. dl / PDM

Date: 6.1.12 Name: Vicki Runnaga

Chief Complaint: C/o headache + sinus congestion

ASCVD Carotid Dz DM Dyslipidemia HTN Osteoporosis PAD Sleep Apnea Truncal Obesity

Depression Homocysteinemia CRF AF Nephropathy Hypothyroidism COPD Metabolic Syndrome

Wt: 165 BP: 138/74 T: 98.4 P: 85 HT: 5'0" R: 20 BMI: WC: Allergies:

Alcohol: Yes No # of Drinks Tobacco: Yes No # of Packs Exercise: Yes No Diet: Yes No

HPI: Pt fell @ work + required ER visit. Continued to work. Pt is crying about her home situation + sick spouse. Pt is flat affect. Pt has Hx of chronic Pain Syndrome + legs cramping.

Recheck BP

Standing BP

Right Arm BP

Left Arm BP

Glucose Monitoring

Check Med list

Home BP checks:

Const. Eyes ENT Heme/Lymph Resp CV GI GU Skin/Breast MS Endo Neuro Psych Allerg

All other ROS negative Addressed ROS Sheet

PH: No change since SH: No change since

Examination:

General Appearance: NI Ab

Eyes: NI Ab

Conjunctiva & lids: NI Ab

Pupils & iris: NI Ab

Optic Discs: NI Ab

Acuity/Sanilla: NI Ab

ENT: NI Ab

External ears & nose: NI Ab

EACs & TMs: NI Ab

Hearing: NI Ab

Nasal mucosa, septum & turbinates: NI Ab

Lips, teeth & gums: NI Ab

Oropharynx & tonsils: NI Ab

Neck: NI Ab

Thyroid: NI Ab

Lymphatic (2 or more): NI Ab

Neck: NI Ab

Axillae: NI Ab

Grain: NI Ab

Respiratory: NI Ab

Respiratory Effort: NI Ab

Percussion: NI Ab

Palpation of Chest: NI Ab

Auscultation: NI Ab

Cardiovascular: NI Ab

Palpation of Heart: NI Ab

Auscultation (MRGs): NI Ab

Carotids: NI Ab

Abdominal aorta: NI Ab

Femoral arteries: NI Ab

Pedal pulses: NI Ab

Edema/for Varicose veins: NI Ab

GI/Abdomen: NI Ab

Truncal Obesity: NI Ab

Masses, tenderness: NI Ab

Liver & spleen: NI Ab

Hernia: NI Ab

Anus, perineum & rectum: NI Ab

Occult test (if indicated): NI Ab

Chest (Breasts): NI Ab

Inspection of Breasts: NI Ab

Palpation of Breasts & Axillae: NI Ab

Genitourinary: NI Ab

Female: NI Ab

Ext. genitalia & Vagina: NI Ab

Urethra: NI Ab

Bladder: NI Ab

Cervix: NI Ab

Uterus: NI Ab

Adnexa/Parametria: NI Ab

Male: NI Ab

Scrotal contents: NI Ab

Penis: NI Ab

Prostate gland: NI Ab

Skin: NI Ab

Inspection: NI Ab

Palpation: NI Ab

Xanthomas: NI Ab

Neurologic: NI Ab

Cranial nerves: NI Ab

Deep tendon reflexes: NI Ab

Senses: NI Ab

Psychiatric: NI Ab

Judgment & insight: NI Ab

A&O x 3: NI Ab

Recent & remote memory: NI Ab

Mood & affect: NI Ab

Musculoskeletal: NI Ab

Gait & Station: NI Ab

Digits & Nails (Clubbing): NI Ab

Head & Neck: NI Ab

Inspection/Palpation: NI Ab

Range of Motion: NI Ab

Spine, Ribs & Pelvis: NI Ab

Inspection/Palpation: NI Ab

Range of Motion: NI Ab

RUE: NI Ab

Inspection/Palpation: NI Ab

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LUE: NI Ab

Inspection/Palpation: NI Ab

Range of Motion: NI Ab

RLE: NI Ab

Inspection/Palpation: NI Ab

Range of Motion: NI Ab

LLE: NI Ab

Inspection/Palpation: NI Ab

Range of Motion: NI Ab

Foot: NI Ab

Sensation: NI Ab

Observation: NI Ab

Circulation: NI Ab

Labs: NI Ab

ALT: NI Ab

Glucose: NI Ab

TSH: NI Ab

Lipid Profile: NI Ab

PSA: NI Ab

CBC: NI Ab

BMP: NI Ab

CMP: NI Ab

HgbA1C: NI Ab

UA/Malburn: NI Ab

Homocys: NI Ab

Lipomed Panel: NI Ab

hsCRP: NI Ab

Counseling (if 50%): NI Ab

Total Encounter Time: 15 min

Assessment: Stable Unstable

1. Serous/Chills

2. Headache

3. Depression/Chronic

4. Chronic anxiety

5.

6.

7.

8.

Plan:

1. Monitor 3000

2. Monitor 75 #1 d

3. Continue 10mg 2 d

4. Continue 10mg 2 d

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Vicki
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Chart Notes

6/19/12 Rx Percocet 10/150mg #90 g8^o
Xanax 1mg #90 g8^o R#1/PDM

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKI
DICTATING: Fred McQueen, MD
ATTENDING:

DOB: [REDACTED] 7-59 DATE: 07/19/2012

OFFICE VISIT

She had cervical spine x-rays done in June. She was found to have degenerative disc disease of C4-C5, C5-C6 and C6-C7. She has been having problems with her neck and shoulders and now I see why. Her lumbar spine also had degenerative disc disease, L1, L2, L3, L4 and L5-S1. The best I can do is treat the pain because she does have chronic pain. She has problems with bilateral changes in the sacroiliac joints. I am writing her for her pain medicine. She is on her Percocet 10/650 mg and her nerve medicine. Her weight, she gained 1 lb. I want her to come the other way now, below 160. I want her to get to 155.

Patient did have a fall at work. She had a concussion and she is still having problems with headaches but she is to stay on her Percocet. She is on 10/650 and that should ease the pain. She can take Aleve one after breakfast and after supper.

Dictated by Fred D. McQueen, Jr., M.D.

Fred McQueen, MD

cc:

8/7/12

As written Percocet 10/650mg #90 PRN; Vanax/ly #90 PRN - D/om

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

Rumage

PATIENT: VICKY

DOB: [REDACTED] 1959

DATE: 08/23/2012

DICTATING: Fred McQueen, MD

ATTENDING:

HISTORY OF PRESENT ILLNESS: She presents with a prescription that was written on 08/17/2012. The pharmacist will not let her have it until the due date, that is on her Xanax. She is out of her Percocet 10/650 for which she is asking me. She has been advised to hold on to those and pick them up as soon as the pharmacist will let her have them. I am putting her on Fioricet; I am writing her for Fioricet. She can take 2 every 6 hours as needed for severe headache. I am writing her for #100 of same. Her heart sounds good. Her lungs are clear. She has a lot of pain in that foot. I am looking at the foot where she had the injury on that ankle. She had screws placed in and had to take them out. The foot is giving her a lot of pain, but no swelling. She has pretty good motion with the foot.

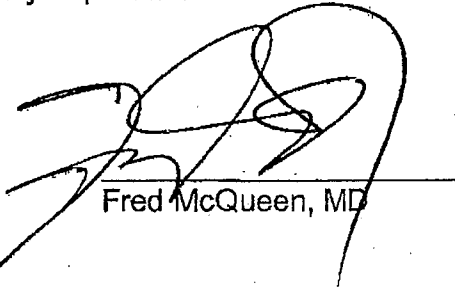
When she comes in today, her blood pressure is 127/76. Weight, she has gained 1 pound.

She has been advised that Fioricet should hold her until she can get her Percocet. She is not to take the Percocet with the Fioricet. The Fioricet is strictly for the headache. I am also writing her for a 2 week leave of absence until we can see about getting her straightened out with these headaches. She has had severe headaches since the fall. She had been on Fioricet, but Workers' Comp changed her doctor and got her in to see a neurologist on 09/05/2012. When she sees the neurologist on 09/05/2012, she is to be sure to let him know that we started her back on the Fioricet. The patient was found to have degenerative disk disease of the C-spine and also degenerative disk disease of the lumbar spine. She had changes in both her sacroiliac joints and I feel that is why she is having the pain. For the headaches, she does need to be evaluated by the neurologist. Back in March, she had a very, very high blood pressure, 200/100, but today she is 127/76.

The patient has been advised that I am also going to be placing her on Effexor XR 75 bedtime. This is an antidepressant and it should also help her to sleep. She is already taking Xanax 3 times a day along with the Percocet, and that is already 2 narcotics. I am also writing her for Fioricet for her tension headaches and so I do not want to add too many narcotics. She is to see a neurologist and, hopefully, he gets to the bottom of her headaches. She needs to take a leave of absence for 2 weeks for medical reasons. She has been advised to not take the

Dumma
VICKY

Prozac. She says she has not been on that for awhile anyway. I think part of her problem is definitely depression and the Effexor will carry serotonin and norepinephrine.



Fred McQueen, MD

cc:

8/28/12 note given to return to work without
restrictions on 8/30/12 RHPDM

Date: 8/23/12 Name: VICKI Burroughs (52)

Chief Complaint: R -

ASCVD ☐ Carotid Dz ☐ DM ☐ Dyslipidemia ☐ HTN ☐ Osteoporosis ☐ PAD ☐ Sleep Apnea ☐ Truncal Obesity ☐

Depression ☐ Homocysteinemia ☐ CRF ☐ AF ☐ Nephropathy ☐ Hypothyroidism ☐ COPD ☐ Metabolic Syndrome ☐

Wt: 167 BP: 127/76 T: 98.4 P: 3 HR: 18 BMI: 24 WC: 34 Allergies: None

Alcohol: ☐ Yes ☒ No # of Drinks: 0 Tobacco: ☐ Yes ☒ No # of Packs: 0 Exercise: ☐ Yes ☒ No Diet: ☐ Yes ☒ No

HPI: Pt c/o pain y @ foot/jerk pt has had surgery on ankle 2008. Pt c/o headache & sinusitis. Correlation. Pt states she sometimes runs out of pain meds. Pt fell several mos ago, hit her head & w/comp Physician gave fixed. w/comp is getting her up with a neurologist.

Home BP checks: Pt c/o Blurred vision, headache. c/o sore throat

ROS	Const.	Eyes	ENT	Heme/Lymph	Resp	CV	GI	GU	Skin/Breast	MS	Endo	Neuro	Psych	Allergy
			<u>+</u>							<u>+</u>		<u>+</u>		

☐ All other ROS negative ☐ Addressed ROS Sheet

PH: ☐ No change since / / FH: ☐ No change since / / SH: ☐ No change since / /

Examination:		Respiratory		Genitourinary		Musculoskeletal		LLE	
NI	Ab	NI	Ab	NI	Ab	NI	Ab	NI	Ab
General Appearance	☒	Respiratory Effort	☒	Female	☒	Gait & Station	☒	Inspection/Palpation	☒
Eyes	☒	Percussion	☒	Ext. genitalia & Vagina	☒	Digits & Nails (Clubbing)	☒	Range of Motion	☒
Conjunctiva & lids	☒	Palpation of Chest	☒	Urethra	☒	Head & Neck	☒	Foot	☒
Pupils & Iridescence	☒	Auscultation	☒	Bladder	☒	Inspection/Palpation	☒	Sensation	☒
Optic Discs	☒	Cardiovascular	☒	Cervix	☒	Range of Motion	☒	Observation	☒
Argus Senilis	☒	Palpation of Heart	☒	Uterus	☒	Spine, Ribs & Pelvis	☒	Circulation	☒
ENT	☒	Auscultation (MRGs)	☒	Adnexa/Parametria	☒	Inspection/Palpation	☒		
External ears & nose	☒	Carotids	☒	Male	☒	Range of Motion	☒		
EACs & TMs	☒	Abdominal aorta	☒	Scrotal contents	☒	RUE	☒	Labs	
Hearing	☒	Femoral arteries	☒	Penis	☒	Inspection/Palpation	☒	ALT	
Nasal mucosa, septum & turbinates	☒	Pedal pulses	☒	Prostate gland	☒	Range of Motion	☒	Glucose	
Lips, teeth & gums	☒	Edema/for Varicose Veins	☒	Skin	☒	LUE	☒	TSH	
Oropharynx & tonsils	☒	GI/Abdomen	☒	Inspection	☒	Inspection/Palpation	☒	Lipid Profile	
Jack	☒	Truncal Obesity	☒	Palpation	☒	Range of Motion	☒	PSA	
Neck	☒	Masses, tenderness	☒	Xanthomas	☒	RLE	☒	CBC	
Trachea	☒	Liver & spleen	☒	Neurologic	☒	Inspection/Palpation	☒	BMP	
Y. (tic 2 or more)	☒	Hernia	☒	Cranial nerves	☒	Range of Motion	☒	CMP	
Back	☒	Anus, perineum & rectum	☒	Deep tendon reflexes	☒			HgbA1C	
Willsae	☒	Occult test (if indicated)	☒	Senses	☒			UA Malburn	
Iron	☒	Chest (Breasts)	☒	Psychiatric	☒			Homocys	
		Inspection of Breasts	☒	Judgment & Insight	☒			Lipomed Panel	
		Palpation of Breasts & Axillae	☒	A&O x3	☒			hsCRP	
				Recent & remote memory	☒				
				Mood & affect	☒				

Counseling (if 50%)
Total Encounter Time

essment:
ble Unstable

Plan:

- ☐ 1. Headaches
- ☐ 2. CPDD
- ☐ 3. IS DDD
- ☐ 4. Anxiety / Depression
- ☐ 5.
- ☐ 6.
- ☐ 7.
- ☐ 8.

L.O.A. note
2 wks.
D/C Prozac
Transit ripog 6L #100
Efferon XR #30 ripog 15
F/U Efferon
made earlier
NASO 475 #1

- ☐ Education materials provided
- ☒ Exercise & dietary measures encouraged
- ☒ Management of RF Meds
- ☐ Independent visualization of Image/Traci
- ☐ Smoking Cessation Counseling
- ☐ Pre or Post Menopausal Issues Reviewed
- ☐ Severe exacerbation of chronic problem
- ☐ Medication side effects reviewed
- ☐ Acute or chronic illness or injury that poses a threat to life or bodily function
- ☐ Drug therapy requiring intensive monitoring
- ☐ Discussed with Dr.

McQueen Medical Center
104 Miss Street
1257

P140

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKIE DOB: [REDACTED]/1959

DATE: 09/18/2012

DICTATING: Fred McQueen, MD

ATTENDING:

OFFICE VISIT

She did see the neurologist and he put her on Topamax. She is taking topiramate 25 mg, takes one twice a day. She said it doesn't last for the full 12 hours. She has been having some swelling of the right side of her nostril. I am going to go ahead at this time and place her on a Z-Pak. She has also been advised I am going to give her a sample of Nasonex because it is so expensive and she is to use 1 squirt each nostril twice a day. Stay away from the fan. She did have an MRI and I am awaiting that report and I am awaiting the report from the neurologist so I am going to go ahead and have her continue on medical leave for 2 weeks. The patient states that she is having problems with crying. She has been on Percocet and she is due so we are going to continue her on same. She is to take the Percocet 10/650 mg every 8 hours and her Xanax so about every 4 hours she has got a pill to take because she cannot take the Percocet with the Xanax so she is to take the Percocet, wait 4 hours and take the Xanax, wait 4 hours and take the Percocet. That way she is taking her medicine around the clock.

Dictated by Fred D. McQueen, Jr., M.D.

Fred McQueen, MD

cc:

9/24/12 note for work per Tom/12 H

Date: 9.18.12 Name: Vicki Runnaga

Chief Complaint: Re-

ASCVD Carotid Dz DM Dyslipidemia HTN Osteoporosis PAD Sleep Apnea Truncal Obesity
Depression Homocysteinemia CRF AF Nephropathy Hypothyroidism COPD Metabolic Syndrome

Wt: BP: T: P: Ht: R: BMI: WC: Allergies:
Last Wt: As charted

Alcohol: Yes No # of Drinks Tobacco: Yes No # of Packs Exercise: Yes No Diet: Yes No

HPI: Pt c/o intermittent epistaxis for several years. Pt has had a head injury. Pt states surgery is not working at this time. Pt continues to have migraines. Some head injury. Stem c/o of "knots" in scalp & face.

Home BP checks: ROS: Const. Eyes ENT Heme/Lymph Resp CV GI GU Skin/Breast MS Endo Neuro Psych Allerg

PH: No change since FH: No change since SH: No change since

Examination: General Appearance, Eyes, Conjunctiva & lids, Pupils & iris, Optic Discs, Arcus Senilis, ENT, External ears & nose, EACs & TMs, Hearing, Nasal mucosa, septum & turbinates, Lips, teeth & gums, Oropharynx & tonsils, Neck, Thyroid, Lymphatics (2 or more), Axillae, Respiratory, Pericardium, Palpation of Chest, Auscultation, Cardiovascular, Palpation of Heart, Auscultation (MRGs), Carotids, Abdominal aorta, Femoral arteries, Pedal pulses, Edema/Varicose veins, GI/Abdomen, Truncal Obesity, Masses, tenderness, Liver & spleen, Hernia, Anus/perineum/rectum, Occult test (if indicated), Chest (Breasts), Inspection of Breasts, Palpation of Breasts & Axillae, Genitourinary, Female, External genitalia & Vagina, Urethra, Bladder, Cervix, Uterus, Adnexa/Parametria, Male, Scrotal contents, Penis, Prostate gland, Skin, Inspection, Palpation, Xanthomas, Neurologic, Cranial nerves, Deep tendon reflexes, Sensory, Psychiatric, Judgment & insight, ABO x 3, Recent & remote memory, Mood & affect, Musculoskeletal, Gait & Station, Digits & Nails (Clubbing), Head & Neck, Inspection/Palpation, Range of Motion, Spine, Ribs & Pelvis, Inspection/Palpation, Range of Motion, RUE, Inspection/Palpation, Range of Motion, LUE, Inspection/Palpation, Range of Motion, RLE, Inspection/Palpation, Range of Motion, LLE, Inspection/Palpation, Range of Motion, Foot, Sensation, Observation, Circulation, Labs, ALT, Glucose, TSH, Lipid Profile, PSA, CBC, BMP, CMP, HgbA1C, UA/Malburn, Homocyst, Lipoprotein Panel, hsCRP, Counseling (if 50%), Total Encounter Time

Assessment: Stable Unstable
Plan: 2 Pak a.d.
Nasorex 7/5 #1
Continue Topamax 500
By Neurologist
Percock 10/10/12
200 x 200
Xanax 1mg #90
McQueen Medical Center
104 Rice Street
P.O. Box 1257
Hamlet, N.C. 28345

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKIE DOB: [REDACTED]/1959

DATE: 10/22/2012

DICTATING: Fred McQueen, MD

ATTENDING:

The patient comes in today for re-evaluation. I have at my disposal her report from the neurologist, Dr. Jeff Benjamin. The patient was injured on 05/18/2012 and she had a head injury and a neck injury at that time. She has been having headaches since that time. The patient was seen by me and taken out of work initially by me because of attempts to control her blood pressure. The patient subsequently was seen by the neurologist and I have to concur with the neurologist. The neurologist placed her on Topamax and she was having problems also with blood pressure and I really feel that when I returned her to work it was based primarily upon my findings of her blood pressure control. Her blood pressure was under control and she was released to return to work on 10/15/2012 with no restrictions but she was then removed from work by Dr. Benjamin after that time and upon reading his report, I will have to concur with Dr. Benjamin. I feel that she will have to continue on medical leave until released by the neurologist because of her headaches that she has had since her head injury. I had treated her in the past for tension headaches, but after reading his report, she has severe trauma to the head. The patient was taken out of work on 09/24. We gave her out-of-work for temporary leave at that time and we wrote her to return to work 10/15. During that time while I had her on leave it was my impression that her blood pressure was the cause of her headaches and so now I have learned that she has had a full evaluation by the neurologist and I concur with him. Patient is having problems today with her sinuses and she has been switched from the Topamax to Trileptal 150 twice a day, by Dr. Benjamin. She is also on Percocet 10/650 that she takes for pain and headaches. What I would like to do at this time is go ahead and place her on a Z-Pak because she was found to have severe sinusitis and also have her go on Nasonex 2 squirts to each nostril twice daily. By patient's request, we are not transferring any of her records _____ at this time. She really had an on-the-job injury and she is _____ with Dr. Benjamin and Workman's Comp.

Fred McQueen, MD

cc:

Date: 10/22/12 Name: Vicki Hummage Age: 59

Chief Complaint:

ASCVD Carotid Dz DM Dyslipidemia HTN Osteoporosis PAD Nurse Signature: Sleep Apnea Truncal Obesity

Depression Homocysteinemia CRF AF Nephropathy Hypothyroidism COPD Metabolic Syndrome

WT: BP: See Flashed P: Ht: R: BMI: WC: Allergies:

Alcohol: Yes No # of Drinks Tobacco: Yes No # of Packs Exercise: Yes No Diet: Yes No

HPI: Pt presents today with regular visit

Recheck BP Standing BP Right Arm BP Left Arm BP Glucose Monitoring Check Med list

Home BP checks:

ROS:	Const.	Eyes	ENT	Heme/Lymph	Resp	CV	GI	GU	Skin/Breast	MS	Endo	Neuro	Psych	Allerg
+														

All other ROS negative Addressed ROS Sheet

RH: No change since FH: No change since SH: No change since

Examination:

General Appearance	NI	Ab	Respiratory	NI	Ab	Genitourinary	NI	Ab	Musculoskeletal	NI	Ab	LLE	NI	Ab
Eyes			Respiratory Effort			Female			Gait & Station			Inspection/Palpation		
Conjunctiva & lids			Percussion			Ext genitalia & Vagina			Digits & Nails (Clubbing)			Range of Motion		
Pupils & irises			Palpation of Chest			Urethra			Head & Neck			Foot		
Optic Discs			Auscultation			Bladder			Inspection/Palpation			Sensation		
Venus Senilis			Cardiovascular			Cervix			Range of Motion			Observation		
ENT			Palpation of Heart			Uterus			Inspection/Palpation			Circulation		
External ears & nose			Auscultation (MRGs)			Adnexa/Parametria			Range of Motion			Labs		
EACs & TMs			Carotids			Male			RUE			ALT		
tearing			Abdominal aorta			Scrotal contents			Inspection/Palpation			Glucose		
Nasal mucosa, septum & turbinates			Femoral arteries			Penis			Range of Motion			TSH		
nasal teeth & gums			Pedal pulses			Prostate gland			LUE			Lipid Profile		
pharynx & tonsils			Edema & Varicosities			Skin			Inspection/Palpation			PSA		
ck			GI/Abdomen			Inspection			Range of Motion			CBC		
ick			Truncal Obesity			Palpation			RLE			BMP		
roid			Masses, tenderness			Xanthoma			Inspection/Palpation			CMP		
mphatic (2 or more)			Liver & spleen			Neurologic			Range of Motion			HgbA1C		
ck			Hernia			Cranial nerves			Range of Motion			UA Malbum		
ile			Anus, perineum & rectum			Deep tendon reflexes			Range of Motion			Homocys		
			Occult test (if indicated)			Sensation						Lipomed Panel		
			Chest (Breasts)			Psychiatric						hsCRP		
			Inspection of Breasts			Judgment & insight								
			Palpation of Breasts & Axillae			A&O x3								
						Recent & remote memory								
						Mood & affect								

Assessment:

Unstable

1. COPD

2. LSPD

3. HTN

4. Sinusitis

5. Headaches

6.

7.

8.

Plan:

Continue Percocet 300mg

Same regimen

Note on work

Z-Pak

Nasal Net Nasal Spray

Education materials provided

Exercise & dietary measures encouraged

Management of Rx

Independent visualization of image/tracing

Smoking Cessation Counseling

Pre or Post Menopausal Issues Reviewed

Severe exacerbation of chronic problem

Medication side effects reviewed

Acute or chronic illness or injury that poses a threat to life or bodily function

Drug therapy requiring intensive monitoring

Discussed with Dr.

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McQUEEN MEDICAL CENTER

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104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKIE DOB: [REDACTED]/1959

DATE: 10/22/2012

DICTATING: Fred McQueen, MD

ATTENDING:

The patient comes in today for re-evaluation. I have at my disposal her report from the neurologist, Dr. Jeff Benjamin. The patient was injured on 05/18/2012 and she had a head injury and a neck injury at that time. She has been having headaches since that time. The patient was seen by me and taken out of work initially by me because of attempts to control her blood pressure. The patient subsequently was seen by the neurologist and I have to concur with the neurologist. The neurologist placed her on Topamax and she was having problems also with blood pressure and I really feel that when I returned her to work it was based primarily upon my findings of her blood pressure control. Her blood pressure was under control and she was released to return to work on 10/15/2012 with no restrictions but she was then removed from work by Dr. Benjamin after that time and upon reading his report, I will have to concur with Dr. Benjamin. I feel that she will have to continue on medical leave until released by the neurologist because of her headaches that she has had since her head injury. I had treated her in the past for tension headaches, but after reading his report, she has severe trauma to the head. The patient was taken out of work on 09/24. We gave her out-of-work for temporary leave at that time and we wrote her to return to work 10/15. During that time while I had her on leave it was my impression that her blood pressure was the cause of her headaches and so now I have learned that she has had a full evaluation by the neurologist and I concur with him. Patient is having problems today with her sinuses and she has been switched from the Topamax to Trileptal 150 twice a day, by Dr. Benjamin. She is also on Percocet 10/650 that she takes for pain and headaches. What I would like to do at this time is go ahead and place her on a Z-Pak because she was found to have severe sinusitis and also have her go on Miconex 2 squirts to each nostril twice daily. By patient's request, we are not transferring any of her records _____ at this time. She really had an on-the-job injury and she is _____ with Dr. Benjamin and Workman's Comp.

Fred McQueen, MD

cc:

Date: 10/22/12 Name: Vicki Hummage Age: [REDACTED]

Chief Complaint: [REDACTED]

ASCVD _____ Carotid Dz _____ DM _____ Dyslipidemia ☒ HTN _____ Osteoporosis _____ PAD _____
 Depression _____ Homocysteinemia _____ CRF _____ AF _____ Nephropathy _____ Hypothyroidism _____ COPD _____ Metabolic Syndrome _____

Wt: _____ BP: See Flow Sheet T: _____ P: _____ HT: _____ R: _____ BMI: _____ WC: _____ Allergies: _____

Alcohol ☐ Yes ☒ No # of Drinks _____ Tobacco ☐ Yes ☒ No # of Packs _____ Exercise ☐ Yes ☒ No Diet ☐ Yes ☒ No

HPI: Pt presents today with regular visit

Recheck BP _____
 Standing BP _____
 Right Arm BP _____
 Left Arm BP _____
 Glucose Monitoring _____
 Check Med List _____

Home BP checks: _____

ROS:	Const.	Eyes	ENT	Heme/Lymph	Resp	CV	GI	GU	Skin/Breast	MS	Endo	Neuro	Psych	Allerg
+														

☐ All other ROS negative

☐ Addressed ROS Sheet

PH: ☐ No change since _____

FH: ☐ No change since _____

SH: ☐ No change since _____

Examination:

General Appearance

Eyes ☐ ☐
 Conjunctiva & lids ☐
 Pupils & irises ☐
 Optic Discs ☐
 Arcus Senilis ☐
 ENT ☐
 External ears & nose ☐
 EACs & TMs ☐
 tearing ☐
 nasal mucosa, septum & turbinates ☐
 lips, teeth & gums ☐
 oropharynx & tonsils ☐
 neck ☐
 thyroid ☐
 lymphatic (2 or more) ☐
 skin ☐
 hair ☐

Respiratory

Respiratory Effort ☐
 Percussion ☐
 Palpation of Chest ☐
 Auscultation ☐
 Cardiovascular ☐
 Palpation of Heart ☐
 Auscultation (MRGs) ☐
 Carotids ☐
 Abdominal aorta ☐
 Femoral arteries ☐
 Pedal pulses ☐
 Edema &/or Varicosities ☐
 GI/Abdomen ☐
 Truncal Obesity ☐
 Masses, tenderness ☐
 Liver & spleen ☐
 Hernia ☐
 Anus, perineum & rectum ☐
 Occult test (if indicated) ☐
 Chest (Breasts) ☐
 Inspection of Breasts ☐
 Palpation of Breasts & Axillae ☐

Genitourinary

Female ☐
 Ext genitalia & Vagina ☐
 Urethra ☐
 Bladder ☐
 Cervix ☐
 Uterus ☐
 Adnexal/Parametria ☐
 Male ☐
 Scrotal contents ☐
 Penis ☐
 Prostate gland ☐
 Skin ☐
 Inspection ☐
 Palpation ☐
 Xanthoma ☐
 Neurologic ☐
 Cranial nerves ☐
 Deep tendon reflexes ☐
 Sensation ☐
 Psychiatric ☐
 Judgment & Insight ☐
 A&O x 3 ☐
 Recent & remote memory ☐
 Mood & affect ☐

Musculoskeletal

Gait & Station ☐
 Digits & Nails (Clubbing) ☐
 Head & Neck ☐
 Inspection/Palpation ☐
 Range of Motion ☐
 Spine, Ribs & Pelvis ☐
 Inspection/Palpation ☐
 Range of Motion ☐
 RUE ☐
 Inspection/Palpation ☐
 Range of Motion ☐
 LUE ☐
 Inspection/Palpation ☐
 Range of Motion ☐
 RLE ☐
 Inspection/Palpation ☐
 Range of Motion ☐

LLE

Inspection/Palpation ☐
 Range of Motion ☐
 Foot ☐
 Sensation ☐
 Observation ☐
 Circulation ☐
 Labs ☐
 ALT ☐
 Glucose ☐
 TSH ☐
 Lipid Profile ☐
 PSA ☐
 CBC ☐
 BMP ☐
 CMP ☐
 HgbA1C ☐
 UA Malbum ☐
 Homocys ☐
 Lipomed Panel ☐
 hsCRP ☐

Counseling (if 50%)
 Total Encounter Time _____

Assessment:

Unstable

1. CDD
2. LDD
3. HTN
4. Sinusitis
5. Headaches
6. _____
7. _____
8. _____

Plan:

Continue Percutaneous
 Same regimen
 note on work
 Z-pak
 nasal dex nasal
 spray

- ☐ Education materials provided
- ☐ Exercise & dietary measures encouraged
- ☐ Management of _____ Meds
- ☐ Independent visualization of image/tracing
- ☐ Smoking Cessation Counseling
- ☐ Pre or Post Menopausal Issues Reviewed
- ☐ Severe exacerbation of chronic problem
- ☐ Medication side effects reviewed
- ☐ Acute or chronic illness or injury that poses a threat to life or bodily function
- ☐ Drug therapy requiring intensive monitoring
- ☐ Discussed with Dr. _____

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 104 RICE STREET
 P.O. DRAWER 1257
 HAMLET, N.C. 28345

P379

P146

Mar. 12. 2014 10:05AM

No. 7070 P. 2/29

ANDREW N. SAFFRAN, LLC
ATTORNEY AT LAW
1400 PICKENS STREET, SUITE 104
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803 253 8889
FACSIMILE 803 799 1003

MAILING ADDRESS:
Post Office Box 18089
COLUMBIA, SOUTH CAROLINA 29211

January 13, 2014

Fred D. McQueen, Jr., M.D.
McQueen Medical Center
104 Rice Street
Hamlet, North Carolina 28345

RE: Vicky Rummage
D/O/B: [REDACTED] 1959

Dear Dr. McQueen:

This will confirm our conversation of this afternoon, during which we discussed several of your opinions relative to the current medical status of Ms. Vicky Rummage, who you: (a) previously treated for various symptoms over an approximately fourteen year period prior to her experiencing a work related accident on May 18, 2012; and (b) initially followed for the consequences of this work related trauma. Specifically, I inquired as to whether: (a) Ms. Rummage's May 18, 2012 fall had resulted in the aggravation/worsening of any previously documented symptoms/pathology; and (b) the symptoms identified by her current treating physician, Dr. Daniel L. Collins, are different (particularly in nature/severity) than those for which you treated Ms. Rummage prior to May 18, 2012.

In this regard, we reviewed pertinent portions of your pre-injury treatment notes, which verify: (a) the absence of any cognitive issues; (b) intermittent references to depression, which was simply treated through medication and never rose to a level requiring assessment/treatment by a psychological/psychiatric specialist; (c) headaches which you characterized as the product of migraines or tension; and (d) intermittent cervical pain that was consistently treated with medication, as opposed to interventional modalities.

We also noted several references to the consequences of Ms. Rummage's May 18, 2012 trauma and reports following this accidental fall, including: (a) your prescription of Voltaren gel with instructions that "her husband rub her neck and shoulders down at least twice a day . . . [due to the fact she was having] a lot of problems with the muscles that were damaged when she fell" (June 1, 2012); (b) the presence of "severe headaches since the fall", which led you to prescribe Fioricet (August 23, 2012); and (c) your belief that the headaches following the "severe trauma to the head" occurring on May 18, 2012 prevented Ms. Rummage from working (October 22, 2012).



Mar. 12. 2014 10:05AM

No. 7070 P. 3/29

Fred D. McQueen, Jr., M.D.
January 13, 2014
Page 2

We also discussed several aspects of Dr. Collins' records, which confirm: (a) Ms. Rummage's need for speech therapy due to mild cognitive impairments; (b) the continued presence of "headache pain"; (c) ringing in the ears, lightheadedness and blurred vision; (d) depressive symptoms of sufficient severity to warrant referral to a psychologist; and (e) his belief consideration of facet injections was warranted.

Based upon our conversation, it is my understanding you feel: (a) Ms. Rummage's current headaches are the product of a post-concussive syndrome, as opposed to the tension headaches for which you provided treatment prior to the May 18, 2012 trauma; (b) the level/frequency of her cervical symptoms have also increased following this work related fall; (c) the nature/intensity of Ms. Rummage's psychological disturbance have also increased in a manner consistent with post-concussive syndrome; and (d) each of these components has been materially aggravated by the consequences of Ms. Rummage's May 18, 2012 work related fall.

At this time, I would greatly appreciate your answering the following questions so that the parties to Ms. Rummage's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage's current headaches are most probably the product of a post-concussive syndrome, as opposed to the tension headaches for which you provided treatment prior to the May 18, 2012 trauma?

Yes ☒ No ☐

2) Do you believe, to a reasonable degree of medical certainty, that the level/frequency of Ms. Rummage's cervical symptoms have also increased following this work related fall?

Yes ☒ No ☐

3) Do you believe, to a reasonable degree of medical certainty, that the nature/intensity of Ms. Rummage's psychological disturbance have also increased in a manner consistent with post-concussive syndrome?

Yes ☒ No ☐

Mar. 12. 2014 10:06AM

No. 7070 P. 4/29

Fred D. McQueen, Jr., M.D.
January 13, 2014
Page 3

4) Do you believe, to a reasonable degree of medical certainty, that each of these components has been materially aggravated by the consequences of Ms. Rummage's May 18, 2012 work related fall?

Yes X No

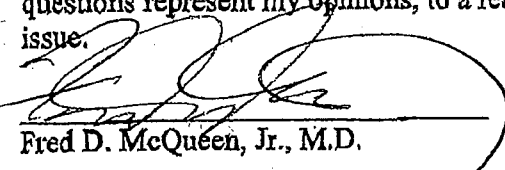
5) Do you believe, to a reasonable degree of medical certainty, that the treatment Dr. Collins has provided/prescribed for these aggravated conditions is different and/or more focused than what Ms. Rummage's symptoms required prior to her May 18, 2012 work related fall?

Yes X No

6) Despite the presence of cervical symptoms, depression and headaches prior to her May 18, 2012 work related fall, did the treatment modalities you provided allow Ms. Rummage to remain employed?

Yes X No

I, Fred D. McQueen, Jr., M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.


Fred D. McQueen, Jr., M.D.

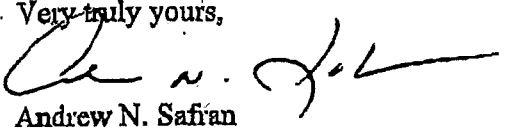
3-13-14
Date

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,


Andrew N. Safian

ANS/rmm

GRAND STRAND
SPECIALTY ASSOCIATES

Orthopedic Surgery/Traumatology:
Christopher Bouillon, DO

Neurosurgery:
Thomas Anderson, MD
Eugene Giddens, MD

Neurology:
Jeff Benjamin, DO
Barbara Sarb, DO
Michael Mc Caffrey, MD

Neurology & Ophthalmology:
George Santoliz, MD

Patient MRN: 135755

Date: 09/05/2012

Category: Dictation

Description: Dr. Benjamin dictation

Provider ID: [REDACTED]

Transcription Date: September 05, 2012

RE-EVALUATION

Patient Name: Vicki Rummate

Date of exam: 9/5/2012

Chart #: [REDACTED]

SSN: [REDACTED]

CHIEF COMPLAINT: Work-related injury. Date of injury is 05/18/2012.

HISTORY OF PRESENT ILLNESS: The patient is a very interesting, very pleasant, very appropriate 52-year-old female who unfortunately was at work. She works in an industrial plant, I believe. She fell backwards, and she landed on her buttocks but that did not hold her, and she kept going backwards. She hit her right parietal occipital head region that actually cut open her scalp, and then she landed hitting her left neck region that cut the neck. She actually got up trying to stop the bleeding, and they actually went, and she glued her cut shut and continued working, but she immediately started getting headaches in the neck as well as head region that continued on and started radiating up over her head. It was almost like it was shooting out her eyes. She has had a history of migraine headaches, but this does not feel anything like a migraine. This is a sharp pain. She did not go to the emergency room that day, her supervisor really wanted her to do this. In fact she made it clear that her supervisor wanted her to go to the emergency room. Her headaches were quite excruciating. Her right parietal occipital head region coming up in to the head and into the eyes very sharp and electrical in nature, same in the left at times. She, on top of this gets fatigue, nausea, blurred vision, spasms in her legs,

Vicki Rummate

9/5/2012

Page 2

and mood swings. She had a CAT scan of her brain done which was normal, and she has no other complaints other than this. She does state where she had glue shut her scalp, it is still quite tender.

PAST MEDICAL HISTORY: Includes hypertension, arthritis, sinus problems, partial hysterectomy, and ____.

MEDICATIONS: Lisinopril, HCTZ, amlodipine, hydrocodone, Effexor, and butalbital.

ALLERGIES: PENICILLIN.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: She does not smoke or drink. She is single.

Vicki Rummate
9/5/2012
Page 3

REVIEW OF SYSTEMS: Generally, no recent fever, chills, nausea, vomiting, diarrhea or constipation, chest pain or palpitations.

CT scan of the patient's brain was evaluated by me. It appeared normal.

PHYSICAL EXAM:

VITAL SIGNS: Blood pressure is 148/78. Pulse is 84. Weight is 160 pounds. Respirations are 15.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS: The patient is oriented to person, place, and time. Speech is fluent. No evidence of cortical defects.

CRANIAL NERVES: Normal visual fields. Funduscopic exam is benign. PERLA, EOM's full, no nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact. Palate is midline. Normal SCM/trapezius. Tongue midline.

MOTOR: Strength is 5 out of 5 upper and lower extremities. Normal bulk and tone. No fasciculations, abnormal involuntary movements, or cogwheel rigidity.

SENSORY: Intact pinprick, vibration, position and temperature sensation.

DTR: DTRs are 2+ throughout. Plantar reflexes are downgoing bilaterally. Negative Hoffmann's. Negative Tromner's. Intact.

GAIT: Intact.

MUSCULOSKELETAL: She has significant range of motion loss of cervical spine with flexion, extension, and side bending.

