

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.

RECORD ON APPEAL

VOLUME I

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APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO.: 1215681

Vickie Rummage, Employee,

Claimant/Appellant,

-v-

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

Defendants/Respondents.

Appellate Panel Review held in Columbia,
South Carolina, on September 18, 2017 per
notices timely and properly served on
all parties of interest.

Appellate Panel Decision and Order filed
2-1, 2018

APPEARANCES:

Claimant/Appellant represented by
Andrew N. Safran of Columbia, SC

Defendants/Respondents represented by
Horton Law Firm, P.A. by
Michael A. Farry of Greenville, SC

STATEMENT OF THE CASE

The parties were heard by Commissioner Susan S. Barden on November 7, 2016 in Hartsville, South Carolina. On March 14, 2017, Commissioner Barden issued the following Order:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with BGF Industries, Inc., Employer, and Great American Alliance Insurance Company, Carrier.

2. Claimant injured her head and neck in an admitted accident on May 18, 2012. Claimant alleges that she aggravated her pre-existing psychological condition, a claim I find is not supported by the greater weight of the evidence.

3. Claimant is not remotely credible (if I did not feel strongly after the hearing, reading Claimant's deposition testimony in its entirety only confirmed my impressions). I base this finding on my observations of Claimant, the inconsistencies in the delivery of her testimony, and on her very "selective" memory at the hearing and at her deposition (particularly with regard to her denial/lack of forthrightness of significant, pre-existing conditions for which Claimant received treatment). After observing Claimant at the hearing, reviewing Claimant's prior medical history along with her sworn testimony, and reviewing what Claimant has told post-accident providers, the descriptive words that come to mind are wily and manipulative.

4. Claimant is 56 years of age (Tr., p. 17).

5. Claimant is a high school graduate, and subsequently received her C.N.A. and other certificates/degrees from a technical college where she also took phlebotomy, computer, and home health courses (Tr., p. 18; Claimant's Depo., pp. 9-10).

6. Claimant's employment history includes work as an assembler, an assistant manager at a drycleaners, a manager of a gym, and a school cafeteria cook (Tr., p. 20; Claimant's Depo., pp. 16, 50-51).

7. Claimant's job with Employer was a weaver (Tr., p. 23; Claimant's Depo., p. 16).

8. Prior to the accident, Claimant has documented longstanding, "chronic" pre-existing depression and anxiety disorder for which she took various psychotropic medications over the years, including Prozac, Wellbutrin, Lexapro, Cymbalta, Effexor, Xanax, Ambien for insomnia, and Lorcet (Dr. Fred D. McQueen, APA #13, 9/12/05, p.191; 1/10/06, p. 192; 4/10/06, p. 193; 9/11/06, p.194; 12/8/06, p. 194; 2/16/07, p. 195; 8/9/07, p. 197; 8/17/07, p. 198; 11/27/07, p. 199; 4/21/08, p. 200; 7/22/08, p. 200; 10/21/08, p. 201; 2/13/09, p. 201; 5/15/09, p. 202, 2/13/09; p. 203, 8/17/09, p. 204; 11/17/09, p. 205; 2/12/10, p. 206; 11/22/10, p. 208; 1/25/11, p. 209; 5/9/11, p. 212, 9/30/11, p. 215; 1/13/12, p. 219; 3/13/12, p.224; Ex. 3 to Depo. of Dr. Daniel L. Collins; 5/14/12; APA #12, Dr. James J. Brennan, 7/27/06, p. 187). This was ongoing treatment and not remote, episodic treatment. Claimant also had longstanding pre-existing chronic neck and back pain (primarily neck pain) for which she was treated with Lorcet, Flexeril, and Percocet (4 days before the accident, she received refills for Flexeril, Percocet, Xanax, and Lyrica) (Ex. 3 to Depo. of Dr. Collins, 5/14/12). Notwithstanding Claimant's extensive history, she would not volunteer (or admit) to her pre-existing chronic pain, chronic depression/anxiety, and chronic migraines. Notwithstanding the degree of her pre-existing pain and extensive treatment, Claimant testified under oath that she could not "remember" whether she was treated for neck or back problems, even though the severity of Claimant's neck was such that cervical surgery is mentioned as a possibility in Claimant's family doctor's records pre-dating the accident in issue (Claimant's Depo., p. 36). Claimant suggested in sworn testimony that her psychological treatment was episodic/"in the past" instead of ongoing. She would not admit to taking pain medication, as the only thing she could "remember" was taking blood pressure medication and medication for hypothyroidism; it is noteworthy that she could "remember" these unrelated medications (Claimant's Depo., pp. 37 & 41). Claimant's failure to be forthright greatly damages her credibility. One only needs to read Claimant's prior medical history in its entirety, then to read her deposition testimony in its entirety, and her Facebook pages to judge credibility. Further, at the hearing, Claimant did not redeem herself by her inconsistent presentation, her selective memory, and her denial of pre-existing conditions (dizziness, etc.) (Tr., p. 28), despite the fact that in January 2011, Claimant underwent a CT scan of her head for dizziness and headaches (APA #14, p. 25; Claimant's Depo. in its entirety; APA #13 in its entirety).

9. Claimant's spouse is disabled and does not work. This has caused a hardship, as Claimant was on probation "again" on the date of the injury because of her having to previously miss work because of her husband's condition (Tr., p. 44; Claimant's Depo., pp. 9, 14, & 25).

10. Claimant also has situational stressors regarding her son, including but not limited to his attempted suicide (APA #3, p. 98). Claimant

also has taken care of both her parents through their deaths, as well as continuing to deal with one of her son's health issues, including kidney problems (Tr., pp. 44-45).

11. Contrary to Claimant's testimony at the hearing that her headaches are now "different," Claimant is documented in medical evidence as having pre-existing "chronic migraines" which were and are debilitating and for which Claimant underwent a CT scan of the brain. In addition, Claimant also has (documented) pre-existing sinus and tension headaches (APA #13, pp. 205-206, 209, and 211-212; APA #14, p. 25).

12. Claimant's testimony that she never had any dizziness prior to the accident in issue is refuted by Defendants' APA #14, page 225, showing that on January 23, 2011 Claimant underwent a pre-accident CT of the brain for the specified reasons of dizziness and headaches (APA #14, p. 225).

13. In 2010, Claimant's physician states that "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." He goes on to suggest that Claimant seek Vocational Rehab assistance and sedentary work. The next year Claimant's physician wrote that he does not feel that Claimant should physically be performing the job she was performing (APA #13, pp. 208 & 217).

14. Claimant has pre-existing sleep difficulties for which she was prescribed medication for years prior to the date of the accident. Claimant's sleep difficulties are not new, as she would have providers believe (APA #13, 9/12/05 – 9/30/11, pp. 191-193, 197, 199, 201-203, 205, 206, 212, 215).

15. After the accident, Claimant continued to work for 3 months. I give this evidence great weight (Tr., p.50; APA #8, p.135; APA #10, p. 161; Claimant's Depo., pp. 49 & 60).

16. Claimant did not lose consciousness on the date of the accident. I base this finding on APA #10, page 161.

17. On June 1, 2012—2 weeks after the date of the accident—Claimant is documented as having "no focal neurological deficits," and that she had no internal head injuries from her fall. Claimant's recent memory and remote memory are documented as normal. Of all the post-accident evidence, I give this the greatest weight, and find it is more compelling than any later evidence to the contrary, Claimant's later statements to providers, Claimant's testimony at the hearing that her memory is compromised, or to Claimant's "performance" at the hearing

(APA #8, pp. 134-135; testimony of Claimant; observations of the undersigned).

18. At her visit with Dr. McQueen two weeks after the date of the accident, Claimant was crying about her "home situation with sick spouse;" Claimant's pre-existing "chronic pain syndrome" and her pre-existing "chronic" depression are also referenced. I give this evidence greater weight than I give to Claimant's self-serving statements/testimony to the contrary (APA #8, p. 135).

19. As to opinions from physicians, I also give great weight to the conclusions of Dr. C. Thomas Gualtieri, a psychiatrist, whose impressions of Claimant mirror the undersigned's, and also match the evidence set forth supra. Dr. Gualtieri states in his report: "the patient's evaluation today demonstrates 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" (APA #20, p. 265). This physician was clearly not fooled or manipulated by Claimant (APA #20, pp. 265-275).

20. Claimant testified that she did not remember seeing Dr. Brennan with Florence Neurosurgery & Spine in July of 2007, complaining of neck pain, low back pain, bilateral hip pain, and numbness and tingling in her hands (Tr., p. 53). Claimant further testified that she did not remember at that time she was taking a number of different medications for pain and depression. When asked about taking Lyrica, Claimant responded, "I cannot remember." When asked if Claimant remembered taking Wellbutrin, Claimant responded, "no sir." When asked if she remembered taking Xanax, Claimant testified, "I can't remember that incident at all." When asked about taking Avandia, Claimant testified that she did not remember that medication. Claimant was asked if she remembered taking the medication Soma and her response was "no sir" (Tr., p. 53). Again when asked about whether she remembered taking Skelaxin, her response was "no sir" (Tr., p. 54). Dr. Fred McQueen states in his report of September 11, 2006, "I do not know how much longer she is going to be able to continue to work, and she works 12 hours a day" (APA #13, p. 194). When Claimant was asked if she remembered Dr. McQueen telling her that, her response was "no sir" (Tr., p. 54). In May of 2009, Dr. McQueen was prescribing Prozac, Lorcet, Xanax, Flexeril, and Ambien, however, Claimant continued to testify that she did not remember those medications (Tr., p. 55). Claimant was asked about a statement in the report from Dr. McQueen dated November 22, 2010, where he wrote "I don't know how much longer she will be able to continue in the work field, because her body is breaking down," and Claimant testified that she did not remember that (Tr., p. 56). In May of 2011, Claimant could not remember

if she was being prescribed Percocet for chronic pain (Tr., p. 56). In February of 2012, three months prior to her accident, Claimant was prescribed Percocet, MS Contin, Morphine Sulfate, and Xanax by Dr. Collins (APA #13, p. 221), however, Claimant could not remember that (Tr., p. 58). Claimant appears to have very selective memory when confronted about the myriad of medications and prior treatment for chronic pain and depression for at least eight years prior to her job injury in May of 2012.

21. Claimant has a long history of pre-existing situational stressors and pre-existing depression as documented by Dr. Fred McQueen on September 12, 2005, "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 a blockage" (APA #13, p. 191). On January 10, 2006, Dr. McQueen notes, "her child has just been at Duke for surgery, she has not been sleeping well at all. She has gained 15 pounds recently, partly due to stress" (APA #13, p. 192). On April 10, 2006, Dr. McQueen notes "she has a lot of problems at home with her husband and son so she did not see Dr. Arthur." "She is taking care of her mother." "She has a problem with her husband who is ill and son who is ill" (APA #13, p. 193). On August 9, 2007, Dr. McQueen notes "she has unfortunately lost her job due to the accident [different employer] and she is in a depressed state at this point." "She has difficulty controlling her temper with her family" (APA #13, p. 197). On August 17, 2007, Dr. McQueen notes "it is my professional opinion since February 13, 2007 evaluation that Ms. Rummage was unable to hold gainful employment and continues to remain disabled. Her last evaluation 8/9/07 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" [different employer] (APA #13, p. 198). On July 22, 2008, Dr. McQueen notes "this is a 48 year old white female with chronic pain and major depression" (APA #13, p. 200). On February 13, 2009, she reports "some days she has trouble getting out of bed and is more tearful than others" (APA #13, p. 201). On May 15, 2009, Dr. McQueen notes "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" (APA #13, p. 202). On August 17, 2009, "she is also on Xanax 1 mg t.i.d. for her nerves" (APA #13, p. 204). On November 17, 2009, "she suffers from longstanding chronic pain secondary to chronic migraines, as well as osteoarthritis." "She also suffers from generalized anxiety disorder" (APA #13, p. 205). On November 22, 2010, "her weight is up remarkably, she went from 152 to 164 for a gain of 12 pounds. This is not like her." "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" (APA #13, p. 208). On January 25, 2011, "she has a history of migraines and her migraines have hit her now" (APA #13, p. 209). On December 13, 2011, "patient comes in today and she is having a lot of problems with chronic pain in her back, neck, and shoulders" (APA #13, p. 217). On January 13,

2012, "the patient admits that she has 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, the VA, and he was sick" (APA #13, p. 219). On May 14, 2012 (four days prior to her job injury), "she is having so much spasm in her neck and shoulder." "She has severe muscle spasm in her cervical spine and she has radiculopathy so I am putting her on Lyrica 75, Flexeril 10, she takes at bedtime, the Lyrica is twice a day" (Depo. of Dr. Daniel Collins, Ex. 3).

22. Claimant told Dr. Collins (post-accident) that she "has not tried Lyrica or Neurontin at this point." Dr. Collins notes again in a later record that "she had not tried Lyrica in the past." In fact, Claimant was prescribed just Lyrica 4 days prior to the date of the accident in issue, and is documented as taking it as early as 2006; Claimant herself wrote on a pre-accident intake sheet that she was taking Lyrica—this greatly damages Claimant's credibility, as it is more evidence that she is simply a stranger to the truth (APA #13, p. 224; APA #12, p. 187). Because of Claimant's presentation to Dr. Collins, he recommended that Claimant continue speech therapy. In fact, Claimant had no difficulty expressing herself at the hearing except perhaps when confronted with evidence regarding pre-existing conditions she had denied. Claimant told Dr. Hutcheson that she developed insomnia, etc. after the accident, when she in fact was medically documented as an insomniac prior to the accident, and for which she was prescribed medication (longstanding problem for years) and for which a sleep study was recommended. Claimant had to discontinue Ambien at one point because it was too expensive (APA #13, p. 197). Effexor was prescribed for psyche and sleep; Xanax was retained for sleep. Yet, now Claimant attributes her sleep problems to the accident, and wants Defendants to pay for sleep medications (APA #13, pp. 197 and 201-202).

23. Dr. Daniel Collins testified that Claimant did not inform him in any way of similar problems and symptoms involving her neck prior to her May 18, 2012 accident (Depo. Dr. Collins, p. 26). Claimant did not inform Dr. Collins of treatment by Dr. Fred McQueen prior to her May 18, 2012 accident for chronic pain and major depression (Depo. Dr. Collins, p. 33). Dr. Collins testified that Claimant did not tell him that four days prior to her admitted accident on May 18, 2012, Dr. McQueen had prescribed and she was taking Lyrica, Flexeril, Percocet, Xanax, and Nuvigil (Depo. Dr. Collins, p. 30). During the deposition of Dr. Collins, when confronted with the existence of years of prior treatment for chronic pain, anxiety, depression, and trouble sleeping, Dr. Collins stated, "any time the patients aren't up front and tell me the truth or tell me all the truth or tell me just what they want to hear, it is of concern ..." (Depo. Dr. Collins, p. 42). "I have more than concerns about her honesty in the past, and there is always an issue now whether she is 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" (Depo. Dr. Collins, p. 46).

24. Claimant was sent by her attorney to see Dr. Amanda B. Salas of Palmetto Center of Psychiatry. Contrary to Claimant's pre-existing problems as documented in the APA Submissions referenced above, Dr. Salas set forth in her report that Claimant "presented an honest and forthcoming individual" (APA #2, p. 83). Claimant "reported that her sleep became disrupted after the workers' compensation injury, that her sleep has worsened, and she has not experienced improved sleep despite limited treatment" (APA #2, p. 84). When Claimant saw Dr. Salas, she apparently did not disclose a history of treatment for headaches, including migraines, as well as neck pain (APA #2, p. 84). In fact, Claimant "denied a history of severe depression, treatment for mood or anxiety problems ..." (APA #2, p. 85). Clearly, Claimant was not candid, forthright, and honest with Dr. Amanda Salas. I give Dr. Amanda Salas's report and opinions little weight.