IMPRESSION/PLAN:

1. Neurologic exam/physical exam does reveal the patient with typical symptoms of closed-head injury. The nausea, poor concentration, difficulty sleeping at night all are associated with this. I do think an MRI of the patient's brain is in order.
2. Regarding her pain, that is really the most limiting factor it does not appear to be headaches. This appears to be bilateral occipital neuralgia and cervical strain. At this point, physical therapy to her cervical spine, Topamax 25 mg twice a day and hydrocodone 10/325 mg twice a day would be appropriate. We are going to get an MRI of the brain. I will follow up the patient. In any case, she can continue to work without any restrictions.

If you have any questions, please feel free to contact me.

Jeff A. Benjamin, DO

Vicki Rummate

9/5/2012

Page 4

JB/jvb

cc: Michelle Estep

Fax #: 803-753-0860

Electronically Signed on 09/10/2012 11:40 AM

The End.

Dr. Jeff Benjamin

GRAND STRAND
SPECIALTY ASSOCIATES

Orthopedic Surgery/Traumatology:
Christopher Boulton, D.O.

Neurosurgery:
Thomas Anderson, MD.
Eugene Giddens, MD.

Neurology:
Jeff Benjamin, D.O.
Barbara Sari, D.O.
Michael McCaffrey, MD.

Neurology & Ophthalmology:
George Sandoz, MD.

Patient MRN: 135755

Date: 10/10/2012

Category: Dictation

Description: Dr. Benjamin dictation

Provider ID: [REDACTED]

Transcription Date: October 10, 2012

RE-EVALUATION

Patient Name: Vicki Rummage
Date of exam: 10/10/2012
Chart #: [REDACTED]
SSN: [REDACTED]

DATE OF INJURY: 05/18/2012.

CHIEF COMPLAINT:

1. Symptoms include foginess, extreme fatigue, lightheadedness, and nausea from a closed head injury.
2. Severe occipital bilateral nerve pain and cervical strain, which I believe is occipital neuralgia from the direct trauma.

HISTORY OF PRESENT ILLNESS: The patient is a very pleasant, very appropriate female who we have put into physical therapy, which definitely helped with some of her neck pain, but she still is very uncomfortable. The Topamax seemed to have a lot of side effects, but helped a little bit with the headache as well. So, there is some benefit to it, but much more side effects from it. Her MRI of the brain is absolutely stable. There are a lot of sinus problems, but no tumors, aneurysm, or bad blood vessels.

PHYSICAL EXAM:

VITAL SIGNS: Blood pressure 138/72, pulse is 86, weight is 164 pounds,

Vicki Rummage
10/10/2012
Page 2

and height is 5 feet 2 inches.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS: The patient is oriented to person, place, and time. Speech is fluent. No evidence of cortical defects.

CRANIAL NERVES: Normal visual fields. Funduscopy exam is benign. PERLA, EOM's full, no nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact. Palate is midline. Normal SCM/trapezius. Tongue midline.

MOTOR: Strength is 5 out of 5 upper and lower extremities. Normal bulk and tone. No fasciculations, abnormal involuntary movements, or cogwheel rigidity.

SENSORY: Intact pinprick, vibration, position and temperature sensation.

DTR: DTRs are 2+ throughout. Plantar reflexes are downgoing bilaterally. Negative Hoffmann's. Negative Tromner's.

GAIT: Intact.

MUSCULOSKELETAL: She has decreased range of motion of the cervical and lumbar spine.

IMPRESSION/PLAN: At this time, we are going to go ahead and set the patient up for occipital nerve blocks. We are going to change her from Topamax to Trileptal. She is to continue physical therapy. We will keep her off work at this point.

Thank you very much for allowing me to participate in the patient's care.

Jeff A. Benjamin, DO

JB/mil

cc: Ms. Michelle Estep
Fax #: 803-753-0860

Electronically Signed on 10/12/2012 5:32 AM

The End.

Dr. Jeff Benjamin

GRAND STRAND
SPECIALTY ASSOCIATES

Orthopedic Surgery/Traumatology:
Christopher Bouillon, DO

Neurosurgery:
Thomas Anderson, MD
Eugene Giddens, MD

Neurology:
Jeff Benjamin, DO
Barbara Sarb, DO
Michael McCaffrey, MD

Neurology & Ophthalmology:
George Sandoz, MD

Patient MRN: [REDACTED]

Date: 10/12/2012

Category: Dictation

Description: Dr. Benjamin dictation

Provider ID: [REDACTED]

Transcription Date: October 12, 2012

PROCEDURE NOTE

Patient Name: Vicky Rummage

Date of exam: 10/12/2012

Chart #: [REDACTED]

SSN:

PROCEDURE: Occipital nerve blocks and trigger point injections.

HISTORY: The patient is a very pleasant, very appropriate female. She is cleaned and prepped in appropriate manner. Right occipital nerve was injected with 40 mg of Depo-Medrol and 0.5 mL of lidocaine and in two other spots on the left paracervical down lower. She received two further injections. There is no blood loss. She tolerated the procedure well and she had no complaints.

The patient was actually given a note to remain off of work until I saw her about in a month and see how she is done with the injections. She states she just cannot possibly go back to work. She is crying. She is in emotional mess. I asked her why and states that the headaches and nausea are not allowing her to go back and she cannot do any lifting.

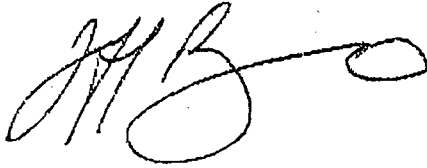
Vicky Rummage

DOB:

Chart: [REDACTED]

Date: 10/12/2012

Page 2

A handwritten signature in black ink, appearing to read 'JB', with a long horizontal flourish extending to the right.

Jeff A. Benjamin, DO

JB/skk

Electronically Signed on 10/15/2012 5:46 AM

The End.

Dr. Jeff Benjamin



Orthopedic Surgery/Traumatology:
Christopher Boulton, DO

Neurosurgery:
Thomas Anderson, MD
Eugene Giddens, MD

Neurology:
Jeri Benjamin, DO
Barbara Sarb, DO
Michael McCaffrey, MD

Neurology & Ophthalmology:
George Sandoz, MD

Patient MRN: 135755

Date: 11/14/2012

Category: Dictation

Description: Dr. Benjamin dictation

Provider ID: [REDACTED]

Transcription Date: November 14, 2012

RE-EVALUATION

Patient Name: Vickie Rummage
Date of exam: 11/14/2012
Chart #: [REDACTED]
SSN: [REDACTED]

CHIEF COMPLAINT:

1. Right occipital neuralgia.
2. Traumatic brain injury.

HISTORY OF PRESENT ILLNESS: The patient is a very interesting, very pleasant, and appropriate female who is on Norco 10/325 mg and states it is just not helping her. She has had occipital nerve blocks which did not help, physical therapy which helped minimally for two months but overall has not really done much at all. She still has nausea and vomiting and states she cannot work.

PHYSICAL EXAM:

VITAL SIGNS: Blood pressure: 128/72. Pulse: 80. Weight: 168 pounds.
Height: 5 feet 2 inches.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS: The patient is oriented to person, place, and time. Speech

Vickie Rummage

11/14/2012

Page 2

is fluent. No evidence of cortical defects. She is sitting in the room and appears to be uncomfortable.

CRANIAL NERVES:

Normal visual fields. Funduscopic exam is benign. PERLA, EOM's full, no nystagmus. No ptosis. Facial sensation is intact. Corneal reflex intact. Facial movement is symmetric. Hearing intact. Palate is midline. Normal SCM/trapezius. Tongue midline.

MOTOR:

Strength is 5 out of 5 upper and lower extremities. Normal bulk and tone. No fasciculations, abnormal involuntary movements, or cogwheel rigidity.

SENSORY:

Intact pinprick, vibration, position and temperature sensation.

DTR:

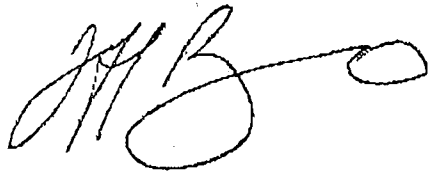
DTRs are 2+ throughout. Plantar reflexes are downgoing bilaterally. Negative Hoffmann's. Negative Tromner's.

GAIT:

Intact.

Vickie Rummage
11/14/2012
Page 3

IMPRESSION/PLAN: At this time, I do not think further physical therapy would be of any benefit. It has not done anything in the last two months. I gave her Roxicodone 15 mg three times a day, 90 tablets; Phenergan 25 mg half to one q.12h., and I will send her over to chronic pain physician to see if we can get some resolution with the discomfort. Otherwise, I have a very little else to do for this patient. We are going to go ahead with Trileptal 150 mg twice a day. We are going to keep her on that.

A handwritten signature in black ink, appearing to be 'JB' with a stylized flourish at the end.

Jeff A. Benjamin, DO

JB/vsv

Electronically Signed on 11/16/2012 6:13 AM

The End.

Dr. Jeff Benjamin

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE- SUITE B2
CHERAW, S.C. 29520

DATE: 5/30/12 WT 167 HT _____
T _____ BP 120/88 P 92 R _____

05-30-12 Vickie Rummage

- S: WC from BGF. Pa reports she involved in accident on 05/18/12 when she was stepping backwards & her legs struck a doffing truck & she fell backwards & struck her head on the some part of the truck. She continues to work daily since then. She has had some intermittent headaches as well as soreness surround the upper back & the neck area. There was no LOC.
- O: Tenderness of the mid posterior scalp. No significant edema there. Neck, no specific tenderness. Has fairly good ROM. Chest, clear. Ribs are nontender. Heart, RR, NS. Neuro, intact.
- A: Status post fall with suspected some element of concussion.
- P: Lodine 400 mg bid. #30. FU 2 w. Also pa takes other meds from her usual physician including Prinivil, Lopid, Xanax 1 mg prn., Percocet 10/650 mg prn. Light duty work & FU 2 w. ✓

DATE: 6/6/12 WT 167 HT _____
T _____ BP 120/90 P 88 R _____

06-06-12 Vickie Rummage

- S: FU from visit on 05/30/12. Still c/o of headaches & posterior scalp pain as well as upper back & neck pain. Also some low-back pain bilateral hurts more with certain movements. No paralysis.
- O: Tenderness over the posterior scalp with some mild edema over the side of previous laceration. Neck is mildly tender over the posterior aspect. Mildly tender over the upper back as well as lower back paraspinal muscles. Gait is stable. Neuro, grossly intact with no focal deficits noted. X-ray of the C-spine & LS-spine appeared to be neg for any acute changes to be reviewed by radiology. CT scan of the head was also obtained & report is pending.
- A: #1 Status post fall with suspected concussion as well as neck/upper & lower back contusions.
- P: Lorcet 10/650 mg #30 R1, Fioricet #30 R1 prn. for headache, & Ambien 10 mg q.h.s. prn. #14. Also Toradol 60 mg IM for pain prior to x-ray studies as pa was c/o of worsening pain. FU 2 w or sooner if needed. Also FU regarding the CT of brain. ✓

9/12/05..wt. 162

Re✓

97.4 - 123/09

89-20

RUMMAGE, VICKIE

CHART #: [REDACTED]

09/12/05

Ms. Rummage is in today feeling really, really bad. She is having some rhinitis symptoms, her head is stuffed up, her ears are scratchy, her throat hurts, her nose is stuffed up, and she is just feeling generally rotten. In addition, she is having a lot of pain in her neck and in her lower back with radiculopathy down her shoulders, arms, and wrists, and down her legs and feet. She is under quite a lot of stress; her husband, who recently returned from Iraq, has had a heart attack and is now undergoing testing to see if there is blockage, so she is really waiting for those results and just feeling very, very anxious, understandably, about that. Her pain control is good with the Lorcet 10/650; this works for her; she takes 1 every 8 hours, and that works to control her pain. Ambien does help her sleep; she takes it at bedtime, as instructed, and she is asking if there is something that she can have for anxiety. Certainly, with all that she is dealing with, I think that is a reasonable request. She takes Prozac. She has been on Prozac for several years and is beginning to believe that is not doing her much good. She takes Estratest H.S. as a hormone replacement. Dr. McQueen talked in his last note about having her go to Dr. Baimeedi for a sleep study, but with all of the stress surrounding her husband's illness, she has not gotten around to taking care of herself recently. She has not been able, yet, to see Dr. Arthur regarding the cervical disk disease and lumbosacral disk disease that were revealed on her MRIs. I am encouraging her to see Dr. Arthur as soon as she can to see if there is something that he can do to help her short of surgery, but certainly, to get an evaluation as soon as she can. When she feels that she can do this, she will call us so that we can make the appointment for her. Her cardiac rate and rhythm are regular. Her breath sounds are clear. She does have a very stuffed-up nose and is unable to sniff effectively. Tympanic membranes are both clear without injection. Her throat is red, but with no exudate. I am giving her some samples of Allegra D 12-hour formula and writing a prescription for that. Still, I am encouraging her to check the price of Claritin, which is over-the-counter. It may be more economical for her to buy the over-the-counter product. I am writing her Lorcet 10/650, #90, 1 tablet every 8 hours as needed for pain. I am writing her Xanax 1 mg, #90, 1 tablet every 8 hours as needed for anxiety, and I am writing her Ambien 10 mg, #31, 1 tablet at bedtime as needed for insomnia. I am writing her Allegra D 12-hour formula, #60, 1 every 12 hours as needed for nasal and sinus congestion, and I am making that refillable for a year. I am doing 3 refills on her other medications. I am stopping the Prozac and starting her on Cymbalta. I have a sample that I can give her of 30 mg to take daily for 1 week. I am suggesting that she take it at bedtime, as nausea is the most common side effect reported for people who are beginning to take Cymbalta, and then 60 mg every day, again, at bedtime. I am going to schedule a followup appointment for this patient for 4 months, and she has a lot of things that she needs to deal with, and does not particularly need to be running up the road to see us; however, she knows that anytime that she needs us, she can call us, and when she gets ready to see Dr. Arthur, then she is going to call us, and we will make those arrangements for her. Anytime that she needs us, all she has to do is call. KR/jms

12/15/05. Lunesta 2 mg called to phan will not come
anxiety - Ben

1-10-06 175 47.3 134/19 10 14

Left ear aches & sore throat. Wants to go on WT. Program.

RUMMAGE, VICKIE

CHART #: [REDACTED]

01/10/06

Ms. Rummage is in this morning feeling very bad. She has earache and sore throat. She is feeling achy. She is also very tired. Her child has just been at Duke for surgery, and she has been not sleeping well at all. She has gained 15 pounds recently, partly due to stress, partly due to the holidays, possibly partly a side effect of the Cymbalta, though the Cymbalta is working relatively well for her as an antidepressant, so we would like to keep trying that and see if we can help her to lose weight without interfering with that. She denies cough. She denies chest pain. She has had some mild diarrhea, but no nausea or vomiting, and no fever. She denies bowel or bladder dysfunction. Her TMs are both visible and very injected. Her throat is quite red with a mild amount of exudate visible, a grayish-white exudate on the pillars, and she is having some difficulty swallowing, just because her throat is very sore. Her breath sounds over her lung fields are clear. Her cardiac rate and rhythm are regular. Her abdomen is soft and not distended. I am prescribing Levaquin 500 mg, #7; she will take 1 a day for 7 days. This is primarily to protect her son, who is now at home with her following major surgery, and I think that she may have a virus now, but I do not want her to get a superinfection, and certainly do not want her to pass it on to him. I am also writing her Lorcet 10/650. She is in our pain control program, and she has constant back pain. The Lorcet 10/650 relieves it to some degree such that she can engage in her ADLs. Her Xanax 1 mg, I am writing for #90; she takes 1 of those every 8 hours as needed for anxiety, and I am writing Auralgan otic drops for her earache, 3 drops in affected ear 3 times a day as needed for pain. I am writing her Ambien CR 12.5 mg, #30, 1 tablet at bedtime as needed for insomnia, and she has been on Adipex before and was successful with losing weight. I am prescribing her Adipex P 37.5 mg, 1 every morning after breakfast. She is to continue her Cymbalta 60 mg every day. She still takes Estratest HS as a hormone replacement, and I gave her some Zyrtec samples and told her that she can buy an over-the-counter Claritin or Claritin D if her nasal stuffiness continues. It is unfortunate that, at this point, this lady is just too busy and overwhelmed with her son's illness to really take care of herself. She needs to see Dr. Arthur to see if there is anything that can be done for her back, because it seems to be getting worse and not better, but certainly, we will be happy to make that referral whenever she feels like she is able to do it. I am making a followup appointment for her for 3 months, but she knows that she can call us anytime that she needs us. KR/jms

4/10/06 w
174'2

uue 8

7.7, 78, 29, 140/92

8

RUMMAGE, VICKIE

CHART #: [REDACTED]

04/10/06

The patient did have degenerative disk disease and endplate disease at C4-C5, C5-C6, and C6-C7 with a mild impression upon the vertebral thecal sac. She does have some spurring compromising the neuroforamen bilaterally, so she does have some problems with her neck and her low back. She had a disk at L4-L5, anular bulging of the disk, no significant compromise, so the main problem is her neck. She has had a lot of problems at home with her husband and son, so she did not see Dr. Arthur. The patient has been advised that I am writing her for her Xanax. I am also writing her for her Lorcet 10/650. She has been advised that she is going to have to find a way to slow down. She is taking care of her mother. She has a problem with her husband, who is ill, and a son who is ill. All of this is falling on her, and plus, she is working 12 hours a day. She might want to consider eventually getting family medical leave so that she can take advantage of the family medical leave act, so that she can be home with her husband and do what she has to do. Heart sounds good. The main problem is that neck. She is not really to see Dr. Arthur yet. I am putting her on some Wellbutrin XL, which will not make her gain weight; in fact, it will help her lose weight. I am putting her on XL 150. On her Wellbutrin XL, I want her to wait at least 3-4 weeks before she begins to see maximum results with the same. She should stop taking all other medicines, especially Cymbalta and the Prozac. I am putting her on Wellbutrin XL. The patient states that she had to pay about 40 dollars on her medication. I am putting her on Meridia, writing her for Meridia 15, 1 a day, and fixing it for refills to last her for 3 months. We are going to try a different medication, because the Adipex is not working, plus she is already tense and nervous. I do not want to give her anything else that will wire her up or make her more uptight. FM/jms

4-21-06 Returned call regarding prior authorization unable to
Authoize Ambien CR will call in Rx for Ambien
4-24-06 called into Walmart pharmacy Chesaw, 843-537-2741. Ambien 100mg
i po qhs prn, Wellbutrin XL 150mg i po qhs prn refills. @11PM

7/24/06 Referral Dr.

9/11/06 wtf. 164

Rec 98-6-

Vickie
Rummage
149/89 - 82-18

RUMMAGE, VICKIE

CHART #:

09/11/06

We did get her down to see the neurologist, and he definitely feels that she has carpal tunnel in both hands, and he does feel that she would probably benefit from it. She has seen the best already, too, because she has already seen Dr. Shupeck, and I do not think that surgery is the answer at this time for her neck or her back. The patient, I feel, definitely needs to consider a different lifestyle. I do not know how much longer she is going to be able to continue to work, and she works 12 hours a day. She is making it on the Avinza. How much longer she is going to be able to make it like that, I do not know, but we are going to continue to try. The patient is losing weight; she did well. She did drop 4 pounds. I am proud of her. She did very well with that. I want her to continue to work on her diet. I do not want her to lose too much, though. I do not want her to get below 150. She has been advised that she is at 164. She has been advised that we are going to stop the Avinza. We are going to drop her back to her Lorcet 10/650. The problem is that she is having a difficult time trying to afford the Avinza; it is very expensive. She has also been advised, too, that on her Lorcet 10/650, we are writing it, and I am writing it for refills to last her for 3 months. I am writing her for her Xanax 1 mg that she takes as needed for her nerves. We are going to write her for #90, and she is to take it as directed. The patient does not smoke. We are stopping the Wellbutrin, and I am going to switch her over to Prozac, putting her on Prozac 40. FM/jms

12/8/06 150 (14...) 137/... 997/77-10
She comes in today as a regular appointment. She is a member of our pain management program. She does have severe degenerative disk disease with spurring in C4-C5, C5-C6 and C6-C7. She also has severe muscle spasms with this. She is presently taking Flexeril 10 mg t.i.d. as needed for muscle spasms, which she states, does help some. She is also on Lyrica 75 mg b.i.d. She is also complaining of some discomfort in her left ear, some pain around her eyes. She also is complaining of having some burning with urination. I did have her give us a urine sample and she was found to have trace blood, trace protein but amber urine. She might be just on the verge of having urinary tract infection. Upon assessment, her tympanic membrane on the left is bulging with no erythema. Tympanic membrane on the right is within normal limits. Her nares are within normal limits. Her posterior pharynx is erythematous with some clear mucus drainage in the posterior aspect. Lungs are clear throughout. Heart rhythm is regular, S1 and S2 noted. No skips, gallops or murmurs. She does have pain on palpation of her maxillary and frontal sinuses. I think she has sinusitis with possible otitis media. I have given her a prescription for Levaquin 750 mg #5 one tablet daily for 5 days. That should cover the possible urinary tract infection as well as the sinusitis and the otitis media. I also refilled her prescription for Lorcet 10/650 with no refills with instructions to have the pharmacy contact us again in 1 month so we can okay her for 2 more refills. I also gave her her prescription for Xanax 1 mg #90 one tablet every 8 hours again with no refills with the same instructions to have a pharmacy contact us for more refills. She also was complaining of a cyst on her back which is approximately the size of a pea it is very hard, there is no cellulitis noted. I was able to express a little bit of purulent drainage. I did try to lance it and express more drainage however I was unable to express anymore than I had gotten on initial assessment. I did instruct her to put hot warm compresses on that site that would bring that purulent drainage to a head. The Levaquin will help with the infection from the inside to avoid any possible cellulitis. She did verbalize understanding. We will see her back in 3 months. If she needs anything in the meantime she nows to give us a call. NH/eje

2/16/07 wt
154

~~age~~
Sinus problems
Hot flashes

Vickie Rummage
98.2, 143/82, 83

VICKIE RUMMAGE

Chart [REDACTED]

02-16-07

The patient was going to school and in training and she damaged her right shoulder. It appears that she has got a rotator cuff. We are going to get a MRI. I want to see the results of the MRI. In the meantime she is to stay on her Lorcet 10/650 that she takes for pain and her Xanax 1 mg she takes for her nerves. We are going to fix both of them for refills to last her for three months. She has been advised also to keep her weight steady. She is at 154. And she definitely does not need a tan, so she can get out of the tanning bed. She also has been advised to go ahead and get some Estrogen ES to try and see if it works over-the-counter. It should give her some energy and pick up her libido, especially since she only has one ovary. FDM/elr

3/12/07. Just taking R's to pharmacy due on 3/15/07. Had old R's on old bottle - Gae

3/12/07. Just taking R's to pharmacy due on 3/15/07. Had old R's on old bottle - Gae

5/11/07:

159 ebs (75932) Res

5-14-07 Referral made Dr. Veasy 6-1-07 @ 9:30 am, pt notified via letter. 786-18-78-138/78

Rummage, VICKIE

Chart

05-11-07

I am looking through her records where she was evaluated for right shoulder pain. The patient on February 7, 2007 she was practicing strong arm hold and she had pain in her shoulder and she has had pain since that time. The patient has never had problems with me with her shoulder it was always her neck. She had a MRI and she was found to have a rotator cuff. She was set up for surgery of that and to repair same, but then they will not pay her with Workmen's Comp because they are arguing point that she did not have an on-the-job injury. She does have a witness and that witness however is unavailable at this time. She is right-hand dominant. I am going to get her in to see Dr. Veasy and we are going to get a copy of these records so that he will have them for his records and also we are going to continue to follow. She had degenerative disc disease at the AC joint in the right shoulder and a rotator cuff of the right shoulder with impingement syndrome of the right shoulder. With these findings I think the patient needs to be evaluated by a joint specialist. I am sending her to the best and that is Dr. Veasy for a second opinion to see whether or not she requires surgery. I really am concerned in that the patient is very honest and truthful about it. She definitely had not had problems with that shoulder prior to the accident with her being put in the hold by a colleague on the job. Because she got hurt on the job she is now being relieved from her job, which I think is most unfair. The patient was definitely desirous of working. She was removed from the academy and her insurance company South Carolina Mutual Insurance Trust does not want to honor her Workmen's Comp so now she is going to have to get a second opinion and surgery with Dr. Veasy. In fact it might be a blessing because he is the best. FDM/elr

5/25/07 records mailed to Harris + Graves. jomale

8/9/07wh

Vickie Rummage

routine follow up 157/89 97-83-20
has enough meds until Sept. advised to call and
will sk refills until next appt. Dec.

Rummage, Vicki

Chart No. [REDACTED]

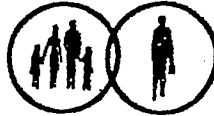
08/09/07

She comes in today as a followup appointment. She has just recently had a rotator cuff repair on her right shoulder approximately 1 month ago. She is in the process of getting physical therapy. She is however in a lot of pain. She is presently taking Lorcet 10/650 every 8 hours as well as Xanax 1 mg every 8 hours which does give her some relief however at this moment she is having extra pain due to her physical therapy. Chief complaint today is insomnia. She was on Ambien at one point however, because of the expense she did have to stop. Now with it being generic she was asking if she could restart that. Blood pressure 157/89, which in review of the chart is high for her. However, she does tend to have a systolic pressure in the 140s for the most part. I have started her on lisinopril/HCT 20/12.5 #30 one tablet daily. She also is concerned about her weight, which has been getting worse since her accident at work. Her rotator cuff surgery was done as a Worker's Compensation issue. She unfortunately has lost her job due to the accident and she is in a depressed state at this point. She is taking Prozac 40 mg daily but she does state that she does not think it is effective anymore. She has difficulty controlling her temper with her family. I did give her a 1-month sample worth of Lexapro 10 mg to try daily and see if that works for her. I did suggest she check with the pharmacy to see how much that would cost with her insurance. ASSESSMENT: Lungs are clear throughout. Heart rhythm is regular, S1 and S2 noted. No skips, gallops or murmurs. I did notice that her Lorcet and Xanax both have 1 more month's refill on them. I did state that this could be considered her visit for refills at the end of the month, just have the pharmacy fax us a form and we will be glad to give her 3 more month's refill with that. I did give her a prescription for Ambien 10 mg #10 one tablet nightly with 1 year's refill as well as a prescription for Flexeril 10 mg #60 one tablet b.i.d. for muscle spasms. I did state that it will make her very sedated, to be careful when she does take them. If they make her too groggy she might want to break those in half and she did verbalize understanding. Did give her a prescription for Adipex P 37.5, #30 one tablet daily with 2 month's refill. I did advise her take 6 small meals a day watching her salt, pork and carbohydrate intake, and she did verbalize understanding. Gave her a month's worth of Lexapro 10 mg as well as a prescription for Lexapro 10 mg #30 one tablet daily with 1 year's refill with instructions not to fill that until she sees whether the Lexapro is working for her. If she finds it does not work she cannot stop that abruptly. She will need to wean herself off after a week and she did verbalize understanding. We will see her back in December. She knows if she needs anything in the meantime to give us a call and we will be looking for the fax from the pharmacy for her Lorcet and Xanax. NH/eje

10/5/07 Pt. called c/o Lexapro not helping wanted to go back on Prozac
40mg. Pt. stated had refills left on Prozac 40mg and would
try. @

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post Office Drawer 1257 • Hamlet, North Carolina 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

August 17, 2007

Harris & Graves, P.A.
P.O. Box 11566
Columbia, S.C. 29211

RE: Vicki Rummage
File # [REDACTED]

Dear Attorney Haymond:

As you know, the above named patient has been under my care since 02/16/07 for severe pain of the right shoulder secondary to rotator cuff impingement. She is right hand dominant. She was noted to have degenerative disease as well of the AC joint. She did report injury on the job, but was having difficulty with Workers' Compensation agreeing to treatment. The patient has become anxious and depressed over her limitations and lifestyle change with chronic pain syndrome since the initial injury. She also is suffering with chronic muscle spasms since the accident.

It was my professional opinion since 02/13/07 evaluation that Ms. Rummage was unable to hold gainful employment and continues to remain disabled. Her last evaluation 08/09/07 found her depression and anxiety somewhat worse due to the chronic pain she is having and inability to maintain her lifestyle and activity that she was accustomed to prior to the accident.

If I can be of further assistance, please advise.

Sincerely,

Fred D. McQueen, Jr., M.D.

FDM:dd

11/24/07 wt Ht 5'2
163

152/96, 97.8, 80

Vicki Rummage

Rummage, VICKIE

Chart [REDACTED]

11-26-07

The patient comes in today for follow-up evaluation of her rotator cuff. She stated that she was not told the truth about her shoulder. She has been under my care now since way back first treated by me in 1991. I have gone through her records and there is no documentation of any x-rays done of her right shoulder. Now she did have muscle spasms of the right shoulder in August of 2000 and she was given trigger point into the shoulder at that time; but she was diagnosed as having a rotator cuff. Why, because there were no x-rays done. She received trigger points in her right shoulder again in 05/24/02. I think that is what the attorneys are trying to say, that she has had problems with her shoulder prior, but she did not have the type of problems that she has with her shoulder until she had the trauma while she was in training at the school. And during the time that she was being treated by me and receiving trigger points it was for bursitis and not for rotator cuff. She also had degenerative disc disease of the cervical spine. She was even referred to Dr. Shupeck for same. I feel that her rotator cuff was caused by an injury on the job. There is no documentation in my records of diagnosis of rotator cuff prior to that time. She comes in today for further evaluation. She has been advised that I am going to have my nurse to go ahead and schedule her back first thing in the morning, like say at 9 o'clock, when we are not at the end of the day so we can go ahead on and get her CCL physical form filled out. FDM/elr

Rummage, VICKIE

Chart [REDACTED]

11-26-07

She has sinusitis. She states that she has been stopped up with her head. We are going to go ahead and put her on Nasacort, or better still Astelin because she can use it as often as she wants. We are putting her on Astelin Nasal Spray 2 squirts each nostril as needed p.r.n. She is also does not have any fever though. She is afebrile. I will put her on doxy 10 mg twice a day for ten days. I think she might be trying to come down with the flu. FDM/elr

Rummage, Vicki

Chart No. [REDACTED]

11/27/07

She comes in today. She was just here yesterday to see Dr. McQueen as a regular check-up. She does have some sinus issues that had been treated. She comes back today with a commercial license physical that she neglected to have done yesterday. We did of course go ahead and fill out the whole form for her. I did check her hearing and it is greater than 5 feet, which I did mark on her form. Also checked her peripheral vision and she does have at least 100 feet peripheral vision bilaterally. All other systems are within normal limits. The form has been filled out. She is having a little sinus congestion. We gave her a sample of Astelin nasal spray to take 2 puffs each nostril b.i.d. She does have a prescription for that as well. So, again we did fill out the form and we were able to help her with that today. She also has an appointment on December 17. She is due to pick up her Lorcet 10/650, Xanax 1 mg, as well as her lisinopril/HCT 20/12.5, Prozac 40 mg daily as well as her Ambien 10 mg nightly, Flexeril 10 mg b.i.d. and Adipex 37.5 daily. All these medicines she thinks will be up for refill here in the next month or so. We do know the Lorcet, Xanax and the Adipex will definitely need filled. I informed her to have the pharmacy just fax us the forms, we can refill all of those medicines via fax giving her the 3 month's supply of Lorcet, Xanax and Adipex as well as her other medicines for a year. I did let her know that is not a problem. We will see her back in 3 months. She knows if she needs anything in the meantime to give us a call. NH/ate

VICKY Rummage

11/7/08. Rx ~~Adipex~~ ^{6R J} Adipex P 375. 3 refills
Lorcet 10/650 #90 3 refills
Xanax 1mg #90. 3 refills -

4/14/08 Pt. called via Fax - Gail. (NH)
requesting refill on medication, advised must be seen
4/21/08 wt 164 BMI = 20 c/o ears bothering her - 128/76 97²-83-20

RUMMAGE, VICKY

CHART # [REDACTED]

04/21/2008

This is a 48-year-old white female with chronic pain. She comes in for her Lorcet, which we are going to give her, 10/650, 2 refills, and Xanax 1 mg t.i.d., 2 refills. Also for her Adipex, which we are going to give her 2 refills on that, too. She comes in with complaints of bilateral ear pain and headache. I think this is secondary to earache. Review of systems: Everything is pretty much within normal limits, except she does have the chronic pain and bilateral ear pain. Vital signs: Weight 164, with a BMI of about 25, temp 97.2, respiratory rate 20, pulse 83, blood pressure 128/76. Pupils are responsive to light. Mouth: Good moist oral mucosa. Evaluation of her ears, I do note that there is fluid in both ears. There is also tenderness to palpation when you palpate around the ear. Lungs are clear. Heart sounds S1, S2, no murmur was noted. The patient's skin is very sensitive to the sun. I am recommending that she use some sunblock. Abdomen: Benign. Lower extremities: There is no edema there. I mentioned the medications that we did give her. I am going to give her Xyzal samples and she can also get it over the counter, along with some Cortisporin Otic ear drops. As far as blood work, the patient is not up to date, so we are going to get routine blood work, including a TSH for the weight gain. She is on Adipex, but we will make sure there is no organic problem as to the reason that she is gaining this weight. We will also schedule her for a mammogram, and the next time she comes back, I will do a Pap smear on her. DY/dmf

7/22/08 wt 163 BMI 30 1/2 #. 5'2" "Pap" 98, 81, 142/90

This is a 48-year-old white female with chronic pain and major depression. The patient comes in for a Pap, but with complaints that her sinuses are really draining. Also, her shoulder is really bothering her. She does have a history of rotator cuff tear and it is really causing some irritation, so she does want an injection of steroids there. It seems like she might have some bursitis in that area. Review of systems is pretty much as I mentioned. Everything else is within normal limits. Vital signs: Weight 163, temp 98.0, respiratory rate 18, pulse 81, blood pressure 142/90. Pupils are responsive to the light. Lungs are clear. Heart sounds S1, S2, no murmurs are noted. The patient does have some ethmoid and frontal sinus tenderness. Mouth: No inflammation noted there. Nose: Just mild inflamed nasal conchae, not much. Ears: The right side looks pretty good. The left side looks like she does have a mild bulging tympanic membrane, but I do not note any type of fluid or anything like that in her ear. Pap smear was done. The patient is status post hysterectomy. She does not have any complaints of discharge or anything like that. On evaluation of the labia majora: There are no lesions noted there. On entering, I did do some swabs and cultures. She did have some whitish discharge. It looked like she might have a mild yeast infection, which is asymptomatic, so I am not going to worry about treating it. A couple of things we are going to give her: For her sinusitis, we are going to give her the nasal spray, Xyzal, and a Z-Pak, because she has Penicillin allergies. I also gave her Lorcet 10/650 #90 with 2 refills, Xanax 1 mg with 2 refills there, her Adipex-P, and also some ear drops. The patient did not get a chance to do blood work or a mammogram so she stated that she is going to do that by the time she comes back in. I am also going to give her an injection in her shoulder. Hopefully that will help with the pain. DY/dmf

9/26/08 Attempted to call in Rx's for Vicky Rummage
Ambien and Flexeril Keep on phone over
5 minutes. ————— B. Bell, MD

10/21/08
wt
155

"ck up"

97.6, 77, 142/76

RUMMAGE, VICKIE

DOB: 12/09/1959

10/21/2008

The patient comes in today and we are going to write her for Flexeril 10 t.i.d. that she takes for muscle relaxants. She also has pain in her right heel. We are going to give her a trigger point of Decadron plain and Decadron-LA, along with Marcaine 0.5 cc each. She is to soak the foot in some warm Epsom salts water when she gets home and after about 20 minutes at a time, she should notice by tomorrow that the foot should be 100% improved. She is to be very careful of walking up steps and climbing. She is on Prozac 40, she is on her Ambien 10, only as needed for sleep, Xanax, which she takes for her nerves, and Lorcet 10/650, which she takes for pain. The patient has a longstanding history of chronic pain and anxiety. She has done real well on her diet, but I want her to get her thyroid checked now. I want a TSH done. Her weight is down to 155. She states that she wants to get down to 145. I am also going to give her a Z-Pak for her sinuses, because she does have sinusitis, Nasacort, which she is to take 2 squirts to each nostril every day, and she should notice a big difference by Monday. FDM/dmf

1/24/09. Rx called to Wal-Mart - 847-537-2741 - (Pt's mother is dying)
Lorcet 10/650mg #90 OPR, Xanax 1mg #30 OPR -
Prozac 40mg OPR - Pt states her mother is in the hospital
dying & office is closed due to snow - Covid - Reschedule 1 month
Covid
2/13/09 wt 163 Re✓ 97.2 - 161/91 - 72 -
Pt due 2/21/09 for meds.

PATIENT: RUMMAGE, VICKI
DOB: [REDACTED] 1959
DATE: 02/13/2009

HISTORY OF PRESENT ILLNESS: Ms. Rummage presents today in routine followup of chronic pain syndrome as well as chronic anxiety and depressive symptoms. She reports that she has not had any recent exacerbations and she is compliant with her medications. She does not exhibit any diversionary activity and has been well maintained on this current regimen. She does report increasing depressive symptoms since the loss of her mother. She reports some days she has trouble getting out of bed and is more tearful than others. She denies any suicidal or homicidal ideations but does report that she is willing to increase or change her antidepressant if need be. After a long discussion with that I informed her that we probably would just go ahead and increase her Prozac to 40 mg twice a day versus once a day and she is in agreement with that.

P405

201

5/15/09 Wt. 160 Re-✓ % HA

98° - 140/85 - 80-20

Vicki Kummage

RUMMAGE, VICKIE

DOB: 12/09/1959

05/15/2009

The patient has been doing well with her weight. She dropped another 3 pounds, but the problem she is having now is with her migraines. She has been under a lot of stress and I think a lot of it is also related to the fact that she recently lost her mother. Her son was also injured in the war in Iraq, so she has had a lot of stressors. When she was in the last time, she came in and she was seen by my nurse practitioner she was diagnosed as having chronic depression. Her Prozac was increased to 40 mg b.i.d. She has been advised that I think she would do better with a different antidepressant. I would like to give her the Effexor XR, give her a coupon for same, give her some samples of same, and have her titrate down and off the Prozac. I want her to take one a day for 2 days and then just stop taking it altogether, wait 2 days, and then switch on over to the Effexor XR. The patient states that the Lorcet 10 is not holding her pain. We are going to try to her on the Lortab 10/500. She has been advised that with the Lortab 10/500 she can take one every 6 hours without worrying about getting toxic amounts of Tylenol. She has been advised that it works just as well, the same drug, it is just less Tylenol. The patient's heart sounds good. We are going to treat her migraines with Relpax. I am writing her for #9 and that is 40 mg. She is to take it as directed. As stated earlier, she is to titrate off the Prozac and switch over to the extended Effexor, which is venlafaxine, which is the extended release of Effexor. We will give her a starter pack and she will start out in 4 days with the 37.5 and then she will go up to the 75. I really feel that once she goes with the Effexor for 2 weeks, she will not need a sleeping pill. The good thing about the Effexor is that it will also help her because she will take it even at bedtime and it will also help her with her sleep, with which she has had a longstanding problem. In the meantime, I will be writing her for Ambien 10 to use as needed until the Effexor takes over. When the Effexor takes over she will not need the Ambien. She has been advised that since she is on Xanax, we will not write the Ambien because Xanax and Ambien are the same drug; they are identical, therefore, she can just take the Xanax as she needs it at night and just the take the Xanax during the daytime as she needs it for her nerves. She has been advised that once we get her migraines under control, get her pain under control, we are making so many changes now, and get her on her Effexor, I really feel that we will then be able to see her back again and get her back on her diet plan. In the meantime, if she eats small feedings and eats frequently every 3 hours, a snack, she will lose the weight and she will not have to worry about the weight. The weight is not really an issue because she is not really obese. We will give her a trigger point to her heel. FDM/dmj

843- Wal-Mart
6/15/09. 537-2741- Re called Lorcet 10/650mg #90 / RF
Cancelled Lortab 10/500mg. - Pt states not working

Cont / FDM.

7/7/09 Returned call 4:05 no answer left message said
advised Pt would have to be seen for antibiotic -

CURRENT MEDICATIONS:

1. Prozac.
2. Lorcet.
3. Xanax.
4. Flexeril.
5. Adipex.
6. Ambien.

PAST MEDICAL HISTORY:

1. Depression.
2. Tension headaches.
3. Osteoarthritis.
4. Muscle spasms.
5. Cervical disk disease.
6. Lumbosacral disk disease.

SOCIAL HISTORY: She does smoke. She does not drink or use any drugs.

REVIEW OF SYSTEMS: Twelve point review of systems is negative with the exception of increasing depressive symptoms.

PHYSICAL EXAMINATION: Constitutionally, she is a well Caucasian female in no acute distress. Skin is warm, dry, and intact. HEENT: Head is normocephalic with normal hair distribution. EYES: PERRLA. Neck is supple without any lymphadenopathy.

CARDIOPULMONARY: Regular rate and rhythm. Lungs are clear to auscultation. GI/GU: Abdomen is benign and soft. MUSCULOSKELETAL/EXTREMITIES: She exhibits full range of motion. Pedal pulses are palpable bilaterally without any edema. NEURO: Intact.

PSYCHIATRIC: She has a flat affect.

PATIENT: RUMMAGE, VICKI

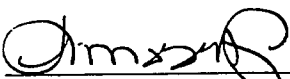
DOB: [REDACTED] 1959

DATE: 02/13/2009

PAGE TWO

DIAGNOSTIC IMPRESSION/PLAN:

1. Chronic pain syndrome. I will renew her pain medication. She is reminded that she is under pain contract.
2. Chronic depression. I will increase her Prozac from 40 mg q.d. to 40 mg b.i.d. She is to return to the clinic in three months as scheduled.



Layla Mabe, A.N.P.

D: 02/13/2009

T: 02/14/2009

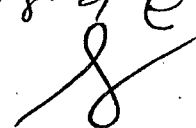
LM/rj

P407

203

V. Chi Kummage

8-17-09 wt. 153½ Re-✓
earache, sore throat 97° - 149
(R) footache 86 - 75-20

8-17-9 referral Dr. Mirian 9.18.9 C 1030 Am
via p-s- 

RUMMAGE, VICKIE

DOB: [REDACTED]/1959

08/17/2009

The patient comes in today. She has multiple problems. She has a longstanding history of chronic pain and osteoarthritis, and now she comes in with sinusitis. We are going to continue her with her pain medication. She did receive her Lorcet 10/650, which she takes for chronic pain. She has also been on Prozac in the past, but we changed her to the Effexor, which is venlafaxine, 75 at h.s. which is the same as Effexor. She is also on Xanax 1 mg t.i.d. for her nerves. I am want to go ahead and give her some samples of Xyzal and Astepro, but right now what I would like to do is get her in to see Dr. Mirian and check her for rheumatoid arthritis. I definitely want a sedimentation rate and ANA, with a rheumatoid and lupus factor to check her for systemic lupus. She does have a strong family history for rheumatoid arthritis. I feel that she does have a pulled Achilles tendon on that right heel. She broke and had to have surgery on her left foot. I think because her gait was changed with surgery on the left foot that she is now shifting over to her right foot. The pain is also radiating all the way up to her knee and into her hip. She has good range of motion of the knee and negative straight leg raising. I think the problem is definitely originating from the foot. The patient's weight is down to 153. She has lost 7 pounds. She is desirous of keeping her weight down. She wants to get on down into the 140s, about 145. But right now my main concern is swelling that is going on with her foot. I am getting her in to see Dr. Mirian. I am checking her for lupus, I am checking her for rheumatoid arthritis, and we are also going to continue her on her pain medication. FDM/amf

10-5-09 Rx refill Adipix-P 37.5 approved / FDM.

11/17/09 wt 162

Rev

1.2/78

VICKIE
Rummage
QTS 80-20

by refills

RUMMAGE, VICKI

DOB: [REDACTED] 1959

11/17/2009

Ms. Rummage presents today in routine followup. She suffers from longstanding chronic pain secondary to chronic migraines as well as osteoarthritis. She has been maintained on Lorcet 10/650 for same. She also suffers from generalized anxiety disorder. She has been maintained on Xanax for that as well. She denies any recent exacerbations. She reports she is in her usual state of health. She does not display any diversionary activity and appears to be compliant with her medications.

ALLERGIES: She is allergic to **PENICILLIN**.

CURRENT MEDICATIONS: Prozac, Lorcet, Xanax, Flexeril, Adipex, and Ambien.

PAST MEDICAL HISTORY: Depression, tension headaches, migraine headaches, osteoarthritis, muscle spasms, cervical and lumbosacral disk disease.

REVIEW OF SYSTEMS: Twelve point review of systems is negative except for items mentioned in the HPI.

PHYSICAL EXAMINATION: Constitutionally, she is a well-appearing Caucasian female in no acute distress. Skin is warm, dry, and intact. HEENT: Head is normocephalic with normal hair distribution. EYES: PERRLA. Neck is supple without any lymphadenopathy.

CARDIOPULMONARY: Regular rate and rhythm. Lungs are clear to auscultation. GI/GU:

Abdomen is benign. **MUSCULOSKELETAL/EXTREMITIES:** She exhibits full range of motion. Pedal pulses are palpable bilaterally without any edema. **NEURO:** Intact without any focal signs. **PSYCHIATRIC:** She has a pleasant, calm affect.

DIAGNOSTIC IMPRESSION/PLAN: Chronic pain syndrome and generalized anxiety disorder. The patient is issued refills of Xanax 1 mg every eight hours for a total of 90 per month with two refills as well as Lorcet 10/650 one every eight hours for a total of 90 per month with two refills. She is reminded she is under pain contract. We will see her back in the clinic in approximately three months.

LM/rlj

2-12-10 wt. 159

Re-✓

② lower flank pain
"comes + goes"

Vickie Rummage

97² - $\frac{124}{74}$ - 80 - 20

UA
1 neg
1 neg uro

RUMMAGE, VICKI

DOB: [REDACTED] 1959

02/12/2010

Ms. Rummage presents today with complaints of flank pain on the left side. She reports this is an ongoing issue and in reviewing her records I see that it is a recurrent complaint of hers. Urinalysis did not reveal anything significant. With that being said I think it probably is in our best interest to refer her over to urology for them to evaluate the patient and advise further. She also suffers from chronic migraines, osteoarthritis, and chronic pain syndrome as well as generalized anxiety and depression. She has been maintained on Lorcet and Xanax for same. She does not display any diversionary activity and appears to be compliant with her medications.

ALLERGIES: She is allergic to **PENICILLIN**.

CURRENT MEDICATIONS: Prozac, Lorcet, Xanax, Flexeril, Adipex, and Ambien.

PAST MEDICAL HISTORY: Depression, tension headaches, migraines, osteoarthritis, muscle spasms, and cervical and lumbosacral disk disease.

REVIEW OF SYSTEMS: Twelve point review of systems is negative except for items mentioned in the HPI.

PHYSICAL EXAMINATION: Constitutionally, she is a well-appearing Caucasian female in no acute distress. Skin is warm, dry, and intact. HEENT: Head is normocephalic with normal hair distribution. EYES: PERRLA. Neck is supple without any lymphadenopathy.

CARDIOPULMONARY: Regular rate and rhythm. Lungs are clear to auscultation. GI/GU: Abdomen is benign. She does not display any suprapubic tenderness. She will not allow me to evaluate the CVA area secondary to her reports of pain.

MUSCULOSKELETAL/EXTREMITIES: She exhibits full range of motion. Pedal pulses are palpable bilaterally without any edema. **NEURO:** Intact without any focal signs.

PSYCHIATRIC: She has a pleasant, calm affect.

DIAGNOSTIC IMPRESSION/PLAN: Chronic pain syndrome and generalized anxiety disorder. The patient is issued refills of Xanax 1 mg every eight hours as well as Lorcet 10/650 one every eight for a total of 90 per month each with two refills. She is referred to Dr. Al-Droubi for persistent flank pain. We will see her back in the clinic in approximately three months.

LM/rhj

2.15.10 referral Dr. Eldroubi 3.15.10
@ 2:30 pm 12 hr med. 18

5/13/10 the refills

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.

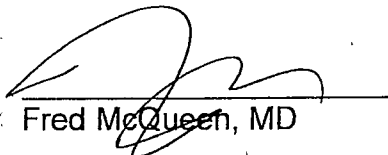


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PATIENT: RUMMAGE, ^{Vicki}~~AK~~ DOB: [REDACTED] 1959

DATE: 08/24/2010

The patient comes in today and we are going to give her Decadron plain and Decadron LA. She has soreness where she was involved in an automobile accident. She was ridding with her son, he swerved to miss a deer, and he overcorrected. The patient comes in today and my concern at this time is that she has been on Lorcet 10/650 mg and Xanax, for her nerves, 1 mg t.i.d. I want her to continue with the Effexor 75 mg and her lisinopril. We are going to write her for her lisinopril also. She has soreness in her right knee with crepitation in that knee. She maybe a candidate for arthroscopic knee surgery, eventually. She also has pain in the right shoulder where she had a rotator cuff in that shoulder that is giving her a lot of pain. Since she hurting all over, and she is stiff all over, I want her to take a hot sitz bath. She needs to use a Jacuzzi or swimming. I am going to go ahead and give her the Decadron plain and Decadron LA. She has been advised that there is a medication that she can take for the arthritis. I am going to give her that today. I am going to put her on Indocin SR 75 mg. The Indocin 75 mg as a generic should not cost her that much. She needs to eat before she takes it, because it will upset her stomach if she takes it on an empty stomach.


Fred McQueen, MD

cc:

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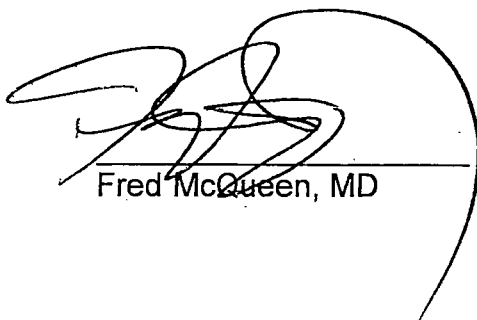
PATIENT: RUMMAGE, VICKI

DOB:

59

DATE: 11/22/2010

I want her on Animi 3. She states she has been feeling tired. Her weight is up remarkably. She went from 152 to 164 for a gain of 12 pounds. That is not like her. She usually keeps her weight in check but she cannot do any walking because she has severe pain on the heel of her left foot. She broke the tibia and fibula on that leg a long time ago. I think at this time she has a heel spur. We are sending for x-ray of left foot, attention calcaneus or heel to look for heel spur. If there is a spur, then we can get her to the podiatrist to see about getting it removed. I also instructed her about mole foam for her shoe and cut a hole in it where she pain is to keep the pressure off that part. She states she has to continue to work at this time. Heart has normal sinus rhythm. No gallops or murmurs. Lungs clear. She had her flu shot at the plant. Her lab work that she brought from the plant looks good. Hemoglobin was good. They said it was low but 13 is a good hemoglobin. Red blood cell count was also normal and white blood cell count is okay. She also had normal chemistry. HDL was good at 56 and LDL was 113. She has been advised to continue to stay on her diet. In reference to her other meds, she is on Lorcet for pain and Xanax 1 mg every 8 hours and Valifaxen at bedtime, Indocin SR 75 and Lisinopril. Blood pressure is good at 146/84. It is up a tad. She was running 123/76. It is probably secondary to the pain in her foot. Her Lorcet is 10/650, #90. She has been advised I will help her with her diet after the holidays but right now I am not concerned about her weight. I am concerned about her foot. If she gets to where she can't go, then we will put her in the big house. I am writing her for 2 pair of medium strength knee high support hose she can use when she works. I don't know how much longer she will be able to continue in the work field because her body at this time is breaking down. She might want to consider Voc Rehab and start looking for sedentary type work so she can get off her feet. She also has a ganglion cyst on her left wrist but it is not serious at this time. We will watch it and follow.



Fred McQueen, MD

cc:

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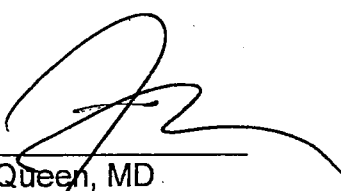
PATIENT: RUMMAGE, VICKI
DICTATING: Fred McQueen, MD
ATTENDING:

DOB:

DATE: 01/25/2011

She has history of migraines and her migraines have hit her now. She has been unable to work Sunday. She tried to go back in and she couldn't. She works as a weaver. She is also having problem with that left hip and the pain is radiating down her thigh. I think it is definitely in the muscle. She has to stand and walk on concrete all the time. She has good range of motion of the bone as far as her left femur. Also in reference to her migraines, she is not on any medicine for her migraines. We put her on Maxalt MLT which means it is sublingual, she just puts it under her tongue and it dissolves. She has been advised I want her to stay on the Maxalt MLT taking no more than 2 in 24 hours. I am writing a note stating she was seen by me today and she will be able to return to work tomorrow with no restrictions. She has been switched from Lorcet to Percocet 10/650 mg one every 8 hours as needed and Xanax for her nerves, 1 mg every 8 hours as needed. She is not to take it with the Percocet, to make sure there is at least 1-2 hours in between. She is also on Valifaxen 75 mg at bedtime as antidepressant. She cannot afford the Indocin SR because it has gone up so high. It cost her 80 some dollars for that so we are going to be placing her on Motrin 800 mg one every 8 hours as needed for arthritic pain. Heart sounds good. Lungs are clear. She does have a depressed affect. She did lose a pound during Thanksgiving. Patient wants to get back on her diet plan but she has been advised that Phentermine and migraines don't mix. It may accentuate a migraine. She is definitely not to take anything to curb her appetite while she has a migraine because it will make it worse.

She has been advised that since she is now on Percocet she has to pick it up in 30 days and also pick up her Adipex and her Xanax at the same time. I will write her for Flexeril 10 mg one three times daily. It is a muscle relaxer and she is to be very careful when she is around machinery or anything like that because it is a muscle relaxer.


Fred McQueen, MD

cc:

2/22/11. Rx with Xanax 1mg #30 OAR
Adipex P 37.5 mg #30 OAR
Percocet 10/650mg #90 OAR
Prozac 40mg #30 1 year Gail/LM

3-4-11

Rx rewritten for Percocet 10/650 mg #90 + po q 8^h prn pain
1/c Rx written on 2-22-11 was signed by Layla make ANF
or a SC pt. Pt returned RX; I also called Wal-Mart in Choral
spoke to Tammy pt last Rx for Percocet was filled on
-8-11 which was written on 1-25-11; which will not make her
we til 3-10-11. This was explained to the pt. + she was
given Rx but it can't get filled til 3-10-11. The Rx writer
on 2-22-~~11~~ for Percocet 10/650 mg #90 + po q 8^h prn pain
was destroyed + new Rx for Percocet 10/650 mg #90 + po
q 8^h prn pain ~~or~~ was given to her Signed by FOM ———— ~~TD~~:-

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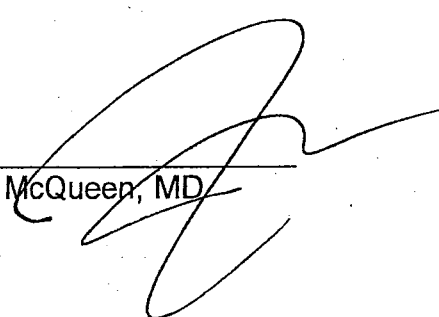
PATIENT: RUMMAGE, VICKIE
DICTATING: Fred McQueen, MD
ATTENDING:

DOB:

DATE: 03/25/2011

She comes in today with chest pain. She states her mom and dad both had chest pain. She has been complaining of having problems with sinuses. Patient states her sinuses are giving her a severe headache. What is bothering me more than anything is the fact that she is having chest pain. We are going to go ahead and give her nitroglycerin to see if she gets chest pain relieved by nitroglycerin. Plus it is radiating out to her left shoulder. She has a strong family history on her mother and father with heart disease. She is in normal sinus rhythm and her blood pressure today is 135/80. She is afebrile but her weight is up to 165.

We are going to admit her to rule out myocardial infarction. We will get a set of enzymes on admission and in the morning. If her enzymes are negative and she remains stable on telemetry, fine. If not, we will get a cardiology consult.


Fred McQueen, MD

cc:

3-31-11

Rx faxed Wal-mart (Cheraw) Adipex-P 37.5mg #30 + pogam def 2/11

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKIE DOB: [REDACTED] 1959

DATE: 05/09/2011

DICTATING: Layla Mabe, A.N.P.

ATTENDING: Fred McQueen, MD

HISTORY OF PRESENT ILLNESS: The patient comes in today with complaints of a recurrent cyst on her back. It is right across the bra line and it is very irritating and painful at times. She is requesting to have that removed. I do not have any objections to that and will be happy to accommodate her accordingly. She also suffers from longstanding chronic pain. He has been well maintained on Percocet for same. Denies any exacerbations and reports that she is otherwise in her usual state of health.

ALLERGIES: PENICILLIN.

CURRENT MEDICATIONS:

1. Percocet.
2. Prozac.
3. Xanax.
4. Flexeril.
5. Adipex.
6. Ambien.
7. Nitroglycerin.

PAST MEDICAL HISTORY:

1. Tension headaches.
2. Depression.
3. Anxiety.
4. Migraines.
5. Unstable angina.
6. Osteoarthritis.
7. Muscle spasms.
8. Cervical and lumbosacral disk disease.

REVIEW OF SYSTEMS: A 12-point review of systems is negative, except for items mentioned in HPI.

PHYSICAL EXAMINATION:

GENERAL: Constitutionally, a well-appearing Caucasian female in no acute distress.

SKIN: Warm, dry, and intact.

HEENT: Head normocephalic, with a normal hair distribution. Eyes PERRLA.

NECK: Supple without any lymphadenopathy.

CARDIOPULMONARY: In a regular rate and rhythm. Lungs are clear to auscultation.

RUMMAGE, VICKIE

GASTROINTESTINAL AND GENITOURINARY: Abdomen is benign.

MUSCULOSKELETAL AND EXTREMITIES: Exhibits full range of motion. Pedal pulses are palpable bilaterally without any edema.

NEUROLOGIC: Intact without focal signs.

PSYCHIATRIC: Has a pleasant, calm affect.

DIAGNOSTIC IMPRESSION AND PLAN:

1. Cystic mass on her back. She is referred to Dr. Zeidan for excision of same.
2. Chronic pain. She is issued a refill of Percocet 10/650 mg 1 every 8 for a total of 90 per month with no refills. Adipex 37.5 one-half p.o. b.i.d. number 30 with no refills. She has lost 4 pounds since last visit. She is given outpatient requisition for her mammogram. Her labs are up to date. She is also referred to Dr. Ansari for evaluation of colonoscopy.

Layla Mabe, A.N.P.

cc:

5-10-11- Dr. Ansari 5-25-11 @ 2:30 pm
letter mailed. f

6/7/11 Percocet 10/650mg #90; po q 8^h prn pain URH/PDM
Adipex-P 37.5mg #30 1/2 po bid

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Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

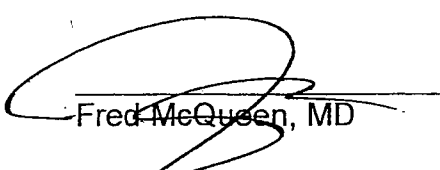
PATIENT: RUMMAGE, VICKIE DOB: [REDACTED] 1959

DATE: 06/30/2011

DICTATING: Fred McQueen, MD

ATTENDING:

We had a long talk. Her blood pressure is perfect today, 127/78. She has been advised that I want her to lose some weight for me. She is the same that she was back in May. She weighed 161 but she did drop down from the spring. On 3/25/11, she weighed 165 so she did drop 4 pounds to 161. I want her to stay on her diet medication, stay on her diet, stay away from red meat and bread unless it is whole wheat bread and stay away from sodas completely. Absolutely no sodas, diet or otherwise. She is to stay away from sugar and use Splenda.


Fred McQueen, MD

cc:

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKY DOB: [REDACTED] 1959

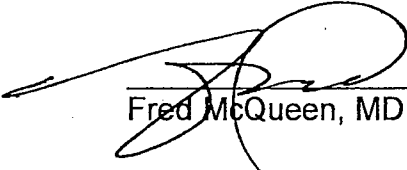
DATE: 09/30/2011

DICTATING: Fred McQueen, MD

ATTENDING:

She comes in today. She is having some dysuria, some burning. She has been advised that she has a trace of blood in her urine and trace ketones and trace protein. Her baby son has a problem with kidney stones and from what I am looking at on her urinalysis I worry about her having a kidney stone. I'd like to go ahead and flush her kidneys first. I am putting her on Pyridium 200 mg 3 times a day for 5 days and having her to drink plenty of water and flush her kidneys, but she is sweating a lot, she is working a lot. She works all night. I am putting her on Nuvigil to help her because she has problems with drowsiness, then when she gets off work she is having a problem going to sleep. So what I would like to do is give her Restoril 30 mg to take in the morning and when she gets ready to go to bed, to unplug the phone, cut out all the noise and no visitors so that she can get her sleep. She should definitely get off in the morning, try to sleep at least 2 or 3 in the afternoon. That way she can get on schedule. She has to do the same thing when she is not working.

The patient has been advised I am keeping her on her Xanax which she takes for her nerves, and I am also writing her Percocet 10/650 #90. She has been advised that the Percocet is a little stronger than the Lorcet, and if it does not hold her pain, we may have to see about getting her into a pain clinic to see what we can do for further different modalities of pain control. She is to be very careful with lifting, pulling or pushing, and I do not like giving her pain medicine so she can keep on working.


Fred McQueen, MD

cc:

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.

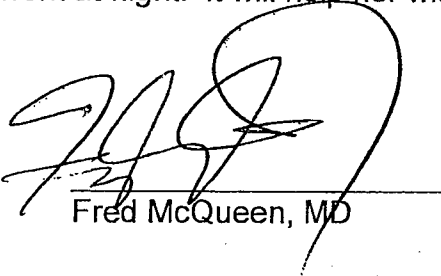


104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKI
DICTATING: Fred McQueen, MD
ATTENDING:

DOB: [REDACTED] 59 DATE: 10/13/2011

I am proud of her weight too. She has gradually come down since the spring. On 3/25/11, she weighed 165. Then in May she dropped to 161. Then she dropped again in September to 160 and today she has dropped to 159. I want her to continue to work on her weight. What I would like is for her to drop on down to 145. I am fixing her Nuvigil 150 and she is to take it when she goes to work at night. It will help her with alertness and I am fixing it for a year.


Fred McQueen, MD

cc:

D-3H11
Rx written Xanax 1mg #90 ref; Percocet 10/650mg #90 ref-10
AD

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



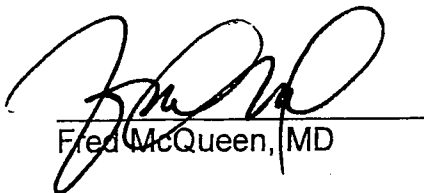
104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKI DOB: [REDACTED] 1959
DICTATING: Fred McQueen, MD
ATTENDING:

DATE: 12/13/2011

Patient comes in today and she is having a lot of problem with chronic pain in her back, neck and shoulders. She has to doff on her job, which handles those big rolls of cloth. I really feel that she is not able to do that. We had her on Percocet but it is not holding her pain. I am stepping her up to MS Contin. For the first dose, she is to just stay at home and don't drive or do anything until she gets used to the medicine. It will take about 2-3 days for her to get accustomed to the stronger medicine. I'd rather her not take it on the job but take it at home. Writing her for Voltaren gel #5 pack to apply twice a day to neck and shoulders. She is to pick up her MS Contin in one month and also pick up her Xanax 1 mg. She is concerned about the deformity of her fingers. Because she has a strong family history for rheumatoid, I really feel that she may have rheumatoid. There is really no cure for it. The main thing is the MS Contin should stop the pain where she can continue to work for just a little while. She also would benefit from being on anti-inflammatory. She is on Indocin SR 75 mg one daily, Lisinopril 20-12.5 and Valifaxen at bedtime. Her weight is at 163. She knows I am upset. She has gained 4 pounds and her blood pressure is perfect. I will put her on Nasonex and she can get Zyrtec across the counter and Allegra. She is not running a fever but I will put her on Z-Pak just to make sure.

Dictated by Fred D. McQueen, Jr., M.D.


Fred McQueen, MD

cc:

1/12/12 - pt is coming in @ 11:00/13/12 for consult with Dr. [unclear]

Chief Complaint: 1/3/12 Vicki Runn
A/CVD Carotid Dz DM Dyslipidemia HTN Osteoporosis PAD Sleep Apnea Truncal Obesity
Depression Homocysteinemia CRF AF Nephropathy Hypothyroidism COPD Metabolic Syndrome

Wt: 163 BP: 110/63 T: 98.6 P: 72 Ht: 5'6" R: 160 BMI: 24.5 WC: 34 Allergies: Pen

Alcohol: ☐ Yes ☒ No # of Drinks: 1 Tobacco: ☒ Yes ☐ No # of Packs: 1 Exercise: ☐ Yes ☒ No Diet: ☐ Yes ☒ No

HPI: pt presents today with test results
Recheck BP
Standing BP
Right Arm BP
Left Arm BP
Glucose Monitoring
Check Med list

ROS:	Const.	Eyes	ENT	Heme/Lymph	Resp	CV	GI	GU	Skin/Breast	MS	Endo	Neuro	Psych	Aller
+														
-														

☐ All other ROS negative ☐ Addressed ROS Sheet

PH: ☐ No change since 1/3/12 FH: ☐ No change since 1/3/12 SH: ☐ No change since 1/3/12

Examination:

General Appearance	NI	Ab	Respiratory	NI	Ab	Genitourinary	NI	Ab	Musculoskeletal	NI	Ab	LLE	NI
Eyes	☒	☐	Respiratory Effort	☒	☐	Female	☒	☐	Gait & Station	☒	☐	Inspection/Palpation	☒
Conjunctiva & lids	☒	☐	Percussion	☒	☐	Ext. genitalia & Vagina	☒	☐	Digits & Nails (Clubbing)	☒	☐	Range of Motion	☒
Pupils & Irids	☒	☐	Palpation of Chest	☒	☐	Urethra	☒	☐	Head & Neck	☒	☐	Foot	☒
Optic Discs	☒	☐	Auscultation	☒	☐	Bladder	☒	☐	Inspection/Palpation	☒	☐	Sensation	☒
Arcus Senilis	☒	☐	Cardiovascular	☒	☐	Cervix	☒	☐	Range of Motion	☒	☐	Observation	☒
ENT	☒	☐	Palpation of Heart	☒	☐	Uterus	☒	☐	Spline, Ribs & Pelvis	☒	☐	Circulation	☒
External ears & nose	☒	☐	Auscultation (MRGs)	☒	☐	Adnexa/Parametria	☒	☐	Inspection/Palpation	☒	☐	Labs	☒
EACs & TMs	☒	☐	Carotids	☒	☐	Male	☒	☐	Range of Motion	☒	☐	ALT	☒
Hearing	☒	☐	Abdominal aorta	☒	☐	Scrotal contents	☒	☐	RUE	☒	☐	Glucose	☒
Nasal mucosa, septum & turbinates	☒	☐	Femoral arteries	☒	☐	Penis	☒	☐	Inspection/Palpation	☒	☐	TSH	☒
Lips, teeth & gums	☒	☐	Pedal pulses	☒	☐	Prostate gland	☒	☐	Range of Motion	☒	☐	Lipid Profile	☒
Oropharynx & tonsils	☒	☐	Edema &/or Varicosities	☒	☐	Skin	☒	☐	LUE	☒	☐	PSA	☒
Neck	☒	☐	GI/Abdomen	☒	☐	Inspection	☒	☐	Inspection/Palpation	☒	☐	CBC	☒
Neck	☒	☐	Truncal Obesity	☒	☐	Palpation	☒	☐	Range of Motion	☒	☐	BMP	☒
Thyroid	☒	☐	Masses, tenderness	☒	☐	Xanthoma	☒	☐	RLE	☒	☐	CMF	☒
Lymphatic (2 or more)	☒	☐	Liver & spleen	☒	☐	Neurologic	☒	☐	Inspection/Palpation	☒	☐	HgbA1C	☒
Neck	☒	☐	Hernia	☒	☐	Cranial nerves	☒	☐	Range of Motion	☒	☐	UA Malbum	☒
Axillae	☒	☐	Anus, perineum & rectum	☒	☐	Deep tendon reflexes	☒	☐				Homocys	☒
Grain	☒	☐	Occult test (if indicated)	☒	☐	Sensation	☒	☐				Lipomed Panel	☒
			Chest (Breasts)	☒	☐	Psychiatric	☒	☐				hsCRP	☒
			Inspection of Breasts	☒	☐	Judgment & Insight	☒	☐					
			Palpation of Breasts & Axillae	☒	☐	A&O x 3	☒	☐					
						Recent & remote memory	☒	☐					
						Mood & affect	☒	☐					

Counseling (if 50%)
Total Encounter Time

- Assessment:
able Unstable
1. Chronic pain
2. DA
3. CDID
4.
5.
6.
7.
8.

Plan:
Rx Vioxx 125mg
Mscophan 30mg
Tasalon Perls 100mg
#180 #20 980
Cipro 500mg b.i.d. 14d
☐ Education materials provided
☐ Exercise & dietary measures encouraged
☒ Management of Rx Meds
☐ Independent visualization of Image/track
☐ Smoking Cessation Counseling
☐ Pre or Post Menopausal Issues Reviewed
☐ Severe exacerbation of chronic problem
☐ Medication side effects reviewed
☐ Acute or chronic illness or injury that poses a threat to life or bodily function
☐ Drug therapy requiring intensive monitor
☐ Discussed with Dr.

McQueen Medical Center
104 Rice Street
P.O. Drawer 1257
Hamlet, N.C. 28345
P422

McQUEEN MEDICAL CENTER

Fred D. McQueen, Jr., M.D.



104 Rice Street • Post office Drawer 1257 • Hamlet, NC 28345 • (910) 582-4003 • (910) 582-4004 • FAX (910) 582-8212

PATIENT: RUMMAGE, VICKI DOB: [REDACTED] 1959

DATE: 01/13/2012

DICTATING: Fred McQueen, MD

ATTENDING:

The patient admits that she had a breach of her contract with me for pain. She is never to take anyone else's pain medication, but her husband was in Columbia at that time, in the VA, and he was sick. She was there, and she did take a Lorcet that was her husband's because she did not have hers, because he was admitted as an emergency, and she did not get time to get home to get her medications. She explained the fact that she admits that she was not supposed to take his medications because she is on Percocet. She did not have hers, and she took her husband's. In answer to the questionnaire, she was under the impression that Percocet and Lorcet were the same drug, but it is not. The Lorcet showed up in her system, but her Percocet was negative. She was positive for her Xanax. She has been advised that is very important that she adheres to her pain contract.

She has been my patient for many years. She first came to see me back in 1991, which is greater than 10 years, going on 11 or 12 years. Now that she understands the urgency of maintaining her contract and maintaining the fact of not taking anyone else's medication, even though it is her husband, she is now taking only her medication. She is to take it as prescribed and not to run out.

Based upon her honesty in telling me about what happened and due to the fact that she now understands, we will give her another chance on her medication because she does have a problem with chronic pain. She has lumbosacral disk disease and cervical disk disease. She has been on a pain regimen and management now for many years. We have changed her to MS Contin 30 mg. She has been advised to keep it locked up at all times. She is to take her medicine only and not let anyone else have her medicine and not to take anybody else's.

Fred McQueen, MD

cc:



HORTON
LAW FIRM, P.A.

DAVID B. WARD
WALLACE A. MULLINAX, JR.
MICHAEL A. FARRY
THOMAS F. DUGAS
BRUCE B. CAMPBELL
W. ANDREW ARNOLD
JEREMY R. SUMMERLIN

VANCE B. DRAWDY
1928-1997

J. WRIGHT HORTON
1919-2011

OF COUNSEL

JOSEPH M. JENKINS, JR.
RICHARD N. TAPP, P.A.

January 12, 2018

VIA EMAIL

Eugenia C. Hollmon
Judicial Department
SC Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Re: Vickie Rummage v. BGF Industries
WCC File No.: 1215681

Dear Ms. Hollmon:

I am writing in response to Andy Safran's letter to you of January 11, 2018 concerning the revised proposed Order by the Appellate Panel of the Full Commission I submitted on January 5, 2018. As set forth in the email from my assistant, the revised proposed Order did include some of the revisions requested by Andy Safran, as well as the revisions requested in your email of December 20, 2017.

The remaining revisions requested by Andy Safran were not included in the proposed Order as the reference to the Michau v. Georgetown County case is a repetitive trauma case, unlike the present case, and the Form 30 does not contain any exception objecting to the introduction of the report of defendants' expert on the grounds that it failed to satisfy the requirements of § 42-9-35.

I would respectfully request that the Appellate Panel consider for signature the revised proposed Order submitted on January 5, 2018.

Eugenia Hollmon
January 12, 2018
Page 2

With kind regards, I remain,

Yours very truly,

HORTON LAW FIRM, P.A.

A handwritten signature in cursive script, appearing to read "Michael A. Farry".

Michael A. Farry

MAF/lc

cc: Andrew N. Safran (via email)
Strategic Comp Services, 564576533

ANDREW N. SAFRAN, LLC
ATTORNEY AT LAW
1400 PICKENS STREET, SUITE 300
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803.256.6689
FACSIMILE: 803.799.1003

MAILING ADDRESS
POST OFFICE BOX 12089
COLUMBIA, SOUTH CAROLINA 29211

January 11, 2018

VIA E-MAIL ATTACHMENT

Ms. Eugenia Hollmon
Judicial Department
South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Columbia, South Carolina 29201

RE: Vicki W. Rummage v. BGF Industries, Inc.
and Great American Alliance Insurance Company,
c/o Strategic Comp Services
W.C.C. File No.: 1215681

Dear Eugenia:

Following consideration of the parties' written and oral arguments relative to the above-captioned matter, the Appellate Panel requested Mike Farry, counsel for Defendants, to prepare a proposed order affirming the Hearing Commissioner's ruling that Claimant, Vicki W. Rummage, had not established an aggravation of her preexisting psychological condition. After reviewing the proposed order prepared by Mr. Farry, which encompasses 44 pages, I requested insertion of a comparatively limited amendment that is conspicuously identified in the attached revised Order draft.

While Mr. Farry included a small portion of this language in the proposed Order that he has submitted to you for the Panel's consideration, he has declined to insert the remainder based upon the contention this issue was not adequately preserved/advanced on appeal. I respectfully disagree with this position, as the proposed language clearly reflects the thrust of my position that the Hearing Commissioner's ultimate denial of Ms. Rummage's claimed aggravated condition is inconsistent with the only reasonable evidentiary inference, not supported by competent evidence and the product of an unlawful procedure.

Inspection of our March 28, 2017 W.C.C. Form 30 confirms the presence of multiple exceptions addressing the lack of evidentiary basis for the Hearing Commissioner's ultimate ruling, asserting it is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record and the product of an "unlawful adjudication process". Among others, exceptions 12, 30, 40, 44, 50 and 55 speak to our position as to this absence of evidentiary basis, the flawed opinions of Defendants' designated evaluator and the unlawful adjudication process, as well as our belief the only

Ms. Eugenia Hollmon
January 11, 2018
Page 2

reasonable inference arising from the evidence verifies Ms. Rummage's compliance with the provisions of S.C. Code Ann. Section 42-9-35 (2007).

Our Memorandum similarly/consistently advances our position as to the absence of competent evidence supporting the denial of Ms. Rummage's claim for treatment of the aggravated psychological condition. It likewise maintains the Hearing Commissioner's conclusion that Ms. Rummage "has failed to prove an aggravation of her pre-existing psychological condition per Section 42-9-35" results from "an arbitrary, capricious and unlawful adjudication procedure, which is wholly inconsistent with the competent evidence of record."

This focus on this absence of evidentiary basis was further highlighted during oral argument, where several inherent flaws of Defendants' evaluator's opinions were discussed. My arguments not only focused on obvious indications his report was created prior to actually seeing Ms. Rummage, but also the fact it could not rebut the only reasonable inference arising from the hearing record due to the absence of compliance with Section 42-9-35, which rendered opinions not stated to a reasonable degree of medical certainty incompetent. In fact, this argument prompted Commissioner McCaskill to specifically question Mr. Farry as to whether his evaluator's opinions were stated in this fashion, triggering a responsive acknowledgement the operative words were not utilized.

While I certainly recognize the Panel has elected to affirm the Hearing Commissioner's determination, the fact remains the arguments referenced in my requested amendment to the proposed Order accurately reflect the position we have pursued on appeal. Although the Panel members were not persuaded by these arguments, they undoubtedly considered the merits of each contention identified in my amendment to Mr. Farry's proposed Order. I consequently respectfully request that the Panel include my limited revision in its final Order.

Thank you for your cooperation.

With kindest regards, I am

Very truly yours,

A handwritten signature in black ink, appearing to read "Andrew N. Safran", with a stylized flourish at the end.

Andrew N. Safran

ANS/pfb

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION.

VICKIE RUMMAGE,

Employee

-VS-

BGF INDUSTRIES, INC.,

Employer

and

GREAT AMERICAN ALLIANCE INSURANCE
COMPANY C/O STRATEGIC COMP SERVICES,

Carrier

WCC FILE NUMBER:
1215681

Deposition of VICKIE RUMMAGE, a witness called by Counsel on behalf of the Employer, pursuant to the applicable provisions of the South Carolina Rules of Civil Procedure, taken before Holly Gleason, a Professional Court Reporter and Notary Public in and for the State of South Carolina, on Monday, December 9, 2013, at the Law Office of Andrew N. Safran, Esquire, Safran Law Offices, 1400 Pickens Street, Suite 104, Columbia, South Carolina, commencing at the hour of 1:01 p.m.

Page 3

INDEX

STIPULATIONS	4
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OBJECTIONS:

[None]

EXHIBITS

<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>PAGE</u>
	[None entered]	

LEGEND OF THE TRANSCRIPT

dashes [--] intentional or purposeful interruption
[ph] denotes phonetically written
[sic] written as said

Page 2

APPEARANCES

Andrew N. Safran, Esq.
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REPRESENTING THE EMPLOYEE

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770-225-4572
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REPRESENTING THE CARRIER

Page 4

STIPULATIONS

It is hereby stipulated and agreed by and between counsel for the respective parties that the Witness will waive the reading and signing of the deposition transcript.

Whereupon,

VICKIE W. RUMMAGE,

having been first duly sworn,
was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LOCKHART:

Q. Ms. Rummage, good afternoon, ma'am. My name is Jason Lockhart. I'm a lawyer here in Columbia. I represent BGF and their workers' compensation insurance company in your workers' comp case.

A. Okay.

Q. And I'm here this afternoon to take your deposition.

A. Okay.

Q. Have you ever had your deposition taken before?

A. No, sir.

Q. Well, a deposition is just a legal term to describe a conversation that you and I are

going to have this afternoon in the presence of your lawyer.

A. Okay.

Q. I'm going to ask you some questions about your job over with BGF, then we're going to talk about your work accident.

A. Okay.

Q. Then I want to talk to you about the medical care you've received for the injuries that you sustained.

A. Okay.

Q. Then I want to talk to you about what kind of problems you still may be having as a result of your work accident.

A. Yes, sir.

Q. Normally, this takes about an hour or so, and I'll try to get through my questions as efficiently as I can so as to not take up too much of your time.

A. Yes, sir.

Q. Mr. Adams, who's the adjustor on your workers' comp case, he may be coming to the deposition.

A. Okay.

Q. So if he comes in at some point, I don't want you to be alarmed or disturbed.

Q. And then, finally, if at any point during the deposition you need to go to the restroom or take a break for any reason, let me know and I'll let you take whatever breaks you need to, okay?