25. Claimant was sent by her attorney to Dr. Tora Brawley, a clinical psychologist. Once again, claimant was not candid and forthright with Dr. Tora Brawley. Claimant did not reveal that she had been treated for prior headaches, including migraines, that she had taken medication for years due to trouble sleeping, and had daily feelings of depression, including crying spells (APA #3, pp. 97-101). It is obvious that Claimant was telling Dr. Tora Brawley only what Claimant wanted her to know and not fully disclosing all of her prior medical history and extensive treatment. I give Dr. Tora Brawley's report and opinions little weight.

26. Claimant was also sent by her attorney to Dr. Donna Schwartz Maddox, a psychiatrist. According to Dr. Maddox's report, Claimant's "chief complaint remains memory impairment," (APA #4, p. 104) an allegation that I do not find believable based upon the lack of Claimant's credibility as set forth hereinabove. I place little weight upon the report and opinions of Dr. Maddox.

27. Claimant was also sent by her attorney to see Dr. J. Kelby Hutcheson of Carolinas Center for Advanced Management of Pain. Dr. Hutcheson's report of September 18, 2013 makes no reference to Claimant's pre-existing chronic pain treatment by Dr. Fred McQueen as set forth hereinabove. In fact, under the past treatment portion of Dr. Hutcheson's report, where it asks "has patient been treated at another pain management center," the response is no (APA #6, p.124). When asked has patient ever had previous psychiatric or psychological treatment, again the response is "no" (APA #6, p. 124). I place little weight on the report and opinions by Dr. J. Kelby Hutcheson.

28. Although Claimant reported that she cries all the time post-accident, (etc.), her Facebook entries show (a) cognitive abilities she denies having, and (b) that she is quite social. At the end of 2014 (two years after the date of the accident), Claimant wrote "It's been a great year!" This is antithetical to Claimant's testimony/presentation at the hearing and to providers (APA #24, p. 365). I give greater weight to what Claimant shares with friends than what she portrays to providers and to the Commission. The entries on APA #25, pp. 378 and 380 alone do not suggest the cognitive impairment Claimant would like providers and the Commission to believe. [For someone as depressed/withdrawn as Claimant says she is, she surely does use a lot of exclamation points (!) in all her posts.]

29. If a claimant's statements and purported problems and presentations to providers were dispositive, Commission involvement would be unnecessary. For instance, Claimant told myriad physicians that she has memory problems and that she now drops things and that she never had previous psychological treatment. They believed Claimant just as they believed that she "developed" headaches, dizziness, and insomnia only after the accident (APA #6, pp. 123-124). In fact, Claimant had numbness in her hands (and positive Tinel's and Phalen's signs) as early as 2006 (APA #12, pp. 187-188). In fact, in 2011 (the year before the accident), Claimant reported a deformity of her fingers, such that her family physician pondered whether Claimant had rheumatoid arthritis in her hands (APA #13, page 217).

30. This is a claimant that requests the Commission to find a compensable aggravation, yet will not admit to the extent (or at her deposition, even the existence) of her pre-existing problems, even when a body part is admitted. Claimant would not even admit to the extent of an unrelated, prior workers' compensation claim (Claimant's Depo. in its entirety), particularly with regard to prior conditions and medications: Claimant would not admit to an ongoing or prior neck problem, nor admit that she took ongoing pain medication, etc. (Depo., pp. 36, 40, 41, 51, 52).

31. Claimant, in her deposition, would only admit to high blood pressure, a thyroid condition, and sinus infections (Depo., pp. 40, 41, 51, 52). She also testified (under oath) at her deposition that her headaches, dizziness, neck problems, and depression "first began" after her work accident—none of this is true (Depo., pp. 53 and 55).

32. Claimant's testimony at the hearing and at her deposition are not imbued with any indicia of trustworthiness.

33. I did not consider the findings of Commissioner Lyndon. However, Claimant's sworn deposition testimony—regarding her prior workers' compensation claim—is untrue and evasive (Depo., pp. 4, 11-12).

34. As to memory, Claimant remembers the time of the accident, the fact that she was getting ready to go to break, that she was trying to clean waste out of the roll, that Ethan helped Claimant up, that Ethan told her she was bleeding, that she told Employer that she would like to stay at work because she was already on probation "again" because of her husband's illness, (which I think is very key in this case—a sick husband with a need to care for him plus all her pre-existing health issues which were escalating), and that she worked until August 2012— three months after the accident, etc. (Depo., pp. 21-27, 49, particularly page 25; Tr., pp. 23, 24, 50).

35. I considered all the "opinions" of physicians who did not (a) observe Claimant's change in demeanor/presentation at the hearing, particularly when being asked about pre-existing conditions, and (b) review the entirety of her deposition testimony, which was just as damning as (if not worse than) her testimony at the hearing.

36. Although the undersigned does not condone prevarication to any degree, the things which Claimant hides or about which she is evasive are salient issues, particularly given the fact that she seeks a finding of an aggravation of a pre-existing condition. Even where admitted body parts/conditions are concerned, Claimant prevaricates. This seriously calls into question Claimant's veracity in general, as well her statements/presentation to providers upon which statements/presentation these experts relied in good faith in formulating opinions and treatment recommendations.

37. I believe that Claimant is using the workers' compensation system for purposes of secondary gain. I decline to require Defendants to subsidize her need to care for family members who rely upon her for support, or because of a host of myriad problems she has unrelated to the accident in issue. Further, Claimant wants Defendants to pay for medications she was already taking (or could not afford) on the date of the accident.

38. Claimant's average weekly wage is \$578.23, yielding a compensation rate of \$385.51.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, S.C. Code Ann., it is the determination of this Commissioner:

1. Under § 42-17-160, Claimant sustained an injury by admitted accident to her head and neck on May 18, 2012, arising out of and in the course of her employment.

2. Under § 42-9-35, Claimant has failed to prove an aggravation of her pre-existing psychological condition.

3. Having failed to establish a compensable aggravation of her pre-existing psychological condition, Claimant is not entitled to any workers' compensation benefits for any medical treatment for her psychological condition.

ORDER

IT IS ORDERED that the claim by Vickie Rummage for medical treatment and compensation benefits due to an alleged aggravation of her pre-existing psychological condition is denied.

No hearing costs are assessed in this instance.

IT IS SO ORDERED.

Within the statutory period, counsel for Claimant/Appellant filed a Request for Commission Review (Form 30) setting forth fifty-seven grounds for review, copies of which were furnished to all interested parties prior to oral argument that was scheduled before the Appellate Panel of the Full Commission on September 18, 2017. Prior to oral argument, the Commission received Briefs filed by counsel for the respective parties. All proffered testimony has been taken. Such testimony, together with all documentary evidence, has been delivered to individual members of the Appellate Panel of the Commission, along with the Briefs filed, and has since been under study and consideration.

By appeal, the Claimant/Appellant respectfully submitted the following grounds for appeal:

- 1) Did the hearing commissioner err in admitting the "Decision and Order by Commissioner G. Bryan Lyndon dated March 5, 2008" into evidence when: (a) this document was clearly introduced for the purpose of attacking Ms. Vickie Rummage's credibility; (b) the South Carolina Supreme Court recognized this

form of impeachment cannot be accomplished through introduction of extrinsic evidence (See, Mizell v. Glover, 351 S.C. 392, 370 S.E. 2d 176 (2002)); (c) the March 5, 2008 Decision and Order clearly constitutes extrinsic evidence; and (d) inclusion of this document in the evidentiary record was legally inappropriate?

2) Did the hearing commissioner err in finding the contents of the March 5, 2008 Decision and Order were not "consider[ed] ... " when: (a) this document was clearly introduced into the evidentiary record; (b) this inclusion necessarily led to a review of the contents of this Decision and Order; (c) it cannot be assumed this extrinsic evidence did not impact upon the decision making process in this instance; and (d) this finding cannot remove the tainting effect of this inadmissible evidence?

3) Did the hearing commissioner err in stating Ms. Vickie Rummage's contention as to the causal relationship/compensability of her current psychiatric symptoms was exclusively founded upon the opinions of her authorized treater, Dr. Daniel L. Collins, when: (a) this statement ignores the fact she submitted evidence from no less than three other qualified expert evaluators verifying this causal connection; (b) she likewise maintained that notwithstanding any prior questions/concerns he may have developed relative to Ms. Rummage's candor or compliance, Dr. Collins, with the passage of time and multiple assessments, determined she was not exhibiting evidence of either symptom magnification or secondary gain; (c) Ms. Rummage also focused on compelling evidence as to the unreliability of Defendants' expert's opinions/conclusions; and (d) this statement simply does not accurately reflect the nature/breadth of Ms. Rummage's contentions?

4) Did the hearing commissioner err in failing to find Ms. Rummage not only acknowledged a long history of pre-injury depression, necessitating use of psychotropic medication, through both her hearing testimony but also interviews with various psychological/psychiatric experts, when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

5) Did the hearing commissioner err in failing to find that, notwithstanding her pre-injury history of depression, Ms. Rummage's treatment prior to sustaining the May 18, 2012 compensable accident did not include/involve specialized

psychological or psychiatric care when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

6) Did the hearing commissioner err in failing to find that several opinions Dr. Daniel L. Collins expressed during the course of his March 14, 2014 deposition, including (but not limited to) his perception of Ms. Rummage's credibility/sincerity and the legitimacy of her symptoms, had favorably changed during his ensuing 2 (+) year course of treatment when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unequivocally establishes this fact?

7) Did the hearing commissioner err in excessively focusing upon the deposition testimony of Ms. Rummage and Dr. Daniel L. Collins, as opposed to her relevant hearing testimony and this authorized treating physician's subsequently generated opinions, when this adjudication process: (a) substantially ignores highly relevant opinions developed by this treating physician subsequent to his deposition; (b) likewise affords no weight to candid acknowledgements of prior testimonial discrepancies; (c) reflects an unreasonable disinclination to recognize either Ms. Rummage's contrition or the multiple medical opinions (rendered with full awareness of her pre-injury history) confirming aggravation of her prior depressive symptoms; and (d) constitutes an arbitrary, capricious and unlawful adjudication procedure?

8) Did the hearing commissioner err in failing to find inspection of the reports generated by Drs. Donna Schwartz Watts-Maddox and Amanda B. Salas not only reflect Ms. Rummage's admission of pre-injury depression, for which she received treatment over an extended period, but also these physicians' review of medical records confirming this pre-injury treatment course, when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

9) Did the hearing commissioner err in failing to find the preponderance of the evidence of record indicates that notwithstanding her pre-injury depression, Ms. Rummage was able to remain employed, perform household chores and engage in essentially all activities of daily living prior to sustaining the May 18, 2012 accident when the only reasonable inference which may be gleaned from the evidence contained in the hearing record certainly establishes this fact?

10) Did the hearing commissioner err in failing to find that, notwithstanding the presence of various stressors, including family illness, death of parents, etc., Ms. Rummage remained sufficiently functional to maintain employment, engaged in household chores and perform essentially all activities of daily living when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

11) Did the hearing commissioner err in failing to find inspection of her hearing testimony reveals Ms. Rummage did not deny receipt of any treatment documented in records generated by Dr. Fred D. McQueen, Jr. when the only reasonable inference which may be gleaned from the evidence contained in the hearing record certainly verifies this fact?

12) Did the hearing commissioner err in finding Ms. Rummage's current psychiatric/psychological symptoms do not proximately result from the aggravation of a preexisting condition by the consequences of her May 18, 2012 compensable accident when this determination is: (a) wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (b) the product of not only an arbitrary, capricious and unlawful adjudication process, but also an unusual finesse of reasoning?

13) Did the hearing commissioner err in finding Ms. Rummage "is not remotely credible" when: (a) this determination is substantially the product of a personal, subjective lay assessment ("observations", "delivery of her testimony", "evasiveness" "selective memory"); (b) given the statutory requirements relative to the standard of proof governing compensability of psychiatric/psychological conditions (as well as associated treatment needs), this subjective determination constitutes a legally insufficient basis upon which to assess credibility in the context of mental illness and cognitive loss, areas that are reserved to expert opinion; (c) the substantial weight afforded these personal, subjective lay impressions in this instance is reflective of an arbitrary, capricious and unlawful adjudication procedure; and (d) these findings are inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

14) Did the hearing commissioner err in finding Ms. Rummage "appears wily and manipulative" when: (a) this statement is

substantially the product of a personal, subjective lay assessment ("observations", "delivery of her testimony", "evasiveness" "selective memory"); (b) given the statutory requirements relative to the standard of proof governing compensability of psychiatric/psychological conditions (as well as associated treatment needs), this subjective determination constitutes a legally insufficient basis upon which to assess credibility in the context of mental illness and cognitive loss; (c) the substantial weight afforded these personal, subjective lay impressions in this instance is reflective of an arbitrary, capricious and unlawful adjudication procedure; and (d) these findings are inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

15) Did the hearing commissioner err in failing to find both Dr. Donna Schwartz Watts-Maddox and Dr. Amanda B. Salas were clearly aware of Ms. Rummage's "longstanding" preexisting psychological symptoms (as outlined in Finding of Fact Number 8) when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably establishes this fact?

16) Did the hearing commissioner err in failing to find Ms. Rummage "would not volunteer (or admit) to her preexisting" conditions when the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her hearing testimony, unquestionably establishes her repeated acknowledgement of any preexisting conditions outlined in previously generated medical records?

17) Did the hearing commissioner err in finding Ms. Rummage "suggested" in sworn testimony that her psychological treatment was "episodic/'in the past' instead of ongoing" when the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her hearing testimony, reflects her acknowledgment of this pre-injury course of treatment?

18) Did the hearing commissioner err in failing to find Ms. Rummage repeatedly clarified any prior discrepancies created by her deposition testimony through candid acknowledgement of the nature/degree of her pre-injury course of treatment when the only reasonable inference which may be gleaned from the evidence contained in the hearing record undoubtedly establishes this fact?

19) Did the hearing commissioner err in finding Ms. Rummage "fail[ed] ... to be forthright" in the delivery of her hearing testimony when this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her repeated acknowledgement of extended receipt of treatment through Dr. Fred D. McQueen, Jr.?

20) Did the hearing commissioner err in finding Ms. Rummage "did not redeem herself by her inconsistent presentation, her selective memory, her evasiveness, her outright denial of pre-existing conditions" during the course of the November 7, 2016 hearing when this finding is wholly inconsistent with the only reasonable inference may be gleaned from the evidence contained in the hearing record, particularly her repeated acknowledgement as to the nature/degree of treatment obtained through Dr. Fred D. McQueen, Jr. prior to sustaining the May 18, 2012 compensable accident?

21) Did the hearing commissioner err in finding the medical condition of Ms. Rummage's husband "has caused a hardship" sufficient to independently produce her current level of psychiatric/psychological symptoms when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) is the product of a personal, subjective lay assessment of conditions (mental illness and cognitive loss) which are legally reserved to expert opinion; (c) constitutes an impermissible medical opinion generated by the Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

22) Did the hearing commissioner err in similarly finding other "situational stressors" (involving her son and parents) independently constituted the source of her current level of psychiatric/psychological symptoms when: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) is the product of a personal, subjective lay assessment of conditions (mental illness and cognitive loss) which are legally reserved to expert opinion; (c) constitutes an impermissible medical opinion generated by the Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

23) Did the hearing commissioner err in finding Ms. Rummage's current headaches were not "different" from those she was experiencing prior to the May 18, 2012 trauma when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) likewise ignores the contrary opinions expressed by Dr. Fred D. McQueen, Jr., who

unquestionably possessed the most reliable knowledge as to the nature of Ms. Rummage's pre-injury and post-injury symptom level; (c) constitutes an impermissible medical opinion generated by the Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

24) Did the hearing commissioner err in essentially finding Ms. Rummage had deliberately misrepresented the pre-injury presence of "dizziness" when: (a) this finding is premised upon an isolated reference contained on a January 23, 2011 diagnostic test report; (b) inspection of treatment records contemporaneously generated by her long time physician Dr. Fred D. McQueen, Jr., do not identify dizziness as symptom/complaint; (c) Dr. McQueen's records do reflect the presence of migraine headaches, which is also referenced on the January 23, 2011 diagnostic report; (d) the presence of this record is hardly indicative of an attempt to conceal any purported dizziness associated with prior migraines; (e) the nature of this evidence does not justify the emphasis (displayed through the use of bold type) afforded this relatively innocuous reference; and (f) reliance on this isolated finding as justification to either question Ms. Rummage's credibility or deny the causal relationship of her current psychiatric/psychological symptoms to the consequences of her compensable accident is reflective of an arbitrary, capricious and unlawful adjudication procedure?