A. Okay.

Q. Ms. Rummage, if I could get you to state your full name for the record, please.

A. Vickie W. Rummage.

Q. And, Ms. Rummage, what's your present address?

A. 5579 Highway 1 North, Wallace, South Carolina 29596.

Q. And who lives with you in that residence in Wallace?

A. My husband, Darryl, and my youngest son, Robin.

Q. And how long have you and Darryl been married?

A. All our life.

Q. All your life.

A. All our life. Thirty -- we just had an anniversary, 38 -- 39 years.

Q. Well, congratulations, that's something to be proud of. I assume he's the only gentleman you've ever been married to?

A. Yes, sir.

Q. And you said your one son lives with you.

A. Okay.

Q. But he may be or he may not.

A. That's fine.

Q. Just a couple things to keep in mind during the course of the deposition, and the first is that the court reporter is taking down everything we say to each other, so I need you to speak your answers for me, okay?

A. Yes, sir.

Q. If you nod your head or your shake your head, I may understand your response, but the court reporter can't take down what's called a nonverbal response.

A. Yes, sir.

Q. Secondly, if I ask you a question that you don't understand or is any way confusing to you, let me know and I'll be happy to repeat myself.

A. Okay.

Q. I'm not here to trick you or mislead you in any way, so it's important that you understand my questions. And if you answer my question, I'm going to assume that you understood what I was asking.

A. Okay.

Do you have any other children at all?

A. Yes, sir, I do.

Q. How many total do you have?

A. I have two boys, total.

Q. And your son that lives with you, how old is he?

A. He's 27.

Q. Other than your children or your husband, is there anyone in your life, family, friends, who rely upon you for financial support?

A. No, sir.

Q. And how long have you lived at 5579 Highway 1 North in Wallace?

A. Thirty -- it's been 38 years, 39 years, but the address changed, you know. We had a box address, so it -- it did change.

Q. When 911 came along, --

A. Yes, sir.

Q. -- I guess they had to give you an address.

And is that a house, or a mobile home, or an apartment? What type of residence do you live in?

A. Double-wide mobile home.

Q. Do you own that home or do you have a mortgage on it? Do you rent it?

1 A. We have a mortgage.
 2 Q. And your husband is here at the deposition
 3 today?
 4 A. Yes, sir.
 5 Q. And what does he do? Where does he work?
 6 A. He's disabled.
 7 Q. And what's your date of birth, Ms. Rummage?
 8 A. 12/9, 1959.
 9 Q. So you've got a birthday coming up, is it --
 10 A. Today.
 11 Q. -- today? Well, not the way I'm sure you
 12 planned on spending your birthday. I apologize
 13 about that.
 14 So how old are you today? Let's see.
 15 A. Fifty-four.
 16 Q. Fifty-four. How far did you go in school?
 17 A. I finished high school and then I went back and
 18 got some degrees at tech later on in life after
 19 my children were up in age.
 20 Q. When did you graduate from high school?
 21 A. 1979.
 22 Q. And you said you went to tech to get some --
 23 A. Yes.
 24 Q. -- degrees. What tech school did you go to?
 25 A. Northeastern Technical College.

1 Q. And, I'm sorry, where is that located at?
 2 A. Cheraw, South Carolina.
 3 Q. And what did you study there?
 4 A. I studied multiple skills. CNA, --
 5 Q. Go ahead, I'm listening.
 6 A. -- phlebotomy, home health, computer.
 7 (Mr. Adams joins deposition)
 8 MR. LOCKHART: Y'all want to hold on for
 9 just a minute?
 10 MR. SAFRAN: Sure.
 11 (Brief Recess)
 12 BY MR. LOCKHART:
 13 Q. Ms. Rummage, we took a brief recess. You were
 14 telling me about your studies at the technical
 15 school in Cheraw. You were telling me about
 16 the various things that you studied there.
 17 Anything else, other than what you've told
 18 me about?
 19 A. There was numerous degrees, but I can't
 20 remember all of them.
 21 Q. So you do actually have some degrees from this
 22 technical school?
 23 A. Yes, sir, I do.
 24 Q. Any other studies at any other colleges, or
 25 technical schools, or universities, other than

1 your studies at tech in Cheraw?
 2 A. No, sir.
 3 Q. Have you ever served in the military?
 4 A. No, sir.
 5 Q. Within the last five years, have you either
 6 pled guilty to a crime or been convicted of a
 7 crime by a jury?
 8 A. No, sir.
 9 Q. Other than the workers' comp claim we're here
 10 to talk about today, have you ever filed a
 11 workers' comp claim before?
 12 A. Yes, sir, it was a small one and didn't turn
 13 into anything, and I can't actually remember
 14 when, but my husband's insurance paid what it
 15 was.
 16 Q. Where were you working or who were you working
 17 for when you were injured?
 18 A. Cheraw Police Department.
 19 Q. Do you remember how you were injured?
 20 A. No, sir, it's been a while. It was to my
 21 rotator cuff.
 22 Q. And on which side?
 23 A. Right.
 24 Q. Did you receive any type of workers' comp
 25 benefits?

1 A. No, sir, I did not.
 2 Q. Did your case go to a hearing and all before
 3 the workers' comp commission?
 4 A. I can't remember, sir. I really can't
 5 remember.
 6 Q. Did you have a lawyer?
 7 A. No, sir.
 8 Q. Other than your rotator cuff, did you injure
 9 any other parts of your body?
 10 A. No, sir.
 11 Q. And did you receive any type of settlement as a
 12 result of this?
 13 A. No, sir.
 14 Q. Is that the only workers' comp claim you ever
 15 had?
 16 A. Yes, sir.
 17 Q. Ms. Rummage, have you ever been involved in an
 18 automobile accident?
 19 A. Yes, sir, but it's been so many years I can't
 20 remember.
 21 Q. Were you injured at all in the accident?
 22 A. No, sir, not that I can remember.
 23 Q. Was there any type --
 24 A. Not seriously.
 25 Q. Do you recall treating with a physician at all

following this automobile accident?

A. I can't remember.

Q. Was there any type of lawsuit that came about as a result of this car accident?

A. No, sir.

Q. Have you ever been involved in a lawsuit as a plaintiff, and when I ask you that question, I mean have you ever filed a lawsuit against another person or an entity in a court of law?

A. No, sir, not that I can remember.

Q. Have you ever been involved in a lawsuit as a defendant, and when I ask you that question, I mean has anyone ever sued you before?

A. No, sir.

Q. Have you ever filed for or received unemployment benefits?

A. Yes, sir.

Q. When was the last time you would have received unemployment?

A. Actually, with BGF during the process of my hiring process.

Q. Were you placed on a layoff, is that why you were given unemployment?

A. Yes, sir.

Q. How long ago has that been?

A. I can't remember, sir, 'cause I've been out of work over a year now.

Q. Are you receiving unemployment at the present time?

A. No, sir, I was working.

Q. Have you filed for unemployment since you last worked for BGF?

A. No, sir.

Q. What's your current source of income right now?

A. Workman's comp.

Q. Other than your weekly workers' comp checks, what other income do you have at the present time?

A. None.

Q. You said your husband is disabled. Does he receive disability benefits?

A. Yes, sir.

Q. Is that because of a workers' comp claim or through some other source?

A. No, sir, it's due to health.

Q. Is this through the military or through some other means, or?

A. It's -- I don't know, sir, it's just health problems that disability -- he had to give up truck driving for disability.

Q. Since you last worked with BGF, have you filed for Social Security benefits?

A. No, sir.

Q. Ms. Rummage, let me talk to you for a moment about your job with BGF, and then we're going to move on and talk about your work accident for a moment.

Based on some information I have, I have your date of hire there as May 17, 2010; does that sound about right to you?

A. Yes, sir, 'cause I worked for a couple years temporary before I got hired on for permanent.

Q. Was that through a temp agency?

A. Yes, sir.

Q. Do you remember the temp agency that you worked through?

A. I think it was Olsten. I'm not sure.

Q. Olsten?

A. Olsten.

Q. Olsten.

A. O-l-s-t-o-n, I think. I'm --

Q. And where were they located?

A. In Cheraw.

Q. When you began working with BGF, were you working anywhere else at all?

A. Yes, sir, I was working a part-time job with the gym in Cheraw.

Q. And what was it called?

A. Fitness World.

Q. Is it still around?

A. Yes, sir.

Q. And what was your job there?

A. I helped manage and take care of the place in the afternoons.

Q. When your work accident happened in May of 2012, were you working anywhere else at all besides with BGF?

A. No, sir.

Q. Why did you leave Fitness World, ultimately?

A. It was part time, and then BGF gave me a full-time job which I was looking for.

Q. When you started working with BGF, what was your job?

A. Weaver.

Q. And was that the job that you were performing when your work accident happened?

A. Yes, sir.

Q. Is that the only position that you ever held with BGF?

A. Yes, sir.

Q. Tell me what a weaver does.

A. We watch the looms run yarn through that winds in the cloth, and it runs at a real high rate of speed, and you have to watch the quality of the cloth, keep the ends out, and you have to doff the machines when the rolls are at certain yards of cloth.

Q. When your work accident happened in May of 2012, who was your supervisor? Who did you answer to?

A. Sidney O'Neill.

Q. And is that a man or a woman?

A. A man.

Q. And how long had Mr. O'Neill been your supervisor?

A. Ever since I started at BGF.

Q. Did you have anyone else that you answered to on a day-to-day basis besides Mr. O'Neill?

A. No, sir.

Q. Were you a supervisor when you were there?

A. No, sir.

Q. And when did you last work?

A. I think it was August -- September the 24th, I believe.

Q. Of 2000 and --

Q. What would they help you out doing?

A. Like doffing, you know, the doffing machine and stuff like that.

Q. Anything else that you can recall that they would help you out with besides the doffing?

A. I can recall one night, we were running some bright colored cloth, and I started getting dizzy, and I went to them and they put another weaver on that job and switched me out.

Q. When you were working with BGF, this is around the time your accident happened, do you remember what your rate of pay was?

A. 11.34.

Q. Per hour?

A. Yes, sir.

Q. And how many hours a week did you work?

A. It varied. Sometimes we worked -- most of the time 40 hours, but sometimes there was six and seven days, and then sometimes there was short periods where they would lay off, rotate out.

Q. When you last worked for BGF in September of 2012, were you working 40 hours a week?

A. Yes, sir.

Q. When you last worked for BGF in September of 2012, would you drive yourself to and from work

A. '12.

Q. What happened on that day? Why was that your last day of work?

A. That's when the workmen's comp doctor took me out.

Q. When you last worked over at BGF in September of 2012, were you doing your regular job as a weaver or did they have you doing another job?

A. I was doing my regular job.

Q. At any point in time between your accident in May of 2012 and when you last worked with BGF in September of 2012, did you ever work on what we would call light duty or modified duty, or did you work as a weaver during that entire time?

A. I weaved, but they -- they looked out for me, they did.

Q. And when you say they, is that Mr. O'Neill or other people?

A. Well, people around you that know you had something going on, that would kind of chip in and help.

Q. Who are some of those folks that would help you out?

A. Sir, I can't remember. I mean, --

or did someone else drive you to work?

A. I drove most of the time.

Q. And how far of a drive would that be for you?

A. About ten minutes.

Q. When was the last time that you had any contact or communication with anybody over at BGF; do you remember?

A. When they asked for my stuff back.

Q. And how long ago has that been?

A. In September my husband drove me out there and he took it in the door for me.

Q. That would be September of this year?

A. Yes, sir.

Q. And who did you speak with or --

A. Vicky Bostic.

Q. Who is that?

A. She's HR in Cheraw.

Q. Did you speak with her over the phone?

A. No, sir, she walked to the vehicle.

Q. So you spoke to her in person?

A. Yes, sir.

Q. Did you speak with anybody else on that day?

A. No, sir.

Q. Have you worked anywhere at all since you last worked for BGF?

1 A. No, sir.

2 Q. Ms. Rummage, let's talk about your work
3 accident for a moment, and then we're going to
4 move on and talk about the doctors that you've
5 seen for your injuries.

6 I've got May 18, 2012 as the date of your
7 accident; does that sound correct to you?

8 A. Yes, sir.

9 Q. What time would you have gotten to work that
10 day?

11 A. Our work starts at 12 o'clock.

12 Q. Is that a.m. or p.m.?

13 A. At night, third shift.

14 Q. How long had you been at work that night before
15 your accident happened; do you remember?

16 A. I got there and the accident probably happened
17 before my first break. I was getting ready to
18 go to break when it happened. I had stopped
19 the machine off and was trying to clean waste
20 out of the roll of cloth, yes, sir, and that
21 would have had to be around 3:00.

22 Q. 3:00 a.m.?

23 A. Yes, sir.

24 Q. Tell me how your accident happened.

25 A. When I weave -- I have to visualize a lot of

1 stuff now, but when I weave, if my break period
2 came up before -- you know, at time for me to
3 take a break, I would cut my machine -- unroll
4 my machine and cut it off if they didn't have
5 anybody to relieve it, and go take a break and
6 then come back, but that night I had run it up
7 'til time to take a break. My machine was
8 ready to doff, so I just stopped the machine
9 off at the yardage it was supposed to be and
10 walked around to the back to clean waste from
11 the yarn, and I didn't know that somebody had
12 put a doff truck behind me, because I was going
13 to take my break before I doffed my roll of
14 yarn, and as I was cleaning the waste, and I
15 got through cleaning my waste, I went to take a
16 step back to turn around to go log out of my
17 machine, and when I -- before I could ever take
18 a whole step back, the bottom of the doff truck
19 caught my leg.

20 Q. What happened next?

21 A. I lost my balance and started falling, and I
22 can remember going down, and I could -- you
23 know, I was thinking if I could break the fall
24 with my butt on the part that doffs the yarn,
25 and then when I hit, it couldn't, and it

1 threw the back of my head and my neck into
2 the metal part that doffs the truck off.

3 Q. Did you land on your behind first?

4 A. Yes, sir, I did.

5 Q. You said your head struck something with --

6 A. Yes, sir, this right here in my head and the
7 chain cut this side of my neck and grazed it
8 (indicating).

9 Q. You are pointing to the back, right side of
10 your head and --

11 A. Yes, sir, it was busted on the right side
12 'cause you have a metal part that doffs the
13 roll up and it's -- it's got a big thick chain
14 on it, and this side caught the metal and down
15 here caught the chain on my neck (indicating).

16 Q. And you're talking on the bottom, left of the
17 left side of your neck?

18 A. Yes, sir.

19 Q. Right above the collar of your shirt?

20 A. Down in here, yes, sir (indicating).

21 Q. What happened next?

22 A. I was really, really dazed, and the boy that
23 put the doff truck there was standing in front
24 of me, and I can't remember everything that
25 happened from there.

1 Q. Who is this fellow that was there when you
2 fell?

3 A. His name was Ethan. He was temporary.

4 Q. Okay.

5 A. Now, I think, he's full time.

6 Q. Did you get up on your own power or did you
7 have to have somebody help you up?

8 A. He helped me.

9 Q. Ethan did?

10 A. Uh-huh.

11 Q. What happened next?

12 A. He -- he walked behind me and he said, I think,
13 Ms. Vickie, you're bleeding. I was so dazed, I
14 can't remember, and he said that he was going
15 to get Sidney, and they took me to the room,
16 you know, up front and --

17 Q. When you say the room, is this a nurse's
18 station?

19 A. First aid, yes, sir.

20 Q. Did you lose consciousness at all?

21 A. I was dazed, so 'til -- I just can't remember.

22 Q. I mean, do you recall being awoken by anybody?

23 A. No, sir.

24 Q. They took you up front, what happened next?

25 A. I really can't remember, but I think some glue

was applied to my head to glue it back together.

Q. This was applied to your head?

A. Yes, sir.

Q. How about to your neck?

A. No, sir, it was cleaned up, I believe.

Q. Were you offered the opportunity to go to the doctor?

A. Yes, sir, I was.

Q. What was your response?

A. I told them that, you know, I'd rather try to stay.

Q. Any particular reason why?

A. There was.

Q. And what was that?

A. I was on probation again because I had to be out with my husband sick, and they had put me on probation and told me I couldn't miss any time, and had put me back through training, and I didn't want to lose my job.

Q. How much longer would you have worked that night?

A. I stayed.

Q. You completed your shift?

A. Yes, sir, I did.

Q. Did you continue to do your job as a weaver that night?

A. No, sir, not very much of it.

Q. What did you actually do?

A. Basically, just sat in the canteen and, you know, maybe walk back out to the machine.

Q. When you left that night, did you drive yourself home?

A. After my shift, yes, sir.

Q. Did you work the next day?

A. Yes, sir, they offered to go to the doctor and I, you know, thought I would be okay. Well, it was the weekend, that's it. It was the weekend and I thought I would be okay, but that weekend was bad, and I tried it a couple more days and I told the personnel lady, Karen, I said, Karen, I said, my head, I said, I'm having such bad headaches, so I'd rather just go on and get my head checking now -- checked out, if I could.

Q. So you were injured on a Friday and then you tried to recover over the weekend?

A. Yes, sir.

Q. Then you tried to go back to work on Monday?

A. Yes, sir.

Q. And it was at that point that you were offered the opportunity to go to a doctor?

A. No, I was offered that night.

Q. Who was the first doctor that you would have gone and seen as a result of your accident?

A. They sent me to John Frank Mcleod, their workmen's comp doctor.

Q. He's the company doctor?

A. Yes, sir.

Q. Had you ever seen him before for any reason?

A. Yes, sir.

Q. Why would you have seen him previously?

A. He has been the family doctor in the past.

Q. He's been your family doctor?

A. Yes, sir.

Q. So you had seen Dr. Mcleod prior to May 18, 2012?

A. Yes, sir.

Q. What types of things had you seen him for prior to May 18, 2012?

A. Just physical stuff, colds and blood pressure and --

Q. Anything else?

A. No, sir.

Q. When you went to see Dr. Mcleod for the first

time after your accident occurred, what type of problems did you tell him you were having?

A. My head, my neck, my back, and my legs.

Q. What types of problems in particular were you having with your neck and your back and your legs?

A. Well, I was really concerned mainly about my head, that was my main concern.

Q. Well, what type of problems in particular did you tell him you were having with your neck and back and legs?

A. The same thing that I'm having now with my neck: pains, stiffness, pain going up through my head, now coming down through my shoulder, down through my arm, but it's gotten worse since then.

Q. What type of treatment did Dr. Mcleod provide to you?

A. He just gave me -- he did CT scan and gave me medication.

Q. Did he discuss the results of the CT scan with you?

A. Yes, sir.

Q. What did he tell you the CT scan showed?

A. Concussion and whiplash.

1 Q. How long did you treat with Dr. Mcleod for your
2 work injuries?
3 A. They maybe had left me there a month or so, it
4 wasn't long, and they stopped me from seeing
5 him to try to get me in somewhere else.
6 Q. Did you experience any improvement of your
7 problems with the treatment you received from
8 Dr. Mcleod?
9 A. I kept getting worse as the day went -- as the
10 days went.
11 Q. Who is the next doctor that you would have seen
12 for the injuries you suffered in your work
13 accident?
14 A. Dr. Benjamin, at the beach.
15 Q. And were you referred to Dr. Benjamin by
16 workers' comp?
17 A. Yes, sir.
18 Q. I believe I've got a copy of his records. It
19 looks like he saw you for the first time in
20 September 2012; does that sound about right to
21 you?
22 A. Yes, sir.
23 Q. When you would go and see Dr. Benjamin, how
24 would you get there, would you drive yourself?
25 A. No, sir, my husband drove me.

1 Q. When you went to see Dr. Benjamin for the first
2 time, what type of complaints did you provide
3 to him?
4 A. My neck and my head.
5 Q. And what type of treatment did Dr. Benjamin
6 provide to you?
7 A. He tried nerve blocks on both sides and
8 medication.
9 Q. How many injections do you think Dr. Benjamin
10 gave you?
11 A. Two.
12 Q. Did you experience any improvement with those
13 injections?
14 A. It seemed like I did on the right side, but not
15 the left side.
16 Q. He also gave you medication?
17 A. Yes, sir.
18 Q. The last record I have from him is from
19 November of 2012.
20 Do you think you've seen Dr. Benjamin at
21 all since November of 2012?
22 A. No, sir, workmen's comp changed me from
23 Dr. Benjamin and started sending me to
24 Dr. Collins in Florence.
25 Q. Is Dr. Collins the next doctor that you would

1 have seen?
2 A. Yes, sir, that's who they sent me to.
3 Q. The first note that I have from Dr. Collins is
4 dated December 17, 2012; does that sound about
5 right to you?
6 A. Yes, sir.
7 Q. When you saw Dr. Collins for the first time,
8 did you provide any medical history to him
9 about other doctors you had seen in the past,
10 medications you were taking at the time that
11 you saw him?
12 A. From Dr. Benjamin, yes, sir.
13 Q. Did you provide Dr. Collins with any other
14 medical history at all about any problems you
15 had had in the past, not even problems related
16 to your accident, but problems that even
17 preexisted those?
18 A. He didn't ask.
19 Q. What type of complaints did you provide to
20 Dr. Collins when you saw him initially?
21 A. Headaches, dizziness, ringing in the ears,
22 blurred vision, and neck pain.
23 Q. And what type of treatment has he provided to
24 you?
25 A. Medication and trigger points.

1 Q. How many trigger point injections have you had?
2 A. Sir, I don't remember.
3 Q. Have you had any of those recently?
4 A. Yes, sir, I had some last month.
5 Q. Did you experience any improvement of your
6 symptoms with the trigger point injections?
7 A. It seemed like it helped a little bit, and I do
8 believe he's done everything he can in his
9 power. He's really tried.
10 Q. When you say the injections have helped some,
11 how have they helped?
12 A. It would like, maybe, ease the pain a little
13 bit in my neck for maybe a day or two, and then
14 it goes back to the same old same old.
15 Q. His medical records indicate that at some point
16 he was discussing a TENS Unit with you.
17 Has he given you a TENS Unit?
18 A. Workmen's comp has not approved anything. He's
19 -- he's tried to get me things and workmen's
20 comp hasn't approved it.
21 Q. He referred you to an optometrist or an eye
22 doctor, didn't he?
23 A. Yes, sir.
24 Q. Did you see the eye doctor?
25 A. Yes, sir.

1 Q. Dr. Covington?
 2 A. In Cheraw.
 3 Q. What was your understanding as far as
 4 your vision was concerned after seeing
 5 Dr. Covington?
 6 A. That he thought it was the same, but -- yes,
 7 sir, he thought it was the same as it had been.
 8 Q. Was Dr. Covington treating you for any type of
 9 vision problems or anything?
 10 A. No, sir.
 11 Q. Have you undergone any physical therapy while
 12 under the care of Dr. Collins?
 13 A. Yes, sir.
 14 Q. How long has it been since you last underwent
 15 physical therapy?
 16 A. I can't remember the dates.
 17 Q. Was there a period of time when you were going
 18 to physical therapy?
 19 A. Yes, sir.
 20 Q. And how frequently were you going?
 21 A. Two times a week, maybe three times a week.
 22 Q. And when you would go to physical therapy,
 23 where were they providing you with therapy; in
 24 other words, what parts of your body were they
 25 addressing?

1 A. My neck and shoulders (indicating).
 2 Q. You're pointing to your shoulder and your neck?
 3 A. Here and (indicating) -- uh-huh.
 4 Q. Did you experience any improvement of your
 5 problems with physical therapy?
 6 A. Yes, sir, it seemed to help, but when I would
 7 go back, they would say it was knotted back up.
 8 Q. How would it help?
 9 A. It seemed to relieve the pressure and the pain.
 10 Q. Are you still taking medications prescribed to
 11 you by Dr. Collins?
 12 A. Yes, sir, I am, but I have not had anything
 13 today because I wanted to have a clear head.
 14 Q. How many medicines does he have you taking
 15 right now?
 16 A. Sir, I can't remember and I didn't bring it
 17 with me.
 18 Q. When was the last time you saw Dr. Collins?
 19 A. In November, but I have an appointment to go
 20 back this Wednesday.
 21 Q. When you saw him in November, what type of
 22 problems did you tell him you were having?
 23 A. Basically, the same thing.
 24 Q. And you said you're supposed to see him on
 25 Wednesday, which would be the 11th?

1 A. Yes, sir.
 2 Q. As far as your work status is concerned right
 3 now, does Dr. Collins have you out of work
 4 entirely or has he released you to return to
 5 work with restrictions?
 6 A. They wouldn't -- he wouldn't let me go back,
 7 and they terminated me September 24th from the
 8 job.
 9 Q. What is your work status right now, though,
 10 following this visit in November; did he write
 11 you out of work or did he release you to go
 12 back with restrictions?
 13 A. I'm out of work.
 14 Q. Other than referring you to Dr. Covington, and
 15 you told me that you actually did see him, has
 16 Dr. Collins referred you to any other
 17 physicians?
 18 A. He's tried, but no approval.
 19 Q. When you go and see Dr. Collins, does your
 20 husband attend those appointments with you?
 21 A. Yes, sir. If he doesn't go in, he's outside.
 22 Q. Does anyone else from your family attend those
 23 appointments?
 24 A. No, sir.
 25 Q. Who's Dr. McQueen?

1 A. He was a doctor that I had seen some in Hamlet,
 2 North Carolina, and I -- actually, he was a
 3 family doctor that I had seen prior to Dr.
 4 McLeod when you couldn't see him. So, I mean,
 5 I would use whichever one I could get in to.
 6 Q. How long was Dr. McQueen your family doctor?
 7 A. Sir, I can't remember, but I do know that he
 8 had taken me out of work for my blood pressure,
 9 and I had seen him on several occasions.
 10 Q. Were you treating with Dr. McQueen at the time
 11 of your work accident?
 12 A. Yes, sir.
 13 Q. What type of medical problems or health
 14 conditions was Dr. McQueen treating you for at
 15 the time your work accident occurred?
 16 A. Blood pressure.
 17 Q. What else?
 18 A. Just little medical -- like blood pressure and,
 19 you know, thyroid and stuff like that,
 20 whatever.
 21 Q. Was Dr. McQueen treating you for chronic pain?
 22 A. He had given me something in the past for pain,
 23 yes, sir.
 24 Q. Was Dr. McQueen treating you for neck or back
 25 problems?

1 A. I can't remember, sir. The main thing I can
2 think of is my leg.
3 Q. Which one?
4 A. My left one.
5 Q. Was Dr. McQueen treating you for psychological
6 problems like depression or anxiety?
7 A. He had in the past, when -- like when my
8 parents passed away or something, he had give
9 me something.
10 Q. At the time that your work accident occurred,
11 were you taking prescription medications that
12 were prescribed to you by Dr. McQueen?
13 A. I was taking blood pressure medications.
14 Q. Were those the only medications that you were
15 taking that were prescribed by Dr. McQueen at
16 the time your work accident occurred?
17 A. That's the only thing I can remember taking at
18 the time.
19 Q. Had Dr. McQueen ever made any recommendations
20 to you about no longer working because of your
21 chronic health problems?
22 A. Not that I can remember, sir.
23 Q. Have you informed, or at any point in time,
24 talked with Dr. Collins about the medical care
25 you received from Dr. McQueen and the

1 medications that were prescribed to you by Dr.
2 McQueen?
3 A. No, sir, we've only talked about Dr. Benjamin
4 because I haven't seen McQueen. I haven't seen
5 -- only the work -- the workmen comp doctors.
6 Q. Have you seen Dr. McQueen at all since your
7 work accident occurred?
8 A. Yes, sir, I did.
9 Q. The last record that I have from him is from
10 January 28, 2013; does that sound about right
11 to you or do you think it was some other time
12 that you would have last seen him?
13 A. I can't remember. I can't remember. I can't
14 remember going to him in January of 2013, no,
15 sir.
16 Q. His records reflect that he gave you a
17 prescription refill for Percocet, Xanax, and
18 Adipex?
19 A. I don't remember that, sir.
20 Q. Have you ever taken Adipex that was prescribed
21 to you by Dr. McQueen?
22 A. Yes, sir, I have, due to the fact when I broke
23 my leg he would give it to me sometimes to take
24 the weight off -- to try to keep my weight off
25 -- keep from putting so much weight on my leg.

1 Q. Would you have any problems with the use of the
2 Adipex, any side effects at all?
3 A. I didn't use it that much.
4 Q. When you used it, would you have any side
5 effects?
6 A. No, sir.
7 Q. Had Dr. McQueen ever advised you that the
8 Adipex would aggravate migraine headaches?
9 A. No, sir.
10 Q. Is there any particular reason why you haven't
11 seen Dr. McQueen in nearly a year?
12 A. No, sir, I just, you know, was going back to
13 Dr. McLeod. When I went back for my accident,
14 I just kept following up with him.
15 Q. If we have a record from Dr. McQueen that's
16 dated May 14, 2012, which is about four days
17 before your accident, would you have any reason
18 to dispute that record?
19 A. I can't remember.
20 Q. Are you still taking any prescription
21 medications right now that are prescribed to
22 you by Dr. McQueen?
23 A. No, sir.
24 Q. Prior to May 18, 2012, had you ever complained
25 to Dr. McQueen specifically about lower back

1 problems?
2 A. Yes, sir. Now, I have talked about my back.
3 Q. Prior to May 18, 2012, had you ever
4 specifically complained to Dr. McQueen about
5 having problems with your neck?
6 A. Not that I can remember.
7 Q. Not that you can remember or that you've never
8 complained to him about?
9 A. Not that I can remember complaining to him.
10 Q. Before we move on from Dr. McQueen, I want to
11 make sure I'm clear.
12 You told me that at the time your work
13 accident happened, you were taking prescription
14 medications for high blood pressure; is that
15 correct?
16 A. Yes, sir. Yes, sir.
17 Q. Were you taking any other prescription
18 medications at all at the time of your work
19 accident, besides your high blood pressure
20 medication?
21 A. I can't remember, sir, because I know that I
22 would be treated for sinus infections.
23 Q. I understand that, but I mean as far as you can
24 remember, the only medicine you were taking at
25 the time your work accident happened was

prescription medicine for high blood pressure?

A. High blood pressure and maybe some sinus medicine, yes, sir.

Q. Other than Dr. Mcleod and Dr. Collins and Dr. Benjamin and Dr. Covington, have you seen any other physicians at all for the injuries that you suffered in your work accident?

A. No, sir.

Q. Has your lawyer sent you to see any doctors?

A. I did see a couple, but I can't remember the names, and I couldn't even tell you how to get there. My husband did the driving.

Q. You've seen two different doctors that your lawyer sent you to?

A. Yes, sir.

Q. Were they here in Columbia or were they --

A. Yes, sir, here in Columbia, I think.

Q. When did you see those doctors?

A. I can't remember the dates.

Q. Has it been within the last 30 days?

A. No, sir.

MR. LOCKHART: Let's go off the record for just a moment.

(Off the record)

BY MR. LOCKHART:

Q. Ms. Rummage, Mr. Safran was kind enough to hand me a copy of a report from a Dr. Hutcheson, dated September 18, 2013.

Do you recall seeing Dr. Hutcheson?

A. Yes, sir.

Q. How many times have you seen Dr. Hutcheson?

A. I've only seen him one time.

Q. What type of complaints did you provide to him?

A. I told him about the head pain, the neck pain, the dizziness, the ringing in the ears.

Q. How long did you spend with Dr. Hutcheson?

A. Sir, I can't remember.

Q. Did he provide you with any medical treatment?

A. No, sir.

Q. Do you have any followup visits scheduled with him?

A. No, sir.

Q. Did he make any referrals for you to see any other physicians?

A. No, sir.

Q. Did he prescribe any medications to you?

A. No, sir.

Q. His report references a Dr. Tollison; did you see anybody by that name?

A. I can't remember the names, sir.

Q. Well, you said that Mr. Safran sent you to see two doctors, one is Dr. Hutcheson?

A. Uh-huh.

Q. Is that a yes?

A. Yes, sir, he sent me to see a couple doctors, but I cannot remember the names.

Q. But we know one of them is Dr. Hutcheson because we've got his report.

A. Okay.

Q. Let me ask you about the second one; was it a man or a woman?

A. A man.

Q. Caucasian or African-American?

A. He was Caucasian.

Q. The second doctor, the one who you can't recall, did you talk to him about your physical problems you were having or did you talk to him about psychological problems that you were having?

A. I talked to him about physical problems.

Q. Did this second doctor, this unknown physician, did he provide you with any medical treatment at all?

A. No, sir.

Q. Do you have any follow-ups scheduled with this

second physician?

A. No, sir.

Q. Did this second physician provide you with any referrals?

A. No, sir.

Q. Did you see the second physician before or after you saw Dr. Collins -- I mean Dr. Hutcheson, my apologies.

A. Before.

Q. Before. Okay. When you saw Dr. Hutcheson, did you take any of your MRIs, any of the films, the actual scans that they'd done of your head and neck, did you take those to your visit with Dr. Hutcheson?

A. No, sir, I didn't.

Q. Do you know if he had those to review at all?

A. I assumed that Andy would have sent them. I don't know.

Q. I asked you a little bit earlier about some treatment that you'd gotten and some doctors that you'd seen before your work accident happened, and we talked a little bit about Dr. McQueen.

Other than Dr. McQueen, had you ever sought or received treatment from a doctor for

neck or back problems before your work accident happened?

A. Not that I can remember, sir.

Q. I've got some medical records from a group called Florence Neurosurgery and Spine, a Dr. James Brennan.

Do you recall seeing a Dr. Brennan for neck or back problems?

A. I do know that a Dr. Denton did surgery on my right rotator cuff.

Q. I've got a note from a Dr. Brennan, who saw you, he says, back in 2006 for neck and low back pain.

Do you recall seeing a Dr. Brennan?

A. I can't remember it, sir.

Q. Okay.

A. Unless it was my rotator cuff. I can't remember.

Q. Do you have any other visits with the physicians that have been scheduled by your lawyer that you're aware of?

A. No, sir.

Q. So it's only been those two?

A. Yes, sir.

Q. Ms. Rummage, since your work accident happened

very dizzy, and I seen myself falling, and I kind of kicked my leg out real hard to try to prevent my fall. If you ever have a bad fall, you don't want another one, and -- that's all you can see, and it pulled everything in my left leg.

Q. What type of treatment did you receive at Scotland Memorial?

A. That night they did CT scans.

Q. Of?

A. My leg, my left leg.

Q. Were you admitted and stayed overnight?

A. No, sir.

Q. Is that the only time you've been to Scotland Memorial?

A. Yes, sir, it is.

Q. Have you been to any other hospitals or emergency rooms at all since your work accident occurred?

A. No, sir.

Q. Okay.

A. Only when they did -- Cheraw -- Dr. Mcleod sent me to Cheraw for my CT scan.

Q. But no other visits to an emergency room?

A. No, sir.

in May of 2012, have you had any type of surgery?

A. No, sir.

Q. Since your work accident happened in May of 2012, have you been hospitalized for any reason, and when I ask you that question, I mean, have you been admitted to the hospital for any overnight stay for a medical condition?

A. No, sir, I haven't been admitted.

Q. Since your work accident occurred in May of 2012, have you gone to a hospital or an emergency room for any reason?

A. Yes, sir.

Q. Where have you gone?

A. Scotland Memorial.

Q. And where is that located?

A. Laurinburg.

Q. When did you go to Scotland Memorial?

A. I cannot remember the month or the date, sir, but I can tell you what happened.

Q. Okay.

A. I was -- I have these dizzy spells. I had got up and went to put a load of clothes in the washing machine or in the dryer, one, I can't remember which, but on my way back I was very,

Q. Before your work accident happened in May of 2012, have you ever undergone any type of surgical procedures?

A. Yes, sir.

Q. You mentioned your rotator cuff.

A. Yes, sir.

Q. Was that over in Florence?

A. Yes, sir.

Q. Any other surgeries at all?

A. Yes, sir, on -- I broke the tibia fibula in my left leg and they had to, you know, go in and re-break it and put nails and stuff in it, and put a cast on it, and I had a partial hysterectomy and an ovary removed.

Q. Your last surgery, was it in the Florence area or did you have it somewhere else?

A. In Cheraw.

Q. In Cheraw at the hospital there?

A. Yes, sir.

Q. Any other surgeries at all besides the ones you just told me about?

A. Not that I can remember.

Q. Any other hospitalizations before your work accident happened, other than those associated with your surgeries and the birth of your

1 children?
 2 A. No, sir.
 3 Q. Any other hospitalizations?
 4 A. No, sir.
 5 Q. Ms. Rummage, before your work accident
 6 happened, had you ever sought or received
 7 treatment with a chiropractor?
 8 A. Not that I can remember.
 9 Q. Have you seen one at all since this work
 10 accident happened?
 11 A. No, sir.
 12 Q. You told me earlier that you haven't worked at
 13 all since your work accident happened.
 14 A. Yes, sir.
 15 Q. Well, let me take that back. You did work for
 16 a period of time.
 17 A. 'Til September.
 18 Q. But other than working with BGF for that four
 19 month period, did you or have you worked
 20 anywhere else?
 21 A. No, sir.
 22 Q. You had mentioned earlier that Dr. Collins has
 23 you written out of work right now.
 24 A. Yes, sir.
 25 Q. Did you return to work when he --

1 A.. No, sir, he never gave me the okay to go back.
 2 Q. Are you of the opinion that you could
 3 physically perform your job with BGF right now?
 4 A. No, sir.
 5 Q. And what about that job would you be unable to
 6 perform?
 7 A. The lifting, the visual part, the speed part.
 8 Q. Anything else about the job that you would have
 9 difficulty performing right now?
 10 A. Sir, I really don't know what all I could do as
 11 far as that.
 12 Q. Where did you work right before you worked for
 13 BGF?
 14 A. I worked at the gym in Cheraw.
 15 Q. Fitness World.
 16 A. Uh-huh.
 17 Q. And how about before that?
 18 A. I worked at -- I worked a part-time job for
 19 Modern Cleaners.
 20 Q. Was that a dry cleaning?
 21 A. Yes, sir, managing them -- helped managing it.
 22 I worked for the school system in Cheraw, but I
 23 -- my main job, I had worked with Cooper Tools
 24 of Cheraw for twenty-something years and they
 25 shut down and went to Mexico.

1 Q. Modern Cleaners, were they also in Cheraw?
 2 A. Yes, sir.
 3 Q. Are they still around, do you know?
 4 A. No, sir.
 5 Q. They're not. Okay. And were you basically the
 6 manager of the store?
 7 A. I helped manage it, yes, sir.
 8 Q. Is your intention to ultimately go back to work
 9 somewhere?
 10 A. I thought that's what it was, that they was
 11 going to have me return to my normal job.
 12 Q. Is your intention to return to work somewhere
 13 else if you're --
 14 A. Able.
 15 Q. -- released to do so?
 16 A. Yes, sir.
 17 Q. There was some reference in some of your
 18 medical records to you at some point maybe
 19 being treated for hypothyroidism.
 20 Have you ever been diagnosed with that
 21 condition?
 22 A. Yes, sir.
 23 Q. And have you ever received treatment for that
 24 condition?
 25 A. Yes, sir.

1 Q. Are you under the care of a doctor for it right
 2 now?
 3 A. Yes, sir.
 4 Q. Who's treating you for that?
 5 A. Dr. Mcleod.
 6 Q. How is he treating you for that?
 7 A. Medication.
 8 Q. Is he treating you for any other medical
 9 conditions or health problems that we haven't
 10 discussed so far besides hypothyroidism and, I
 11 guess, the high blood pressure? Is he treating
 12 you for anything else?
 13 A. He keeps asking when I go in, you know, how I'm
 14 progressing with my fall and everything.
 15 Q. But is he treating you for any other medical
 16 problem other than hypothyroidism?
 17 A. No, sir.
 18 Q. And high blood pressure.
 19 A. Not that I can think of, that's all.
 20 Q. When you go and see him, do you tell him about
 21 the medicines you're taking --
 22 A. Yes, sir.
 23 Q. -- from Dr. Collins?
 24 A. Yes, sir.
 25 Q. Ms. Rummage, what type of problems are you

1 having today, problems that first began with
2 your work accident?

3 A. Headaches, dizziness, ringing in the ears, loss
4 of memory, and depression, and my neck.

5 Q. Let's talk about your headaches for a moment.

6 How often do you have headaches?

7 A. Every day or every other day.

8 Q. Where are they located?

9 A. You don't know where they're gonna come 'cause
10 it comes like a knife jabbing in the -- in your
11 head where it's gonna start. It's not like a
12 headache that I have ever had before.

13 Q. How long do they last?

14 A. Days, sometimes.

15 Q. The dizziness, how frequently does that occur?

16 A. About every day.

17 Q. Ringing in the ears, how frequently does that
18 occur?

19 A. I'd say I have it at least once a week.

20 Q. Do you have any loss of hearing?

21 A. I don't think so.

22 Q. Is there anything that you do from a physical
23 or even mental standpoint that causes you to
24 develop a headache?

25 A. No, sir, it just -- I can't say that there's

1 Q. If you had to rate your neck pain and your arm
2 pain on a scale of zero to ten, zero being no
3 pain and ten being the most excruciating pain
4 you've ever experienced, how would you rate
5 your daily neck pain and arm pain?

6 A. About an eight or a nine.

7 Q. Is there anything that you do from a physical
8 standpoint that causes you to develop neck or
9 arm pain?

10 A. There's not a lot I can do. I can't even keep
11 my housework up.

12 Q. Had you ever experienced similar neck pain or
13 arm pain before your work accident occurred?

14 A. No, sir.

15 Q. What do you do to alleviate your neck and arm
16 pain when it develops?

17 A. He has me taking Flexeril, five milligram, and
18 he has me on Percocet. I have a TENS Unit at
19 home that I use. I have heat. I have ice.

20 Q. How frequently do you use the TENS Unit?

21 A. Every day.

22 Q. For how long?

23 A. Thirty minutes to an hour, sometimes two times
24 a day.

25 Q. How often do you use the heating?

1 anything that I do that causes it, it just
2 comes.

3 Q. When you have headaches, what do you do to try
4 to alleviate them or reduce them?

5 A. Dr. Collins has me take an Imitrex and I go to
6 bed.

7 Q. Do you ever take any over-the-counter
8 medications for your headaches?

9 A. No, sir.

10 Q. You mentioned your neck. What type of problems
11 are you having with your neck?

12 A. Pain.

13 Q. Where is it located?

14 A. It starts in here and goes all the way down my
15 neck, all the way down past my shoulder blade,
16 and now it radiates all the way down my arm
17 (indicating).

18 Q. And you're pointing to the left side of your
19 body?

20 A. Yes, sir.

21 Q. Is that neck pain and the radiation of the pain
22 in your arm, is it generally worse in the
23 mornings, or the evenings, or does it stay the
24 same throughout the day?

25 A. It doesn't have any certain time.

1 A. Every day.

2 Q. This is a heating pad, I presume?

3 A. Heating pad, yes, sir.

4 Q. How long do you use it?

5 A. I usually get on it about 30 minutes at the
6 time.

7 Q. And how about the ice pack?

8 A. About 15, 20 minutes at the time. I rotate
9 them out.

10 Q. Do you ever take any over-the-counter medicine
11 for your neck?

12 A. No, sir.

13 Q. Ms. Rummage, in light of your husband's
14 disability, do you have to care for him or
15 provide him with any medical treatment at home?

16 A. I can't do it.

17 Q. Do you have to, or?

18 A. No, sir, he does it himself now.

19 Q. Ms. Rummage, take me through a typical day, if
20 you would.

21 What time do you normally get up in the
22 mornings?

23 A. Well, generally, I have no set time because I
24 don't sleep well at night.

25 Q. What time did you get up this morning?

1 A. What time did I get up this morning? Okay. I
 2 dozed off to sleep at 6:15 and I was up at
 3 quarter 'til 7:00.
 4 Q. What did you do when you got up?
 5 A. Started to take a shower.
 6 Q. What did you do next?
 7 A. Got a bite to eat and then we got dressed to
 8 come down here..
 9 Q. Who drove here?
 10 A. My husband.
 11 Q. Are you physically able to drive an automobile?
 12 A. I cannot drive. I do drive, but I don't -- I
 13 cannot drive like in this one-lane construction
 14 stuff. I can't. I can't concentrate with it.
 15 I have -- even going through it, I've tried to
 16 drive coming down here and I can't, and even
 17 going through it now I have to put my head down
 18 and I can't look at it to get through it.
 19 Q. Where do you drive?
 20 A. I -- I was driving to a speech therapy some,
 21 but I got throwed off and got turned around and
 22 lost by myself, and that was in Hamlet.
 23 Q. Where was the last place you drove?
 24 A. To the store in Wallace.
 25 Q. And when was that?

1 A. It had to be one day last week 'cause I didn't
 2 even leave the house this weekend.
 3 Q. What do you do around your home?
 4 A. I try to do what housework I can.
 5 Q. Such as?
 6 A. Everyday typical things that a wife would do,
 7 which would be washing and cooking and keeping
 8 my house up, but I can't do a whole lot of it.
 9 I can't remember. I run around the house
 10 making myself tired, not remembering what I was
 11 doing. I can start out folding up clothes.
 12 I've went to put up the clothes and come back
 13 to find myself cleaning the refrigerator out.
 14 Q. What else do you do around your home besides
 15 the limited housework that you've just told me
 16 about?
 17 A. The cooking.
 18 Q. What else?
 19 A. Just everyday housewife stuff that you can do,
 20 and there's not much of it I can do anymore. I
 21 used to help my husband a lot.
 22 Q. Who manages the money in your home? Who keeps
 23 up and pays the bills?
 24 A. He does now because I can't remember.
 25 Q. Are you able to use the computer?

1 A. I can use it for like 5, 10, 15 minutes at the
 2 time.
 3 Q. What do you typically use it for?
 4 A. My -- my oldest son lives a little way away
 5 from us and they put pictures of the children
 6 on Facebook and stuff like that.
 7 Q. So what exactly do you do on the computer?
 8 A. Just looking at pictures, and my therapist had
 9 had -- my speech therapist had had me doing
 10 memory games..
 11 Q. How often do you play those?
 12 A. It's -- I try to do them as often as I can, but
 13 I can't last over 15 minutes or so because my
 14 mind expansion won't go too long, and I try to
 15 play them as often as I can every day.
 16 Q. So that's something that you do every day?
 17 A. Yes, sir.
 18 Q. What time do you normally go to bed in the
 19 evening?
 20 A. I have no certain time.
 21 Q. What time did you go to bed last night?
 22 A. I just told you, sir, I dozed off at 6:15 this
 23 morning and got back up at 6:45.
 24 Q. So you had been up all night, up until 6:15?
 25 A. Just laying, couldn't go to sleep, tossing and

1 turning and hurting.
 2 MR. LOCKHART: Ms. Rummage, let me talk
 3 with my client and I'll be right back with you.
 4 I think I've asked you all the questions I need
 5 to. I'll be back in just a second.
 6 (Off the record)
 7 MR. LOCKHART: I'm sorry.
 8 BY MR. LOCKHART:
 9 Q. Ms. Rummage, I just have one more question just
 10 to ask you and I think we're done.
 11 A. Okay.
 12 Q. You told me earlier that your work accident
 13 happened in May and then you eventually got
 14 written out of work in September, so there's
 15 about four months there.
 16 A. Yes, sir.
 17 Q. Did you take any leave of absences from work
 18 between May of 2012 and September?
 19 A. Yes, sir, I did. I came out in August, Dr.
 20 Fred McQueen wrote me out.
 21 Q. Okay.
 22 A. And he was gonna release me to go back and
 23 that's when Dr. Benjamin wrote me out.
 24 Q. So you said Dr. McQueen wrote you out of work?
 25 A. Yes, sir.

1 Q. And how long was that, do you remember?
 2 A. A month.
 3 Q. Okay.
 4 A. About a month, I think.
 5 Q. Did you receive any wages at that time, or?
 6 A. I got, what you call it, short-term disability.
 7 Q. And you received that for about a month?
 8 A. About a month.
 9 Q. Do you remember how much that was, how much you
 10 were getting paid?
 11 A. No, sir, I don't.
 12 Q. At some point did it stop and workers' comp
 13 started?
 14 A. Yes, sir.
 15 Q. Have you received any short-term or long-term
 16 disability benefits since workers' comp
 17 benefits began?
 18 A. No, sir.

19 MR. LOCKHART: Those are all the questions
 20 I have, Ms. Rummage. Thank you.

21 MR. SAFRAN: I don't have any questions.

22 *

23 *

24 (Whereupon, the deposition concluded at 2:14 p.m.)

STATE OF SOUTH CAROLINA
 CERTIFICATE

Be it known that I, Holly Gleason, a
 Professional Court Reporter and Notary Public, did have
 VICKIE RUMMAGE, appear before me on Monday, December 9,
 2013, at 1:01 a.m., at the Safran Law Office, Columbia,
 South Carolina, 29201;

That the witness was duly sworn under
 pains and penalties of perjury to testify the truth, the
 whole truth, and nothing but the truth;

That the foregoing pages constitute a
 true and accurate transcription of the testimony given
 at that time and place aforesaid to the best of my skill
 and ability;

I further certify that I am not counsel
 or kin to any of the parties to this cause of action,
 nor am I interested in any matter of its outcome.

In Witness whereof, I have hereunto set my
 hand this 9th Day of December 2013.

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

VICKIE RUMMAGE,

Employee

-VS-

BGF INDUSTRIES, INC.,

Employer

and

GREAT AMERICAN ALLIANCE INSURANCE
COMPANY C/O STRATEGIC COMP SERVICES,

Carrier

WCC FILE NUMBER:
1215681

Deposition of DANIEL L. COLLINS, M.D., a witness called by Counsel on behalf of the Employer, pursuant to the applicable provisions of the South Carolina Rules of Civil Procedure, taken before Holly Gleason, a Professional Court Reporter and Notary Public in and for the State of South Carolina, on Thursday, March 13, 2014, at the Office of Daniel L. Collins, M.D., 900 East Cheves Street, Florence, South Carolina, commencing at the hour of 2:29 P.M.

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EXHIBITS

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LEGEND OF THE TRANSCRIPT

dashes [--] intentional or purposeful interruption
[ph] denotes phonetically written
[sic] written as said

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STIPULATIONS

It is hereby stipulated and agreed by and between counsel for the respective parties that the Witness will waive the reading and signing of the deposition transcript.

(Whereupon, Documents were pre-marked Employer's Exhibit Nos. 1 through 4, respectively.)

Whereupon,

DANIEL L. COLLINS, M.D.,

having been first duly sworn,
was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LOCKHART:

Q. Dr. Collins, good afternoon.

A. Hey.

Q. My name is Jason Lockhart. I'm a lawyer from Columbia. I represent a company called BGF Industries and their workers' compensation insurance carrier in a workers' compensation claim filed by Vickie Rummage who I understand is a patient of yours.

I understand that Ms. Rummage is receiving medical treatment from you at the present time as a result of this work accident, and I am here this afternoon to take your deposition, just to ask you some questions about your treatment of Ms. Rummage.

I'm here, of course, today with Mr. Safran who represents Ms. Rummage, just to ask you just a couple of very brief background questions, then I want to talk to you in particular about Ms. Rummage.

You practice medicine here in Florence, is that correct?

A. That's right.

Q. And how long have you been practicing medicine in South Carolina?

A. Since June of 2010.

Q. Do you have any board certifications?

A. Yes. Physical --

Q. What --

A. Physical medicine and rehabilitation, PM and R.

Q. And are you board eligible in any other specialties?

A. No.

Q. Dr. Collins, I want to talk to you for a moment

about Ms. Rummage, and I have some of your records here I'm going to present to you in just a moment, and we've marked these as exhibits.

Most of my questions, initially, are going to deal with your treatment of her, and then I have some questions for you about some treatment that she received before she actually began treating in your office.

So I'm going to start. I'm going to hand you a copy of Defendant's Exhibit Number 1 and you, actually, I know, have your chart here with you, but the record I just handed to you, or the exhibit, appears to be a note from your office from 12-17-12.

Is that the first time that you had an occasion to see Ms. Rummage?

A. Yes.

Q. And when she saw you initially in December of 2012, what were her primary complaints at that time?

A. She was -- at the bottom of that first page, she was complaining of bilateral pain in the posterior neck, sharp on the right heading up to the right scalp, and on the left it heads

towards behind her left ear.

She reported ringing of her ears along with lightheadedness, slight memory loss. She preferred not to drive. She reported headaches starting with a knifelike sensation at the right scalp. She tried heat at home for that headache pain. She had not tried Lyrica or Neurontin, and then --

Yeah, so those were the most -- most of it would -- and in my impression there, I said status post work injury, May 18, 2012, with persistent headaches, neck pain, ringing in ears, lightheadedness, and short-term memory loss.

Q. When you initially examined Ms. Rummage, did she inform you that she'd experienced any similar problems prior to her work related accident?

A. No.

Q. When she was initially seen by you, do you know if she would have filled out any type of intake sheet or patient registration form?

A. Yes.

Q. I do not see one in the records that I --

A. Yes, there's one right here.

Q. Excellent. Thank you very much. This intake form lists a collection of medications that she was taking at the time you saw her?

A. That she reported that she was taking, right.

Q. And those medications are generally -- the ones that are listed on there -- and you're free to, if you want to, identify them individually and just tell us what those medications are generally for.

A. Well, one is Hydrocodone or Lortab or Vicodin.

It's a pain medicine. She also lists Oxycodone, which is another narcotic pain medicine, and she lists Phenergan, which is an anti-nausea medication, and Oxcarbazepine, which is probably a tricyclic antidepressant.

I -- I'm not that familiar with that in the generic form, so it might be -- I think it might be, possibly, related to the Tegrinol, but I'm not sure.

Q. When you initially examined her in December of 2012, you mentioned that she complained of neck pain, and she also had, I believe, some complaints about pain radiating from her neck into her -- into one of her arms or into both of her arms?

1 A. I don't see anything in here specifically about
2 pain radiating to her arms. I see a lot of the
3 pain complaints of her neck and her head, but I
4 don't see anything specifically about arm pain.

5 Q. At some point you recommended that she undergo
6 a nerve conduction study or an EMG of her upper
7 extremities, and that report is attached as
8 part of our exhibit.

9 Do you recall recommending that she
10 undergo this particular diagnostic test?

11 A. Yes.

12 Q. And I believe that the test was performed by
13 your colleague, and it was performed on or
14 about August the 14th, and it revealed that she
15 had bilateral carpal tunnel syndrome; is that
16 correct?

17 A. Yes.

18 Q. And I believe that same report reflected that
19 there was no evidence of radiculopathy or
20 plexopathy; is that correct?

21 A. Plexopathy.

22 Q. Plexopathy. Okay.

23 A. Uh-huh.

24 Q. And in layman's terms, what is that?

25 A. Disease of the nerves as they form a plexus, so

1 that they come out of the neck in individual --
2 in individual levels, and then in the upper
3 shoulder here (indicating), interiorly, they
4 crisscross and join together and split apart so
5 that you get different components making up the
6 three main nerves that go down the arm, so
7 that's -- that would be up in the shoulder
8 region.

9 Q. In the exhibit that I've provided to you is
10 your follow-up note right after, I believe,
11 that EMG was conducted. You saw her in your
12 office on August 19, 2013, and I believe you
13 indicated in that note that you were of the
14 opinion that her carpal tunnel syndrome was
15 probably not related to her original workers'
16 comp injury.

17 A. Right.

18 Q. And are you still of that opinion today?

19 A. Yes.

20 Q. Now, when she saw you in August of 2013, what
21 type of complaints was she providing to you at
22 that time?

23 A. Okay. Complained of ringing in her ears along
24 with dizziness, pain in her back and pain in
25 the posterior left leg, pain -- shooting pain

1 in the thigh. She -- we had done trigger point
2 injections and she had told me that she had
3 gained some benefit from that. Those trigger
4 point injections were done in her upper back
5 neck region, posteriorly, and she -- we talked
6 about the nerve conduction studies and the
7 carpal tunnel. I'd said it was hard to connect
8 the carpal tunnel to the type of injury that
9 she had, and then in my impression, it was
10 post-concussive symptoms including persistent
11 headaches, neck pain, ringing of her ears,
12 lightheadedness, blurred vision, short-term
13 memory loss, and insomnia.

14 Q. And you prescribed a collection of medications
15 to her following that examination; is that
16 correct?

17 A. Right. Basically, continued some that she had
18 been on for -- since I started with her.

19 Q. And your note on that particular day indicates
20 that those medications included Lyrica,
21 Flexeril, Cymbalta, Percocet and Ambien; is
22 that correct?

23 A. That's right.

24 Q. You continue to treat Ms. Rummage; is that
25 correct? She remains under your care?

1 A. Oh, yes, and I saw her today.

2 Q. And that's what I was getting ready to ask you.
3 It's my understanding that you were supposed to
4 see her today.

5 What type of complaints did she provide to
6 you during your examination today?

7 A. Well, she was coming in specifically for toxin
8 injections for migraine headaches and,
9 basically, we didn't go in depth about all of
10 her symptoms. She was just coming in for a
11 procedure today, more than anything else.

12 We refilled medications, but she still
13 complained about the neck pain, but the
14 headache pain had been eased by the last toxin
15 injections that were done in November. And so
16 she was telling me that her headaches had
17 improved for a good bit for about two months,
18 but over the past month they had returned, more
19 or less, and that's not unusual because these
20 injections are done every three -- at the -- at
21 the most frequent basis, every three months.
22 So it had been a little bit more than three
23 months, and so she was telling me about that.
24 She still told me about she was having trouble
25 concentrating, memory, things like that.

Q. When is she scheduled to be seen by you again either for a procedure or for just a general examination?

A. One month.

Q. With regards to the diagnosis that you've provided to Ms. Rummage as a result of her work injury, has she reached maximum medical improvement or is she in need of additional

medical treatment?

A. Well, she's -- it's ongoing. Right now this is the third injection that we've -- no, probably the second -- second injection that -- toxin injections, and she did gain benefit with the first one. So she -- if she qualifies, she could probably continue to go on and receive the toxin injections for the migraines.

She would definitely need somebody to manage pain medicines for her; those are being managed by myself right now. Somebody would have to see her there and -- and I think that's probably the room in the elephant about whether there's ongoing treatment depending on what comes out of this court case.

Q. And I apologize, just to make sure I'm clear, so do you believe that she is at maximum

medical improvement or that she continues to need more treatment?

A. She needs ongoing treatment.

Q. The third injection, presuming that she has it, do those have to be done at a 60-day sort of time frame, or?

A. More than 90.

Q. More than 90.

A. Yeah, anything more than 90, so she was actually a little bit overdue. She was -- I think I did the last one November 14th, and so she would have been eligible, probably, middle of February. So it's -- it's a few weeks later, but it's -- it's not that unusual for somebody to come in, you know, a -- a few days late or a few months later. It's -- it's just -- it has to be at least three months, but it -- it can be after that. It can't be any sooner than three months.

Q. So under that scenario and based on that time frame, it would appear that it would be mid-June or so before she would be able to return to have an additional injection?

A. Right. After June 13th. Anytime after June 13th, she's eligible.

Q. With regards to her work status at the present time, have you released her to return to work with restrictions?

A. No.

Q. Give me an indication as to your thought process behind her inability to work at the present time.

A. Well, I -- I'm trying to remember back here.

Somewhere along the line, I -- I'm trying to remember, and I think she told me that, unless she could go back and do all of her work duties, that she would not be able to return to work, that they didn't have modified duty, and -- and I think she may have told me that she was released from her job. I -- I tend to remember that, but I can't tell you exactly when she might have told me that, but I -- I think -- I think she told me a while ago that she may have been released from her job, but I -- I can't swear to that.

Q. Do you recall recommending that she undergo a functional capacity evaluation?

A. Well, it's been going on for a year, almost two. Yeah, I may have done it in the past, I can't remember when, but that wouldn't be that

unusual.

Q. Just to help refresh your memory and sort of to expedite the deposition, Mr. Safran and I both -- I assume he has a copy of this. We have a functional capacity evaluation from a group called Select Physical Therapy, where Ms. Rummage underwent an evaluation there on April 4, 2013 per your recommendation.

A. Okay.

Q. If we have a report from that, provided on that day, would that seem logical to you, or?

A. Yeah, I -- if I could just go back to maybe April, May, and see if it was included. I -- I don't -- my chart is not completely in chronological order.

Q. That's okay. What I'll do, just in the interest of time and to assist you with my questions, is I'll hand you a copy of it.

A. Okay.

Q. Just so you can have it to review.

A. Okay.

Q. Having now had the opportunity to review that, does that appear to be consistent with your recollection of having sent her for an FCE in April of last year?

1 A. Yes.

2 Q. And according to that functional capacity
3 evaluation, does it appear that she had been
4 found capable of performing light work?

5 A. Yes, their final assessment was that she was
6 capable of a light physical demand level.

7 Q. Would you agree with the conclusions of the
8 functional capacity evaluation with regards to
9 her ability to perform light work?

10 A. I -- I think, considering what I've been
11 seeing, she -- she will have a lot of symptoms
12 if she tries to do that work; whether she can
13 work through those symptoms, I -- I'm not sure.
14 Again, this is a rather limited period of time
15 that they are asking her to do these functions
16 and I -- I question whether she could do this
17 on an eight-hour day basis, day in day out,
18 considering what I -- what she's been telling
19 me about her symptoms and her memory and her
20 functioning, things like that.

21 Q. What are the primary objective findings that
22 you've reached that would support a conclusion
23 that she is incapable of even performing light
24 work?

25 A. Well, her symptoms, when she tells me about the

1 memory loss and everything, she tells me that
2 she can't remember day-to-day, she can't
3 remember where to go, what to do, so that's --
4 she tells me about that frequently, and that
5 has me somewhat concerned whether she could
6 actually carry out duties at work, whether they
7 were light, heavy, or physical -- or heavier
8 demand level. I'm -- that's the biggest
9 concern I have, is the cognitive abilities and
10 her memory and things like that, which that --
11 really, they can't take that into account
12 during this functional capacity evaluation.
13 This doesn't really evaluate her cognitive
14 abilities at all.

15 Q. And not to put words in your mouth, but is it
16 my understanding that your conclusions
17 regarding her ability to work are based
18 primarily upon the information she's providing
19 to you about her physical and mental condition?

20 A. For a significant degree, yeah.

21 Q. Do you feel as though, based on your
22 interactions with Ms. Rummage, that she's been
23 honest with you about her problems?

24 A. Well, I -- I received a phone call, of course,
25 you know, a few months ago, telling me that

1 there had been some prior -- some prior medical
2 attention, and I'm not sure, I think it was,
3 maybe, this office that called -- or the
4 Plaintiff's attorney's office that called me
5 and just wanted me to be aware that there had
6 been some records that were discovered, or
7 somehow it became -- they became aware that
8 there was some medical attention that had been
9 provided prior to my first office visit, and
10 that -- that is a bit of a concern.

11 I, actually, even asked her about it, I
12 think, the next visit, whenever she was in, and
13 that -- that not having been completely
14 up-front with me, telling me about prior
15 medical treatment, is -- is just not ideal.

16 She may or may not feel that that was
17 something important, but -- and I really don't
18 know all the details about the treatment. I'm
19 sure some of that will come up here, but that
20 -- that's something that I would prefer to know
21 about while I'm treating her, and the first day
22 that I'm treating her, not a year in or a year
23 and a half into the treatment.

24 Q. Would that information impact your ability to
25 discern what problems were caused by her work

1 injury and what problems may have preexisted
2 her work injury?

3 A. Depending on what is in the information, but
4 any treatment that occurred prior to her
5 reported work injury would be important in
6 terms of causality and preexisting and, of
7 course, all those types of things.

8 Q. Are you aware, either through communications
9 with Ms. Rummage's lawyer's office or with
10 Ms. Rummage, that she had been seen previously
11 by Dr. Brennan?

12 A. I -- I remember that we had a conversation
13 about prior medical attention and I can't
14 remember who the -- the physicians that were --
15 that were involved, but -- actually, let me go
16 back to my original.

17 When I saw her, basically, I just had
18 knowledge about Dr. Benjamin being involved, is
19 the only -- when I look through this,
20 Dr. Benjamin is pretty much the only person, --
21 and -- and he's a neurologist at the beach,
22 that was mentioned as previously treating her,
23 but I still don't know who the physicians that
24 were treating her previously were, other than
25 Dr. Benjamin.

Q. Dr. Collins, I'm going to show you a copy of another collection of medical records that have been marked as Defendant's Exhibit Number 2. These are records from Florence Neurosurgery and Spine. I'm sure you're familiar with their practice.

A. Yes.

Q. And it appears that Ms. Rummage was examined by Dr. Brennan on or about July 27, 2006. I want to give you just a moment, if you would, take a look at that record for me, and I just want to ask you a couple of questions:

A. Okay. I've breezed through it.

Q. Sure. Would you agree with me that, at least according to this note, that when Ms. Rummage was seen by Dr. Brennan in July of '06, she complained of neck pain and low back pain, bilateral hip pains, and numbness and tingling into her hands?

A. That's what was the chief complaint on Dr. Brennan's dictated note, yes.

Q. How would you compare those complaints with the complaints that Ms. Rummage has provided to you since the inception of your treatment of her in December of 2012?

A. I -- on her first visit with me, she really didn't have any complaints of low back or hip pain. She -- she was telling me more about symptoms involving her head and neck, and in his report I don't see anything mentioned about lightheadedness, ringing of her ears or memory loss. So his -- most of the complaints that he was getting from her were hip pain, numbness and tingling of her hands.

Q. Numbness and tingling of her hands are a symptom, though, that she ultimately complained to you about, correct?

A. Yes, and I think that's probably what led to the nerve conduction studies; although, he, I think, was potentially sending her for nerve conduction studies back in July of 2006.

Q. And his note also reflects that she was taking Lyrica at the time that he saw her in July of '06, and that is a medication that you've prescribed to her, as well, correct?

A. Yes. Yes, we continued -- we started her on Lyrica -- well, I started her on Lyrica not knowing that she had been on Lyrica in the past, but whenever -- at the bottom of my first page it says that she had not tried Lyrica or

Neurontin. Again, that wasn't what she was telling me, so we did try Neurontin, and I think eventually we switched from Neurontin to Lyrica. I know she's on Lyrica now.

Q. So she told you at one point or at least early on that she had not used Lyrica before?

A. When I asked her about it, yes.

Q. And it turns out, according to Dr. Brennan's notes, she actually had?

A. Apparently, yes.

Q. Let's look at the physical examination portion of Dr. Brennan's notes in which he examines her neck. His note reflects decreased range of motion in all rotations and flexion and extension, is that correct, according to what his note says?

A. Yes, decreased range of motion in all rotations including -- well, in all rotations and flexion and extension, so yeah.

Q. Is that objective finding consistent with your physical examinations of Ms. Rummage with regards to her neck?

A. She -- she reported some trouble -- some pain with cervical extension and lateral bending to the left. It's -- it's fairly similar. It's

hard to say. I wasn't -- you know, I'm reading his -- his dictation of an evaluation. I certainly wasn't there, so it's really hard to compare my in-person evaluation and his dictated evaluation. Two people doing the same exam may -- may read -- may write something different, but that's what he writes.

Q. There are some similarities, though, I think you would agree, correct?

A. Well, if -- we only really started talking about the -- in the physical exam we are talking about the decreased range of motion, so that -- that seems to be one similarity, yes.

Q. And, also, complaints of neck pain and numbness into the hands which were complaints ultimately given to you, as well, correct?

A. Yes.

Q. At any point in time, have you prescribed Xanax to Ms. Rummage?

A. Oh, she's on it now, yes.

Q. And you would agree this is a medication that she clearly had been on previously at least in July of '06?

A. According to Dr. Brennan's note, yes.

Q. Do you see -- and I apologize. We are looking

at page 3 of Dr. Brennan's report. He ultimately diagnoses Ms. Rummage with cervical spondylosis and mild cervical stenosis, but no overwhelming evidence of myelopathy.

How does that diagnosis of her cervical pathology compare with the diagnosis that you've given to her with regards to her neck?

A. Well, I -- my evaluation mostly focused on the headache and the neck pain. In my original evaluation, I was noting back in June of 2012 that she had a C-spine that showed degenerative disc disease at C-4 -- C-4 through C-7 with multilevel facet arthropathy, and so that's the main -- CAT scan -- we did not, as far as I know, do any immediate CAT scans or cervical spine films because she had a fairly significant work-up with an MRI scan and cervical scans back in June of 2012. And I think she reported the injury in May 2012, so it was about a month later, so we didn't do any repeat films at that time, and I was basing a lot of her neck symptoms on the plain films that she had already undergone in June of 2012, I think, probably, with Dr. Benjamin.

Q. Is the diagnosis that Dr. Brennan provided

similar to the diagnosis that you've given to her with regards to her cervical spine?

A. Yeah, I haven't -- if you'll see in -- in most of my evaluations, I've not focused significantly on the cervical stenosis, cervical spondylosis. It's been mostly the post-concussive headaches symptoms that -- that I've listed, but certainly I would be very surprised if the cervical spondylosis and mild cervical stenosis doesn't fit her at this point.

Q. And, again, just so we're clear, when Ms. Rummage initially was seen by you, did she inform you that she had at least some neck problems in the past, at least similar -- did she inform you in any way of problems that preexisted her work accident that you now know she had according to Dr. Brennan's note?

A. Not that I can remember and not that I've documented.

Q. Did Ms. Rummage, during your initial examination, inform you that she had sought and received treatment from a Dr. McQueen?

A. No. No, I don't know anything about that evaluation.

Q. Has she, at any point in time during your care of her, mentioned a Dr. McQueen or her having received treatment from a Dr. McQueen?

A. Going back to when I asked her about this, whenever I saw her in follow-up -- I'm trying to -- trying to figure out exactly when I was made aware -- first made aware that there was some preexisting, or otherwise involved, medical attention, and I'm trying to figure that out right now.

Q. Take your time.

A. Okay. So that was just after -- so it -- yeah, I had a phone call from the Plaintiff's attorney's office sometime, possibly, December of 2013, and that's whenever they told me, we just want to make sure -- make you aware there is some paperwork and some evidence of some other physicians treating the patient. I can't remember how many or what doctors were involved, but they -- they just said, we just want you to be aware of that, and so I did ask her about that, that there was some, quote, prior treatment for possible depression, muscular skeletal problems, and I said I didn't have any of the written information in front of

me or the extent or the severity of -- of the evaluations by the other physicians, but that I did say that it muddled the picture. And I -- I told her that it would -- it really would have been much better off if -- if I had known about some of that ahead of time, and pretty much made it clear to her that that would have been good for me to know instead of finding out January or December -- January of 2014 or December of 2013.

Q. So as far as a Dr. McQueen is concerned, you haven't -- have you had Ms. --

A. I never answered your question. I --

Q. That's okay.

A. I didn't -- that may have been one of the physicians that was mentioned during our brief two or three-minute conversation, but I can't remember specifically who was mentioned, and I didn't have any of the paperwork in front of me. So there was just mention that there would -- had been some other prior treatment prior to the initial evaluation with myself.

Q. Dr. Collins, I'm going to hand you a collection of medical records that I have obtained by subpoena from an entity called McQueen Medical

Center. These records are arranged in chronological order, but I'm going to talk to you about them in reverse chronological order. So I'm going to hand you this exhibit and I've turned to the very last page which is, of the records I've given you, the most recent in this collection. It may not be the most recent overall, but it's the most recent in this collection.

If you would, just take a brief moment to review that and I just wanted to ask you a couple of questions about it.

A. Okay.

Q. Just for some background, Ms. Rummage was injured on or about May 18, 2012, and this note I've provided to you from Dr. McQueen is dated May 14, 2012; is that correct?

A. Yes.

Q. And does it appear, according to his note, that she complained to him of spasm in the neck and shoulder, muscle spasm in the cervical spine, and radiculopathy?

A. She definitely said she was having spasms in her neck and shoulder and severe muscle spasms in her cervical spine, and he says she has

radiculopathy. She wouldn't be able to say I have radiculopathy, but he was saying she has radiculopathy.

There is not a -- in this one single note, there's not a whole lot to say why he put that diagnosis on her, but -- he may have other knowledge, but he did say that she has radiculopathy. She didn't say that, but he did.

Q. The record reflects, does it not, that at the time of that examination, she was being prescribed Lyrica, Flexeril, Percocet, Xanax, and then a medication called Nuvigil?

A. Nuvigil.

Q. Nuvigil. Okay. Did Ms. Rummage, at any point in time during your treatment of her, inform you that prior to her work injury, as recently as four days prior, that she was taking all those medications?

A. No.

Q. Again, I think you said a moment ago that she has never informed you of treatment with this particular physician at all, correct?

A. Right.

Q. If you would, go with me to the next page.

Again, we're looking at these in reverse chronological order.

A. Okay. So now we're going back into March.

Q. This would be 3-13-12.

A. Can I ask one question?

Q. Yes, sir.

A. Is this her primary care doctor?

Q. I will let Mr. Safran answer that question because I don't know for certain.

A. Okay. Well, maybe it's not important. I'm just -- I'm -- they're -- they're dealing with hypertension, and in his original note he talks about salt intake, and I would think that maybe her primary care doctor --

Q. It's clear from this note, is it not, that at least in March of 2012, Dr. McQueen was prescribing Xanax for severe anxiety?

A. That's what he writes, yes.

Q. And isn't it true that, throughout the course of your treatment of Ms. Rummage, you have prescribed medications to assist her with anxiety, as well, correct?

A. Yes. Yes.

Q. Including Xanax?

A. Specifically, yes.

Q. Did she ever indicate to you that she was taking Xanax for anxiety prior to her work injury?

A. No. Again, all of this is new information. I -- I -- and she -- she knows that she didn't bring up any of this to me. Why she didn't do it, I have no idea, but I really have no information other than what I wrote in my original note, and that was, basically, Dr. Benjamin seeing her, and that she was seen at McLeod, things like that. So things occurring, other than Dr. Benjamin seeing her, I -- I wasn't aware of anybody, including Dr. Brennan and Dr. McQueen, or anybody else.

Q. Let's turn to the next note which is from December 13, 2011.

In this particular note, Dr. McQueen indicates that Ms. Rummage is having a lot of problem with chronic pain in her back, neck, and shoulders.

Again, are those similar to the complaints that Ms. Rummage provided to you following her work injury?

A. The upper back, neck, and shoulders, definitely, yes.

Q. He, again, has her on a collection of medications, as well. Turn with me, if you would, to the next page. I believe it's two notes, one from 4-21 of '08, the other one from 7-22 of '08.

The 4-21-08 note references chronic pain, and, also, indicates that Ms. Rummage came in with complaints of bilateral ear pain and headache. The 7-22-08 note reflects complaints of chronic pain and major depression.

A. He writes that in both of those notes, yes.

Q. Again, were you aware that Ms. Rummage had been provided diagnoses of chronic pain and major depression by a physician prior to her work injury?

A. No.

Q. Turn back with me, if you would, there is a page, I believe it begins with a note of 9-11-06.

A. Okay.

Q. There's another note, I believe, on that same page from 12-08-06 in which she is diagnosed with spurring and severe degenerative disc disease.

A. Yes, I see that written.

Q. Again, you were unaware of these records or these diagnoses prior to today?

A. Right.

Q. And in light of the information that I've provided to you today -- and let's just start with the psychological component for a moment because you've diagnosed her with at least some psychological issue for which you feel like she needs to be taking antidepressant medications, correct?

A. Right.

Q. I believe you told me earlier you were unaware that she had been diagnosed with these conditions prior to your initial examination, correct?

A. That's right.

Q. Based on the information that I've provided to you so far, are you able, to a reasonable degree of medical certainty, to relate her current psychological condition to her work injury?

A. Well, it's clear, if -- if everything that I'm seeing is -- is correct, that the depression has been an ongoing issue. It definitely predates May 18, 2012 when she tells me she had

a work fall -- a work injury. So there's -- it's pretty clear that depression and anxiety are definitely present in her history a good bit before May 2012.

Q. So would it be difficult for you to relate her psychological condition to her work related injury based on the information that was provided to you today?

A. I would say that there were the depressive and anxiety symptoms. How much effect a new injury at work can exacerbate would be really difficult to say, but it's fairly clear that she had some of these symptoms before the work injury, how much now is related to anxiety and depression because she's not working, because she may not work because she has ongoing pain, it's -- it's -- it's really hard to tease out. Of course, everybody would say the same thing, it's really impossible to tell at this point, how much or how little the work injury from May 2012 played into symptoms that she had, apparently, been experiencing for a few years, several years.

Q. The treatment that you recommended to her in the way of medication is virtually identical to

the treatment that she was receiving previously.

A. Well, the -- the Flexeril has been mentioned. The Percocet has been mentioned. The Xanax definitely has been mentioned. I've been using Cymbalta, which is a different antidepressant, possibly, than what they have.

We've looked at just a few records here. Cymbalta would be the antidepressant. Lyrica has been used. The Imitrex is for migraine headache-type pain, and now we're using a combination of toxins, Botox, for her migraine symptoms. So some of it is new and some of it is very similar to what has been used in the past.

Q. As far as her chronic pain is concerned, is that a diagnosis that you've given to her, that of chronic pain?

A. Yeah, it's been going on a long enough period of time that she definitely qualifies for chronic pain.

Q. And would you agree that that's a diagnosis that she had been given previously, at least by Dr. McQueen?

A. I think that was -- Dr. McQueen's notes, he

sort of mentions some diagnoses all through his notes, he doesn't list them, and I'm not saying I do any better, but I'm just saying that he starts off here in April of 2008, he says, 48-year-old female with chronic pain. So it's not listed as sort of an end office note summary of -- of her conditions. He sort of mentions some of these things like depression, anxiety, chronic pain, various places throughout the notes.

Q. And he appears to be treating her for chronic pain with prescription medications that you, also, have prescribed to her, as well, correct?

A. Well, he, at one point, was using MS-Contin. I don't think we used MS-Contin, but he did use Percocet and I definitely have been using Percocet.

Q. And you also prescribed Lyrica and Flexeril to her which she was taking four days before her work accident occurred?

A. Yes.

Q. Dr. Collins, I also wanted to ask you if Ms. Rummage has ever given you a history of receiving medical treatment from a Dr. McLeod in Cheraw, South Carolina.

October of '13, correct?

A. Yes, I -- I'm sure. I mean, I've been seeing her mostly every month. I saw her as close as November 14, 2013 and December 17, 2013, so that -- that October 31st is in-between my office visits.

Q. Let me ask you a question about a portion of this note and I'll tell you why I'm bringing it up to you.

It appears that Dr. McLeod has prescribed Ms. Rummage a variety of medications; does it not?

A. He says he's going to continue Synthroid, and he's put her on vitamin D, he refills Xanax, he puts her on Adipex, he prescribes Lorcet, and then he mentions that she was getting Flexeril and Cymbalta from myself.

Q. Were you prescribing Xanax to her in October of 2013 and/or were you aware that she was receiving Xanax from another physician?

A. Well, I definitely wasn't aware she was receiving any medication from another physician, and I -- October 17th, it -- it -- not in my current medications list, but the paragraph above that, it does indicate that she

Has she ever mentioned a Dr. McLeod to you?

A. She actually told me -- and Cheraw comes up here in my notes. She told me that she attended therapy in Cheraw, C-h-e-r-a-w, but I only knew of a Dr. Benjamin. I didn't know of any other physicians besides Dr. Benjamin. Again, I think I've said that a couple of times.

Q. I want to show you a copy of a record that's been marked as Defendant's Exhibit 4. This is a note from a physician in Cheraw named John F. McLeod, III. This is one note out of his chart where he, apparently, saw Ms. Rummage on or about October 31, 2013, and you began seeing her in September 2012, correct?

A. December.

Q. I'm sorry, December of 2012.

A. December of 2012.

Q. My apologies. Yes, sir.

A. Yeah, I saw her -- started seeing her in December 2012, and this -- the bottom part of this note is from October 31, 2013, with Dr. McLeod.

Q. And you would have been still seeing her in

continues to take Xanax, and I would -- I really can't say for sure if I was giving her Xanax or, you know, I -- she was getting Xanax from somebody else.