25) Did the hearing commissioner err in finding Ms. Rummage has attempted to lead "providers ... [to] believe" she did not encounter some degree of sleep difficulties prior to the May 18, 2012 trauma when: (a) Drs. Donna Schwartz Watts - Maddox and Amanda B. Salas were clearly aware of any pre-injury sleep difficulties through review of records generated by Dr. Fred D. McQueen, Jr.; (b) neither of these independent evaluators identified sleep loss as a significant basis for their diagnosis of aggravated preexisting psychiatric/psychological symptoms; (d) the absence of this nexus renders this finding irrelevant to the current dispute; (d) given this lack of relevance, the focus on sleep difficulties is not only unwarranted, but prejudicial; and (e) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

26) Did the hearing commissioner err in finding Ms. Rummage's attempt to continue working following her compensable accident deserves "great weight as to the severity of her condition" when this finding; (a) clearly constitutes the unlawful rendering of a medical opinion by the Commission; (b) conflicts with the applicable standard of proof requiring medical evidence on issues of this nature; (c) seeks to substitute a personal, subjective, speculative lay opinion for the

legally requisite medical evidence; (d) is inconsistent with the only reasonable inference which may be gleaned from the evidence of record; and (e) reflects the use of an arbitrary, capricious and unlawful adjudication procedure?

27) Did the hearing commissioner err in finding a June 1, 2012 report of Dr. Fred D. McQueen, Jr. warranted "the greatest weight ...[o]f all the post-accident evidence" when: (a) Ms. Rummage obviously developed a sufficient level of symptoms to warrant referral to a specialist; (b) the neurologist designated by Defendants subsequently confirmed she exhibited the "typical symptoms of closed-head injury"; (c) after continuing to follow her for the consequences of this injury, Dr. McQueen acknowledged the fact her May 18, 2012 trauma had produced "a concussion"; (d) Dr. McQueen further confirmed a worsening of her pre-injury headache symptoms to a level which warranted neurological evaluation; (e) after reviewing the report of Defendants' designated neurologist, Dr. McQueen concurred with his assessment; (f) this long time primary care physician similarly verified Ms. Rummage's increased headaches were "most probably the product of a post-concussive syndrome", which had also increased her pre-injury cervical and psychological symptoms, to the extent they required further treatment; (g) this finding is consequently wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (h) the hearing commissioner's determination on this point likewise constitutes a legally impermissible medical opinion; and (i) the nature of this finding, which seeks to ignore Dr. McQueen's recognition of the material consequences of Ms. Rummage's injury is reflective of an arbitrary, capricious and unlawful decision making process?

28) Did the hearing commissioner err in characterizing Ms. Rummage's hearing testimony as a "performance" when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) impermissibly ignores Ms. Rummage's repeated acknowledgements of preexisting medical conditions, treatment, etc. throughout her hearing testimony; (c) constitutes a highly subjective, impermissible medical opinion by the Commission on a subject (mental illness and cognitive loss) that has been legally reserved for qualified experts; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

29) Did the hearing commissioner err in finding Dr. Fred D. McQueen, Jr.'s June 1, 2012 references to certain preexisting

elements to deserve "great weight" when this finding: (a) constitutes a legally impermissible medical opinion; (b) substitutes personal, subjective lay impressions for the medically technical standard of proof governing the current circumstances; and (c) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

30) Did the hearing commissioner err in finding Dr. C. Thomas Gualtieri's impressions of Ms. Rummage were accurate or worthy of any weight when the only reasonable inference which may be gleaned from the evidence contained in the hearing record establishes: (a) this designated evaluator substantially generated his initial report prior to ever meeting Ms. Rummage; (b) Dr. Gualtieri likewise utilized self-serving testing mechanisms that are not considered acceptable tools in either psychiatric or neuropsychological circles; (c) this physician similarly does not possess the training/expertise to interpret neuropsychological test data; and (d) this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

31) Did the hearing commissioner err in finding Ms. Rummage "appears to have very selective memory" when this finding: (a) constitutes a legally impermissible medical opinion; (b) circumvents the governing standard of proof through reliance on personal, subjective lay impressions, as opposed to the legally mandated medical evidence required in the context of mental illness and cognitive loss; and (c) is reflective of arbitrary, capricious and unlawful adjudication procedure?

32) Did the hearing commissioner err in finding Dr. Daniel L. Collins' December 17, 2012 statement that Ms. Rummage "has not tried Lyrica or Neurontin at this point", as well as his January 11, 2013 notation that "[s]he had not tried Neurontin or Lyrica in the past" constituted "more evidence that she is not credible" when: (a) this finding completely ignores the context of these statements, which relate to her post-May 18, 2012 treatment course; (b) likewise assumes this physician even ask about the **pre-May 18, 2012 usage** of these medications, an inquiry which is certainly not reflected in this physician's records; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

33) Did the hearing commissioner err in questioning Ms. Rummage's need for speech therapy, purportedly due to a personal, subjective lay impression that she "had no difficulty expressing herself at the hearing" when this finding: (a) constitutes a legally impermissible medical opinion; (b) incorrectly seeks to create an issue which had never been raised by the respective parties, contrary to any notion of due process; (c) similarly seeks to not only ignore the admitted/acknowledged medical consequences of Ms. Rummage's May 18, 2012 trauma, but also generate additional rationale for challenging her credibility through focus on elements that were not deemed material by either Dr. Donna Schwartz Watts-Maddox or Dr. Amanda B. Salas in determining the causal connection of her current psychiatric/psychological symptoms; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

34) Did the hearing commissioner err in focusing on certain elements in Dr. Daniel L. Collins' March 13, 2014 deposition testimony, while effectively ignoring this authorized treater's subsequent opinions confirming the absence of "any evidence of malingering, symptom magnification or secondary gain", when: (a) utilization of Dr. Collins' deposition in this fashion does not constitute an accurate representation of Ms. Rummage's authorized treating physician's opinions relative to the nature/degree or legitimacy of her current symptoms; (b) this rather narrow preoccupation with Dr. Collins' March 13, 2014 statements unfairly rejects the positive evolution of this authorized treating physician's impressions of Ms. Rummage; (c) the generation of findings based on Dr. Collins' deposition testimony, as opposed to various opinions which were subsequently developed after numerous evaluations, results in an inaccurate and prejudicial characterization of material evidence; and (d) these findings are reflective of an arbitrary, capricious and unlawful adjudication procedure?

35) Did the hearing commissioner err in finding Dr. Amanda B. Salas was unaware of Ms. Rummage's "pre-existing problems" when this finding: (a) is contrary to the only reasonable inference which may be gleaned from the evidence contained in the hearing record, including Dr. Salas' acknowledged review of records generated by Dr. Fred D. McQueen, Jr.; (b) these records not only reference physical and psychological symptoms, but also sleep disturbance; (c) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

36) Did the hearing commissioner err in basing her finding Ms. Rummage "was not candid, forthright, and honest with Dr. Amanda Salas", to any extent on a purported denial of "a history of severe

depression, treatment for mood anxiety or anxiety problems" contained on page 4 of her report (Claimant's APA Exhibit 2, p. 85) when: (a) even a cursory review of Dr. Salas' entire report reveals references to prior depression, medication use for this mood disorder, the absence of pre-May 18, 2012 treatment by a mental health professional and no history of suicide attempts; (b) the reference contained in Finding of Fact Number 24 of the hearing commissioner's March 14, 2017 order relates to "family members"; (c) given this misconception, the finding Ms. Rummage was not candid/forthright/honest with Dr. Salas is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (d) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

37) Did the hearing commissioner err in finding Ms. Rummage "was not candid and forthright with Dr. Tora Brawley" when this finding: (a) ignores the fact Dr. Brawley specifically referenced "a prior history of depression"; (b) similarly overlooks Dr. Brawley's role as neuropsychological evaluator per referral of Dr. Donna Schwartz Watts-Maddox who not only reviewed the extensive pre-May 18, 2012 treatment notes generated by Dr. Fred D. McQueen, Jr., but also referenced the presence of depression, with associated use of psychotropic medication, prior to her accident date; (c) incorrectly/speculatively presumes Ms. Rummage simply "told Dr. Tora Brawley only what Claimant wanted her to know, instead of fully disclosing all of her prior medical history and extensive treatment"; (d) is unsupported by the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (e) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

38) Did the hearing commissioner err in rejecting Ms. Rummage's contention of causally related memory loss "based upon the lack of Claimant's creditability ... selective memory at the hearing, and temporal records documenting both normal recent and normal remote memory" when this finding: (a) is premised upon a personal, subjective lay assessment of symptoms attributable to complex medical conditions (mental illness and cognitive loss); (b) ignores the governing standard of proof, which requires expert opinion as to all pertinent issues surrounding these medical conditions; (c) constitutes an unlawful medical opinion by the Commission; (d) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

39) Did the hearing commissioner err in giving "little weight" to the opinions expressed by Drs. Donna Schwartz Watts-Maddox, Tora Brawley and Amanda B. Salas when: (a) the opinions expressed by these experts are clearly consistent with the pertinent medical evidence of record; (b) the attempts to dismiss and/or minimize the impact of these opinions are the product of an unusual finesse of reasoning and personal, subjective lay misconstruction of the evidence relative to issues (mental illness and cognitive loss) legally reserved for expert opinion; (c) the findings relative to the lack of weight afforded these experts' opinions are not only wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but also indicative of a summary rejection stemming from personal, subjective lay assessment of Ms. Rummage's condition in a fashion which is inconsistent with the governing standard of proof; and (d) these finds are reflective of an arbitrary, capricious and unlawful adjudication procedure?

40) Did the hearing commissioner err in failing to find Ms. Rummage's post-May 18, 2012 psychiatric/psychological symptoms most probably result from the aggravation of a preexisting condition by the consequences of her compensable accident when the only reasonable inferences may be gleaned from the evidence contained in the hearing record firmly establishes this fact?

41) Did the hearing commissioner err in failing to find the causally related psychiatric/psychological symptoms identified by Drs. Schwartz Watts-Maddox, Amanda B. Salas, Tora Brawley and Daniel L. Collins require focused treatment that is medically reasonable, necessary and intended to lessen the period of disability produced by the consequences of her May 18, 2012 compensable accident when the only reasonable inferences may be gleaned from the evidence contained in the hearing record firmly establishes this fact?

42) Did the hearing commissioner err in finding the pre-May 18, 2012 treatment Ms. Rummage received from Dr. Fred D. McQueen, Jr., her primary care physician, constituted treatment obtained through a pain management center when the only reasonable inference which may be gleaned from the evidence contained in the hearing record clearly does not support this finding?

43) Did the hearing commissioner err in finding Ms. Rummage's utilization of Facebook reflects either a lack of causally related psychiatric/psychological symptoms or cognitive loss when: (a) conditions of this nature (mental illness and cognitive loss) are medically technical; (b) resolution of issues relating to medically technical issues hinges upon opinions expressed by appropriate medical experts; (c) the hearing commissioner's finding constitutes a legally impermissible medical opinion of the Commission stemming from the personal, subjective impressions of the lay person; (d) this finding is also inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (e) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

44) Did the hearing commissioner err in finding the medical opinions which support Ms. Rummage's contentions as to the causal relationship of her current psychiatric/psychological symptoms and cognitive loss to the consequences of her compensable accident were flawed due to unfamiliarity with her pre-May 18, 2012 medical history when: (a) these supportive opinions were not generated in a vacuum, but rather with awareness of her lengthy treatment history through Dr. Fred D. McQueen, Jr.; after considering her preexisting conditions, Drs. Donna Schwartz Watts-Maddox and Amanda B. Salas each verified not only the causal relationship of these symptoms to the consequences of her May 18, 2012 trauma, but also Ms. Rummage's need for treatment; unlike Defendants' evaluator, these medical experts did not begin the process of generating substantive opinions prior to ever examining Ms. Rummage; and (d) this finding is not only inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but also reflective of an arbitrary, capricious and unlawful adjudication procedure?

45) Did the hearing commissioner err in finding Ms. Rummage declined to admit the presence of her preexisting physical and emotional problems when: (a) the only reasonable inference which may be gleaned from the evidence contained in the hearing record, including hearing testimony replete with admissions of this nature, simply does not support this finding; (b) this determination also ignores not only Ms. Rummage's contrition on various points following the deposition, but also extensive medical evidence supporting her contention as to the causal relationship of her current depressive symptoms and cognitive loss; and (c) this

finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

46) Did the hearing commissioner err in finding Ms. Rummage did not acknowledge the presence of headaches, neck problems and depression prior to May 18, 2012 when this finding: (a) is contrary to the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) ignores her repeated acknowledgements as to the presence of these conditions; and (c) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

47) Did the hearing commissioner err in characterizing Ms. Rummage as untrustworthy when this finding: (a) is premised, in large part, on a personal, subjective lay assessment of mental illness and cognitive loss, which are medically technical areas reserved to expert opinion; (b) constitutes a legally impermissible medical opinion; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

48) Did the hearing commissioner err in finding several statements referenced in Finding of Fact Number 34 were purportedly inconsistent with Ms. Rummage's current level of memory loss when this finding: (a) is premised, in large part, on a personal, subjective lay assessment of mental illness and cognitive loss, medically technical areas reserved to expert opinion; (b) constitutes a legally impermissible medical opinion; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

49) Did the hearing commissioner err in finding Ms. Rummage's "sick husband with a need to care for him plus all her pre-existing health issues which were escalating" were "very key in this case" when this finding: (a) is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) seeks to create an issue that has never been raised by the respective parties, in violation of due process; (c) is founded upon subjective lay conjecture and surmise; and (d) reflects an arbitrary, capricious and unlawful adjudication procedure?

50) Did the hearing commissioner err in rejecting the various expert opinions supporting Ms. Rummage's contentions as to the causal relationship of her current psychiatric/psychological symptoms and cognitive loss due to her subjective lay impressions of Ms. Rummage's "demeanor/presentation at the hearing" and lack of "review of the entirety of her deposition testimony" when: (a) the record contains no objections as to either the qualifications or foundations of the opinions expressed by these experts; (b) this finding constitutes the *sua sponte* creation of an "issue" which had never been raised by the respective parties, in violation of due process; (c) the hearing commissioner did not identify similar flaws in the opinions expressed by Defendants' designated evaluator (who likewise did not attend the hearing or reference review of the deposition transcript); (d) this finding is not only inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but it is also the product of a personal, subjective lay assessment of medically technical conditions (mental illness and cognitive loss) reserved to expert opinion; (e) it constitutes a legally impermissible medical opinion; and (f) this finding is similarly reflective of an arbitrary, capricious and unlawful adjudication procedure?

51) Did the hearing commissioner err in characterizing the nature of Ms. Rummage's testimony as "prevarication" when: (a) this finding presumes equivocation stems from dishonesty, as opposed to mental illness or cognitive loss; (b) it is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, particularly Ms. Rummage's repeated acknowledgements of preexisting physical and psychological symptoms through her hearing testimony; (c) this finding, which makes no mention of any expert opinion, stems from the personal, subjective lay assessment of two medically technical conditions, mental illness and cognitive loss; (d) this finding consequently constitutes a legally impermissible medical opinion; and (e) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

52) Did the hearing commissioner err in finding Ms. Rummage "is using the workers' compensation system for purposes of secondary gain" when: (a) this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) given the nature of the hearing commissioner's determinations, this finding likewise stems from her personal, subjective lay assessment in the context of

conditions (mental illness and cognitive loss) which are medically technical in nature; and (c) this finding constitutes a legally impermissible medical opinion generated by the Commission; and (d) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

53) Did the hearing commissioner err in finding Ms. Rummage has sought "to require Defendants to subsidize her need to care for family members who rely upon her for support, or because of a host of myriad and escalating problems unrelated to the accident on issue" when this finding: (a) is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) the product of an unusual finesse of reasoning, as well as a personal, subjective lay assessment of medically technical conditions involving mental illness and cognitive loss; (c) necessarily constitutes a legally impermissible medical opinion of the Commission; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

54) Did the hearing commissioner err in failing to conclude Ms. Rummage's receipt of treatment for her aggravated psychiatric/psychological symptoms will tend to lessen her period of disability within the meaning of S.C Code Ann. Section 42-15-60 (2007), when the only reasonable inference which may be gleaned from the evidence contained in the hearing record warrants this conclusion?

55) Did the hearing commissioner err in concluding Ms. Rummage "has failed to prove an aggravation of her pre-existing psychological condition" per the provisions of S.C. Code Ann. Section 42-9-35 (2007) when consideration of the only reasonable inference arising from the evidence of record, in light of the provisions of this statute, establish she has satisfactorily proven her entitlement to rulings: (a) the consequences of her compensable accident have materially aggravated the preexisting psychiatric/psychological condition; and (b) she requires focused treatment of this condition per Section 42-15-60?

56) Did the hearing commissioner err in determining the crux of the parties' current dispute (causal relationship between Ms. Rummage's current psychiatric/ psychological symptoms and the consequences of her compensable accident) based upon a personal, subjective lay assessment of Ms. Rummage's appearance/presentation/demeanor/body language when: (a) the

focal issue involves mental illness and cognitive loss, which are each medically technical subjects; (b) an individual's presentation/appearance/demeanor/body language are unquestionably impacted by mental illness and cognitive loss; (c) the Legislature, as well as our Appellate Courts, have consequently required that determinations as to the source and consequences of these conditions in the current context must be premised upon expert opinion; (d) despite this fact, the hearing commissioner unquestionably determined this medically technical issue based upon personal, subjective lay criteria; (e) while there was reference to opinions expressed by Defendants' designated evaluator, these opinions were not followed/relied upon to reach a conclusion, but rather noted to "mirror the undersigned's" personal opinions; (f) this use of expert opinion runs completely counter to the legal standard, which demands that medical evidence guides the fact finder to a determination, rather than using the medical evidence to validate a personal/objective/lay assessment; (g) the fact finding mechanism utilized in this instance clearly began and ended with the formulation of an impermissible medical opinion by the Commission, as opposed to truly analyzing the expert evidence; and (h) this arbitrary, capricious and unlawful adjudication procedure resulted in a determination premised on personal/subjective/lay standards, rather than the requisite medical criteria?

57) Did the hearing commissioner err in determining the crux of the parties' current dispute (causal relationship between Ms. Rummage's current psychiatric/psychological symptoms and the consequences of her compensable accident) based upon a personal, subjective lay assessment of Ms. Rummage's appearance/presentation/demeanor/body language when: (a) the focal issue involves mental illness and cognitive loss, which are each medically technical subjects; (b) an individual's presentation/appearance/demeanor/body language are unquestionably impacted by mental illness and cognitive loss; (c) the Legislature, as well as our Appellate Courts, have consequently required that determinations as to the source and consequences of these conditions in the current context must be premised upon expert opinion; (d) the analysis/decision making process utilized by the hearing commissioner focuses on personal/subjective/lay standards of conduct, which neither comport with the applicable legal criteria nor adequately assess the impact of medically technical conditions (mental illness and cognitive loss) on Ms. Rummage's conduct; (e) this manner of assessment likewise lacks the objectivity which the governing medical standard (identified by both the Legislature and our

Appellate Courts) is designed to promote; (f) this decision making process, which involves the impermissible generation of a medical opinion by the Commission, is unavoidably premised upon personal standards/views/feelings/ideologies, rather than the objective criteria required by the Legislature and our Appellate Courts; and (g) the ultimate determination Ms. Rummage's psychiatric/psychological symptoms are not causally related to the consequences of her compensable accident results from an arbitrary, capricious and unlawful adjudication procedure?

Pursuant to § 42-17-50, S.C. Code Ann., we, the Appellate Panel, have reviewed the award, weighed all the evidence presented, and considered all fifty-seven grounds for appeal, as set forth in Claimant/Appellant's Form 30. Appellant takes exception to the Commission's finding as to Appellant's lack of credibility and refusal to rule in favor of Appellant based upon medical evidence submitted by Appellant. Additionally, Appellant: (a) relying on the decision in Michau v. Georgetown County, 396 S.C. 589, 723 S.E. 2d 805 (2012), contends the provisions of §42-9-35, S.C. Code Ann. not only require medical evidence to prove the aggravation of a preexisting condition, but also to rebut any medical evidence supporting this contention; (b) maintains the record contains no competent evidence which supports the Hearing Commissioner's ruling that she did not meet her burden of proof, as there is no contrary medical evidence that satisfies the requirements of §42-9-35, as Defendants'/Respondents' expert did not offer any opinions to a reasonable degree of medical certainty; (c) argues the Hearing Commissioner's adverse credibility findings alone are insufficient to rebut the multiple medical opinions confirming the aggravation of her preexisting psychological condition by the consequences of her compensable injury; and (d) claims the denial of her request for treatment resulted from an arbitrary decision-making process through which a medical question was determined through the Hearing Commissioner's rendering of an expert opinion. However, while

"medical evidence is entitled to great respect, the Commission is not bound by the opinions of medical experts and may disregard medical evidence in favor of other competent evidence in the record." Burnette v. City of Greenville, 401 S.C. 417, 427-28, 737 S.E. 2nd, 200, 206 (Ct. App. 2012), citing Potter v. Spartanburg School District 7, 395 S.C. 17, 23, 716 S.E. 2nd 123, 126 (Ct. App. 2011). "The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence" Palmetto Alliance, Inc. v. SC Pub. Serv. Comm'n, 282 S.C. 430, 432, 319 S.E. 2nd 695, 696 (1984). Contrary to the assertion by Appellant that the hearing commissioner's decision "is reflective of an arbitrary, capricious, and unlawful adjudication procedure," the hearing commissioner considered all the evidence presented and based her conclusions on the evidence, including:

- Claimant's long-standing depression and anxiety disorder, which pre-dated her May 2012 accident;
- Claimant's selective memory when it came to her pre-accident symptoms and treatment, including medication she had been prescribed just a few days or months prior to the accident;
- Claimant's long-standing migraines and sinus headaches, which pre-dated her May 2012 accident;
- Claimant's long-standing sleep difficulties, which pre-dated her May 2012 accident;
- The expert opinion of Dr. Gualtieri;
- Claimant's long-standing situational stressors that caused her depression and anxiety for many years prior to the accident;
- Claimant's dishonesty with Dr. Collins in failing to inform him of her extensive pre-existing chronic pain, anxiety, depression, and trouble sleeping, and accompanying medication for treatment; and
- Claimant's selective memory and selective disclosure of prior medical history with a series of doctors that she hired to evaluate her.

Ultimately, this Appellate Panel may make its own Findings of Fact and reach its own Conclusions of Law.

After careful review in the instant case of all fifty-seven grounds for appeal, and after weighing all of the evidence presented, the Appellate Panel of the S.C. Workers Compensation Commission has determined by unanimous vote that all of the Hearing Commissioner's Findings of Fact and Conclusions of Law are correct as stated and are supported by the substantial evidence in the record. The Findings of Fact and Conclusions of Law by the Hearing Commissioner are adopted verbatim by this Appellate Panel. Therefore, based upon the foregoing, the Order of the Hearing Commissioner is affirmed.

ORDER

IT IS THEREFORE ORDERED that the Order by the Hearing Commissioner filed in the above-captioned claim on March 14, 2017 is hereby unanimously affirmed by the Appellate Panel, and the same shall constitute the Decision and Order of this Appellate Panel as follows:

FINDINGS OF FACT

1 The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with BGF Industries, Inc., Employer, and Great American Alliance Insurance Company, Carrier.

2 Claimant injured her head and neck in an admitted accident on May 18, 2012. Claimant alleges that she aggravated her pre-existing psychological condition, a claim I find is not supported by the greater weight of the evidence.

3. Claimant is not remotely credible (if I did not feel strongly after the hearing, reading Claimant's deposition testimony in its entirety only confirmed my impressions). I base this finding on my observations of Claimant, the inconsistencies in the delivery of

her testimony, and on her very "selective" memory at the hearing and at her deposition (particularly with regard to her denial/lack of forthrightness of significant, pre-existing conditions for which Claimant received treatment). After observing Claimant at the hearing, reviewing Claimant's prior medical history along with her sworn testimony, and reviewing what Claimant has told post-accident providers, the descriptive words that come to mind are wily and manipulative.

4. Claimant is 56 years of age (Tr., p. 17).

5. Claimant is a high school graduate, and subsequently received her C.N.A. and other certificates/degrees from a technical college where she also took phlebotomy, computer, and home health courses (Tr., p. 18; Claimant's Depo., pp. 9-10).

6. Claimant's employment history includes work as an assembler, an assistant manager at a drycleaners, a manager of a gym, and a school cafeteria cook (Tr., p. 20; Claimant's Depo., pp. 16, 50-51).

7. Claimant's job with Employer was a weaver (Tr., p. 23; Claimant's Depo., p. 16).

8. Prior to the accident, Claimant has documented longstanding, "chronic" pre-existing depression and anxiety disorder for which she took various psychotropic medications over the years, including Prozac, Wellbutrin, Lexapro, Cymbalta, Effexor, Xanax, Ambien for insomnia, and Lorcet (Dr. Fred D. McQueen, APA #13, 9/12/05, p.191; 1/10/06, p. 192; 4/10/06, p. 193; 9/11/06, p.194; 12/8/06, p. 194; 2/16/07, p. 195; 8/9/07, p. 197; 8/17/07, p. 198; 11/27/07, p. 199; 4/21/08, p. 200; 7/22/08, p. 200; 10/21/08, p. 201; 2/13/09, p. 201; 5/15/09, p. 202, 2/13/09; p. 203, 8/17/09, p. 204; 11/17/09, p. 205; 2/12/10, p. 206; 11/22/10, p. 208; 1/25/11, p. 209; 5/9/11, p. 212, 9/30/11, p. 215; 1/13/12,

p. 219; 3/13/12, p.224; Ex. 3 to Depo. of Dr. Daniel L. Collins; 5/14/12; APA #12, Dr. James J. Brennan, 7/27/06, p. 187). This was ongoing treatment and not remote, episodic treatment. Claimant also had longstanding pre-existing chronic neck and back pain (primarily neck pain) for which she was treated with Lorcet, Flexeril, and Percocet (4 days before the accident, she received refills for Flexeril, Percocet, Xanax, and Lyrica) (Ex. 3 to Depo. of Dr. Collins, 5/14/12). Notwithstanding Claimant's extensive history, she would not volunteer (or admit) to her pre-existing chronic pain, chronic depression/anxiety, and chronic migraines. Notwithstanding the degree of her pre-existing pain and extensive treatment, Claimant testified under oath that she could not "remember" whether she was treated for neck or back problems, even though the severity of Claimant's neck was such that cervical surgery is mentioned as a possibility in Claimant's family doctor's records pre-dating the accident in issue (Claimant's Depo., p. 36). Claimant suggested in sworn testimony that her psychological treatment was episodic/"in the past" instead of ongoing. She would not admit to taking pain medication, as the only thing she could "remember" was taking blood pressure medication and medication for hypothyroidism; it is noteworthy that she could "remember" these unrelated medications (Claimant's Depo., pp. 37 & 41). Claimant's failure to be forthright greatly damages her credibility. One only needs to read Claimant's prior medical history in its entirety, then to read her deposition testimony in its entirety, and her Facebook pages to judge credibility. Further, at the hearing, Claimant did not redeem herself by her inconsistent presentation, her selective memory, and her denial of pre-existing conditions (dizziness, etc.) (Tr., p. 28), despite the fact that in January 2011, Claimant underwent a

CT scan of her head for dizziness and headaches (APA #14, p. 25; Claimant's Depo. in its entirety; APA #13 in its entirety).

9. Claimant's spouse is disabled and does not work. This has caused a hardship, as Claimant was on probation "again" on the date of the injury because of her having to previously miss work because of her husband's condition (Tr., p. 44; Claimant's Depo., pp. 9, 14, & 25).

10. Claimant also has situational stressors regarding her son, including but not limited to his attempted suicide (APA #3, p. 98). Claimant also has taken care of both her parents through their deaths, as well as continuing to deal with one of her son's health issues, including kidney problems (Tr., pp. 44-45).

11. Contrary to Claimant's testimony at the hearing that her headaches are now "different," Claimant is documented in medical evidence as having pre-existing "chronic migraines" which were and are debilitating and for which Claimant underwent a CT scan of the brain. In addition, Claimant also has (documented) pre-existing sinus and tension headaches (APA #13, pp. 205-206, 209, and 211-212; APA #14, p. 25).

12. Claimant's testimony that she never had any dizziness prior to the accident in issue is refuted by Defendants' APA #14, page 225, showing that on January 23, 2011 Claimant underwent a pre-accident CT of the brain for the specified reasons of dizziness and headaches (APA #14, p. 225).

13. In 2010, Claimant's physician states that "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." He goes on to suggest that Claimant seek Vocational Rehab assistance and sedentary

work. The next year Claimant's physician wrote that he does not feel that Claimant should physically be performing the job she was performing (APA #13, pp. 208 & 217).

14. Claimant has **pre-existing sleep difficulties** for which she was prescribed medication for years prior to the date of the accident. Claimant's sleep difficulties are not new, as she would have providers believe (APA #13, 9/12/05 – 9/30/11, pp. 191-193, 197, 199, 201-203, 205, 206, 212, 215).

15. After the accident, Claimant continued to work for 3 months. I give this evidence great weight (Tr., p.50; APA #8, p.135; APA #10, p. 161; Claimant's Depo., pp. 49 & 60).

16. Claimant did not lose consciousness on the date of the accident. I base this finding on APA #10, page 161.

17. On June 1, 2012—2 weeks after the date of the accident—Claimant is documented as having "**no focal neurological deficits**," and that she had no internal head injuries from her fall. Claimant's **recent memory and remote memory are documented as normal**. Of all the post-accident evidence, I give this the greatest weight, and find it is more compelling than any later evidence to the contrary, Claimant's later statements to providers, Claimant's testimony at the hearing that her memory is compromised, or to Claimant's "performance" at the hearing (APA #8, pp. 134-135; testimony of Claimant; observations of the undersigned).

18. At her visit with Dr. McQueen two weeks after the date of the accident, Claimant was crying about her "home situation with sick spouse;" Claimant's pre-existing "chronic pain syndrome" and her pre-existing "chronic" depression are also referenced. I

give this evidence greater weight than I give to Claimant's self-serving statements/testimony to the contrary (APA #8, p. 135).