Sometimes different medications -- we will tolerate primary care doctors using medication even if I don't prescribe it. I definitely don't want somebody prescribing narcotic medications if I'm prescribing narcotic medications, but I -- we frequently have primary care doctors that will give patients things like Xanax without having to notify us and tell us about that.

Q. But, again, you were not aware that she was receiving Xanax from a Dr. McLeod in October of 2013?

A. I wasn't aware that she was even seeing Dr. McLeod in -- in October of 2013, let alone getting Lorcet or Xanax or those types of medications.

Q. What is Lorcet design to do? What type of medication is it?

A. It's a narcotic medication.

Q. And again, --

A. Narcotic pain reliever.

1 Q. It's designed to address pain, --
 2 A. Pain.
 3 Q. -- correct?
 4 A. Pain.
 5 Q. What impact, if any, does this information have
 6 on your assessment of the information that's
 7 being provided to you by Ms. Rummage?
 8 A. Well, I always want the patients to be up front
 9 and tell me the whole story and tell me
 10 everything that's been going on, and at some
 11 point, I guess it was November or December, I
 12 discovered through her attorney that -- that
 13 this was not the case, that there was some
 14 information out there that I was not aware of.
 15 This is possibly part of that same information.
 16 It's -- it's not since that time when I was
 17 made aware. It -- it's, again, part of this
 18 information that muddies the whole picture, and
 19 -- and I told her that I really needed her to
 20 be up front with me about treatment, and she --
 21 she tells me that she will be, but again, I
 22 don't know if there is anything else occurring.
 23 This is from October of 2013, which is only
 24 five months ago, so fairly recently.
 25 Q. Is this information a cause for concern?

1 A. Any time the patients aren't up front and tell
 2 me the truth or tell me all of the truth or
 3 tell me just what they want to me to hear, it's
 4 of concern, because again, this shows that she
 5 is getting Lorcet from a different physician
 6 and she is accepting Percocet from myself, and
 7 that is an absolute.
 8 Q. What impact can that have on her recovery or
 9 her ability to reach maximum medical
 10 improvement based on the treatment modalities
 11 that you've been providing to her?
 12 A. Well, it very quickly could earn her a
 13 dismissal from my practice, whenever this type
 14 of thing goes on. We do not tolerate people
 15 getting narcotic medications from anyone other
 16 than myself, and so this is the first time -- I
 17 mean, up until this time, a lot of the records
 18 that you had shown me were predating my
 19 evaluation, December 2012. This does not
 20 predate. This is concurrent with my treating
 21 and, if I had known about this last week, she
 22 would probably be discharged, and she still may
 23 be discharged for dishonesty and using two
 24 different physicians for narcotics without
 25 letting the other person know. And my guess

1 is, that she may or may not have told
 2 Dr. McLeod.

3 She, apparently, told Dr. McLeod that I
 4 was prescribing Cymbalta and Flexeril, but may
 5 not have told Dr. McLeod that I was prescribing
 6 Percocet. That's not -- there is a difference
 7 between her being dishonest or being less than
 8 truthful about all of it and -- and getting me
 9 in trouble with prescribing regulators, and
 10 that's not appreciated.

11 Q. I just have a few more questions, Dr. Collins,
 12 and we should be finished in just a moment.
 13 With regards to her condition at the present
 14 time and the diagnoses that you have provided
 15 to her, which of her diagnoses do you relate to
 16 her May 2012 work accident?
 17 A. Well, that is the million-dollar question at
 18 this point. It -- it gets harder and harder
 19 with the more information that I'm provided to
 20 try to figure out what is related specifically
 21 to the work injury from May 2012 and what is
 22 possibly an exacerbation of a preexisting or
 23 possibly a completely new diagnosis.

24 It's fairly clear that she had back in
 25 2000 -- back in 2006 with Dr. Brennan, cervical

1 degenerative disc disease. He notes that back
 2 in 2006. So whether she had an exacerbation of
 3 that with her injury in May of 2012, it's --
 4 it's hard to say. We don't have serial CAT
 5 scans or MRIs scans of her neck to show what
 6 her -- what her scan looks like in 2007, 2008,
 7 2009, 2010, 2011, and then 2012. She
 8 definitely has multilevel -- or, you know,
 9 degenerative disc disease in -- by plain films,
 10 in June of 2012, but exactly how it was
 11 progressing and comparing them, I don't know if
 12 anybody's been shown -- the radiologist has
 13 been shown these films and said, you know,
 14 here's the film from 2006, here's the film from
 15 2012. What do you see as, you know,
 16 significantly different here? That would be --
 17 that would be, you know, something that
 18 possibly might be helpful. But it's hard to
 19 say, really, what is specifically as a result
 20 of her work injury in May 2012 and what was
 21 maybe an exacerbation of what was already
 22 present six years previously.
 23 Q. And, Doctor, finally, let me go back to
 24 something that I believe we touched on a few
 25 moments ago. I think I asked you at some point

earlier, your opinion regarding her ability to work at the present time, either at all or with limitations, was based primarily upon her subjective complaints to you; is that correct?

A. Yes, the biggest issue that I think I've been reluctant to return her to work is because of the complaints of memory loss, concentration problem, blurred vision, those types of things. That's been one of the biggest reasons that I was hesitant to return her to work.

Q. And are you, to a certain extent, relying upon her being honest with you about those problems?

A. Yes, her subjective complaints about the memory loss, the vision, the headaches, almost all of that is dependent on her reports. I really don't have any way of documenting blurred vision. There is no way for me to know if she has blurred vision or if she has memory loss. It's -- it's -- I mean, there could be some testing for the memory loss, but the migraine headaches, the blurred vision, the ringing in her ears, neck pain, any of those, headaches, there is no way that anybody can document the presence or absence of those with any diagnostic test.

Q. You're relying upon her being honest with you?

A. Yes.

Q. And based on the information that I've provided to you today, do you now have some concerns about whether she is being honest with you?

A. I have more than concerns about her honesty in the past, and there is always an issue now whether she's being honest with me. She's definitely not been honest in the past, so I would say a lack of honesty in the past makes me worrisome about a lack of honesty at present.

MR. LOCKHART: Those are all the questions I have.

CROSS-EXAMINATION

BY MR. SAFRAN:

Q. Doctor, let me just ask you a few questions. As I understand it, this history of injury that was reported, really from the outset, was a fall which caused her to strike her head and neck from a standing position falling backwards?

A. That's what she told me, yes.

Q. And I don't think anybody's ever disputed that.

MR. SAFRAN: Jason, are you there?

MR. LOCKHART: Yes.

MR. SAFRAN: We don't dispute her injury, do we?

MR. LOCKHART: I mean, the claim has been accepted as compensable.

MR. SAFRAN: Okay.

MR. LOCKHART: The accident, itself, -- and I think what we're arguing about or potentially have issue about, are the --

MR. SAFRAN: Consequences. I understand.

MR. LOCKHART: -- consequences or the cause of the relationship --

MR. SAFRAN: Sure. Sure.

MR. LOCKHART: -- between current problems and the accident, itself.

Q. But, Doctor, I'll represent to you, I don't think there's any dispute about the injury, itself, the mechanism of injury, or that it occurred, you know, in a way that made it under the Workers' Comp Act, so just --

A. Okay.

Q. -- I ask you just to assume that.

A. Okay.

Q. I mean, that nature of injury, she was

initially seen by Dr. McQueen, were you aware of that, that he was actually the one who treated her immediately post-injury?

A. No, she told me that she went about a week later to -- well, Dr. McLeod, yeah, but she didn't give me a lot of specifics about that. She told me that there was a CAT scan done and she was prescribed Fioricet and Lorcet, but she didn't go into any more details about that. That was about the only thing that she said.

Q. Well, before I get there, let me just ask it this way.

That type of injury, I think in Dr. Benjamin's records, as well as in yours, there have been references to what is generically referred to as a post-concussive syndrome?

A. I -- I made reference to that. I'm not sure that I've seen records from Dr. McQueen --

Q. No, I'm not asking about McQueen.

A. Okay.

Q. I'm talking about, I think you mentioned Dr. Benjamin.

A. Dr. -- yeah, Dr. Benjamin definitely saw her. I -- I'm trying to remember whether you guys

1 have given me anything from Dr. McLeod right
2 after her work injury, and I -- I just don't
3 remember if -- if I saw anything from McLeod
4 that was right after May 18, 2012, but I
5 definitely have used post-concussive headache,
6 post-concussive symptoms, post-concussive
7 syndrome through my evaluation, absolutely.

8 Q. And let me ask you this.

9 Are many of the symptoms that you've
10 listed, whether it be lightheadedness, ringing
11 in the ears, memory loss, or even emotional
12 liability, aren't those all symptoms that are
13 classically seen with a post-concussive
14 syndrome?

15 A. Yes, that's why I've used that diagnosis.

16 Q. And so I guess my point is, is that, at least
17 in terms of what you've focused on and as far
18 as your treatment, headaches and, basically,
19 trying to deal with the emotional issue, if she
20 came and presented to you with that history of
21 injury with those symptoms, you wouldn't find
22 it surprising at all that they were present?

23 A. No.

24 Q. Now, let me ask this.

25 You were shown a great deal of records

1 from Dr. McQueen, and I think you asked a
2 question at some point, was he a primary care
3 physician. We've got a tremendous amount of
4 records that date back with Dr. McQueen into
5 the '90s, and I'd be more than happy to show
6 you, but I think many of them, not only deal
7 with what Mr. Lockhart showed you, but also
8 primary health issues. So if, in fact, based
9 on the records you looked at, I think it was a
10 question you asked, is this something that he
11 was seeing her for as her primary care doctor,
12 based on those records, you wouldn't find that
13 unusual, at least with that kind of spectrum of
14 things that he addresses --

15 A. No, primary care doctors deal with almost
16 anything and everything that a patient comes in
17 and -- and tells them about. So primary care
18 doctors deal with pain and depression and
19 anxiety, and that's run-of-the-mill complaints
20 for them in their practice.

21 Q. This is the first note I have from Dr. McQueen
22 after the fall. This was dated June 1, 2012.

23 A. Okay.

24 Q. If you look at the second paragraph where he
25 actually gave her some Volteran Gel, what was

1 the reason why he gave it to her?

2 A. What -- you're asking me what would the reason
3 --

4 Q. Yes. Well, I mean, I guess, what would --

5 A. She has -- he says she has a history of chronic
6 pain, she has to stay on her Percocet and her
7 Xanax, and I am going to write her for Volteran
8 Gel to give her husband to rub her neck and
9 shoulders down at least twice a day. It will
10 give her great relief.

11 Q. And I guess, what did he basically say here in
12 the last line?

13 A. She has a lot of problems with the muscles that
14 were damaged when she fell.

15 Q. So at least when he gave her that prescription,
16 was the thing that he was attributing it to, as
17 far as giving her the Volteran Gel, talking
18 about the fact that she is having a lot of
19 muscle --

20 A. That's what he writes, yeah, that's -- I mean,
21 --

22 Q. And obviously you didn't see her then.

23 A. I didn't see her, yeah.

24 Q. But I guess my simple question is, is he
25 attributing it, at least in part, to what she's

1 experiencing after she fell?

2 A. I assume he is, but I mean, there's no way to
3 say. I mean, he also has her up here on
4 Percocet, and he says she has needed pain along
5 -- she's needed Percocet for pain, along with
6 Neurontin, and he says these two should
7 definitely ease off her neuropathic type pain
8 she has in her back. So he must have been
9 treating her with Percocet and Neurontin.
10 Whether the Volteran Gel -- what specifically
11 the Volteran Gel is being used for, it's hard
12 to say. He's adding it to her regimen. He
13 seems to indicate that it might be related to
14 the -- the injury, but he doesn't say,
15 specifically.

16 Q. Well, let me ask a simple question.

17 Does he not say she has a lot of problems
18 with the muscles that were damaged when she
19 fell?

20 A. That's what he says.

21 Q. And these were muscles that, obviously, were in
22 her shoulders, is what he refers to in this
23 line before?

24 A. Yeah, shoulder, neck, probably.

25 Q. So, again, based on that mechanism of injury,

1 if he's indicating, as someone who'd seen her
2 for quite some time prior, that she's having,
3 you know, more problems with what was damaged
4 in the fall, is it fair to say that at least
5 he's referencing there is something that's a
6 sequela of the fall that's in this report?

7 A. He seems to indicate that, yes.

8 Q. Let me ask you, also, when we look at another
9 document after he saw her, I guess following
10 the fall, this is in July, patient did have a
11 fall at work, she had a concussion and she is
12 still having problems with headaches.

13 Again, would that be consistent with the
14 fall, at least generically?

15 A. Well, I -- I don't really know if she truly had
16 a concussion. Concussion might indicate some
17 loss of consciousness or some period when she
18 -- I don't really have that. In fact, I don't
19 even have her going to the hospital at that
20 point until she was seen by Dr. McLeod a few
21 days later. So if somebody had a fall at work
22 and had a significant injury, I would think
23 somebody would say this is a person -- if there
24 was any sign of loss of consciousness, any
25 problem with alertness or confusion, I would

1 hope somebody at a work site would say, we're
2 not just going to have her finish out the day
3 and go home, we're going to have her evaluated,
4 but I don't know that that took place. So I
5 don't know the severity of her head injury when
6 she first had that. I wasn't there and I
7 certainly didn't see her 'til, gosh, probably
8 seven months later.

9 Q. Sure.

10 A. So I have no idea how severe her concussion
11 was. He said she had a concussion. I -- it's
12 -- she had some type of trauma to her head and
13 neck; exactly how severe and how significant, I
14 don't know.

15 Q. Well, let me ask this question.

16 You were familiar with Dr. Benjamin. I
17 think you've mentioned he had seen her
18 previously.

19 A. He --

20 Q. He was one that you were aware of?

21 A. He was mentioned as somebody who had seen her,
22 yes.

23 Q. Well, let's clear this up a little bit. In
24 looking at Dr. Benjamin's records, I see here
25 that his impression was that she had typical

1 symptoms of a closed head injury.

2 A. Uh-huh.

3 Q. And it goes into some of the same ones: poor
4 concentration, difficulty sleeping. So, I
5 mean, at least prior to coming to you, she was
6 seen by someone per workers' comp who
7 characterized this as a closed head injury.

8 A. Yes.

9 Q. And is that in some ways similar to a
10 post-concussive problem?

11 A. Yeah, I mean, it's -- it -- some people might
12 say concussion, post-concussive syndrome,
13 closed head injury, pretty, you know, similar
14 types of symptoms can be -- can occur.

15 Q. Well, let me ask you this.

16 I looked at another one of Dr. Benjamin's
17 reports and, basically, you were very good
18 about kind of what would really be the doctor's
19 characterization as opposed to a patient. I
20 think you were asking earlier about
21 radiculopathy, where she wouldn't come in and
22 say radiculopathy, that would be what the
23 doctor would, more or less, generate after some
24 assessment, correct?

25 A. Right. Right.

1 Q. Dr. Benjamin actually puts under a chief
2 complaint, traumatic brain injury.

3 So, again, is that something that would
4 come out of a patient's mouth or is that,
5 again, through --

6 A. No, I mean, that's -- that's -- he --
7 certainly, the first one he says is right
8 occipital neuralgia.

9 Q. Right.

10 A. A patient would never say right occipital
11 neuralgia, and patients usually would not say
12 traumatic brain injury; maybe the more educated
13 people would, but typically, that would be
14 something that the physician would state and --
15 and if he's putting it in that type of -- he's
16 putting it under the chief complaint, but it's
17 really more a diagnosis because people don't
18 say my chief complaint is I have trigeminal
19 neuralgia or occipital neuralgia, but it --
20 it's just sometimes people move the things
21 around a little bit.

22 Q. And I guess my simple question is, he says
23 traumatic brain injury, Dr. McQueen says
24 concussion, you say post-concussive syndrome,
25 at least generally I think it seems like

everybody's talking about, roughly, the same thing?

A. Very similar.

Q. So I guess my point is, is when we were talking about this, when Dr. McQueen mentions concussion, that's at least his way of saying that she took a blow to the head, basically?

A. That's what he seems to be saying, yes.

Q. And he says that she's having problems with headaches which, certainly, he's attributing to the concussion?

A. Seems to be, yes.

Q. Now, there is no question that there is some old records that talk about headaches, but let me ask you -- actually, here, I think Dr. McQueen, in a couple of notes, went on and actually was talking about -- this is on October 22nd, not too, too long before you saw her.

A. Uh-huh.

Q. Where he talks about how she's having difficulties that he attributed following the fall; is that correct?

A. He says that she had had a head injury and a neck injury at the time of her accident and

she's been having headaches since that time.

Q. And does he also talk about the distinction between the headaches that he treated her for in the past compared --

A. Let's see what he says. He says, I've treated her in the past for tension headaches, but after reading his report -- and I'm not sure --

Q. That's Dr. Benjamin.

A. Dr. Benjamin. After he's -- there's a Dr. McQueen saying, after reading Dr. Benjamin's report, he says, she has severe trauma to the brain, so he's saying that she had some tension headaches, but he feels that it's somewhat different, I guess, compared to what he was treating her for in the past after he reads Dr. Benjamin's notes.

Q. So he actually made a distinction to some extent --

A. Yes.

Q. -- in this note?

A. Yes.

Q. And, again, would it be in any way surprising that someone, even if they had some history of tension headaches or what was called migraines -- you know, I know that term is used very

loosely many times by primary care physicians, but would it be surprising that, after a blow to the head like this, that somebody would have headaches as part of post-concussive syndrome?

A. Wouldn't be that unusual.

Q. And it would actually fit what you would see as symptoms that would be within the spectrum that you would expect after this particular type of head trauma?

A. Right.

Q. So, Doctor, is it fair to say that, if Dr. McQueen, who actually was familiar with her for some years prior, is indicating that he thinks there is a difference in the headaches, would he probably be the best person to judge that? You know, --

A. I definitely didn't see her before the work injury, so I don't know anything about her actual exam. I'm reading reports from different people, two and three and four different people now: Dr. Benjamin, Dr. Brennan, Dr. McQueen, Dr. McLeod. So I don't know what her symptoms were like prior to the work injury. I'm reading what other people are assessing, --

Q. Sure.

A. -- but I have no idea. I can't say whether their assessments are correct, their assessments are wrong. They -- they evaluate the patients, and I have no idea what she was like before May -- before December of 2012.

Q. Well, I guess my question is, given that fact that Dr. McQueen who was familiar is indicating there was a distinction, would you have any reason to dispute that?

A. I don't know for sure. I mean, it's -- it's -- I just don't know what she was like before, and I'd really -- I -- I think maybe somebody who has seen her before and somebody afterwards would be in the best position to make a judgment, but I don't know if his judgment is correct.

Q. But he is a physician?

A. Right.

Q. And he is a physician, obviously, that has a long history of dealing with her?

A. Right.

Q. And if you would assume for the purpose of my question that he did say it was worse, I do think there's a distinction, would you have any

reason to dispute that?

A. No.

Q. Doctor, let me ask you just a couple of other things. I know we went into some detail earlier. I think you were -- I don't even see where it is right now, but there was an intake questionnaire that we had --

A. It's here.

Q. This is, basically, what was presented to Ms. Rummage at the time she came over?

A. Right.

Q. And, in addition, I know you were provided with some records, I think from the case nurse, potentially.

A. Sometimes yes and sometimes no, just to be honest. I think some of this was included. Exactly -- some of this was marked, faxed 12-17, so that would have been the same day that I saw her. It's -- it's hard to say out of all of this how much I had when I saw her that day and how much was put in the record afterwards.

Q. Let me ask you this, though.

From what I'm understanding, she's asked to fill this out as, more or less, a history

They -- they certainly can write those things in. It doesn't say tell me about what doctors you've seen in the past, there's not enough room on this form for that, but it does ask about, you know, past medical, and it -- it can be included here. It's definitely something that can be written down. It's not something that we would say -- this form does not say don't tell me about anything that you've had occur in the past.

Q. Sure. Sure. I understand.

A. It encourages people to tell us everything that they can about their history.

Q. Well, and, in fact, there were a lot of things checked off yes, weren't there?

A. History, yes.

Q. And, in fact, if she was told that she had arthritis in her neck, which is, I think, what the layperson would refer to, whether it's spondylosis or degenerative disc disease, I mean, that would be consistent with previously having some type of indication that there was some neck arthritis?

A. Yes.

Q. So we can't, obviously, from the gleaned page,

form, correct?

A. Yes.

Q. And then I guess when you actually see her, you review the history form and, if there is anything, you know, that you need to question further, you do; if not, you really focus on what she's there about for the here and the now?

A. Well, this, as you can see, I've written on it. Some of this is my handwriting, some of this is her handwriting. So I am looking at this and looking at whatever other records that I have -- may have at that time, and so this is just a starting point. This doesn't go into any significant depth. This is just a basic information sheet about some of her past medical allergies, medications, things like that.

Q. Let me ask this question.

The form, itself, doesn't talk about any prior trauma, per se, does it?

A. Well, in past medical, if somebody has prior trauma -- I mean, if somebody was in a motor vehicle accident or had prior trauma, they -- there's space here for them to write that in.

say, you know, oh, no, she didn't tell you that she'd had prior neck problems because, frankly, she was asked about arthritis and she checked it off as saying yes.

A. Well, I guess she marked arthritis. I -- I don't consider the depth that she told me about to be anywhere close to complete when you are dealing with a workers' comp injury. I have to be honest with you.

Q. Sure.

A. I don't think that when you are saying, I had injuries related to this injury, this date and this fall, and -- and other information that is very similar, because you're saying, well, closed head injury, concussion, yeah, it's all about the same, and what my point would be, headache, neck pain, shoulder pain that I've been treated for, for two or three, or four, or five, or six years in the past is similar, and not saying anything about that, I don't think is fair. I don't think it's fair. It's -- it's saying -- it's just letting out some of the truth and not all of the truth, and I -- I definitely don't feel comfortable with that knowledge, and I -- and I think I mentioned

1 that on the phone. I said this definitely
2 muddies this picture. It is never a good idea
3 to find out about things that were going on
4 before you started the patient, six months or
5 nine months into treatment.

6 Q. Are you aware that she ever received anything
7 in terms of treatment for psychological
8 conditions, depression, etcetera, other than
9 medication? I'm talking about in the past, not
10 with you.

11 A. Oh, in the past?

12 Q. Yeah.

13 A. No, because I -- I wasn't told about anything
14 until today. I mean, -- well, other than maybe
15 the conversation that you had with me back in
16 December or November, or whatever, but I -- I
17 didn't know about any psychiatric history. I'm
18 not sure if this -- this -- other than maybe
19 substance abuse, this really doesn't ask about
20 psychological history on our form. It's --
21 it's fairly short. Patients don't want to fill
22 out a six-page form when they come in.

23 Q. Oh, sure. Well, let me ask this.

24 Though it's not uncommon for primary care
25 physicians to prescribe things like

1 depression that she was receiving medication
2 for, I think, based on what I'm hearing, as far
3 as this accident, didn't that have the
4 potential to have an aggravating impact on
5 those problems based on the nature of her
6 injury?

7 A. Definitely could have been an aggravating
8 factor.

9 Q. And I think from what you've indicated, is that
10 something that you would assess or is that
11 something that a psychiatrist should assess?

12 A. Well, I mean, if it -- if it's -- if it's
13 something I don't feel comfortable with,
14 sometimes we will refer patients on to
15 psychologists or psychiatrists.

16 Q. But I guess in terms of -- or at least based on
17 your understanding of a post-concussive
18 syndrome, is it something that is reasonable
19 that that type of condition would aggravate
20 preexisting psychological issues?

21 A. Yeah, I think I just said that. It's very,
22 very -- it's not unusual at all that somebody
23 with depression or anxiety, and having a work
24 injury, and concussive syndrome, afterwards --
25 traumatic brain injury, whatever you want to

1 antidepressants, etcetera, for people if they
2 come in saying they've got stress or that they
3 are having issues?

4 A. No, probably antidepressants are prescribed
5 more by primary care doctors than anybody else,
6 I would be willing to bet. Not everybody
7 that's depressed is seeing a psychologist or
8 psychiatrist.

9 Q. And I guess my question is, though, then you
10 don't have any indication she's ever seen
11 anybody specialized, whether it be a
12 psychologist, psychiatrist, for any of these
13 periods of time that we've talked about today?

14 A. Not that I know of.

15 Q. And do those conditions in some circumstances
16 get to a point where they warrant seeing
17 somebody more specialized?

18 A. They can, sure.

19 Q. And I guess the thing is, you answered one of
20 my questions earlier, from a post-concussive
21 syndrome it is not unusual to see some level of
22 emotional liability? I mean, that's part of
23 the spectrum of what you --

24 A. That's part of the syndrome.

25 Q. And if, in fact, she had some previous anxiety, P460

1 call it, would have an exacerbation of -- of
2 symptoms that she went into the -- the accident
3 with, like depression or anxiety.

4 Q. And to a reasonable degree of medical
5 certainty, is that most probably what we have
6 here, an aggravation, obviously, not a sole
7 cause?

8 A. Again, I wasn't -- I don't know how bad her
9 depression or anxiety was. I did not see her
10 prior to May 18, 2012, the date of the
11 accident. I really didn't see her until seven
12 months later, almost to the day, so I don't
13 know how severe her anxiety and depression were
14 prior to this. I just have seen her since
15 December of 2012. So I -- I really -- I
16 couldn't possibly make an assessment about how
17 severe her depression or anxiety, any -- I
18 couldn't make an estimate about how bad her
19 hypertension was before her accident because I
20 did not evaluate her then, and all my
21 evaluation -- all my opinion could be is based
22 on records that you are showing me from other
23 physicians.

24 I really don't feel comfortable making
25 this -- an assessment about somebody's mental

or physical or emotional status based on somebody else's assessment of that patient at that time. So that's --

Q. So I guess what I'm hearing is, it wouldn't be unusual for a trauma like this with a post-concussive syndrome to be an aggravating factor, but at this point you don't feel maybe that you have the ability to say one way or another how much of an aggravation it was?

A. I would be willing to say that nobody who sees her now, who hasn't seen her prior to her accident, can honestly, accurately say what degree of exacerbation has occurred.

Q. Let me ask you just a couple of other things. I think we went through a little bit of Dr. McQueen's situation where he talked about at least referencing severe headaches since the fall, and I think he indicated, at least in here, that the headaches were different than what he had done before.

You are treating the headaches, correct?

A. Yeah, I'm treating migraine headache right now.

Q. And at least based upon this information that we have, vis-à-vis the person who was familiar with her headaches before, are you satisfied.

that there was an aggravation here, most probably that has -- you know, has made her headaches different or to some degree more intense which you are now treating?

A. I mean, he says tension headaches. I -- she complains of symptoms that are more consistent with migraine headaches now, so that's why I'm treating her for migraine headaches. She tells me about some symptoms that fit more with migraines now. I -- he says tension headaches, so I don't really know all of the symptoms or what symptoms she was having then, that he says tension. He doesn't say migraine headaches. He -- he just says tension headaches. So I'm treating her for migraine headaches. I don't know how close her symptoms are to what she was having before because I didn't see her then.

Q. Well, let me ask this.

Isn't it, I think, true, I think what you've already testified to, that a post-concussive syndrome, however we want to put it, brain injury as Dr. Benjamin described it, that those types of traumas frequently produce headache symptoms?

A. Yes, that's -- again, I've said, that's --

that's in the realm of the post-concussive symptoms, headaches, memory loss, vision problems, ringing in the ears, concentration problems, memory, so all of that, that she is complaining about, is consistent with the injury that she had. The issue is how much was preexisting and how much is new, and that's the part that's --

Q. Well, let me ask you this way.

Assume for the purpose of my question that our law doesn't require you to parse it out like that, that they'd simply ask whether or not there has been an aggravation, and again, you don't have to try to go into trying to say it's X percent versus Y percent. I think really that is the standard anyway, so.

A. I -- again, I wouldn't be surprised if she had an aggravation, but I didn't see her before, so I cannot say. Now, these people have seen her before and I assume have seen her after. They say that there's a difference. I didn't see her before, so all I can do, just like any one of us, is go with -- nobody can go back and say, well, I'm going to go back and see her before May 18, 2012. So I would have to say,

well, if they think that there is a change, then there must be a change, but I don't know for sure that there has been a change. I don't know what she was like before that accident.

Q. Are you aware that any records are out there that show that she had any cognitive deficits before this fall?

A. Well, I've been given some records here, but I don't -- I don't know. I didn't look through these in detail to see if anybody noted any cognitive deficits. I have not been shown anything so far that noted any cognitive deficits prior to, you know, her complaints with me.

Q. And absent any evidence that indicates there's cognitive deficit, would you feel that it is most likely or most probable that any cognitive issues she's having right now are the result of her post-concussive syndrome?

A. Well, again, her -- we don't really have an evaluation about the degree of cognitive impairment. She tells me she has memory loss, but we don't have any objective testing, which can be done. I think I said, of all of her symptoms, we can't -- we can't refute ringing

1 in the ears, we can't refute headache pain, we
2 can't refute double vision, we can't refute
3 memory. I mean, we can't -- we can evaluate
4 her cognitive degree to some level with some
5 cognitive testing, but we don't have pre- and
6 post-testing on her. So they -- they may be
7 able to give us some indication, but still,
8 somebody is going to have to give their
9 opinion. Is this consistent with what she had
10 before the injury? Well, unless somebody has a
11 cognitive test that they can pull out that says
12 what her cognitive testing was like back then,
13 it would just be somebody's opinion, but there
14 can be some testing to evaluate cognitive
15 status now. Now, how that compares to what she
16 was like cognitively before --

17 Q. Wasn't she seeing a speech therapist for a
18 period of time?

19 A. She was. She was, yes.

20 Q. I mean, and is that something that was just
21 done for the sake of doing it or was there a
22 reason why she was doing that?

23 A. Yeah, it was done for the memory, the memory
24 problems that she was reporting.

25 Q. Do you have any indication she'd ever seen

1 we're still talking about, at least what
2 everything is pointing to, a relatively
3 significant trauma?

4 A. I -- I'm not -- I wasn't there. I don't know.
5 I mean, I guess to me a significant trauma
6 would be something that you go to the hospital
7 for, and she told me she did not go to the
8 hospital at that point. I would think that, if
9 somebody suffered significant trauma, that
10 there would be an emergency room visit that
11 day, not a day later, not five days later, not
12 seven days later, but if I had somebody that I
13 was saying this is a significant trauma, and
14 especially a work injury, I would be saying
15 we've got to get them off to the emergency room
16 now so that we can document what problems the
17 patient has.

18 Q. Do you know what the circumstances were at the
19 time she got hurt?

20 A. No, she just told me that she did not go to the
21 hospital at that point, so I don't know.
22 Somebody -- somebody made a decision not to
23 have her go to the hospital. I don't know the
24 issues regarding that, but I know she tells me
25 she didn't go to the hospital, so.

1 anyone of that type before this accident?

2 A. No.

3 Q. Doctor, would a fall of the nature that we just
4 described certainly have the potential to
5 create by way of aggravation or cause
6 facetogenic pain because of the location?

7 A. Possibly, yeah.

8 Q. And I know that you were shown records talking
9 about neck pain, talking about degenerative
10 disc disease. I'll represent to you that I've
11 never seen any record that talks about a
12 facetogenic component, prior. Even if there
13 was some, you know, degeneration of the facets
14 prior to this fall, would the nature of the
15 fall and the type, you know, falling backwards,
16 with the impact, the -- really, the torsion of
17 the neck, certainly be consistent with someone
18 developing facet pain?

19 A. It's possible. It's also possible with
20 advancement of the cervical spondylosis that
21 people can develop facet issues, so it could be
22 as a result of the fall, but it could be a
23 natural progression from degenerative disc
24 disease.

25 Q. And, again, Doctor, I guess my point is, is

1 Q. But she, actually, did tell you about a
2 laceration that had to be glued closed?

3 A. She told me about a laceration that was glued
4 together.

5 Q. Laceration on her head?

6 A. That's what she said.

7 Q. And I guess a laceration of that type is not
8 something that necessarily comes from a
9 scratch, is it?

10 A. No, but I wouldn't call a laceration
11 significant trauma, either. We have patients
12 upstairs on our unit that fall and have a cut
13 and they never leave the hospital. So not
14 every laceration -- there's degrees there, and
15 somebody may not even require suturing. They
16 may not have -- the bleeding may stop on its
17 own. So it's -- it's hard to say -- to
18 characterize a fall as severe or significant --
19 or what's your word, severe trauma, and there
20 really wasn't a hospital visit. That -- to me
21 it doesn't -- it doesn't quite fit with severe
22 trauma, because I would say, well, what's less
23 than that? What is -- what would be a -- if a
24 severe doesn't warrant a trip to the emergency
25 room for a CAT scan -- because if somebody

1 bleeds on the surface, maybe they've bled
2 underneath the scalp, and it's not just a scalp
3 laceration, but it could be a bleed inside, and
4 so if that's not a significant enough injury to
5 require a hospital visit, then I'm not sure
6 what would be in terms of a work injury. But I
7 would think that a fall that -- if it's a
8 severe work injury, a severe fall, that that
9 would warrant a trip to the hospital just to
10 make sure; even to glue it together. I mean,
11 glued together at the site, I mean, that --
12 that sounds like somebody's in a Third World
13 country. I mean, you have to clean out the
14 wound. You just don't glue something together
15 at the site. That -- that just doesn't sound
16 right. That's why I put it in quotations,
17 because that's not the way most cases are
18 handled.

19 Q. Well, but again, Doctor, aren't you really kind
20 of going into a great deal of supposition and
21 speculation about the fact that she didn't go
22 to the hospital?

23 A. Well, you asked me about severe injury and I'm
24 trying to say, to me, I don't think I would
25 classify this as a severe trauma --

1 Q. But you've also testified --

2 A. -- based on these things.

3 Q. You've also testified that, throughout these
4 records, we're using the word concussion,
5 post-concussive syndrome, and traumatic brain
6 injury, and from my understanding those don't
7 come from, basically, you know, somebody
8 flicking their nail on the back of your head.

9 A. Well, all the more reason to have it evaluated.

10 Q. And we --

11 A. So there's some things that occurred here that,
12 looking back at it, you would say, well, it was
13 severe enough to cause a traumatic brain --
14 we're going to use the term traumatic brain
15 injury, as you -- as you say, but then we're
16 not going to have it evaluated with a CAT scan,
17 when CAT scans are sort of like x-rays now. It
18 -- it's a little bit -- the fit -- it just
19 doesn't quite fit together as -- as far as I
20 can see the situation. I don't know all the
21 details. I don't know who decided not to have
22 her go to the hospital, whether she decided,
23 whether the employer decided. I have no idea.
24 It just doesn't quite fit, to me, together as a
25 severe traumatic injury. That's -- that's my

1 impression.

2 Q. And from what I'm hearing, for the record,
3 that's based upon the fact she didn't go to the
4 hospital that night?

5 A. That's a big issue, yes.

6 Q. Okay.

7 A. That's a big issue.

8 Q. And you have --

9 A. One -- yeah.

10 Q. And you've already testified that, basically,
11 you have no indication, no understanding, one
12 way or other, as to what the reasoning -- was
13 why she didn't go?

14 A. No.

15 Q. Let me just sum this up and I'll be done. So I
16 think it's your testimony that Dr. McQueen
17 would probably be in a better position to
18 determine the before and after, vis-à-vis,
19 whether her headaches were worse.

20 A. No, what I said was, somebody who has seen her
21 before --

22 Q. Right.

23 A. -- would be in the best position, somebody who
24 has seen her before and after --

25 Q. Right.

1 A. -- because I haven't seen her before.

2 Q. Are you aware of anybody other than Dr. McQueen
3 who has seen her before and after?

4 A. I don't know if Dr. Brennan has seen her. I --
5 he saw her --

6 Q. He hasn't.

7 A. I don't know that. I don't know if
8 Dr. Benjamin has seen her before.

9 Q. He hasn't.

10 A. So, no, I don't know of anybody.

11 Q. Let me ask you, also, as I understand it,
12 again, you still indicated that, not only you,
13 but Dr. Benjamin and Dr. McQueen have all
14 indicated that she had symptoms that were
15 within the spectrum of what you would expect
16 from a post-concussive syndrome, correct?

17 A. Right.

18 Q. And that necessarily involves trauma to the
19 head and some element of disruption of the
20 brain, even if it may just be --

21 A. To some degree.

22 Q. Right. Okay. And I think you've also
23 indicated that the nature and mechanism of this
24 injury was certainly sufficient to have an
25 aggravating impact if someone had some

preexisting conditions. You're just not rendering an opinion at this day because you didn't see her before?

A. Right.

Q. She actually did tell you she got a positive response from the injections you gave?

A. Yes.

Q. And would somebody who is not being honest with you be telling you they got better from having it done?

MR. LOCKHART: I have to object to the form. It requires a state of mind on behalf of the patient.

MR. SAFRAN: That's fine. I'll rephrase it.

Q. Would you expect, if someone was trying to be, I guess, -- I'm trying to think of the best word.

If someone was not trying to get better or improve, would you expect them to report improvement?

A. No, I think -- I think she wants to get better. I have no doubt that she wants to get better, and I believe her when she tells me that the injections helped. So I don't -- I'm not

saying that I disbelieve everything that she says. I've said it, that I wish she had been honest with me, up front in many matters, but what she does tell me, I sometimes now believe and sometimes don't. I just don't know what to believe all the time, but if somebody tells me that an injection seems to be working, then -- then I try to help them out.

Q. And she did report that to you?

A. Yes.

Q. Do you think an evaluation by a psychiatrist, particularly one with forensic abilities, would be helpful in a situation like this?

A. It would be more helpful if you had the same person evaluate her pre- and post. I just don't know how much -- I mean, I guess the question is, what's the purpose of the evaluation with the psychiatrist? Is the purpose with the psychiatrist to evaluate her current status, okay, or is the purpose to try to figure out what she was like beforehand? That, I don't think you're going to get out -- that's not going to be -- that's going to be a waste of time, but to get a current status of her depression, that would -- that would be the

best way, see a psychiatrist for depression symptoms, yes.

Q. Doctor, are you familiar I guess with the fact that there are actually forensic psychiatrists?

A. Yes.

Q. Isn't that speciality one that does do exactly, effectively, what --

A. I -- I really -- I've heard the term, but I don't what their expertise is or exactly how much they can go back and try to figure out things beforehand. I don't -- I don't know about --

Q. You don't know?

A. I don't know about their -- their field.

Q. All right.

MR. SAFRAN: I don't think I have anything else. Thank you very much.

MR. LOCKHART: Doctor, I just have two questions.

THE WITNESS: Okay.

MR. LOCKHART: You've been very patient with us.

REDIRECT-EXAMINATION

BY MR. LOCKHART:

Q. Number one, have all of the answers that you've given to us in your deposition this afternoon been in your expert opinion and to a reasonable degree of medical certainty?

A. Yes.

Q. Secondly, you referenced a couple of times today your having spoken with Mr. Safran in the fall of 2013?

A. Boy, I'm looking through here and -- and I'm trying to figure out when we had a discussion. Okay. So I note in my January 17, 2014 that -- that we had talked and that her attorney had made me aware of, quote, prior treatment, probably told me about some doctor's names. I really didn't remember them because I had no paperwork at that time, and -- and he just said that this is -- had become aware -- he had become aware of this and he wanted to make me aware of it, that type of thing, and that's whenever I told that -- that I was concerned about, you know, information that may not have been completely presented to me. And I told her that it muddled the picture and that type of thing. So my best recollection would be that it -- just after the last clinic visit, so

1 that would have had to have been just after
2 December 11, 2013.

3 Q. And is that the only time that your notes
4 reflect you've had any conversations with her
5 lawyer about her case or her treatment?