19. As to opinions from physicians, I also give great weight to the conclusions of Dr. C. Thomas Gualtieri, a psychiatrist, whose impressions of Claimant mirror the undersigned's, and also match the evidence set forth supra. Dr. Gualtieri states in his report: "the patient's evaluation today demonstrates 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" (APA #20, p. 265). This physician was clearly not fooled or manipulated by Claimant (APA #20, pp. 265-275).

20. Claimant testified that she did not remember seeing Dr. Brennan with Florence Neurosurgery & Spine in July of 2007, complaining of neck pain, low back pain, bilateral hip pain, and numbness and tingling in her hands (Tr., p. 53). Claimant further testified that she did not remember at that time she was taking a number of different medications for pain and depression. When asked about taking Lyrica, Claimant responded, "I cannot remember." When asked if Claimant remembered taking Wellbutrin, Claimant responded, "no sir." When asked if she remembered taking Xanax, Claimant testified, "I can't remember that incident at all." When asked about taking Avandia, Claimant testified that she did not remember that medication. Claimant was asked if she remembered taking the medication Soma and her response was "no sir" (Tr., p. 53). Again when asked about whether she remembered taking Skelaxin, her response was "no sir" (Tr., p. 54). Dr. Fred McQueen states in his report of September 11, 2006, "I do

not know how much longer she is going to be able to continue to work, and she works 12 hours a day" (APA #13, p. 194). When Claimant was asked if she remembered Dr. McQueen telling her that, her response was "no sir" (Tr., p. 54). In May of 2009, Dr. McQueen was prescribing Prozac, Lorcet, Xanax, Flexeril, and Ambien, however, Claimant continued to testify that she did not remember those medications (Tr., p. 55). Claimant was asked about a statement in the report from Dr. McQueen dated November 22, 2010, where he wrote "I don't know how much longer she will be able to continue in the work field, because her body is breaking down," and Claimant testified that she did not remember that (Tr., p. 56). In May of 2011, Claimant could not remember if she was being prescribed Percocet for chronic pain (Tr., p. 56). In February of 2012, three months prior to her accident, Claimant was prescribed Percocet, MS Contin, Morphine Sulfate, and Xanax by Dr. Collins (APA #13, p. 221), however, Claimant could not remember that (Tr., p. 58). Claimant appears to have very selective memory when confronted about the myriad of medications and prior treatment for chronic pain and depression for at least eight years prior to her job injury in May of 2012.

21. Claimant has a long history of pre-existing situational stressors and pre-existing depression as documented by Dr. Fred McQueen on September 12, 2005, "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 a blockage" (APA #13, p. 191). On January 10, 2006, Dr. McQueen notes, "her child has just been at Duke for surgery, she has not been sleeping well at all. She has gained 15 pounds recently, partly due to stress" (APA 313, p. 192). On April 10, 2006, Dr. McQueen notes "she has a lot of problems at home with her husband and son so she did not see Dr. Arthur." "She is taking care of her

mother." "She has a problem with her husband who is ill and son who is ill" (APA #13, p. 193). On August 9, 2007, Dr. McQueen notes "she has unfortunately lost her job due to the accident [different employer] and she is in a depressed state at this point." "She has difficulty controlling her temper with her family" (APA #13, p. 197). On August 17, 2007, Dr. McQueen notes "it is my professional opinion since February 13, 2007 evaluation that Ms. Rummage was unable to hold gainful employment and continues to remain disabled. Her last evaluation 8/9/07 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" [different employer] (APA #13, p. 198). On July 22, 2008, Dr. McQueen notes "this is a 48 year old white female with chronic pain and major depression" (APA #13, p. 200). On February 13, 2009, she reports "some days she has trouble getting out of bed and is more tearful than others" (APA #13, p. 201). On May 15, 2009, Dr. McQueen notes "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" (APA #13, p. 202). On August 17, 2009, "she is also on Xanax 1 mg t.i.d. for her nerves" (APA #13, p. 204). On November 17, 2009, "she suffers from longstanding chronic pain secondary to chronic migraines, as well as osteoarthritis." "She also suffers from generalized anxiety disorder" (APA #13, p. 205). On November 22, 2010, "her weight is up remarkably, she went from 152 to 164 for a gain of 12 pounds. This is not like her." "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" (APA #13, p. 208). On January 25, 2011, "she has a history of migraines and her migraines have hit her now" (APA #13, p. 209). On December 13, 2011, "patient comes in today and she is having a lot of problems with chronic pain in her back, neck, and shoulders"

(APA #13, p. 217). On January 13, 2012, "the patient admits that she has 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, the VA, and he was sick" (APA #13, p. 219). On May 14, 2012 (four days prior to her job injury), "she is having so much spasm in her neck and shoulder." "She has severe muscle spasm in her cervical spine and she has radiculopathy so I am putting her on Lyrica 75, Flexeril 10, she takes at bedtime, the Lyrica is twice a day" (Depo. of Dr. Daniel Collins, Ex. 3).

22. Claimant told Dr. Collins (post-accident) that she "has not tried Lyrica or Neurontin at this point." Dr. Collins notes again in a later record that "she had not tried Lyrica in the past." In fact, Claimant was prescribed just Lyrica 4 days prior to the date of the accident in issue, and is documented as taking it as early as 2006; Claimant herself wrote on a pre-accident intake sheet that she was taking Lyrica—this greatly damages Claimant's credibility, as it is more evidence that she is simply a stranger to the truth (APA #13, p. 224; APA #12, p. 187). Because of Claimant's presentation to Dr. Collins, he recommended that Claimant continue speech therapy. In fact, Claimant had no difficulty expressing herself at the hearing except perhaps when confronted with evidence regarding pre-existing conditions she had denied. Claimant told Dr. Hutcheson that she developed insomnia, etc. after the accident, when she in fact was medically documented as an insomniac prior to the accident, and for which she was prescribed medication (longstanding problem for years) and for which a sleep study was recommended. Claimant had to discontinue Ambien at one point because it was too expensive (APA #13, p. 197). Effexor was prescribed for psyche and sleep; Xanax was retained for sleep. Yet, now Claimant attributes her sleep problems to

the accident, and wants Defendants to pay for sleep medications (APA #13, pp. 197 and 201-202).

23. Dr. Daniel Collins testified that Claimant did not inform him in any way of similar problems and symptoms involving her neck prior to her May 18, 2012 accident (Depo. Dr. Collins, p. 26). Claimant did not inform Dr. Collins of treatment by Dr. Fred McQueen prior to her May 18, 2012 accident for chronic pain and major depression (Depo. Dr. Collins, p. 33). Dr. Collins testified that Claimant did not tell him that four days prior to her admitted accident on May 18, 2012, Dr. McQueen had prescribed and she was taking Lyrica, Flexeril, Percocet, Xanax, and Nuvigil (Depo. Dr. Collins, p. 30). During the deposition of Dr. Collins, when confronted with the existence of years of prior treatment for chronic pain, anxiety, depression, and trouble sleeping, Dr. Collins stated, "any time the patients aren't up front and tell me the truth or tell me all the truth or tell me just what they want to hear, it is of concern ..." (Depo. Dr. Collins, p. 42). "I have more than concerns about her honesty in the past, and there is always an issue now whether she is 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" (Depo. Dr. Collins, p. 46).

24. Claimant was sent by her attorney to see Dr. Amanda B. Salas of Palmetto Center of Psychiatry. Contrary to Claimant's pre-existing problems as documented in the APA Submissions referenced above, Dr. Salas set forth in her report that Claimant "presented an honest and forthcoming individual" (APA #2, p. 83). Claimant "reported that her sleep became disrupted after the workers' compensation injury, that her sleep has worsened, and she has not experienced improved sleep despite limited treatment" (APA

#2, p. 84). When Claimant saw Dr. Salas, she apparently did not disclose a history of treatment for headaches, including migraines, as well as neck pain (APA #2, p. 84). In fact, Claimant "denied a history of severe depression, treatment for mood or anxiety problems ..." (APA #2, p. 85). Clearly, Claimant was not candid, forthright, and honest with Dr. Amanda Salas. I give Dr. Amanda Salas's report and opinions little weight.

25. Claimant was sent by her attorney to Dr. Tora Brawley, a clinical psychologist. Once again, claimant was not candid and forthright with Dr. Tora Brawley. Claimant did not reveal that she had been treated for prior headaches, including migraines, that she had taken medication for years due to trouble sleeping, and had daily feelings of depression, including crying spells (APA #3, pp. 97-101). It is obvious that Claimant was telling Dr. Tora Brawley only what Claimant wanted her to know and not fully disclosing all of her prior medical history and extensive treatment. I give Dr. Tora Brawley's report and opinions little weight.

26. Claimant was also sent by her attorney to Dr. Donna Schwartz Maddox, a psychiatrist. According to Dr. Maddox's report, Claimant's "chief complaint remains memory impairment," (APA #4, p. 104) an allegation that I do not find believable based upon the lack of Claimant's credibility as set forth hereinabove. I place little weight upon the report and opinions of Dr. Maddox.

27. Claimant was also sent by her attorney to see Dr. J. Kelby Hutcheson of Carolinas Center for Advanced Management of Pain. Dr. Hutcheson's report of September 18, 2013 makes no reference to Claimant's pre-existing chronic pain treatment by Dr. Fred McQueen as set forth hereinabove. In fact, under the past treatment portion of Dr. Hutcheson's report, where it asks "has patient been treated at

another pain management center," the response is no (APA #6, p.124). When asked has patient ever had previous psychiatric or psychological treatment, again the response is "no" (APA #6, p. 124). I place little weight on the report and opinions by Dr. J. Kelby Hutcheson.

28. Although Claimant reported that she cries all the time post-accident, (etc.), her Facebook entries show (a) cognitive abilities she denies having, and (b) that she is quite social. At the end of 2014 (two years after the date of the accident), Claimant wrote **"It's been a great year!"** This is antithetical to Claimant's testimony/presentation at the hearing and to providers (APA #24, p. 365). I give greater weight to what Claimant shares with friends than what she portrays to providers and to the Commission. The entries on APA #25, pp. 378 and 380 alone do not suggest the cognitive impairment Claimant would like providers and the Commission to believe. [For someone as depressed/withdrawn as Claimant says she is, she surely does use a lot of exclamation points (!) in all her posts.]

29. If a claimant's statements and purported problems and presentations to providers were dispositive, Commission involvement would be unnecessary. For instance, Claimant told myriad physicians that she has memory problems and that she now drops things and that she never had previous psychological treatment. They believed Claimant just as they believed that she "developed" headaches, dizziness, and insomnia only after the accident (APA #6, pp. 123-124). In fact, Claimant had numbness in her hands (and positive Tinel's and Phalen's signs) as early as 2006 (APA #12, pp. 187-188). In fact, in 2011 (the year before the accident), Claimant reported a deformity of her fingers, such that her family physician pondered whether Claimant had rheumatoid arthritis in her hands (APA #13, page 217).

30. This is a claimant that requests the Commission to find a compensable aggravation, yet will not admit to the extent (or at her deposition, even the existence) of her pre-existing problems, even when a body part is admitted. Claimant would not even admit to the extent of an unrelated, prior workers' compensation claim (Claimant's Depo. in its entirety), particularly with regard to prior conditions and medications: Claimant would not admit to an ongoing or prior neck problem, nor admit that she took ongoing pain medication, etc.(Depo., pp.36, 40, 41, 51, 52).

31. Claimant, in her deposition, would only admit to high blood pressure, a thyroid condition, and sinus infections (Depo., pp.40, 41, 51, 52). She also testified (under oath) at her deposition that her headaches, dizziness, neck problems, and depression "first began" after her work accident—none of this is true (Depo., pp. 53 and 55).

32. Claimant's testimony at the hearing and at her deposition are not imbued with any indicia of trustworthiness.

33. I did not consider the findings of Commissioner Lyndon. However, Claimant's sworn deposition testimony—regarding her prior workers' compensation claim-- is untrue and evasive (Depo., pp 4, 11-12).

34. As to memory, Claimant remembers the time of the accident, the fact that she was getting ready to go to break, that she was trying to clean waste out of the roll, that Ethan helped Claimant up, that Ethan told her she was bleeding, that she told Employer that she would like to stay at work because she was already on probation "again" because of her husband's illness, (which I think is very key in this case—a sick husband with a need to care for him plus all her pre-existing health issues which were

escalating), and that she worked until August 2012— three months after the accident, etc. (Depo., pp. 21-27, 49, particularly page 25; Tr., pp. 23, 24, 50).

35. I considered all the "opinions" of physicians who did not (a) observe Claimant's change in demeanor/presentation at the hearing, particularly when being asked about pre-existing conditions, and (b) review the entirety of her deposition testimony, which was just as damning as (if not worse than) her testimony at the hearing.

36. Although the undersigned does not condone prevarication to any degree, the things which Claimant hides or about which she is evasive are salient issues, particularly given the fact that she seeks a finding of an aggravation of a pre-existing condition. Even where admitted body parts/conditions are concerned, Claimant prevaricates. This seriously calls into question Claimant's veracity in general, as well her statements/presentation to providers upon which statements/presentation these experts relied in good faith in formulating opinions and treatment recommendations.

37. I believe that Claimant is using the workers' compensation system for purposes of secondary gain. I decline to require Defendants to subsidize her need to care for family members who rely upon her for support, or because of a host of myriad problems she has unrelated to the accident in issue. Further, Claimant wants Defendants to pay for medications she was already taking (or could not afford) on the date of the accident.

38. Claimant's average weekly wage is \$578.23, yielding a compensation rate of \$385.51.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, S.C. Code Ann., it is the determination of this Commissioner:

1. Under § 42-17-160, Claimant sustained an injury by admitted accident to her head and neck on May 18, 2012, arising out of and in the course of her employment.

2 Under § 42-9-35, Claimant has failed to prove an aggravation of her pre-existing psychological condition.

3. Having failed to establish a compensable aggravation of her pre-existing psychological condition, Claimant is not entitled to any workers' compensation benefits for any medical treatment for her psychological condition.

ORDER

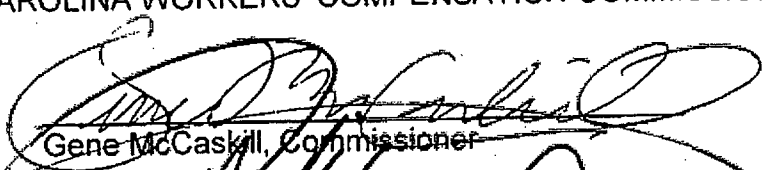
IT IS ORDERED that the claim by Vickie Rummage for medical treatment and compensation benefits due to an alleged aggravation of her pre-existing psychological condition is denied.

No hearing costs are assessed in this instance.

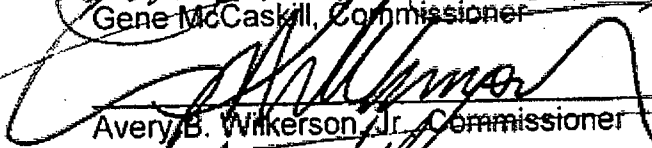
IT IS SO ORDERED.

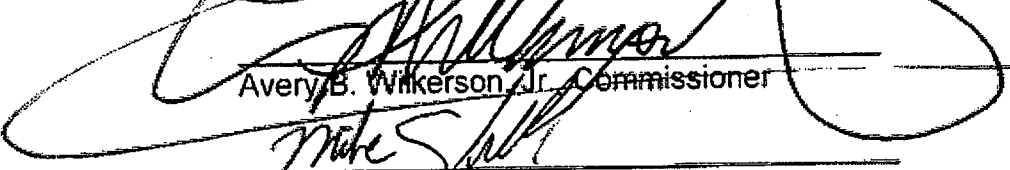
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

FULL AFFIRMATION


Gene McCaskill, Commissioner

CONCUR


Avery B. Wilkerson, Jr., Commissioner


R. Michael Campbell, II, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Valerie Deller on February 1, 2018

DECISION AND ORDER
OF
THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 1215681

Vickie Rummage, Employee,

Claimant,

v.

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

Defendants.

Hearing: Held in Hartsville, South Carolina, on November 7, 2016.

Appearances: Claimant represented by Andrew N. Safran of
Columbia, South Carolina.

Defendants represented by Horton Law Firm, P.A., by
Michael A. Farry of Greenville, South Carolina.

Purpose of Hearing: To determine issues set forth on Forms 50, 51, and 21.

Decision and Order: By: Susan S. Barden, Commissioner

Filed: March 14, 2017

Defendants filed Form 21 Employer's Request for Hearing which was to be tried concurrently with the Forms 50 and 51 filed. However, Claimant has been scheduled for an evaluation with Dr. Daniel Williams which Defendants had hoped would have been completed and a report rendered by the time of hearing. Given the fact that Claimant had not seen Dr. Williams as of the date of the hearing, Defendants withdrew the Form 21 Employer's Request for hearing.

STIPULATIONS

Counsel for the parties stipulated at the hearing to the following issues:

1. The purpose of this hearing is to determine issues as set forth in Forms 50 and 51, together with any other issues which may timely come before the Commission.
2. Notice of the hearing was timely and properly served upon all parties of interest.
3. Venue, set in Darlington County, is proper.
4. Claimant is currently being paid temporary total compensation based upon an average weekly wage of \$578.23, resulting in a compensation rate of \$385.51, as set forth on Form 20 filed with the Commission. Claimant's attorney questioned the calculation of the average weekly wage and compensation rate. The attorneys for the respective parties agreed Claimant shall continue to be paid at the compensation rate set forth hereinabove until the attorneys for the respective parties agree to a different compensation rate, or upon further order of the Commission.
5. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon an injury by accident occurring on May 18, 2012, while in the employ of the

Defendant/Employer, and therefore the South Carolina Workers' Compensation Commission has jurisdiction of this case.

APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence:

APA #1	Dr. Daniel L. Collins, 12/17/12/ - 1/22/16	Pages 1 – 81
APA #2	Dr. Amanda B. Salas, 9/1/15 – 10/21/16	Pages 82 – 96
APA #3	Dr. Tora L. Brawley, 5/15/14 – 9/16/15	Pages 97 – 101
APA #4	Dr. Donna Schwartz-Watts (Maddox), 4/10/16 – 10/19/16	Pages 102 – 111
APA #5	Sandhills Regional Medical Center, 1/2/13 – 10/16/13	Pages 112 – 122
APA #6	Dr. J. Kelby Hutcheson, 9/18/13 – 10/18/16	Pages 123 – 130
APA #7	Dr. Ezra b. Riber, 9/13/13	Pages 131 – 133
APA #8	Dr. Fred D. McQueen, 6/1/12 – 3/13/14	Pages 134 – 149
APA #9	Dr. Jeff Benjamin, 9/5/12 – 11/16/12	Pages 150 – 160
APA #10	Dr. John F. McLeod, III, 5/10/12 – 6/6/12	Page 161
APA #11	Dr. Paul Singh, 5/17/16 – 10/18/16	Pages 162 – 186
APA #12	Dr. James J. Brennen, Florence Neurosurgery & Spine, 7/27/06	Pages 187 – 190
APA #13	Dr. Fred D. McQueen, Jr., McQueen Medical Center, 9/12/05 – 3/12/12	Pages 191 – 224
APA #14	Sandhills Regional Medical Center, 1/23/11	Pages 225 – 226
APA #15	Chesterfield Hospital, 6/6/12	Pages 227 – 232

APA #16	Dr. Daniel L. Collins, Florence Rehabilitation Medicine, 7/8/13 – 7/22/14	Pages 233 – 238
APA #17	Select Physical Therapy FCE, 4/4/13	Pages 239 – 251
APA #18	Covington Eye Clinic, 3/24/11 – 8/23/12	Pages 252 – 261
APA #19	InMed Diagnostics, 7/17/13 – 6/21/16	Pages 262 – 264
APA #20	Dr. C. Thomas Gualtieri, NC Neuropsychiatry, 12/11/4 – 10/19/16	Pages 265 – 275
APA #21	Transcript from Deposition of Dr. Tora Brawly, Ph.D., 11/10/15	Pages 276 – 288
APA #22	Transcript from Deposition of Dr. Daniel L. Collins, 3/13/14	Pages 289 – 311

Exhibits

APA #23	Decision and Order by Commissioner Bryan G. Lyndon (WCC File No.: 0705223), 3/5/08	Pages 312 – 334
APA #24	Excerpts from Claimant's Facebook profile page, 2/10/14 – 2/21/15	Pages 335 – 368
APA #25	Portion from Claimant's Facebook page, 11/3/14 – 12/7/14	Pages 369 – 381
APA #26	Portion from Claimant's Facebook page, 10/8/14 – 11/5/14	Pages 382 – 393
APA #27	Portion from Claimant's Facebook page, 5/23/14 – 11/4/14	Pages 394 – 414
APA #28	Portion from Claimant's Facebook page, 8/5/15 – 1/13/16	Pages 415 – 419
APA #29	Portion from Claimant's Facebook page, 7/3/16 – 10/23/16	Pages 420 – 488
APA #30	Report of Accident Investigation, 5/18/12	Pages 489 – 492

Counsel for Claimant objected to Defendants' APA Submission #23, pages 312

through 334, consisting of Decision and Order by Commissioner G. Bryan Lyndon dated March 5, 2008, on the grounds that the claim then before the Commission resulting in the Decision and Order by Commissioner Lyndon is not relevant to the action presently before the Commission, and any findings of fact by Commissioner Lyndon are not binding upon the Commission in the present case. Claimant's counsel, in making the objection, cited the case of Mizell v. Glover, 351 S.C. 392 (2002). This Commissioner recognizes that APA #23 is an Order of the Commission that deals with a prior injury, and its findings or conclusions of law are in no way dispositive as to any issue before the undersigned Commissioner. Therefore, Claimant's objection to APA #23 being included as a part of the record in this case is overruled, and APA #23 is received as a part of the APA Submissions.

Also received into evidence was the original deposition transcript of the testimony of Dr. Daniel L. Collins taken March 13, 2014, together with Exhibits 1 – 4 and the original deposition transcript of the testimony of Claimant taken December 9, 2013.

STATEMENT OF THE CASE

Counsel for claimant, as the moving party, advised that as a result of the admitted accident Claimant had sustained an aggravation of her pre-existing psychological condition and that she was not at maximum medical improvement for that condition. Claimant seeks treatment with a specialist. Counsel for Claimant relies upon the authorized treating physician, Dr. Collins, who treated claimant from 2012 through 2016, and had stated that Claimant needs psychological or psychiatric treatment. Claimant's counsel further stated that Dr. Collins did not believe that there was any malingering or any symptom

magnification as far as the Claimant is concerned, and Dr. Collins' opinion should be given great weight.

Counsel for Defendants advised that Claimant had a significant pre-existing history of psychological problems of ten years or more for which she received significant medication. Moreover, Claimant has myriad situational stressors that contribute to her condition and she had been treated by her physician, Dr. McQueen, and received a course of approximately ten years of psychotropic medication for this pre-existing condition, such that Claimant could not meet her burden of proof that the pre-existing condition had been aggravated by the admitted job injury. Counsel for Defendants advised that Defendants would rely upon the opinions of Dr. Gualtieri set forth in his report and subsequent addendum, the testimony of Dr. Collins, and medical records of extensive treatment prior to Claimant's admitted accident.

EVIDENCE OF THE CASE

Vickie Rummage testified that she was 56 years old, married for 43 years, and her husband was sitting in the back of the courtroom. She stated that she finished high school, attended Northeastern Technical College, and completed courses in CNA, phlebotomy, computer, and home health (Tr., p. 18). She testified that her work history included working at Cooper Tools as an assembler, a manager of a gym, assistant manager of a dry cleaners, and a school cafeteria cook (Tr., pp. 19-20).

Vickie Rummage stated that Dr. Fred McQueen was her family physician for a number of years before her job injury in 2012. She stated that Dr. McQueen did treat her for depression, but nothing like she experiences now (Tr., pp. 21-22).

Vickie Rummage testified that she had a job injury in 2012. She stated that she stopped the machine off that she was operating. Vickie Rummage said she was standing behind the machine cleaning waste from the roll of yarn when she stepped back and the bottom of her leg caught the doff truck throwing her backwards onto the ground. She stated that she hit her head, had a cut on her head, and a lump on her neck. She said she did not go to the doctor, but did get assistance and some glue for the laceration on her head (Tr., pp. 23-24). Vickie Rummage testified that she saw Dr. McQueen following her accident and was also sent by workers' comp to see a Dr. Benjamin at the beach. She says that she had headaches of a different type following the accident and it felt like someone had taken a knife "jabbing it in her head." She also said that she is still experiencing dizziness, nausea, and problems with her speech. She stated that she was referred to a speech therapist and received therapy for her speech over time (Tr., pp. 25 - 27). Vickie Rummage further testified that she now has dizziness and ringing in her ears which she never had before her job injury on May 18, 2012 (Tr., p. 28).

Vickie Rummage testified that eventually she was referred to Dr. Collins by workers' comp. Vickie Rummage said that Dr. Collins started trigger point injections, Botox, and medication which was helpful, particularly with her headaches (Tr., pp. 29 - 31). She stated that Dr. Collins prescribed antidepressants, pain medication, Lyrica, and Cymbalta to try to help with the pain. She also admitted that Dr. Collins prescribed Xanax and Fioricet for headaches, Effexor for antidepression, and Antivert for dizziness. She stated these medications did help (Tr., p. 32).

When Dr. Collins left the practice, Vickie Rummage said that she saw his partner

briefly who did prescribe the Botox, but no other medication. Vickie Rummage said that she was eventually referred to Dr. Singh, who started her back on Percocet for pain and Fioricet for headaches. She did say that she had to go to her primary care doctor for her thyroid and blood pressure medicine, and she was back on the antidepressants (Tr., pp. 32-33). She also stated that Dr. Singh has given her different types of shots; however, she does not get the same type of headache relief that she was receiving when Dr. Collins was treating her (Tr., pp. 34-35).

Vickie Rummage testified that she has issues with crying all of the time because she does not have a life anymore. She said she cannot "correspond among a crowd" and cannot keep her housework done (Tr., p. 36). She stated that after seeing a speech therapist she increased her Facebook participation (Tr., p. 37).

Vickie Rummage admitted that she had seen Dr. Donna Watts a couple of times and she testified she did not hide from her the fact that she had depression going on before the accident. She stated, "I haven't hid it from anybody" (Tr., p. 39). "I don't try to hide stuff" (Tr., p. 39).

Vickie Rummage also admitted that she was sent to see Dr. Brawley, but had to stop taking the test she was taking at the instruction of Dr. Brawley. She also admitted to seeing Dr. Salas a couple of times and did not ever try to hide from her that she had seen Dr. McQueen in the past and had gotten medication from Dr. McQueen in the past (Tr., pp. 39-40).

Vickie Rummage also admitted to seeing a doctor in Charlotte (Dr. Gualtieri) sometime in April 2015. She said most of the time she was on a computer and did not

have a lot of "face time" with Dr. Gualtieri (Tr., pp. 41-42).

Vickie Rummage also testified that her husband has health issues which pre-existed her job injury in May of 2012, consisting of heart problems, diabetes, and PTSD from serving in Iraq. Vickie Rummage said she dealt with those health issues a long time before her accident. She also stated that she took care of her parents as an only child through their deaths, and dealt with one of her son's health issues (Tr., pp. 44-45). Vickie Rummage testified that she stays in a fog now. She said that before the accident she could always "focus and bring myself back and do what I needed to do" (Tr., p. 47).

Under cross-examination, Vickie Rummage admitted that after her accident on May 18, 2012, she was offered the opportunity to go to the doctor or hospital, but she decided not to do so. She also admitted that she finished out her shift the day of the accident working her regular job and continued to work her regular job up until sometime in August of 2012 -- three months after the date of the accident (Tr., p. 50). Vickie Rummage admitted that Dr. Fred McQueen had been her family doctor for ten years or more prior to the accident, and in 2005 she was receiving treatment for neck pain, low back pain, and depression (Tr., p. 51). When asked to confirm that she had been diagnosed with cervical disc disease by September of 2005 after an MRI of her neck, Vickie Rummage responded "it's in the papers. I guess so" (Tr., p. 51). She did admit taking medication for pain and depression at least since 2005, which included Lorcet, Xanax, Ambien to help her sleep, and Prozac. She could not remember if she was also taking Cymbalta (Tr., pp. 51-52).

When asked if she saw Dr. Brennan with Florence Neurosurgery & Spine in July of 2007 with her chief complaint being neck pain, low back pain, bilateral hip pain, and

numbness and tingling in her hands, she could not remember (Tr., pp. 52-53). When asked if she was taking different medications for pain, including Lyrica at that time, Vickie Rummage responded, "I can't remember." When asked if she remembered taking Wellbutrin at that time, she responded, "no sir." When asked if she remembered taking Xanax, she testified, "I can't remember that incident at all." When asked about the medication Avandia, she responded, "no sir." When asked if she remembered taking the medication Soma, her response was "no sir, I don't." When asked if she remembered taking Skelaxin, her response was "no sir" (Tr., pp. 53-54).

Counsel for Defendants pointed out that in September of 2006, Dr. McQueen wrote in his report "I don't know how much longer she is going to be able to continue to work." Claimant testified that she did not remember that (Tr., p. 54). Claimant did admit that she was in Dr. McQueen's pain management program in December of 2006; however, she did not remember Dr. McQueen discussing the fact that she had severe degenerative disc disease according to his report (Tr., p. 54). When counsel pointed out that in 2008 Dr. McQueen was treating Claimant for depression, chronic pain, and what he called major depression, and counsel asked Claimant "do you remember that," Vickie Rummage responded, "I guess, yes sir" (Tr., p. 55).

Vickie Rummage admitted being treated for chronic pain, chronic anxiety and depression symptoms with medication in 2009. When asked if Claimant was taking Lortab, Reflex, Prozac, Effexor, Ambien, and Xanax in 2009, Claimant testified, "I can't remember" (Tr., p. 55). When counsel asked Vickie Rummage if in November 2009 she was still being treated for chronic pain, chronic migraines, and generalized anxiety disorder, Claimant

responded, "yes sir, but nothing like it's been" (Tr., p. 56). Counsel asked Claimant if she remembered a conversation with Dr. McQueen which he wrote in his report of November 22, 2010, stating, "I don't know how much longer she will be able to continue in the work field, because her body is breaking down," Vickie Rummage responded, "no sir" (Tr., p. 56). When asked if in May of 2011, one year before the accident, Vickie Rummage was still being treated by Dr. McQueen for chronic pain, including Percocet, Vickie Rummage responded, "I don't remember, but if it's in the records, then I agree with it" (Tr., p. 56).

Counsel pointed out that in September 2011, Dr. McQueen continued to treat Vickie Rummage for chronic pain and depression and said in his report that "if Percocet does not hold pain, may have to see about getting you to a pain clinic." Claimant testified that she did not remember, "but if it's in the report, sir, so that's right." Defense counsel pointed out that in February of 2012 -- three months prior to the date of the accident -- Claimant was taking Percocet, MS Contin, Morphine Sulfate, and Xanax, and Claimant responded, "I don't remember sir" (Tr., p. 58).