6 A. I don't think that I've talked with their
7 office any other time. I can't remember.

8 Q. And just to make sure I'm clear, and I
9 apologize because we've talked about a variety
10 of issues, with regards to her -- your
11 treatment plan, you've provided her with an
12 injection today. You're going to see her in a
13 follow up in, approximately, --

14 A. One month.

15 Q. -- one month, okay. At that point in time,
16 you'll continue to make an assessment of her
17 current condition and where to go from there,
18 --

19 A. Right.

20 Q. -- correct? All right.

21 MR. LOCKHART: Those are all the questions
22 I have.

23 MR. SAFRAN: Doctor, give me one second,
24 please. Just give me one second.

25 MR. LOCKHART: Do you need copies of these

1 A. Most visits.

2 Q. And she certainly has an opportunity to ask you
3 questions and find out information just like I
4 would?

5 A. Right.

6 Q. Let me ask you, also, you already had talked
7 about this, in terms of the cervical component
8 that at least we are talking, that may be
9 attributable to this accident, is your
10 testimony also that someone who was there and
11 saw her before and also after would be in a
12 better position, I guess, to assess how much of
13 a change there's been?

14 A. When you say someone, are you talking about a
15 --

16 Q. A physician.

17 A. Oh, a physician.

18 Q. Yeah.

19 A. Oh, you said someone. Well, they would be in
20 the best position to evaluate her physical exam
21 pre- and post-injury, yes, absolutely.

22 Q. And if they had the benefit of your notes, too,
23 you know, they could certainly know what was
24 going on since and how you've been treating
25 her, vis-à-vis, how they would have done it.

1 records for your chart based on what we've
2 discussed today?

3 THE WITNESS: Just this one here.

4 MR. LOCKHART: Do you want to have your
5 office or your staff make a copy?

6 THE WITNESS: I can go right now.

7 MR. LOCKHART: Yes, sir. If you don't
8 mind, that way we don't get it lost in the
9 shuffle.

10 (Off the record)

11 RECROSS-EXAMINATION

12 BY MR. SAFRAN:

13 Q. Doctor, let me just ask you a couple of things,
14 because I know we all want to try to get out of
15 here. I think you were asked about some
16 conversations with me.

17 Does not a case nurse accompany
18 Ms. Rummage to every visit?

19 A. Well, not every. In fact, today she didn't
20 come. Not every time can she make it and, in
21 fact, today she couldn't make it, --

22 Q. Well, let me put it this way, --

23 A. -- but she makes it to most visits.

24 Q. Most visits.

1 Previous, I mean, --

2 A. I don't --

3 Q. -- not as a critique to you, but I'm just
4 saying --

5 A. No. No, I'm not taking it like that. I'm just
6 saying, when you say that they saw her pre- --

7 Q. Pre-.

8 A. And --

9 Q. Saw her post.

10 A. -- when did they see her post? Did they see
11 her immediately after --

12 Q. Yes.

13 A. -- one of the first physicians -- you're
14 talking about Dr. McLeod?

15 Q. Correct. McQueen, excuse me.

16 A. McQueen, pardon me. Yeah, those -- anybody
17 that saw her as close to the injury, pre-, and
18 as close to the injury, post, would be able to
19 give a better evaluation about what her
20 symptoms were like pre- and post.

21 Q. And, actually, Mr. Lockhart pointed out to you
22 that Dr. McQueen had seen this lady a few days
23 before the accident; then, also, within a few
24 weeks after the accident?

25 A. Right.

Q. How about in terms of the headaches, too, would that kind of still be the same?

A. I mean, I think that's the only person that can really judge and give a reasonable opinion about what she's like, is somebody who saw her pre- and post, and if that's the only person, because she might not have been to see me before -- certainly wasn't to see me before and wasn't to see Brennan afterwards, da, da, da, then, yes, the person that has seen her pre- and post would be the best person to give some opinion about her symptoms before and after. I don't know if -- you know, if that's the only -- if that's the only opinion, but that's -- that would be, certainly, an opinion.

MR. SAFRAN: Well, listen, thank you very much for your time this afternoon.

THE WITNESS: No, problem.

MR. SAFRAN: Thank you. I don't have any further questions.

*

*

(Whereupon, the deposition concluded at 4:15 p.m.)

STATE OF SOUTH CAROLINA
CERTIFICATE

Be it known that I, Holly Gleason, a Professional Court Reporter and Notary Public, did have DANIEL L. COLLINS, M.D., appear before me on Monday, March 13, 2014, at 2:29 p.m., at the Office of Daniel L. Collins, M.D., 900 East Cheves Street, Florence, South Carolina, 29506;

That the witness was duly sworn under pains and penalties of perjury to testify the truth, the whole truth, and nothing but the truth;

That the foregoing pages constitute a true and accurate transcription of the testimony given at that time and place aforesaid to the best of my skill and ability;

I further certify that I am not counsel or kin to any of the parties to this cause of action, nor am I interested in any matter of its outcome.

In Witness whereof, I have hereunto set my hand this 27th Day of March 2014.

Holly Gleason
Notary Public for South Carolina
My Commission Expires June 4, 2023

INDEPENDENT MEDICAL EVALUATION

PATIENT: Vickie Rummage
DOB: [REDACTED]/59
DOI: 05/18/12
DOS: 12/11/14
REFERRAL: McAngus, Goudelock, & Courie LLC

SUMMARY & IMPRESSIONS:

Ms. Rummage is a 55-year-old lady from Wallace, South Carolina, who worked as a weaver of carbon and glass, as in fiberglass. In May 2012, the patient had a slip and fall accident, and has subsequently complained of headache and back pain. The nature of her initial accident, however, is still a question mark. The fall was not associated with concussive symptoms, PTA, or LOC. The patient continued working, and wasn't seen by a medical provider until 12 days later.

The patient has been managed by multiple physicians, most recently Dr. Collins, who has aggressively pursued the possibility of posttraumatic migraine. He is aware of course of the patient's multiple premorbid conditions, including hypertension, hypothyroidism, migraine headaches requiring Fioricet, chronic arthritis requiring opiates, and long-term treatment for depression, requiring antidepressants.

The patient's evaluation today demonstrated a non-credible clinical presentation, with dramatic inconsistencies. The patient's overt memory performance, and indeed general appearance, fluency and lucidity is quite a variance with her claimed symptomatology. There was clear evidence of symptom exaggeration. The patient's most likely diagnosis is somatoform pain disorder.

There is no reason to believe that her current problems are related to a head injury, for example in the slip and fall in May 2012. There is simply no evidence that the patient had a head injury, and her subsequent course is not at all typical of recovery from concussion.

The patient is at maximal medical improvement. There is no permanent partial disability that is related to the slip and fall injury three years ago. As an aside, the patient is probably taking too many medications. Opiate medications are not advisable for the treatment of chronic degenerative arthritis, except in the most extreme cases, and Fioricet is a rather archaic treatment for migraine. The patient would be more appropriately treated with medications that are less sedating and less addictive.

BACKGROUND: Ms. Rummage is originally from Wallace, SC. She graduated high school as an A/B student and denies any history of learning disability or ADHD. She took some college courses to earn her CNA Certification. She has worked in many fields - CNA, physical therapy, 911 operator, EMT, jailor, and as a commercial driver. She was working in a plant as a fiberglass weaver at the time of her injury. She has been married for 40 years and has 2 grown sons and 3 grandchildren.

PPH:

1. Depression. Past meds include: Prozac, Lexapro, Wellbutrin XL, Cymbalta
2. Anxiety. Treated with Xanax.

PMH:

1. hypertension
2. arthritis
3. sinus problems
4. partial hysterectomy
5. migraines

PATIENT: Vickie Rummage

6. carpal tunnel
7. right RTC repair
8. cervical and lumbosacral disc disease prior to her injury in 2012, treated with opiates

CURRENT MEDS: Effexor XR 75mg QAM, Cymbalta 30mg QAM, Xanax 0.5mg up to TID prn, Percocet 10/325mg up to TID prn, Fioricet TID prn, Synthroid 75mcg QAM, Phenergan 25mg prn, Meclizine 25mg up to TID prn, Lisinopril/HCTZ 20/12.5mg once daily, Vitamin D

ALLERGIES: PCN

FH: CAD, COPD

HISTORY OF THE PRESENT CONDITION: Ms. Rummage was at work at a loom on 05/18/12 when she stepped backwards and tripped, striking the back of her head on a doff truck. She initially declined treatment but later complained of intermittent headaches, neck pain, and back pain. She also reports inattention and memory problems.

MEDICAL RECORDS REVIEW:

Ms. Rummage was evaluated by Dr. John McLeod on 05/30/12 for intermittent headaches, neck and back pain. She denied LOC with the incident. She was instructed to work light duty and prescribed Lodine BID. At follow up on 06/06/12, x-rays of the C-spine and LS-spine were negative for acute changes. She was prescribed Lorcet, Fioricet, Ambien, and received a Toradol injection prior to imaging. CT of the brain was recommended and was performed on 06/06/12. It showed minimal scalp soft tissue swelling without evidence of acute intracranial injury or fractures. Incidental finding of chronic inflammatory sinus disease. She was referred on 07/13/12 to orthopedics for her continuing back and neck pain and to neurosurgery for her headaches.

Ms. Rummage was evaluated by neurologist Dr. Jeff Benjamin of Grand Strand Specialty Associates on 9/05/12. She reported headaches (different from the migraine headaches she had prior to the injury), fatigue, blurred vision, nausea, spasms in her legs, and mood swings. Dr. Benjamin felt the symptoms were consistent with a closed head injury and an MRI of the brain was necessary. Topamax and hydrocodone were started for head and neck pain, which he assessed to be occipital nerve pain and cervical strain. She returned for follow up on 10/1/12 and MRI was reported as normal. She reported side effects with the Topamax, which was changed to Trileptal. Physical therapy and occipital nerve blocks were recommended. The nerve blocks were not helpful. She was prescribed Roxicodone and was referred to chronic pain. Trileptal was continued.

Ms. Rummage was evaluated by Dr. Daniel Collins of Florence Rehabilitation Medicine on 12/17/12 for evaluation of chronic neck pain and headache pain. She also reported ringing in her ears, lightheadedness, and short term memory loss. She was prescribed Neurontin and hydrocodone. Repeat physical therapy was recommended. Speech therapy was also considered. The patient experienced facial swelling with the Neurontin but the hydrocodone was helpful. She was receiving physical and speech therapy. Lyrica was added on in place of the Neurontin. She received trigger point injections on 2/11/13 and Fioricet was being used for her headaches. At follow up on 03/11/13, Trazodone was added for sleep and a Functional Capacity Evaluation was recommended. On 04/11/13, Dr. Collins reported that the FCE showed the patient could function in a light physical demand category. He noted that he felt that the patient's post-concussive symptoms were likely to persist for an indefinite period of time. She was referred to ophthalmology and prescribed Cymbalta. Trazodone was later replaced with Ambien, Percocet was increased up to 6 pills/day, and Flexeril dose was increased. She was given trigger point injections of the cervical paraspinal muscles and her trapezius bilaterally. MRI of the cervical spine was performed on 07/17/13 and showed multilevel spondylitic changes with moderate central canal stenosis at C4-5 and C5-6 with some foraminal encroachment. There was also a small disc bulge at C5-6 and C6-7; these did not appear to be significantly compressive. A TENS unit was recommended and Imitrex was prescribed for headaches. Nerve conduction studies of the bilateral upper arms on 8/14/13 and showed mild-moderate bilateral carpal tunnel syndrome. At follow up on 8/19/13 the patient was still reporting fatigue with doing housework and significant memory deficits. Dr. Collins felt that it was unlikely the patient would return to her previous job. Psychological counseling was recommended for the patient's depressive symptoms. Antivert was prescribed for intermittent dizziness. Xanax was being used twice daily for anxiety. The patient reported to Dr. Collins in June 2014 that she had an episode of confusion at the mall and she had also been approved for disability. In September 2014 Dr. Collins strongly recommended psychological counseling but, in the meantime, he switched her Cymbalta to Effexor.

PATIENT: Vickie Rummage

PRESENT STATUS:

The patient was given a number of psychological instruments and rating scales.

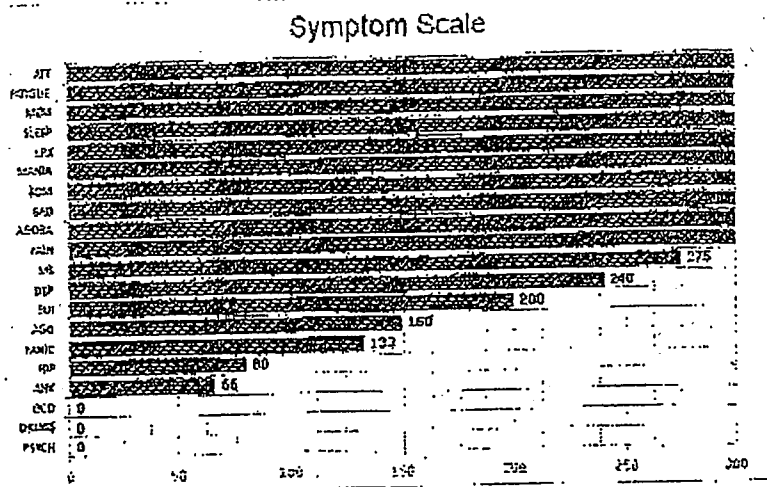
The *Neuropsych Questionnaire* is a symptom checklist with 206 specific items. The questions on the NPQ are about the symptoms of various neuropsychiatric disorders. The items address 24 symptom scales; for example, several questions about insomnia, restlessness, sleep, etc., would constitute the symptom scale for "sleep". 18 of the 24 symptom scales cluster into one of four factors: a somatic factor, which refers to physical symptoms; an anxiety/depression factor; a cognitive factor which refers to symptoms of inattention, poor memory and mental foginess; and a mania factor which refers to hyperactive and impulsive behavior, manic, aggressive or psychotic behavior.

The terminology is similar to that used in the diagnostic manuals, and in many familiar clinical questionnaires and rating scales. In fact, the NPQ is highly correlated ($r > 0.75$) with clinical rating scales in common use. For that reason, the score that a patient would likely generate on a clinical rating scale can be calculated from the patient's responses on the NPQ. This affords the opportunity to consider the patient's responses on the NPQ relative to some familiar benchmarks.

During the Neuropsych Questionnaire, the patient and/or someone who knows him or her well, is asked to describe how the /patient has been over the past couple of weeks, and to rate each symptom that he or she may have had as: "not a problem"; or "a mild problem," that is, present, but not particularly troubling; or "a moderate problem," that is, troubling, but not disabling; or "a severe problem," that is, disabling, because it significantly interferes with their normal day-to-day life. The questions are rated on a scale of 0 to 3.

The average score for each symptom cluster is calculated and multiplied by 100 for the purpose of simplicity. The lowest score one can achieve in any one symptom scale is 0, and the highest is 300. A high score means that the patient is reporting more symptoms of that particular condition. It doesn't necessarily mean that the patient has that condition; just that he or she is reporting a lot of difficulty with the symptoms of the disorder. On the NPQ, normal individuals score less than 75 on every item.

This is how the patient responded on the NPQ:



The patient completed an *Adult Symptom Checklist* identifying symptoms occurring over the past week. Scores range from zero (no problems) to three (severe). In the past week, the patient identified 45/90 severe symptoms and 16/90 moderate symptoms including the following: headaches, unpleasant thoughts, lack of appetite, crying easily, trembling, difficulty falling asleep, feeling a lack of interest in things, worrying that something is wrong with her mind, feeling self-conscious.

EXAMINATION: VITAL SIGNS: Ht 62.25" Wt 171 lbs BP 131/80 P 81

APPEARANCE: She appeared his/her stated age, and was neatly dressed and well groomed. The patient is a well-developed, overweight woman in no acute distress. She has no asymmetries or dysmorphic features.

PATIENT: Vickie Rummage

MSE: The patient was alert, neither sedated nor irritable. She was fluent, lucid and oriented. Her affect was intermittently tearful. She was not agitated, disorganized or paranoid. There were no overt conversational memory or attention deficits. She was very concerned about her condition. She was pleasant, well related, cooperative and compliant. There was no suicidal/violent ideation or behavior. Her responses had prolonged latency and were underdetailed. There were no abnormal movements or dyskinesias.

PE: The patient was normocephalic. Her extraocular movements were full. Her pupils were equally round and slow to react to light and accommodation. There was right sided ptosis. Her skin was clear and the sclerae were white. Her fundoscopic examination was normal. Her neck was supple with normal range of motion and no masses. Her heart rate was regular rate and rhythm. Lungs were clear to auscultation bilaterally. There was full range of motion in all extremities.

NE: The neurological exam was nonfocal. The patient's cranial nerves II-XII were intact. There were no overt visual or auditory deficits and extraocular movements were full. Her strength and muscle tone were equal and bilaterally symmetric. Her gait was unsteady. She was unable to perform tandem walk, heel walking and toe walking, backwards and forwards. Balance was poor. Deep tendon reflexes were equal and bilaterally symmetric. There were no abnormal or pathological reflexes. The patient was slow and deliberate on finger-thumb opposition and also on finger-to-nose. She was also slowed with complex tests of motor imitation or coordination, so-called "kinetic melody."

COGNITIVE TESTING:

The patient was given a battery of neurocognitive tests.

The Test of General Mental Abilities includes the vocabulary test and the visual reasoning test, which correlate with more general measures of verbal and nonverbal IQ respectively. The patient's performance on other tests should be evaluated on the basis of his or her performance on the Test of General Mental Ability.

VOCABULARY TEST	80 = Low Average
VISUAL REASONING TEST	84 = Low Average

The Computerized Neurocognitive Test is a computerized battery that includes tests of verbal and visual memory, finger tapping, symbol-digit coding, the Stroop test, the shifting attention test, and the continuous performance test. Scores for Computerized Neurocognitive Test are reported as standard scores, with a mean of 100 and a standard deviation of 15. Normal performance is from 85 to 115, and 67% of the population will perform in that range. The patient scored as follows:

COMPUTERIZED NEUROCOGNITIVE TEST

DOMAIN	STANDARD SCORE	FUNCTIONAL LEVEL
MEMORY	86	Low Average
ATTENTION CONTROL	--	Invalid
PROCESSING SPEED	77	Below Average
MOTOR SPEED	--	Invalid

Subjects	STANDARD SCORE	FUNCTIONAL LEVEL
MEMORY		
Verbal Memory	80	low average
Visual Memory	94	average
ATTENTION CONTROL		
Stroop Errors	27	Invalid
Continuous Performance Test	9.9	invalid
PROCESSING SPEED		
Symbol Digit Coding	62	Well below average

PATIENT: Vickie Rummage

Stroop Response Time	92	average
Shifting Attention Test	78	below average

The Pediatric Neurocognitive Test is a computerized test of attention, processing speed, motor speed and coordination, and other cognitive functions. It is suitable for young children, for patients who are not literate, or who are non-English speakers, and also for elderly patients. The PNT is a shorter and simpler version of the CNT but generates comparable data

PEDIATRIC NEUROCOGNITIVE TEST

DOMAIN	STANDARD SCORE	FUNCTIONAL LEVEL
Motor Speed and Coordination	51	Well Below Average
Working Memory	132	Well Above Average
Processing Speed	38	Well Below Average
Attention	93	Average

VALIDITY INDICATORS

The 12 tests on CNS vital signs generate a number of "validity indicators." These are indications embedded within the test battery that indicate that the patient may not have been putting forth an appropriate level of effort. In the presence of a completed test battery, a high number of negative validity indicators is strongly suggestive that the patient's low level of performance is motivational in nature, rather than psychological, or neuropsychiatric. In the CNS Vital Signs test battery a "false positive" is a patient with a neurological condition, a psychiatric disorder or a developmental disability who is erroneously classified as "faking bad." If a patient generates invalid scores in five or more indicators, the likelihood of a false positive is one in fifty. If the patient generates invalid scores on seven or more indicators, the likelihood of a false positive is less than one in a thousand.

The patient was given a number of additional cognitive tests:

TEST	SCORE	RESULTS
RAVLT - total recall	25/75	Moderately impaired
RAVLT- delay	3/15	Moderately impaired
REY OSTERREITH COMPLEX FIGURE- copy	35/36	>75 th percentile
ROCF- delay	0/36	Invalid
REY 15 ITEM TEST	9/15	Valid
VERBAL FLUENCY TEST	19/45	Moderately impaired

The Rey Auditory Verbal Learning Test is a word-list learning task. The patient is given 5 repetitions of fifteen words, with five immediate recall trials and one delayed recall trial.

The Verbal Fluency Test is a measure of the patient's ability to generate words that begin with a certain letter with a one minute trial. The test is repeated three times.

The Rey 15-Item Test is a measure of exaggerated responding.

The Rey-Osterreith Complex Figure (ROCF) is a measure of visual memory. The patient's performance is evaluated on the basis of a copy and then his or her immediate recall.

The patient was given the Personality Assessment Inventory, a psychiatric questionnaire that is independently administered, scored and interpreted. A full report of the patient's performance on this test is available upon request. The patient's responses

PATIENT: Vickie Rummag.

were inconsistent on similar items. Her response patterns were unusual in that they indicate a defensiveness about particular personal shortcomings, as well as an exaggeration of certain problems. There was not, however, suggestion of an attempt to portray herself as being free of common shortcomings. Certain aspects raise the possibility of denial of problems with drinking or drug use. With respect to negative impression management, there are indications that the patient endorsed items that present an unfavorable impression. This result raises the possibility of a mild exaggeration of complaints and problems. The profile was marked by elevations in depressive symptoms, concerns of physical functioning, and peculiarities in thinking and experiences. Diagnostic possibilities include Major Depressive disorder, Conversion disorder, and Somatization disorder.

The patient completed the *Test of Memory Malingering (TOMM)*, which is a forced-choice test that indicates whether the patient is appropriately motivated to perform at his or her best. The TOMM will indicate a high level of motivation (scores above 90%), low motivation (70-89%), very low motivation (50-69%) or active dissimulation (scores <50%).

	Patient Score
Block 1	40/50
Block 2	40/50

SUMMARY AND IMPRESSIONS:

Ms. Rummag is a 55-year-old lady from Wallace, South Carolina, who worked as a weaver of carbon and glass, as in fiberglass. In May 2012, the patient had a slip and fall accident, and has subsequently complained of headache and back pain. The nature of her initial accident, however, is still a question mark. The fall was not associated with concussive symptoms, PTA, or LOC. The patient continued working, and wasn't seen by a medical provider until 12 days later.

The patient has been managed by multiple physicians, most recently Dr. Collins, who has aggressively pursued the possibility of posttraumatic migraine. He is aware of course of the patient's multiple premorbid conditions, including hypertension, hypothyroidism, migraine headaches requiring Fioricet, chronic arthritis requiring opiates, and long-term treatment for depression, requiring antidepressants.

The patient's evaluation today demonstrated a non-credible clinical presentation, with dramatic inconsistencies. The patient's overt memory performance, and indeed general appearance, fluency and lucidity is quite a variance with her claimed symptomatology. There was clear evidence of symptom exaggeration. The patient's most likely diagnosis is somatoform pain disorder.

There is no reason to believe that her current problems are related to a head injury, for example in the slip and fall in May 2012. There is simply no evidence that the patient had a head injury, and her subsequent course is not at all typical of recovery from concussion.

The patient is at maximal medical improvement. There is no permanent partial disability that is related to the slip and fall injury three years ago. As an aside, the patient is probably taking too many medications. Opiate medications are not advisable for the treatment of chronic degenerative arthritis, except in the most extreme cases, and Fioricet is a rather archaic treatment for migraine. The patient would be more appropriately treated with medications that are less sedating and less addictive.

C. Thomas Gualtieri MD

C. Thomas Gualtieri, MD
Assisted by Rebecca Kraus, PA-C

cc: WC 678-221-0870

Jason Lockhart - MGC insurance defense fax (803) 748-0526

To: Michael A Farry

Re: Vickie Rummage

ADDENDUM TO AN INDEPENDENT MEDICAL EVALUATION

DOB: [REDACTED] 59

DOA: 05/18/12

DOE: 04/09/15

DOR: 10/19/16

On April 9, 2015, we evaluated Ms Rummage in our clinic in Charlotte. She was at the time a 55-year-old lady from Wallace, South Carolina, who worked as a weaver of carbon in glass, as in fiberglass. In May, 2012, the patient had a slip and fall accident and subsequently complained of headaches and back pain. The nature of her initial accident, however, is still a question mark. The fall was not associated with concussive symptoms, post traumatic amnesia or loss of consciousness. The patient continued working, and wasn't seen by a medical provider until 12 days later.

The patient has subsequently been managed by multiple physicians, most recently Dr. Collins, who has aggressively pursued the possibility of posttraumatic migraine. He was aware of the patient's multiple premorbid conditions, including hypertension, hypothyroidism, migraine headaches requiring Fioricet, chronic arthritis requiring opiates, and long-term treatment for depression, requiring Prozac.

The patient's evaluation demonstrated a non-credible clinical presentation, with dramatic inconsistencies. The patient's overt memory performance, and her general appearance, fluency and lucidity is quite a variance with her claimed symptomatology. There was clear evidence of symptom exaggeration. The patient's most likely diagnosis is somatoform pain disorder.

At the time, I expressed the opinion that there was no reason to believe that the patient's current problems were related to a head injury, for example, the slip and fall in May, 2012. There was no evidence, in fact, that the patient had been concussed at all. There were no immediate symptoms that would indicate concussion, like loss of consciousness, post traumatic amnesia or even feeling dazed or confused. The patient continued working and didn't seek medical attention until twelve days later. Yet, we are expected to believe that this non-event has resulted in severe and disabling condition.

The most important thing about evaluating a traumatic brain injury patient is to understand the nature and the circumstances of the injury itself. One can make a case, perhaps, for a grade 1 concussion with a brief period of confusion. An injury that was more severe than that would not have allowed the patient to continue working, and would have led her to seek medical attention immediately, at the end of the day or the following morning.

At worst, the patient had a grade 1 concussion, that is concussion without LOC or post traumatic amnesia. Such events do not have persistent and disabling effects let alone for three years after the case. The reader is referred to these publications:

Gualtieri, C.T. (1995). The problem of mild brain injury. *Neuropsychiatry, Neuropsychology and Behavioral Neurology*, 8, 127-136.

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F 704 529-6655

2605 Blue Ridge Road, Suite 225
Raleigh, NC 27607
T 919 785-5055
F 919 573-6689

Gualtieri, C.T. *Brain Injury and Mental Retardation: Psychopharmacology and Neuropsychiatry*. Lippincott, Williams & Wilkins, Baltimore, 2002.

The minor nature of the patient's injury in May, 2012, should be contrasted with her many other medical problems, including chronic pain migraine and long-term depression, which entailed the administration of multiple medications including two antidepressants, Xanax, Percocet and the Fioricet, as well as others. In my report I described the Fioricet as a "rather archaic" treatment for migraine, containing, as it does, butalbital. Substantial danger can arise when a barbiturate, a benzodiazepine and an opiate are combined, especially in the patient with depression. In addition, the patient had substantial family problems, including a child who had recently attempted suicide.

In my evaluation, I concluded that the patient's disabilities were not related to the slip and fall injury three years prior, but, to the degree they were real, they are more likely attributable to premorbid difficulties and/or inappropriate medication treatment.

I also suggested that the patient was probably taking too many medications.

Now, why do I say "to the degree the patient's disabilities were real"? In cases where compensation is involved, one can't simply rely on the patient's subjective self-reports. In fact, it's not a good idea to rely entirely on patient's subjective self-reports in any case, but especially a case where the patient complains of being memory impaired.

On the Neuropsych Questionnaire, for example, there are 33 questions that inquire about a patient's problems with memory. Ms. Rummage said that every one of those items represented a "severe problem." In fact, on that questionnaire, most of the symptom subscales were in the 90th percentile or above of *all patients who have ever been seen in the Neuropsychiatry Clinics*. That alone is indication of symptom exaggeration. Moreover, the patient showed the same pattern of symptom over-identification on the adult symptom checklist which is a version of the SCL – 90. The same pattern of symptom exaggeration was discovered on the personality assessment inventory: "there are indications that the patient endorsed items that present an unfavorable impression. This raises the possibility of mild exaggeration of complaints and problems." That particular instrument raised the possibilities of depression, conversion disorder and somatization disorder.

No one in our Clinics use symptom rating scales as diagnostic instruments. The reason is they are based entirely on a patient's subjective opinions. However, we know precisely how patients with various conditions, including brain injury, response to these various instruments, and we also know that high levels of symptom endorsement are almost always a sign of symptom exaggeration.

People often ask me about the Neuropsych Questionnaire, especially because they want to use it in their own clinic. Because it includes items from many established rating scales, it is a convenient way to find out what problems the patient thinks he or she has even before they come to the clinic; the test is on the Internet, and you can take it yourself at www.atonc.com. If you want to learn more about the test, you can find these publications on the Internet:

Gualtieri, CT. An Internet-Based Symptom Checklist For Research And Clinical Practice In Neurology And Psychiatry. *Open Journal of Medical Psychology*, 2014.

Gualtieri, CT. Symptom Report and Diagnostic Properties Of The Neuropsychiatric Questionnaire. *Frontiers in Psychological and Behavioral Science (FPBS)*, 2014..

Gualtieri, CT. A Computerized Symptom Checklist For The Serial Evaluation Of Patients With Major Depression. *Frontiers in Psychological and Behavioral Science (FPBS)*, 2014.

Gualtieri, C.T. Symptom Report and Diagnostic Properties of the Neuropsychiatric Questionnaire" of *Frontiers in Psychological and Behavioral Science*. Vol. 3 Iss. 4, 2014.

Gualtieri, CT. An Internet-based symptom questionnaire that is reliable, valid and available to psychiatrists, neurologists and psychologists. *Medscape General Medicine*, posted Oct 3, 2007.

Gualtieri, CT. Reliability and Factor Structure Of An Internet-Based Symptom Checklist. *Frontiers in Psychological and Behavioral Science*, 2014.

Physicians and psychologists often ask about the computerized neurocognitive tests that my colleagues and I have developed over the past 15 years. To evaluate Ms. Rummage, we used the Computerized Neurocognitive Test. This is an updated version of CNS Vital Signs, a test that has been translated into 56 languages and is widely used by clinicians and researchers around the world. We use the CNT routinely to evaluate patients in the Neuropsychiatry Clinics. In fact, even psychiatrists are advised to administer "formal mental state examinations" to their patients, tests which include rough approximations of the tests that are more systematically presented in the CNT. Readers who are interested in the CNT are referred to the following papers, most of which are on the Internet.

- Gualtieri, CT. Husband-wife correlations in neurocognitive test performance. *Psychology*, 2103.
- Gualtieri, CT, Johnson, LG. Bupropion normalizes cognition in patients with depression. *Medscape General Medicine*. Posted 01/31/2007.
- Gualtieri, C.T., Hervey, A.S. The Structure and Meaning of a Computerized Neurocognitive Test Battery. *Frontiers in Psychological and Behavioral Science (FPBS)*. 2015.
- Gualtieri, C.T., Hervey, A.S. A Computerized Neurocognitive Test to Detect Malingering. *Frontiers in Psychological and Behavioral Science (FPBS)*, 4, 1, 2015.
- Gualtieri, CT, Johnson LG & Benedict, KB. Drug Sensitivity of a Computerized Neurocognitive Test Battery. Abstract, INS Annual Meeting, Baltimore, 2004.
- Gualtieri, CT, Johnson LG & Benedict, KB. Complex Attention in Unipolar and Bipolar Depression. Abstract, INS Annual Meeting, Baltimore, 2004.
- Gualtieri, CT, Johnson LG & Benedict, KB. Reliability and Validity of a Brief Computerized Neurocognitive Screening Battery. Abstract, INS Annual Meeting, Baltimore, 2004.
- Gualtieri, CT, Johnson LG & Benedict, KB. Psychometric and Clinical Properties of a new Computerized Neurocognitive Screening Battery. Abstract, ANPA Annual Meeting, Bal Harbor, Florida, 2004.
- Gualtieri, CT. Dementia Screening in Light of The Diversity of the Condition. *J Insurance Medicine*, 36, 298-309, 2004.
- Gualtieri, CT. Dementia Screening Using Computerized Tests. *J Insurance Medicine*, 36, 213-227, 2004.
- Gualtieri, CT, Johnson LG & Benedict, KB. The Comparative Neurocognitive Effects of Seven Antidepressants. Abstract, APA Annual Meeting, New York City, 2004.
- Gualtieri, CT, Johnson LG & Benedict, KB. A Computerized Cognitive Screening Battery for Psychiatrists. Abstract, APA Annual Meeting, New York City, 2004.
- Lapp CW, Smith RS, Falck, W. A comparison of simple office screening and a computer-based test battery to quantitate elements of cognitive dysfunction in persons with chronic fatigue syndrome and fibromyalgia. Paper, Amer Assoc of Chronic Fatigue Syndrome, 7th annual Research and Clinical Conference, Madison, WI, Oct, 2004.
- Gualtieri, CT. A Practical Approach to Objective ADHD Diagnosis and Management. *Psychiatry* 2005, 2, 16-25, 2005.
- Gualtieri, CT, Johnson, LG. ADHD: Is Objective Diagnosis Possible? *Psychiatry* 2005, 2, 44-53, 2005.
- Gualtieri, CT, Johnson, LG. Efficient Allocation of Attentional Resources in Patients with ADHD: Maturational Changes from Age 10 to 29. *J Attention Dis*, 9, 534-542, 2006.
- Gualtieri, CT, Johnson, LG. Neurocognitive Testing Supports a Broader Concept of Mild Cognitive Impairment. *J Alz Rltd Dem*, 20, 359-366, 2006.
- Gualtieri, CT, Johnson, LG. A Computerized Neurocognitive Test Battery for Studies of Schizophrenic and Bipolar Patients. Abstract, 13th Biennial Winter Workshop on Schizophrenia Research, Davos, 2006. *Schiz. Research*, 81, 122, 2006.
- Gualtieri, CT, Johnson, LG. Reliability and Validity of a Computerized Neurocognitive Test for Research in Schizophrenia. Presentation, ISCTM, 2nd International Congress, Washington, DC, February, 2006.
- Gualtieri, CT, Changes in Neurocognition from Age 7-20 Years. *Functional Brain Changes in Puberty & Adolescence*. Castang & Novartis Foundations, London, April, 2006.
- Gualtieri, CT & Johnson, LG, Reliability and Validity of a Computerized Neurocognitive Test for Research in Schizophrenia & Bipolar Disorder. Presentation, NCDEU, Boca Raton, Florida, June, 2006.
- Gualtieri, CT & Johnson, LG, Reliability and Validity of a Computerized Neurocognitive Test Battery, CNS Vital Signs. *Archives of Clinical Neuropsychology*, 21, 623-643, 2006.
- Masley, S, Roetzheim, R & Gualtieri, CT. Increased Frequency of Aerobic Exercise Enhances Cognitive Flexibility. *J Clin Psychol Med Settings* 16, 186-93, 2009.
- Gualtieri, CT, Johnson, LG. Medications do not necessarily normalize cognition in ADHD patients. *J Attention Dis*, 11(4) 459-469, 2008.

Masley, S, Masley L, Gualtieri, CT. Effect of Mercury Levels & Seafood Intake on Cognitive Function in Middle-aged Adults. Integrative Medicine, 11: 32-40, 2012.

Hervey, AS, Greenfield, K, Gualtieri, CT. Heritability in Cognitive Performance: Evidence Using Computer-Based Testing. J Genetic Psychology, 173:1, 112-118, 2012.

Masley, S, Masley L, Gualtieri, CT. Cardiovascular Biomarkers and Carotid IMT Scores as Predictors of Cognitive Function. Journal of the American College of Nutrition 33(1), 63-69, 2014.

C Thomas Gualtieri M.D.

Chapel Hill, North Carolina

10/19/16

Many more scientific papers have been published by other authors who use the older, commercial version of the CNT. I don't keep track of those papers, but you can find them at www.cnsvs.com.

Many psychiatrists don't do a "formal mental state exam" but simply rely on their observations. When one makes critical observations of Ms. Rummage, one discovers that she is able to give an accurate and detailed history of her complicated medical problems and present them with lucidity and fluently. Nevertheless, she complains of severe memory problems. That is, in itself, should be a clue to the true nature of the patient's problems.

We believe that it's important to be more systematic about evaluating a patient's cognitive abilities. So, having given us an extensive and accurate medical history, as she did to a later psychiatrist in Beaufort, SC, we discovered that the patient's scores on tests of memory are wildly inconsistent. On most tests, the patient performs below average or moderately impaired, then on others, she is well below average and yet others she is well above. Many of the patient's test scores are invalid. This is simply not the cognitive profile that occurs in patients with depression or traumatic brain injury.

CT, Johnson, LG. Neurocognition in Depression: Patients on and off Medication, Compared to Normal Controls. *J Neuropsych Clin Neuroscience*, 18, 217-225, 2006.

Gualtieri, CT, Johnson, LG. A computerized test battery sensitive to mild and severe brain injury. *The Medscape Journal of Medicine*, 2008. Posted 04/15/08.

Ms. Rummage was a pleasant 55-year-old lady when we examined her. She had traveled from Wallace, South Carolina, for the evaluation and when she arrived she was neatly dressed and well groomed. She was an attractive lady, albeit overweight. At no point during a long and arduous evaluation did she seem to be in any particular distress. She spoke well and gave a coherent history. From time to time she would cry but most of the time she was pleasant, well related, cooperative and compliant. There is nothing like psychomotor retardation although she was slow in performing certain tasks, like finger to nose. That sort of slowness is nothing like the psychomotor retardation that occurs in severe depression. Although the patient was sad about her medical condition and numbers of other things that had been happening in her life, she wasn't particularly depressed. She certainly wasn't impaired from taking the tests and questionnaires we gave her. In fact, I examined her after she had been through a long and arduous evaluation and she seemed rather in good spirits, except when she was addressing something painful in her medical history, at which time she would be tearful for a few moments.

I reviewed an evaluation that Ms. Rummage had in Beaufort, South Carolina on 09/01/15, by Dr. Amanda B Salas. I am most grateful for having had the opportunity to read Dr. Salas's report. Nothing in that report, however, changes the opinions I expressed on 12/11/14, although I certainly would have fixed some typos.

I trust that Dr. Salas' practice will advance after she has had the opportunity to read some of the papers listed above. Here are some others that support the validity and clinical utility of the instruments we use during our evaluations:

Gualtieri, CT, Morgan, D. The frequency of cognitive impairment in patients with anxiety, depression and bipolar disorder: an unaccounted source of variance in Clinical trials. *J Clin Psychiatry*, 2008 Jul;69(7):1122-30.

Gualtieri, CT, Johnson, LG. Age-related Cognitive Decline in Patients with Mood Disorders. *Progr Neuro-psychopharmacol Biol Psychiat*, 32, 962-967, 2008.

Gualtieri, CT, Boyd, AM. Subjective experience of cognitive impairment is not highly correlated with objective test data. *ISCTM 4th Annual Meeting*, Washington DC, Feb 26, 2008.

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STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 0705223

Vickie Rummage,

Claimant,

Employee,

v.

Town of Cheraw,

Employer,

and

Municipal Association of South Carolina,

Carrier,

Defendants.

DECISION AND ORDER

MAR 06 2008

5482/8056
FL Appeal
3/19/08

HEARING: Hearing held in Columbia, South Carolina, on January 23, 2008.

APPEARANCES: Claimant represented by Harris & Graves, PA, with Steven D. Haymond, Esquire appearing.
Defendants represented by Sowell Gray Stepp & Laffitte, L.L.C. with Grady L. Beard, Esquire appearing.