Counsel for Defendants next questioned Claimant about her testimony in her deposition and whether she remembered testifying about a prior worker's compensation claim against the Town of Cheraw. Claimant testified that she could not remember being asked about whether she had hired an attorney for that claim (Tr., p. 59; Deposition, page 12). Defense counsel then had Claimant publish a portion of her deposition testimony taken in 2013, beginning at page 11. Claimant testified in her deposition that she could not remember if her prior workers' compensation case went to a hearing before a Commissioner. Claimant was further asked in her deposition, "did you have a lawyer?" and

her response was "no sir" (Tr., pp. 60-61).

Claimant was further asked in her deposition in the present case (Depo., p. 23) about whether she had ever had her deposition taken before, which she denied (Tr., pp. 61-62, 85).

Claimant admitted in further cross-examination that she worked crossword puzzles and played other games including Candy Crush on the computer. She also admitted that she regularly got on Facebook (Tr., p. 63). When asked if she looked at videos in addition to photographs and shared links and photographs, Claimant responded, "I guess" (Tr., p. 64). Upon questioning by the undersigned Commissioner as to whether or not Claimant posts on Facebook, Claimant readily responded, "yes ma'am, I do post" (Tr., p. 64). Claimant admitted to posting about recipes and shared recipes on Facebook, as well as posting photographs of family members and grandchildren that she would send out to friends on her Facebook page (Tr., p. 64).

Counsel for Defendants pointed out that before Vickie Rummage started seeing Dr. Paul Singh, she was prescribed 240 tablets of Percocet a month. Dr. Singh had reduced the Percocet to 75 and stated in his report that Claimant reported she was doing better with that. Claimant took issue with this medical record saying that she was doing okay and she did not know what they put in Dr. Singh's report. Defense counsel further pressed Claimant to answer the question as to whether she was doing better, worse, or the same taking 75 Percocet as prescribed by Dr. Singh versus the 240 prescribed by Dr. Collins, and Claimant responded "it's worse," after instructions by the undersigned Commissioner to answer the question (Tr., pp. 67-68).

Upon further cross-examination by defense counsel, Claimant was asked to publish an additional portion of her deposition beginning at page 36 when she was asked by counsel "was Dr. McQueen treating you for neck or back problems," her answer was "I can't remember sir. The main thing I can think of is my leg." When counsel further asked "but you testified earlier and correct me if I'm wrong, that you were in this chronic pain program for your neck pain for years, a decade, prior to your job injury, correct," Vickie Rummage's response was "sir, it's in the record. Yes sir, I – yes, sir" (Tr., pp. 69-70).

After careful study and evaluation of all the medical evidence submitted, together with the testimony presented, including the observation of the physical facts of the injury, and based upon the foregoing are the following:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with BGF Industries, Inc., Employer, and Great American Alliance Insurance Company, Carrier.

2. Claimant injured her head and neck in an admitted accident on May 18, 2012. Claimant alleges that she aggravated her pre-existing psychological condition, a claim I find is not supported by the greater weight of the evidence.

3. Claimant is not remotely credible (if I did not feel strongly after the hearing, reading Claimant's deposition testimony in its entirety only confirmed my impressions). I base this finding on my observations of Claimant, the inconsistencies in the delivery of her testimony, her evasiveness, and on her very "selective" memory at the hearing and at her deposition (particularly with regard to her denial/lack of forthrightness of significant, pre-

existing conditions for which Claimant received treatment). After observing Claimant at the hearing, reviewing Claimant's prior medical history along with her sworn testimony, and reviewing what Claimant has told post-accident providers, Claimant appears wily and manipulative. I also base this finding on the impressions and opinion of Dr. Gualtieri, whose reward I did not review until after the hearing.

4. Claimant is 56 years of age (Tr., p. 17).

5. Claimant is a high school graduate, and subsequently received her C.N.A. and other certificates/degrees from a technical college where she also took phlebotomy, computer, and home health courses (Tr., p. 18; Claimant's Depo., pp. 9-10).

6. Claimant's employment history includes work as an assembler, an assistant manager at a drycleaners, a manager of a gym, and a school cafeteria cook (Tr., p. 20; Claimant's Depo., pp. 16, 50-51).

7. Claimant's job with Employer was a weaver (Tr., p. 23; Claimant's Depo., p. 16).

8. Prior to the accident, Claimant has documented longstanding, "chronic" pre-existing depression and anxiety disorder for which she took various psychotropic medications over the years, including Prozac, Wellbutrin, Lexapro, Cymbalta, Effexor, Xanax, Ambien for insomnia, and Lorcet (Dr. Fred D. McQueen, APA #13, 9/12/05, p.191; 1/10/06, p. 192; 4/10/06, p. 193; 9/11/06, p.194; 12/8/06, p. 194; 2/16/07, p. 195; 8/9/07, p. 197; 8/17/07, p. 198; 11/27/07, p. 199; 4/21/08, p. 200; 7/22/08, p. 200; 10/21/08, p. 201; 2/13/09, p. 201; 5/15/09, p. 202, 2/13/09, p. 203, 8/17/09, p. 204; 11/17/09, p. 205; 2/12/10, p. 206; 11/22/10, p. 208; 1/25/11, p. 209; 5/9/11, p. 212, 9/30/11, p. 215; 1/13/12,

p. 219; 3/13/12, p.224; Ex. 3 to Depo. of Dr. Daniel L. Collins; 5/14/12; APA #12, Dr. James J. Brennan, 7/27/06, p. 187). This was ongoing treatment and not remote, episodic treatment. Claimant also had longstanding pre-existing chronic neck and back pain (primarily neck pain) for which she was treated with Lorcet, Flexeril, and Percocet (4 days before the accident, she received refills for Flexeril, Percocet, Xanax, and Lyrica) (Ex. 3 to Depo. of Dr. Collins, 5/14/12). Notwithstanding Claimant's extensive history, she would not volunteer (or admit) to her pre-existing chronic pain, chronic depression/anxiety, and chronic migraines. Notwithstanding the degree of her pre-existing pain and extensive treatment, Claimant testified under oath that she could not "remember" whether she was treated for neck or back problems, even though the severity of Claimant's neck was such that cervical surgery is mentioned as a possibility in Claimant's family doctor's records pre-dating the accident in issue (Claimant's Depo., p. 36). Claimant suggested in sworn testimony that her psychological treatment was episodic/"in the past" instead of ongoing. She would not admit to taking pain medication, as the only thing she could "remember" was taking blood pressure medication and medication for hypothyroidism; it is noteworthy that she could "remember" her unrelated medications (Claimant's Depo., pp. 37 & 41). Claimant's failure to be forthright greatly damages her credibility. One only needs to read Claimant's prior medical history in its entirety, then to read her deposition testimony in its entirety, and her Facebook pages to judge credibility. Further, at the hearing, Claimant did not redeem herself by her inconsistent presentation, her selective memory, her evasiveness, and her outright denial of pre-existing conditions (dizziness, etc.) (Tr., p. 28), despite the fact that in January 2011, Claimant underwent a CT scan of her head for

dizziness and headaches (APA #14, p. 25; Claimant's Depo. in its entirety; APA #13 in its entirety).

9. Claimant's spouse is disabled and does not work. This has caused a hardship, as Claimant was on probation "again" on the date of the injury because of her having to previously miss work because of her husband's condition (Tr., p. 44; Claimant's Depo., pp. 9, 14, & 25).

10. Claimant also has situational stressors regarding her son, including but not limited to his attempted suicide (APA #3, p. 98). Claimant also has taken care of both her parents through their deaths, as well as continuing to deal with one of her son's health issues, including kidney problems (Tr., pp. 44-45).

11. Contrary to Claimant's testimony at the hearing that her headaches are now "different," Claimant is documented in medical evidence as having pre-existing "chronic migraines" which were and are debilitating and for which Claimant underwent a CT scan of the brain. In addition, Claimant also has (documented) pre-existing sinus and tension headaches (APA #13, pp. 205-206, 209, and 211-212; APA #14, p. 25).

12. **Claimant's testimony that she never had any dizziness prior to the accident** in issue is refuted by Defendants' APA #14, page 225, showing that on January 23, 2011 **Claimant underwent a pre-accident CT of the brain for the specified reasons of dizziness and headaches** (APA #14, p. 225).

13. In 2010, Claimant's physician states that "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." He goes on to suggest that Claimant seek Vocational Rehab assistance and sedentary

work. The next year Claimant's physician wrote that he does not feel that Claimant should physically be performing the job she was performing (APA #13, pp. 208 & 217).

14. Claimant has **pre-existing sleep difficulties** for which she was prescribed medication for years prior to the date of the accident. Claimant's sleep difficulties are not new, as she would have providers believe. This is yet another example as to why subjective statements to providers are not dispositive (APA #13, 9/12/05 – 9/30/11, pp. 191-193, 197, 199, 201-203, 205, 206, 212, 215).

15. After the accident, Claimant continued to work for 3 months. I give this evidence great weight as to the severity of her condition (Tr., p.50; APA #8, p.135; APA #10, p. 161; Claimant's Depo., pp. 49 & 60).

16. Claimant did not lose consciousness on the date of the accident. I base this finding on APA #10, page 161.

17. On June 1, 2012—2 weeks after the date of the accident—Claimant is documented as having "**no focal neurological deficits**," and that she had no internal head injuries from her fall. Claimant's **recent memory and remote memory are documented as normal**. Of all the post-accident evidence, I give this the greatest weight, and find it is more compelling than any later evidence to the contrary, Claimant's later statements to providers, Claimant's testimony at the hearing that her memory is compromised, or to Claimant's "performance" at the hearing (APA #8, pp. 134-135; testimony of Claimant; observations of the undersigned).

18. At her visit with Dr. McQueen two weeks after the date of the accident, Claimant was crying about her "home situation with sick spouse;" Claimant's pre-existing

"chronic pain syndrome" and her pre-existing "chronic" depression are also referenced. I give this evidence greater weight than I give to Claimant's self-serving statements/testimony to the contrary (APA #8, p. 135).

19. As to opinions from physicians, I also give great weight to the conclusions of Dr. C. Thomas Gualtieri, a psychiatrist, whose impressions of Claimant mirror the undersigned's, and also match the evidence set forth *supra*. Dr. Gualtieri states in his report: "the patient's evaluation today demonstrates 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" (APA #20, p. 265). This physician was clearly not fooled or manipulated by Claimant (APA #20, pp. 265-275).

20. Claimant testified that she did not remember seeing Dr. Brennan with Florence Neurosurgery & Spine in July of 2007, complaining of neck pain, low back pain, bilateral hip pain, and numbness and tingling in her hands (Tr., p. 53). Claimant further testified that she did not remember at that time she was taking a number of different medications for pain and depression. When asked about taking Lyrica, Claimant responded, "I cannot remember." When asked if Claimant remembered taking Wellbutrin, Claimant responded, "no sir." When asked if she remembered taking Xanax, Claimant testified, "I can't remember that incident at all." When asked about taking Avandia, Claimant testified that she did not remember that medication. Claimant was asked if she remembered taking the medication Soma and her response was "no sir" (Tr., p. 53). Again when asked about whether she remembered taking Skelaxin, her response was "no sir"

(Tr., p. 54). Dr. Fred McQueen states in his report of September 11, 2006, "I do not know how much longer she is going to be able to continue to work, and she works 12 hours a day" (APA #13, p. 194). When Claimant was asked if she remembered Dr. McQueen telling her that, her response was "no sir" (Tr., p. 54). In May of 2009, Dr. McQueen was prescribing Prozac, Lorcet, Xanax, Flexeril, and Ambien; however, Claimant continued to testify that she did not remember those medications (Tr., p. 55). Claimant was asked about a statement in the report from Dr. McQueen dated November 22, 2010, where he wrote "I don't know how much longer she will be able to continue in the work field, because her body is breaking down," and Claimant testified that she did not remember that (Tr., p. 56). In May of 2011, Claimant could not remember if she was being prescribed Percocet for chronic pain (Tr., p. 56). In February of 2012, three months prior to her accident, Claimant was prescribed Percocet, MS Contin, Morphine Sulfate, and Xanax by Dr. Collins (APA #13, p. 221); however, Claimant could not "remember" that (Tr., p. 58). Claimant appears to have very selective memory when confronted about the myriad medications and prior treatment for chronic pain and depression for at least eight years prior to her job injury in May of 2012. She could only "remember" the medications she took for unrelated conditions.

21. Claimant has a long history of pre-existing situational stressors and pre-existing depression as documented by Dr. Fred McQueen on September 12, 2005: "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 a blockage" (APA #13, p. 191). On January 10, 2006, Dr. McQueen notes, "her child has just been at Duke for surgery, she has not been

sleeping well at all. She has gained 15 pounds recently, partly due to stress" (APA 313, p. 192). On April 10, 2006, Dr. McQueen notes "she has a lot of problems at home with her husband and son so she did not see Dr. Arthur." "She is taking care of her mother." "She has a problem with her husband who is ill and son who is ill" (APA #13, p. 193). On August 9, 2007, Dr. McQueen notes "she has unfortunately lost her job due to the accident [different employer] and she is in a depressed state at this point." "She has difficulty controlling her temper with her family" (APA #13, p. 197). On August 17, 2007, Dr. McQueen notes "it is my professional opinion since February 13, 2007 evaluation that Ms. Rummage was unable to hold gainful employment and continues to remain disabled. Her last evaluation 8/9/07 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" [different employer] (APA #13, p. 198). On July 22, 2008, Dr. McQueen notes "this is a 48 year old white female with chronic pain and major depression" (APA #13, p. 200). On February 13, 2009, she reports "some days she has trouble getting out of bed and is more tearful than others" (APA #13, p. 201). On May 15, 2009, Dr. McQueen notes "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" (APA #13, p. 202). On August 17, 2009, "she is also on Xanax 1 mg t.i.d. for her nerves" (APA #13, p. 204). On November 17, 2009, "she suffers from longstanding chronic pain secondary to chronic migraines, as well as osteoarthritis." "She also suffers from generalized anxiety disorder" (APA #13, p. 205). On November 22, 2010, "her weight is up remarkably, she went from 152 to 164 for a gain of 12 pounds. This is not like her." "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" (APA #13, p. 208). On January 25, 2011, "she has a history of migraines and her migraines have hit her now" (APA #13, p. 209). On December 13, 2011, "patient comes in today and she is having a lot of problems with chronic pain in her back, neck, and shoulders" (APA #13, p. 217). On January 13, 2012, "the patient admits that she has 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, the VA, and he was sick" (APA #13, p. 219). On May 14, 2012 **(four days prior to her job injury)**, "she is having so much spasm in her neck and shoulder." "She has severe muscle spasm in her cervical spine and she has radiculopathy so I am putting her on Lyrica 75, Flexeril 10, she takes at bedtime, the Lyrica is twice a day" (Depo. of Dr. Daniel Collins, Ex. 3).

22. **Claimant told Dr. Collins (post-accident) that she "has not tried Lyrica or Neurontin at this point."** Dr. Collins notes again in a later record that "she had not tried Lyrica in the past." In fact, Claimant was prescribed just Lyrica 4 days prior to the date of the accident in issue, and is documented as taking it as early as 2006; Claimant herself wrote on a pre-accident intake sheet that she was taking Lyrica—this inconsistency is more evidence that she is not credible (APA #13, p. 224; APA #12, p. 187). Because of Claimant's presentation to Dr. Collins, he recommended that Claimant continue speech therapy. In fact, Claimant had no difficulty expressing herself at the hearing except perhaps when confronted with evidence regarding pre-existing conditions she had denied. Claimant told Dr. Hutcheson that she developed insomnia, etc. after the accident, when she in fact was medically documented as an insomniac prior to the

accident, and for which she was prescribed medication (longstanding problem for years) and for which a sleep study was recommended. Claimant had to discontinue Ambien at one point prior to the accident because Ambien was too expensive (APA #13, p. 197). Effexor was prescribed for psyche and sleep; Xanax was retained for sleep. Yet, now Claimant attributes her sleep problems to the accident, and asks the Commission to require Defendants to pay for sleep medications she already needed prior to the accident (APA #13, pp. 197 and 201-202).