PURPOSE OF HEARING: To determine issues as set forth in the Forms 50 and 51

DECISION AND ORDER: By Honorable G. Bryan Lyndon, Commissioner

FILED: March 5, 2008

APA SUBMISSIONS

The following medical reports and exhibits were submitted on behalf of the claimant pursuant to the Administrative Procedures Act:

Physician	Practice	Date of Report	Page Numbers
1. Dr. Chris Cobbold		02/12/07 - 08/29/07	Pages 1 - 3
2. Dr. Fred McQueen		02/16/07 - 11/27/07	Pages 4 - 8
3. In-Med (MRI)		02/26/07	Page 9
4. Pee Dee Orthopaedics		03/19/07 - 10/17/07	Pages 10 - 26

Exhibits	Date of Reports	Page Numbers
1. De Bene Esse Deposition of Sharonica Henegan.	11/12/07	

The following medical reports were submitted on behalf of the defendants pursuant to the Administrative Procedures Act:

Physician	Practice	Date of Report	Page Numbers
1.	InMed Diagnostic Services of SC, LLC	02/26/07	Page 1
2. Chris Cobbold, MD		06/28/06	Pages 2 - 5
3. Fred D. McQueen, MD		03/18/91 - 01/16/07	Pages 6 - 15

Exhibits	Date of Reports	Page Numbers
A. South Carolina Employment Security Commission records		Pages 1-14
B. The claimant's deposition		
C. Deposition of Sharonica Henegan	11/12/07	

STIPULATIONS

The parties stipulated at the Hearing to the following:

1. The purpose of the Hearing is to determine issues pursuant to the Forms 50 and 51.
2. Notice of the Hearing was timely and properly served upon all parties of interest.
3. The South Carolina Workers' Compensation Commission has jurisdiction over this matter, and venue set in Richland County is proper.
4. The South Carolina Workers' Compensation Commission file is made a part of the record with the exception of any self-serving declarations or unstipulated medical reports.
5. The claimant alleged an injury to the right upper extremity (right shoulder) from a work-related accident on February 7, 2007.
6. The claimant's husband would corroborate that claimant called him the day she was allegedly injured.
7. The parties stipulated that Roy Rogers, a SLED agent, would testify that he performed a thorough orientation at the Criminal Justice Academy that included the immediate reporting of any accident by a participant in the program so that the appropriate reports and action can be taken.
8. The parties also stipulated that Lisa Hughes, South Carolina Law Enforcement Division, would testify that she observed the claimant and never detected any problems whatsoever that would be consistent with the allegation of a right shoulder injury on or about February 7, 2007, or any time thereafter. Further, at no time did claimant complain to Ms. Hughes about right shoulder problems.
9. The parties stipulated that Mary Brown, South Carolina Law Enforcement Division, who creates the files at the Criminal Justice Academy program, would authenticate or confirm that there is no such injury file in existence on the claimant, because no such complaint was ever made of a physical injury. Therefore, a file was never opened under the procedures and policies of the program.
10. The claimant has an average weekly wage of \$364.72, with a corresponding compensation rate of \$243.16.

STATEMENT OF THE CASE

This is a denied claim. The claimant alleges, while employed as a police officer for the Town of Cheraw, she sustained a compensable right shoulder injury on February 7, 2007, while training at Criminal Justice Academy.

The claimant seeks a finding of compensability, payment of all causally-related medical treatment for her right shoulder problems and temporary total benefits due to lost compensable time from work for the periods of February 9, 2007, until October 5, 2007, when she went to work for a new employer. The claimant contends she has not reached maximum medical improvement (MMI) for her rotator cuff injury.

The defendants deny the claimant sustained a compensable injury by accident pursuant to § 42-1-160, and maintain the claimant's current condition is simply a continuation of her significant pre-existing shoulder problems and other conditions. The defendants assert that while the claimant reported the accident several days later, and was provided initial medical treatment after reporting her injury, this in no way implies acceptance of the claim or represents a causal relationship between her right shoulder and neck complaints and the alleged accident. The claimant never advised the defendants of her significant pre-existing right shoulder or neck problems when she was hired to be a jailer. This evidence became available during discovery for this claim.

In the alternative, the defendants maintain if the undersigned finds the claim compensable, a review of the evidence in the record supports the claimant represented on her unemployment application that she was actively seeking work and able to work without restrictions. Accordingly, the claimant misrepresented on her application that she was whole and applying for work as having no restrictions; therefore, bringing her credibility into question. Furthermore, pursuant to § 42-9-

60, the evidence supports the claimant continued to participate in training exercises after the alleged incident, and withheld her alleged problems from her supervisors and trainers, ultimately and intentionally worsening her alleged condition. The defendants maintain the claimant's continued participation in the exercises rises to the level of an intentional act and, therefore, is not compensable as an injury by accident.

EVIDENCE OF THE CASE

The undersigned has carefully considered all of the evidence presented by the parties in this claim, including the claimant's and Chief Brooks' Hearing testimony, the claimant's deposition testimony, the deposition of Sharonica Henegan, stipulations of the parties, as well as the medical records and exhibits properly submitted by the parties through the APA. From this evidence, the following is specifically noted:

CLAIMANT'S TESTIMONY

The claimant is a married 48 year old high-school graduate, with additional education at Northeastern Tech where she received various certificates, including: Certificate Nursing Assistance, phlebotomy, law/ethics, and home health aid. See H.T., p. 11.

The claimant has previous employment with 911 in Marlboro County and worked for Cooper Tools in various capacities for 20 years. See H.T., pp. 11-12. The claimant denied filing any prior workers' compensation claims. See H.T. p. 12. The claimant confirmed that Dr. Fred McQueen is her family physician, and she has treated in the past for problems with her neck, both shoulders, and arthritis. See H.T. p. 12. The claimant denied ever being diagnosed with any rotator cuff problems in the past. See H.T. p. 13.

The claimant testified she was hired and employed as a dispatcher and a jailer for the Town of Cheraw. The claimant testified that she attended the South Carolina Criminal Justice Academy to become a certified jailer. See H.T., pp. 13-14. During her second week at the Academy, the claimant testified she was practicing a strong arm take down with a partner. The claimant testified her partner twisted her arm and she heard a pop, and felt terrible pain go through her shoulder. See H.T., p. 14. The claimant alleged Lisa Hughes of South Carolina Law Enforcement Division asked if her shoulder was okay. The claimant advised Ms. Hughes she would suck it up and go on, but Ms. Hughes told her to take a break, which she did. See H.T., p. 16. The claimant confirmed she later returned to physical activity that afternoon. Id.

The claimant also testified that she spoke with Sharonica Henegan about her shoulder and later with her family, but did not tell anyone at the Criminal Justice Academy. See H.T., p. 17. The claimant did not tell any of the Academy staff because she did not think it would be bad; she just wanted to get through the training. See H.T., p. 17. On February 9, 2007, the claimant failed the written test. Id.

The claimant alleged when the claimant returned to Cheraw on February 9, 2007, she advised Chief Brooks that she hurt her shoulder. See H.T., p. 18. The claimant admitted she was already terminated when she told Chief Brooks of her injury. Id. The claimant testified Chief Brooks told her to go and file for unemployment. See H.T., p. 19.

The claimant testified Suzanne Cottingham sent her to Dr. Cobbold, the company doctor, on February 12, 2007. See H.T., p. 19. The claimant confirmed Dr. Cobbold previously performed a physical for her several months before. See H.T., p. 19. The claimant testified that Dr. Cobbold referred her to Pee-Dee Orthopaedics. See H.T., p. 20. Subsequently, the claimant treated with

her family physician, Dr. McQueen. See H.T., p. 20. The claimant confirmed that, despite her knowledge that her claim had been denied by workers' compensation, she opted to have right shoulder surgery anyway, which was paid by her husband's group insurance. See H.T., p. 21.

The claimant alleged she could not sleep, lay down in the bed, and had been in a recliner until about a month ago. See H.T., p. 21. The claimant testified she is now getting some strength back and physical therapy has helped a lot. See H.T., p. 22.

The claimant testified she begged Dr. Denton to let her return to work, after she had several job offers and her unemployment benefits had run out. She returned to work with Cheraw Primary in the cafeteria, and part-time with Modern Cleaners. See H.T., p. 22. The claimant is currently taking medication for pain and inflammation, and feels that she needs another injection. See H.T., p. 23.

Upon cross-examination, the claimant confirmed Ms. Sharonica Henegan, who provided deposition testimony at the claimant's request, had nothing to gain by giving her testimony in this case. See H.T., pp. 24-25. The claimant confirmed she told no one at the Criminal Justice Academy (CJA) about her alleged injury. See H.T., p. 26. The claimant testified CJA had an orientation program, and in that program the claimant was advised what to do in case of an injury, so the staff could take care of it and so there would be a record of it. See H.T., p. 27. The claimant confirmed she did not advise Chief Brooks immediately after the injury at CJA. See H.T., p. 27.

The claimant testified, contrary to her prior direct testimony, that she advised Chief Brooks prior to her termination about her shoulder injury. See H.T., p. 28. The claimant confirmed she and Sharonica Henegan were terminated at the same time. The claimant was also aware that Ms. Henegan testified the claimant did not advise Chief Brooks until after she was terminated. See H.T., p. 28.

The claimant testified she was unable to treat for the 2005 injury because of emotional issues at home with her husband and her son, including depression. See H.T., p. 42. The claimant failed to advise the Town of Cheraw she was having depression and emotional problems when she applied to work for them. See H.T., p. 42. The claimant admitted she was advised by Dr. McQueen on April 10, 2006, that she needed to "slow down." The claimant admitted, however, her job as a jailer does not constitute "slowing down." See H.T., p. 43. The claimant never advised the Town of Cheraw that Dr. McQueen had advised her to slow down and not work like she was attempting to do, that she needed to consider a "different lifestyle," or that he did not know how much longer she was going to be able to work. See H.T., pp. 44, 52-53.

The claimant confirmed that on July 10, 2006, she had severe pain in both shoulders with severe muscle spasms, yet did not go treat with a neurosurgeon as recommended, and had not had an MRI performed. See H.T., pp. 46-47. The claimant confirmed that, even though the Town of Cheraw specifically asked, she did not inform anyone of her longstanding history of problems with chronic pain. See H.T., pp. 48-49. The claimant understood that the reason employers, such as the Town of Cheraw, ask those questions is so they can make sure people can perform their job, protect themselves, and other innocent people. See H.T., p. 49. Subsequently, the claimant testified she did advise Dr. Cobbold of her prior back, chronic pain, and right shoulder problems, even though she testified previously she never advised Dr. Cobbold of such problems. See H.T., p. 50.

The claimant testified that she was willing to do her job with all the pain, but she did not know it was going to get worse. See H.T., p. 55. The claimant testified that at the time Dr. McQueen recommended she quit due to her pain, he did not know she was working as a dispatcher.

The claimant testified that her instructor, Lisa Hughes, asked her if her arm was okay, which she replied it was. The claimant admitted that no one at the CJA, including Ms. Hughes, knew she was hurt. See H.T., p.30. The claimant confirmed she did not advise Dr. Cobbold of her prior right shoulder problems when she had her physical prior to attending the CJA. In fact, the claimant testified her family physician, Dr. McQueen, would not clear her to go to the Academy. See H.T., pp. 31-32. The claimant confirmed specifically that she knew she had degenerative problems in her right shoulder AC joint and bursitis when she had her physical. See H.T., p. 33. The claimant testified she failed to advise Chief Brooks of these problems as well. See H.T., pp. 33-34.

The claimant testified Dr. McQueen has been her family physician since the early 1990's. See H.T., p. 35. The claimant confirmed she had arthritis in her right shoulder, but never advised anyone at the Town of Cheraw when she filled out the Second Injury Fund Questionnaire. See H.T., p. 36. The claimant also neglected to advise Chief Brooks or anyone at the Town of Cheraw of her pre-existing carpal tunnel syndrome, even though the take down moves, grabbing of the wrists and arms, and putting on handcuffs hurt. See H.T., p. 37.

The claimant admitted she was diagnosed with osteoarthritis in 1993, and had ongoing emotional or depression type problems prior to the accident. See H.T., p. 38. The claimant testified she was continuing to treat until 1999 with Dr. McQueen for osteoarthritis and muscle spasms, which included her right shoulder. See H.T., p. 39. In fact, in 2000, 2001, and 2002, the claimant had trigger point injections in her right shoulder, and was advised to use heat on her shoulder. See H.T., p. 37. The claimant testified she complained of pain in her neck, low back, both shoulders, all the way down to her wrists in 2005. See H.T., p.40. The claimant confirmed she had been referred to a surgeon due to the need for potential neck or low back surgery, but she never went. See H.T., p. 41.

See H.T., p. 56. The claimant denied she took part in Dr. McQueen's pain management program.

Id.

The claimant testified that she was examined by Dr. Cobbold for a pre-employment physical on July 28, 2006. The claimant admitted she misrepresented to Dr. Cobbold during that physical that, while she did have issues with arthritic pains, her planned work is not to be strenuous. See H.T., pp. 57-58. The claimant specifically admitted she misrepresented the facts to Dr. Cobbold because she wanted the job really bad. See H.T., p. 58. The claimant recently returned to Dr. McQueen's office and passed a physical in order to get her C.D.L. license, even though she complains of chronic pain, neck, shoulder, back, and carpal tunnel syndrome. See H.T. p. 62-63.

The claimant admitted she failed to advise Dr. Denton and Dr. Ervin about her pre-existing shoulder problems as noted in the past history portion of those doctors medical questionnaires. See H.T. pp. 64, 65. However, Dr. Denton and Dr. Ervin diagnosed the claimant with degenerative disease in the AC joint, which is the same thing Dr. McQueen diagnosed her with in the past. The claimant confirmed the surgery performed by Dr. Denton was not emergency surgery. See H.T. p. 66.

The claimant advised the unemployment office she was able to work and was seeking a job as a machine operator or assembler. The claimant confirmed this was a "heavy-duty job". See H.T. pp. 68-69. The claimant admitted that she lied to the unemployment officials when she told them that she did not have a medical condition keeping her from working, because she wanted the unemployment check. See H.T. p. 71. The claimant testified Chief Brooks did not tell her to inform the unemployment office she did not have a medical condition. See H.T. p. 70. The claimant testified she was not emotionally or mentally fit to handle the job as a CNA. See H.T. p. 73.

Upon direct questioning by the undersigned, the claimant testified that she and Sharonica Henegan were called in to Chief Brooks office at the same time. See H.T., p. 83. The claimant testified she told Chief Brooks she hurt her shoulder, and then he let the two of them know they were terminated and needed to go to the unemployment office. See H.T., pp. 83-84.

Upon re-cross examination, the claimant testified that she never called Chief Brooks to advise him of her alleged injury, even though Sharonica Henegan told her to do so. See H.T., p. 85.

TESTIMONY OF CHIEF BROOKS

The claimant also called Chief Brooks to testify before the undersigned. Chief Brooks, has been with the Town of Cheraw for 14 years, and is currently the Chief of Police. See H.T., pp. 91-92. Chief Brooks testified the claimant was hired as a dispatcher/jailer. See H.T., p. 92. Chief Brooks confirmed the claimant was given a preemployment physical by Dr. Cobbold, the company doctor, who gave the affirmation the claimant could be employed at her position. See H.T., p. 92. Chief Brooks testified he sent the claimant to speak with Suzanne Cottingham about a referral to Dr. Cobbold after the alleged injury. See H.T., p. 93. Chief Brooks testified the claimant advised him of her shoulder problems after he terminated her for failing the written test at the Criminal Justice Academy. See H.T., p. 93. Ms. Henegan was terminated at this time as well, and was present when the claimant complained about her shoulder. See H.T., pp. 93-94.

Chief Brooks testified the claimant never advised him that she needed to stop working, or did not need to be doing any physical type work in September 2006. See H.T., p. 95. Had he known this, he would never have allowed her to attend the Criminal Justice Academy. See H.T., p. 95. Chief Brooks was surprised the claimant did not call him to advise him of her alleged injury, because he has received numerous calls from the Academy when officers had minor sore throats,

were running a fever, or had shin splints. When reported to the CJA staff, he was generally contacted just minutes later. See H.T., p. 96. Chief Brooks confirmed he never got such a call from the claimant. See H.T., pp. 96-97. Chief Brooks testified both the claimant and Sharonica Henegan knew that if they did not pass the written test they would be terminated pursuant to S.C. Code Ann. § 23-6-430, as they must be certified within the year of their employment. See H.T., p. 97. As this was the claimant's second failure, she was not eligible to be rehired for a period of one year.

MEDICAL EVIDENCE

On February 12, 2007, the claimant treated with Dr. Chris M. Cobbold due to pain in her right shoulder, resulting from an alleged accident while training at the academy. See Claimant's APA #1, p. 1. Dr. Cobbold noted that since that time, the claimant has been unable to lift her arm over her head without a lot of pain, and had to tough it out while at the Academy. Dr. Cobbold was unable to confirm this allegation, but suspected she had right shoulder bursitis and/or even possibly internal derangement. Id. On February 26, 2007, the claimant was referred for an MRI at InMed related to a history of shoulder pain status trauma. See Defendants' APA #1, p. 1. The MRI revealed prominent degenerative changes at the AC joint, which may be causing impingement syndrome; signal consistent with a partial tear; and small joint effusion with fluid seen tracking along the subscapularis, which may represent bursitis. Id. In a letter to the claimant's attorney dated August 29, 2007, Dr. Cobbold noted that the claimant was able to work as of February 27, 2007, and at that point made a referral to orthopedics for their expertise. See Claimant's APA #1, p. 3.

On March 19, 2007, the claimant was referred to Pee Dee Orthopaedics by Dr. Cobbold, with complaints of an injury to the right shoulder on February 7, 2007. Dr. Ervin noted the claimant had a past history of depression, and was currently taking Prozac. The claimant had

posterior and anterior tenderness and tenderness at the AC joint as well, with a positive impingement test. See Claimant's APA#4, p. 10. Dr. Ervin diagnosed the claimant with impingement syndrome, degenerative disease of the AC joint and a probable rotator cuff tear of the right shoulder. Id. p. 10. Subsequently, the claimant was seen by Dr. Denton who opined the claimant had impingement with rotator cuff tendinitis, but did not feel that she had a full-thickness tear of the rotator cuff in her right shoulder. Dr. Denton discussed the possibility of an arthroscopy to evaluate the tendons and repair any tears if needed. Id. pp. 14-15. The claimant returned on May 2, 2007, for a pre-op discussion regarding her right shoulder with Dr. Denton. Dr. Denton again noted the claimant has right shoulder impingement and degenerative AC joint. On May 11, 2007, Dr. McQueen reported the claimant has never had problems while treating with him for her right shoulder; it was always her neck. See Claimant's APA #2, p. 5. Dr. Denton performed the arthroscopic surgery on her right shoulder on June 19, 2007. See Claimant's APA#4, p. 20.

In a letter to the claimant's attorney dated August 17, 2007, Dr. McQueen noted that the claimant had been under his care for the February 16, 2007, injury, and had degenerative disease of the AC joint. Dr. McQueen further noted the claimant has become anxious and depressed over her limitations and lifestyle change with chronic pain syndrome since the initial injury. Id. p. 7. Dr. McQueen opined that the claimant was unable to hold gainful employment and continues to remain disabled since February 13, 2007. Id. Since August 9, 2007, Dr. McQueen found her depression and anxiety much worse due to the chronic pain. Id.

On September 12, 2007, Dr. Denton released the claimant to light-duty work with no use of her right arm and no overhead lifting; no push and pull; and a five pound lifting restriction. See Claimant's APA#4, p. 25. Thereafter, the claimant returned with great range of motion, and Dr.

Denton felt the claimant's tendons had healed. Dr. Denton scheduled a six-week follow-up appointment. Id. p. 26.

On November 26, 2007, Dr. McQueen denied performing x-rays on her right shoulder, noting the claimant had muscle spasms of the right shoulder in August 2000, requiring trigger point injections. The claimant was diagnosed as having a "rotator cuff." Dr. McQueen related these treatments to bursitis not her rotator cuff. See Claimant's APA #2, p. 8. Dr. McQueen felt that her rotator cuff was caused by an injury on the job, and there was no documentation in his records of a diagnosis of rotator cuff prior to that time. Id. The following day, the claimant returned requesting a commercial license physical be performed, which she neglected to previously do. All systems were within normal limits, and Dr. McQueen completed the form. Id.

PRE-EXISTING CONDITIONS

On March 18, 1991, the claimant treated with Dr. McQueen with symptoms of depression and problems with insomnia. See Defendants APA#3, p. 6. Dr. McQueen advised the claimant to consider another job. The report notes the claimant has tendinitis with bursitis of the right upper extremity with pain at the end of the day. The claimant was placed on Feldene and Prozac. Id. On February 11, 1992, the claimant was continuing to use Feldene for her arthritis. Id. Subsequently, the claimant returned for treatment on December 28, 1992, with complaints of neck problems as the result of an automobile accident a month prior. See Defendants APA#3, p. 7. The report notes the claimant was on medication for depression, her right wrist was swollen, and had carpal tunnel syndrome. Id. On January 11, 1993, the claimant was noted as being on medication and on light duty work restrictions due to c-spine and right wrist problems for two weeks. Id. The claimant complained of tenderness of the muscle beneath the breast radiating down from the right side of

the neck and shoulder on June 24, 1993. The report notes the claimant has degenerative disc disease and was placed on the muscle relaxant Norflex. Id.

On June 1, 1995, the claimant complained of pain in the hip and neck, and was noted as having a history of arthritis. See Defendants APA#3, p. 8. Dr. McQueen diagnosed the claimant with osteoarthritis and obesity, and prescribed Ultram for pain. Id. On June 12, 1999, the claimant reported she was depressed, having problems sleeping, and had muscle spasms of the neck. Dr. McQueen assessed the claimant's condition as major depression and osteoarthritis with muscle spasms. Id. p. 9. Two days later on June 14, 1999, the claimant called and advised Dr. McQueen that she was unable to take Buspar and requested Xanax or Atarax. Id.

The claimant treated with Dr. McQueen on August 3, 2000, with complaints of severe muscle spasms of the right shoulder. Id. p. 10. She was provided with a trigger point injection in the right shoulder and advised to provide heat to the shoulder. Id. On March 16, 2001, the claimant complained of neck pain and headaches. Id. The claimant followed up for subsequent trigger point injections on May 31, 2001, and July 5, 2002. See Defendants APA#3, pp.10-11.

On September 12, 2005, the claimant sought evaluation with a lot of pain in neck and low back with radiculopathy down her shoulders, arms, wrists, and down her legs and feet. At that time, the claimant was controlling her pain with Lorcet. See Defendants APA#3, p.12. The claimant requested medication for anxiety, and was noted as being on Prozac for several years, which was not working very well. Therefore, Dr. McQueen wrote her a prescription for Xanax and Cymbalta, and ceased the use of Prozac. Dr. McQueen reported the claimant had not been able to treat with Dr. Arthur for her cervical disc disease and lumbosacral disease that were revealed on her MRI's. Id. Dr. McQueen encouraged the claimant to seek an evaluation with Dr. Arthur as soon as possible in order to see what he could do short of surgery. Id.

On April 10, 2006, Dr. McQueen noted the claimant had degenerative disc disease and end-plate disease at C4-5, C5-6, and C6-7 with mild impression upon the vertebral thecal sac, with some spurring. See Defendants APA#, p. 13. The report notes the claimant's main problem is her neck. The claimant was noted as having problems with her husband and son at home, and has yet to see Dr. Arthur. Dr. McQueen advised her that she had "to find a way to slow down." Defendants APA#3, p. 13. Therefore, Dr. McQueen recommended she consider Family Medical Leave so that she can take advantage of the time at home with her husband and son. The claimant was also placed on Wellbutrin XL. See Defendants APA#3, p. 13.

On June 28, 2006, the claimant was examined by Dr. Cobbold for a physical. Dr. Cobbold noted past history of arthritis in her back and neck, depression, chronic insomnia, and left leg surgery for a broken bone. See Defendants' APA #2, pp. 2-5. The report, however, notes the claimant did not have a mental illness, and had never been unable to hold a job for medical reasons. Id. p. 3. Dr. Cobbold recommended that the claimant proceed with her planned work for the Town of Cheraw as she had no limiting factors. Dr. Cobbold noted the claimant had some issues with arthritic pains but her planned work is not to be strenuous, so it would not be a problem. See Defendants' APA #2, p. 5.

On July 10, 2006, the claimant returned to treat with Dr. McQueen and was again noted as having degenerative disc problems in her neck, now with severe pain in both shoulders and severe muscle spasms. The claimant had full range of motion but has pain upon palpation and "very very" tight muscles across both shoulders, along the trapezius; which are spasming. See Defendants APA#3, p. 14. Dr. McQueen recommended that she be referred to the spine specialist in Florence for further evaluation and treatment for her cervical disc disease. Id. The claimant was noted as having chronic depression secondary to chronic pain. Id.

Following treatment with the neurologist, the claimant treated with Dr. McQueen on September 11, 2006. Dr. McQueen noted the claimant needs to consider a different lifestyle, and did not know how much longer she is going to be able to continue to work. See Defendants APA#3, p. 15. Subsequently, the claimant treated with Dr. McQueen on December 8, 2006, and was noted as being a member of their pain management program. The report notes the claimant has severe degenerative disc disease with spurring in C4-5, C5-6, and C6-7; with severe muscle spasms. Id.

CLAIMANT'S DEPOSITION

The claimant testified she is a high school graduate with certificates from Northeastern Tech in Certified Nursing Assistance, phlebotomy, home health aid, and computers. See Claimant's Deposition p. 6. The claimant admitted to having prior neck and back problems. Id. p. 12. The claimant treated for these problems with her family physician Dr. Fred McQueen. Id. p. 13. The claimant testified that her neck and back problems are the result of degenerative problems, but denied any of her back and neck pain radiated or affected her right shoulder or arm. Id. The claimant testified she had begun the certification process at the Criminal Justice Academy in order to become a jailer. Id. p. 15. This certification process takes three weeks, and by February 7, 2007, the claimant had made it through the first week. Id. p. 16. The claimant alleged she was working on defensive tactics with her partner and felt a popping noise in her arm with awful pain. Id. The claimant did not advise her instructor of the pain, but it was so bad she could not even dress herself the last two days of the academy.

The claimant testified she failed the written test two days later and was sent home. After leaving the academy, the claimant testified that she was terminated by Chief Brooks, and that she advised him of her injury on that day. Id. p. 19. The claimant alleged she told Sharonica Henegan

that she had injured herself and called home and told her family. Id. The claimant alleged she told Chief Brooks about her injury before he fired her. Id.

The claimant testified she went to speak with Dr. McQueen only after her right shoulder surgery was denied. Id. p. 23. The claimant also testified that she has been offered a job with Cheraw Primary Schools but she is unable to start until she is released by her physician. Id. p. 30. The claimant confirmed that she was receiving unemployment benefits at the time her deposition was taken. Id. p. 31. The claimant testified she did not acknowledge whether she was ready, willing and able to return to work at the time she completed her unemployment application. Id. p. 32. The claimant denied having any medical treatment, prior pains, or injuries to her right shoulder. Id. p. 33. The claimant did confirm she has been diagnosed in the past with arthritis, depression and carpal tunnel syndrome. Id.

DEPOSITION OF SHARONICA HENEGAN

Upon direct examination by the claimant's attorney, Sharonica Henegan testified she was employed as a dispatcher and jailer with the Town of Cheraw, which was the same job held by the claimant. See Deposition of Sharonica Henegan, p. 6. Ms. Henegan testified that she and the claimant started the three week course at the academy on January 28, 2007, and left on February 12, 2007. Id. p. 7. Ms. Henegan testified the claimant complained about her shoulder, but the claimant never actually said what caused her pain. Ms. Henegan guessed it was from the takedown move. Id. p. 9. Ms. Henegan testified the claimant did not tell anyone about her shoulder problems. Id. Ms. Henegan confirmed she and the claimant were discharged after they failed the academy. Id. p. 10.

Ms. Henegan testified the academy advised her that if you were injured at any time, she was supposed to let them know and they would take care of it. See Deposition of Sharonica Henegan, p. 16. Ms. Henegan confirmed the claimant was present when the academy advised them of what to do in the case of an injury, which was to report the injury, and they would provide medical treatment and notify their employer. Id. Ms. Henegan testified that she advised the claimant to report her problem to the academy but the claimant wanted to "toughen the situation out." Deposition of Sharonica Henegan, p. 16.

Ms. Henegan and the claimant were roommates while at the Academy in Columbia. The claimant never advised Ms. Henegan of her prior shoulder problems. See Deposition of Sharonica Henegan, pp. 16-17. Ms. Henegan testified the claimant's complaints began during the first week of training. She also confirmed the claimant complained of her shoulder problem the entire two weeks, and never told anyone at the academy, the Chief of Police, or the Town of Cheraw. Id. pp. 18-19. Ms. Henegan advised the claimant to notify the Town officials or someone at the Academy, which she never did. Id. p. 19. Ms. Henegan testified that the Chief of Police met with both she and the claimant and advised them he had to terminate them because of the failed certification. See Deposition of Sharonica Henegan, pp. 19-20. Ms. Henegan testified that no one discussed shoulder problems or an injury during that meeting. Id. p. 19.

Ms. Henegan questioned the cause of the claimant's injuries because claimant was advised of what to do if she got hurt during the program and she failed to tell anyone about her problems. See Deposition of Sharonica Henegan, p. 25. Ms. Henegan testified that she is currently a dispatcher, requiring sitting and answering the phone, and someone with an injured shoulder could do that job. Id. p. 27.

FINDINGS OF FACT

The undersigned has carefully considered and reviewed all of the evidence presented by the parties in this claim, including the testimony of the claimant, the claimant's deposition, the testimony of Chief Brooks, and the stipulations and APA submissions of both parties. From this evidence, IT IS FOUND AS A FACT THAT:

1. Both the claimant and the defendant/employer are subject to the South Carolina Workers' Compensation Act, as the claimant was a covered employee and defendant/employer was a covered employer at the time in question.
2. The claimant alleges injury to the right upper extremity/shoulder in a work-related accident on February 7, 2007.
3. The claimant has had a variety of jobs in the past including assembly work, CNA, and other types of medium to light work.
4. The claimant admitted that she had right and left shoulder problems as well as neck problems in the past. She denied ever having a rotator cuff tear. She later changed her testimony to indicate it was more neck than shoulder problems.
5. The claimant applied for a job with the defendant employer as a jailer. She testified that she injured her shoulder and that a co-workers could sense she was in pain. She further testified that this co-worker told her to take it easy and not do any more "take downs."
6. The claimant continued to participate in the exercises and was required to take a written test, which she failed. It was shortly after this that the claimant first reported an accident. The claimant was terminated for not passing the certification test which is policy with no exceptions. She would have been allowed to reapply after a waiting period.
7. The claimant was referred to the company doctor after reporting the incident. The company doctor reported the claimant's allegations of a workers' compensation injury. When it was discovered that the claimant had reported a rotator cuff tear and needed surgery, the claim was denied.
8. The claimant had surgery and returned to work after her unemployment expired. She continues to work two jobs at the time of the Hearing.

9. On cross-examination, the claimant denied telling Sharonica Henegan that the alleged incident happened two days after training began.
10. Sharonica Henegan, a witness for the claimant who was deposed, was also terminated for failing to pass the written test. She had the same right to reapply after a waiting period.
11. The claimant admits never telling anyone at the criminal justice academy when she got hurt. She also admitted that she went through orientation and knew she should report an accident.
12. In Sharonica Henegan's deposition, she testified the claimant was terminated along with her for not passing the test and there was no mention about the shoulder surgery alleged by the claimant.
13. The claimant admitted at the Hearing that she never advised the defendants that she had previous right shoulder and neck problems. She also has been diagnosed with depression and carpal tunnel syndrome and did not report this pre-hire. This brings the claimant's credibility into question.
14. The claimant has emotional problems dating back to the 1990's and was medically treated for this and osteoarthritis. She has had continued treatment for her right arm, shoulder, depression, and arthritis since 1990.
15. Two months before applying for the jailer job, the claimant's personal family doctor suggested she apply for a leave and "slow down." The job for which she applied has physical elements that the claimant knew she was not physically capable of performing, including running. The physical demands of the job of jailer were unknown to the doctor.
16. In Dr. McQueen's report of July 10, 2006, he states the claimant has severe pain in both shoulders with severe muscle spasms. Up until this time, the claimant had not had an MRI of the right shoulder.
17. On September 11, 2006, Dr. McQueen stated that he did not know how much longer the claimant could work. This was when she was a dispatcher not a jailer.
18. The claimant testified that she knew that withholding her medical history was not fair to the defendants but she thought "she had a right to try." Again, her credibility comes into question.
19. In Dr. Cobbold's report of June 28, 2006, he states the "claimant has issues with arthritic pain, but her planned work is not strenuous." This was not true according

to the claimant's testimony at the Hearing. The doctor cleared the claimant to work based upon this misrepresentation.

20. In Dr. McQueens' report of November 26, 2007, he contradicts himself regarding the claimant's shoulders as it relates to treatment going back to 1991, and that she did not have a rotator cuff tear prior to February 7, 2007. I gave his opinion little to no weight.
21. The claimant filed for and received unemployment and represented she was able to work without restrictions. This also brings the claimant's credibility into question.
22. The claimant testified in her discovery deposition that she had never had pain radiating into her right shoulder. This does not conform to the many medical reports by the claimant's family doctor and her testimony at the Hearing. This also brings the claimant's credibility into question.
23. There were a number of witnesses at the Hearing for the defendant. There was a stipulation by the parties that Roy Rogers, a SLED agent, would testify that there was a thorough orientation that included the immediate reporting of any accident.
24. There was a second stipulation that Ms. Hughes, CJA Trainer, would testify that she observed the claimant and never detected any problems whatsoever with the claimant that would be consistent with the claimant's allegations of a right shoulder injury on or about February 7, 2007.
25. Chief Brooks was called by the claimant's attorney and testified the claimant told him on February 9, 2007, right after she returned from the academy. This conversation happened after the claimant was terminated. He testified the claimant was referred to an individual who handled workers' compensation.
26. Chief Brooks also testified that he had no idea about the claimant's medical past and would not have made her a jailer if he had known the extent of her health problems.
27. The claimant clearly had the responsibility to let the defendants know that she had ongoing shoulder problems as well as other multiple health problems that would disqualify her as a jailer.
28. While the claimant met the technical notice reporting requirements, I find that she had ongoing, continual shoulder problems since the 1990's. There are so many inconsistencies in her testimony as well as her family doctor's medical reports that I did not find either credible.
29. Compensation rate: \$243.16.

30. The claimant failed to prove by the greater weight of the evidence that the alleged incident she described on February 7, 2007, rose to the level of an accident. In fact, the greater weight of the evidence indicates the claimant has had longstanding well documented shoulder problems and the alleged incident was nothing more than a continuation of those pre-existing conditions.
31. The claimant's claim for benefits under the Act is DENIED.

CONCLUSIONS OF LAW

Accordingly, as provided in S.C. Code Ann. § 42-17-40 (1976), it is the determination of this Commissioner that:

1. Pursuant to § 42-1-130, the claimant was a covered employee at the time of the alleged accident in question; and under § 42-1-140, the defendant employer was a covered employer.
2. Pursuant to §§ 42-1-160, the claimant did not sustain a compensable work-related injury to her right shoulder.
3. Pursuant to §§ 42-15-60, 42-9-10 and 42-9-30, the defendants are not responsible for any medical benefits or disability benefits for the claimant.
4. The claimant is entitled to no award of benefits under the Act.

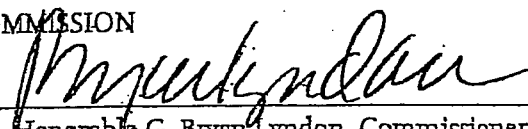
ORDER

IT IS THEREFORE ORDERED that the Findings of Fact and Conclusions of Law are incorporated herein as if set forth verbatim. The claimant's request for benefits under the South Carolina Workers' Compensation Act is hereby DENIED.

No Hearing costs are assessed in this claim.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION
COMMISSION

BY: 

Honorable G. Bryan Lyndon, Commissioner

Columbia, South Carolina

3/3/2008

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 5 day of March, 2008

P500 By Kim Williams
Administrative Assistant to the Commissioner

SH
EB

SANDHILLS REGIONAL MEDICAL CENTER
HAMLET, NC 28345
RADIOLOGICAL INTERPRETATION

PATIENT NAME: RUMMAGE, VICKIE
EXAM DATE: 1/23/2011
ORDERING: ADEBOLA ADEKANMBI, MD
ATTENDING: ALABA ONASANYA
CONSULTING: FRED MCQUEEN, MD
HISTORY: HEADACHE--FREQUENT WITH HX
 Reason: possible bleed

MED REC #: [REDACTED]
D.O.B.: [REDACTED] 1959
X-RAY#: [REDACTED]
ACCOUNT #: [REDACTED]
ROOM: ER

CT HEAD/BRAIN W/O CONTRAST

CPT CDE: 70450

CT SCAN OF THE HEAD: 1/23/11

HISTORY: Dizziness and headache. Clinical suspicion of intracranial hemorrhage.

There is no evidence of any intracranial hemorrhage, hydrocephalus, midline shift, abnormal mass effect or acute cortical-based infarction, although infarction may not be visualized for three to seven days or even longer in some instances. The orbits and mastoids appear within normal limits as much as visualized. Upper left maxillary sinus is opacified. There is minimal mucosal thickening in the ethmoid sinuses. There is some minimal atrophy present, and there may be some minimal chronic ischemic change in the white matter as well.

CONCLUSION:

NO SIGNIFICANT ACUTE INTRACRANIAL ABNORMALITY IDENTIFIED.
LEFT MAXILLARY SINUS DISEASE NOTED.

DD: 01/24/2011 00:00
DT: 01/24/2011 09:15 KS

Dictated By: SMITH, GREGORY
Signed By: SMITH, GREGORY

DATE DICTATED: 1/24/2011
DATE TRANSCRIBED: 1/24/2011 9:15
TRNS: KS TECH: B PATRICK
5853381 CONSULTING FAX

REVIEWED AND SIGNED
GREGORY SMITH
RADIOLOGIST
1/24/2011 11:22:52
PAGE 1 OF 1

13639

SANDHILLS REGIONAL MEDICAL CENTER
HAMLET, NC 28345
RADIOLOGICAL INTERPRETATION

PATIENT NAME: RUMMAGE, VICKIE
EXAM DATE: 5/14/2005
ORDERING: FRED MCQUEEN, MD
ATTENDING:
CONSULTING:
HISTORY: NECK-LOW BACK PAIN

MED REC #: [REDACTED]
D.O.B.: [REDACTED]/1959
X-RAY#: [REDACTED]
ACCOUNT #: [REDACTED]
ROOM: OP

MRI C-SPINE W&WO CONT

CPT CDE: [REDACTED]

Sagittal and axial pre and post contrast images were performed. Alignment is anatomic. There is posterior disk bulges at C4-C5, C5-C6 and C6-C7 along with end plate osteophytic ridging resulting in mild impression upon the ventral thecal sac. Bilateral neural foraminal compromise is also present at these levels secondary to osseous process spurring.

IMPRESSION: DEGENERATIVE DISK AND END PLATE DISEASE C4-C5, C5-C6 AND C6-C7. RESULTING IN MILD IMPRESSION UPON THE VENTRAL THECAL SAC. THERE IS BILATERAL OSSEOUS PROCESS SPURRING RESULTING IN NEURAL FORAMINAL COMPROMISE AT THESE LEVELS.

JOHN WITTENBORN

Dictated by

DATE Dictated: 5/16/2005

DATE Transcribed: 5/16/2005 14:45

TRNS: THF TECH: A BENJAMIN

7936277

ORDERING FAX

REVIEWED AND SIGNED
JAY JONES

5/17/2005 9:16:20
PAGE 1 OF 1

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Gene McCaskill, Commissioner
Avery B. Wilkerson, Jr., Commissioner
R. Michael Campbell, II, Commissioner

W.C.C. FILE NO.: 1215681

APPELLATE CASE NO.: 2018-000359

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SC Court of Appeals

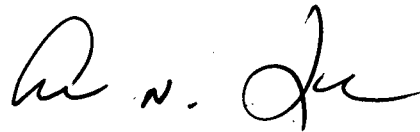
Vickie Rummage, Employee, ...Appellant,

vs.

BGF Industries, Employer, and Great American Alliance Insurance Co., Carrier,
.....Respondents.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies the foregoing Record on Appeal contains all material
proposed to be included in the Record and no other material.



Andrew N. Safran, Esquire
Post Office Box 12089
Columbia, South Carolina 29211
803-256-6689

Attorney for Appellant

November 5, 2018
Columbia, South Carolina