23. Dr. Daniel Collins testified that Claimant did not inform him in any way of similar problems and symptoms involving her neck prior to her May 18, 2012 accident (Depo. Dr. Collins, p. 26). Claimant did not inform Dr. Collins of treatment by Dr. Fred McQueen prior to her May 18, 2012 accident for chronic pain and major depression (Depo. Dr. Collins, p. 33). Dr. Collins testified that Claimant did not tell him that four days prior to her admitted accident on May 18, 2012, Dr. McQueen had prescribed and she was taking Lyrica, Flexeril, Percocet, Xanax, and Nuvigil (Depo. Dr. Collins, p. 30). During the deposition of Dr. Collins, when confronted with the existence of years of prior treatment for chronic pain, anxiety, depression, and trouble sleeping, Dr. Collins stated, "any time the patients aren't up front and tell me the truth or tell me all the truth or tell me just what they want to hear, it is of concern ..." (Depo. Dr. Collins, p. 42). "I have more than concerns about her honesty in the past, and there is always an issue now whether she is 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" (Depo. Dr. Collins, p. 46).

24. Claimant was sent by her attorney to see Dr. Amanda B. Salas of Palmetto Center of Psychiatry. Contrary to Claimant's pre-existing problems as documented in the APA Submissions referenced above, Dr. Salas set forth in her report that Claimant "presented an honest and forthcoming individual" (APA #2, p. 83). Claimant "reported that her sleep became disrupted after the workers' compensation injury, that her sleep has worsened, and she has not experienced improved sleep despite limited treatment" (APA #2, p. 84). When Claimant saw Dr. Salas, she apparently did not disclose a history of treatment for headaches, including migraines, as well as neck pain (APA #2, p. 84). In fact, Claimant "denied a history of severe depression, treatment for mood or anxiety problems ..." (APA #2, p. 85). Clearly, Claimant was not candid, forthright, and honest with Dr. Amanda Salas. I therefore give Dr. Amanda Salas's report and opinions little weight.

25. Claimant was sent by her attorney to Dr. Tora Brawley, a clinical psychologist. Once again, claimant was not candid and forthright with Dr. Tora Brawley. Claimant did not reveal that she had been treated for prior headaches, including migraines, that she had taken medication for years due to trouble sleeping, and had daily feelings of depression, including crying spells (APA #3, pp. 97-101). It is obvious that Claimant told Dr. Tora Brawley only what Claimant wanted her to know, instead of fully disclosing all of her prior medical history and extensive treatment. I therefore give Dr. Tora Brawley's report and opinions little weight.

26. Claimant was also sent by her attorney to Dr. Donna Schwartz Maddox, a psychiatrist. According to Dr. Maddox's report, Claimant's "chief complaint remains memory impairment," (APA #4, p. 104) an allegation that I do not find believable based

upon the lack of Claimant's credibility as set forth hereinabove, selective memory at the hearing, and temporal records documenting both normal recent and normal remote memory. I place little weight upon the report and opinions of Dr. Maddox.

27. Claimant was also sent by her attorney to see Dr. J. Kelby Hutcheson of Carolinas Center for Advanced Management of Pain. Dr. Hutcheson's report of September 18, 2013 makes no reference to Claimant's pre-existing chronic pain treatment by Dr. Fred McQueen as set forth hereinabove. In fact, under the past treatment portion of Dr. Hutcheson's report, where it asks "has patient been treated at another pain management center," the response is no (APA #6, p.124). When asked has patient ever had previous psychiatric or psychological treatment, again the response is "no" (APA #6, p. 124). I therefore can place little weight on the report and opinions by Dr. J. Kelby Hutcheson.

28. Although Claimant reported that she cries all the time post-accident, (etc.), her Facebook entries show (a) cognitive abilities she denies having, and (b) that she is quite social. At the end of 2014 (two years after the date of the accident), Claimant wrote **"It's been a great year!"** This is antithetical to Claimant's testimony/presentation at the hearing and to providers regarding her alleged condition (APA #24, p. 365). I give greater weight to what Claimant shares with friends than what she portrays to providers and to the Commission. The entries on APA #25, pp. 378 and 380 alone do not suggest the cognitive impairment Claimant would like providers and the Commission to believe. I finally note, although in no way dispositive, that it seems rather inconsistent for someone as allegedly depressed/withdrawn as Claimant says she is, to liberally use exclamation points (!) as she does in her posts.

29. If a claimant's statements and purported problems and presentations to providers were dispositive, Commission involvement would be unnecessary. For instance, Claimant has told myriad physicians that she has memory problems, that she now drops things, and that she never had previous psychological treatment. They believed Claimant just as they believed that she "developed" headaches, dizziness, and insomnia only after the accident (APA #6, pp. 123-124). In fact, Claimant had numbness in her hands (and positive Tinel's and Phalen's signs) as early as 2006 (APA #12, pp. 187-188). Additionally, in 2011 (the year before the accident), Claimant reported a deformity of her fingers, such that her family physician pondered whether Claimant had rheumatoid arthritis in her hands (APA #13, page 217).

30. This is a claimant that requests the Commission to find a compensable aggravation, yet will not admit to the extent (or at her deposition, even the existence) of her pre-existing problems, even when a body part is admitted. Claimant would not even admit to the extent of an unrelated, prior workers' compensation claim (Claimant's Depo. in its entirety), particularly with regard to prior conditions and medications: Claimant would not admit to an ongoing or prior neck problem, nor admit that she took ongoing pain medication, etc. (Depo., pp. 36, 40, 41, 51, 52).

31. Claimant, in her sworn deposition testimony, would only admit to high blood pressure, a thyroid condition, and sinus infections, as prior conditions (Depo., pp. 40, 41, 51, 52). She also testified (under oath) at her deposition that her headaches, dizziness, neck problems, and depression "first began" after her work accident; none of this is true (Depo., pp. 53 and 55).

32. Claimant's testimony at the hearing and at her deposition are not imbued with any indicia of trustworthiness.

33. I did not consider the findings of Commissioner Lyndon in his Order. However, Claimant's sworn deposition testimony—regarding her prior workers' compensation claim-- is untrue and evasive (Depo., pp 4, 11-12).

34. As to memory, Claimant remembers the time of the accident, the fact that she was getting ready to go to break, that she was trying to clean waste out of the roll, that Ethan helped Claimant up, that Ethan told her she was bleeding, that she told Employer that she would like to stay at work because she was already on probation "again" because of her husband's illness, (which I think is very key in this case—a sick husband with a need to care for him plus all her pre-existing health issues which were escalating), and that she worked until August 2012— three months after the accident, etc. (Depo., pp. 21-27, 49, particularly page 25; Tr., pp. 23, 24, 50).

35. I considered all the "opinions" of physicians who did not (a) observe Claimant's change in demeanor/presentation at the hearing, particularly when being asked about pre-existing conditions, and (b) review the entirety of her deposition testimony, which was just as damning as (if not worse than) her testimony at the hearing.

36. Although the undersigned does not condone prevarication to any degree, the things which Claimant conceals or about which she is evasive are salient issues, particularly given the fact that she seeks a finding of an aggravation of a pre-existing condition. Even where admitted body parts/conditions are concerned, Claimant prevaricates. This seriously calls into question Claimant's veracity in general, as well her

statements/presentation to providers upon which statements/presentation these experts relied in good faith in formulating opinions and treatment recommendations.

37. I believe that Claimant is using the workers' compensation system for purposes of secondary gain. I decline to require Defendants to subsidize her need to care for family members who rely upon her for support, or because of a host of myriad and escalating problems unrelated to the accident in issue. Further, Claimant asks this Commission to require Defendants to pay for medications she was already taking (or could not afford) on the date of the accident. I decline to do so.

38. Claimant's average weekly wage is \$578.23, yielding a compensation rate of \$385.51.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, S.C. Code Ann., it is the determination of this Commissioner:

1. Under § 42-17-160, Claimant sustained an injury by admitted accident to her head and neck on May 18, 2012, arising out of and in the course of her employment.

2. Under § 42-9-35, Claimant has failed to prove an aggravation of her pre-existing psychological condition.

3. Having failed to establish a compensable aggravation of her pre-existing psychological condition, Claimant is not entitled to any workers' compensation benefits for any medical treatment for her psychological condition.

ORDER

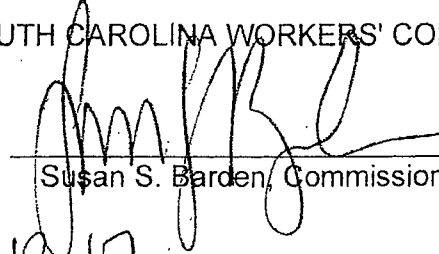
IT IS ORDERED that the claim by Vickie Rummage for medical treatment and

compensation benefits due to an alleged aggravation of her pre-existing psychological condition is denied.

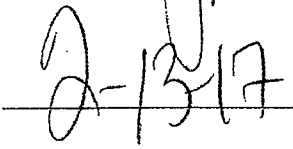
No hearing costs are assessed in this instance.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

By: 

Susan S. Barden, Commissioner.

Dated: 

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Angela D. Kicklighter on March 14, 2017

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March 28, 2017

The Honorable Amy Bracy
Judicial Director
South Carolina Workers' Compensation Commission
1333 Main Street
Columbia, South Carolina 29201

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

Dear Amy:

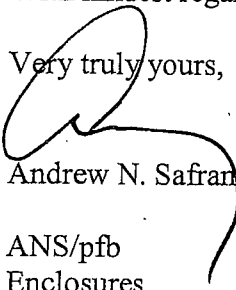
Enclosed please find an original and four copies of a Form 30, with attachment, which I am filing on behalf of Ms. Vickie W. Rummage relative to the above-captioned claim. Additionally, I have enclosed my firm's check in the amount of \$150.00 in satisfaction of your filing fee. At this time, I would greatly appreciate your filing these documents and returning one stamped copy to my courier.

By copy of this letter, I am serving a copy of this Form 30, with attachment, on Mike Farry, counsel for Defendants. As always, in the event he has any questions or comments concerning this matter, I invite him to contact me.

Thank you for your cooperation.

With kindest regards, I am

Very truly yours,


Andrew N. Safran

ANS/pfb
Enclosures

cc: Michael A. Farry, Esquire

RECEIVED

MAR 28 2017

SC WORKERS' COMPENSATION

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

P.O. BOX 1715

Columbia, SC 29202-1715

803-737-5675

www.wcc.sc.govWCC File #: **1215681**

Carrier File #:

Carrier Code #:

Employer FEIN #:

Claimant's Name: Vickie Rummage SSN: 249-17-1832Address: 5579 Highway 1City: Wallace State: SC Zip: 29596Home Phone: () - Work Phone: () -Preparer's Name: Andrew N. Safran, Esquire Law Firm: Andrew N. Safran, LLCPreparer's Phone #: 803-256-6689Employer's Name: BGF Industries, Inc.Address: 90 Huger StreetCity: Cheraw State: SC Zip: 29520Insurance Carrier: Great American Alliance Ins. Co.**REQUEST FOR COMMISSION REVIEW**Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: May 18, 2012

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

******See attachment.**(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.☐ Mediation☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.Questions regarding mediation may be submitted to mediation@wcc.sc.gov.I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Michael A. Farry, Esquire, Horton, Drawdy, Ward,Mullinax & Farry, P.A., 307 Pettigru Street, Greenville, South Carolina 29601 on the 28th day of March, 2017, by ☒ first class postage ☒mail ☐ certified mail ☐ personal service.

Preparer's Signature

Attorney for Employee/Claimant
Titlemsa6631@aol.com
EmailMarch 28, 2017
DateCheck this box if you are not represented by an attorney ☐**RECEIVED****MAR 28 2017****SC WORKERS' COMPENSATION**Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-605 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

- 1) Did the hearing commissioner err in admitting the "Decision and Order by Commissioner G. Bryan Lyndon dated March 5, 2008" into evidence when: (a) this document was clearly introduced for the purpose of attacking Ms. Vickie Rummage's credibility; (b) the South Carolina Supreme Court recognized this form of impeachment cannot be accomplished through introduction of extrinsic evidence (See, Mizell v. Glover, 351 S.C. 392, 370 S.E. 2d 176 (2002)); (c) the March 5, 2008 Decision and Order clearly constitutes extrinsic evidence; and (d) inclusion of this document in the evidentiary record was legally inappropriate?
- 2) Did the hearing commissioner err in finding the contents of the March 5, 2008 Decision and Order were not "consider[ed] . . ." when: (a) this document was clearly introduced into the evidentiary record; (b) this inclusion necessarily led to a review of the contents of this Decision and Order; (c) it cannot be assumed this extrinsic evidence did not impact upon the decision making process in this instance; and (d) this finding cannot remove the tainting effect of this inadmissible evidence?
- 3) Did the hearing commissioner err in stating Ms. Vickie Rummage's contention as to the causal relationship/compensability of her current psychiatric symptoms was exclusively founded upon the opinions of her authorized treater, Dr. Daniel L. Collins, when: (a) this statement ignores the fact she submitted evidence from no less than three other qualified expert evaluators verifying this causal connection; (b) she likewise maintained that notwithstanding any prior questions/concerns he may have developed relative to Ms. Rummage's candor or compliance, Dr. Collins, with the passage of time and multiple assessments, determined she was not exhibiting evidence of either symptom magnification or secondary gain; (c) Ms. Rummage also focused on compelling evidence as to the unreliability of Defendants' expert's opinions/conclusions; and (d) this statement simply does not accurately reflect the nature/breadth of Ms. Rummage's contentions?
- 4) Did the hearing commissioner err in failing to find Ms. Rummage not only acknowledged a long history of pre-injury depression, necessitating use of psychotropic medication, through both her hearing testimony but also interviews with various psychological/psychiatric experts, when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?
- 5) Did the hearing commissioner err in failing to find that, notwithstanding her pre-injury history of depression, Ms. Rummage's treatment prior to sustaining the May 18, 2012 compensable accident did not include/involve specialized psychological or psychiatric care when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?
- 6) Did the hearing commissioner err in failing to find that several opinions Dr. Daniel L. Collins expressed during the course of his March 14, 2014 deposition, including (but not limited to) his perception of Ms. Rummage's credibility/sincerity and the legitimacy of her symptoms, had favorably changed during his ensuing 2 (+) year

course of treatment when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unequivocally establishes this fact?

7) Did the hearing commissioner err in excessively focusing upon the deposition testimony of Ms. Rummage and Dr. Daniel L. Collins, as opposed to her relevant hearing testimony and this authorized treating physician's subsequently generated opinions, when this adjudication process: (a) substantially ignores highly relevant opinions developed by this treating physician subsequent to his deposition; (b) likewise affords no weight to candid acknowledgements of prior testimonial discrepancies; (c) reflects an unreasonable disinclination to recognize either Ms. Rummage's contrition or the multiple medical opinions (rendered with full awareness of her pre-injury history) confirming aggravation of her prior depressive symptoms; and (d) constitutes an arbitrary, capricious and unlawful adjudication procedure?

8) Did the hearing commissioner err in failing to find inspection of the reports generated by Drs. Donna Schwartz Watts-Maddox and Amanda B. Salas not only reflect Ms. Rummage's admission of pre-injury depression, for which she received treatment over an extended period, but also these physicians' review of medical records confirming this pre-injury treatment course, when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

9) Did the hearing commissioner err in failing to find the preponderance of the evidence of record indicates that notwithstanding her pre-injury depression, Ms. Rummage was able to remain employed, perform household chores and engage in essentially all activities of daily living prior to sustaining the May 18, 2012 accident when the only reasonable inference which may be gleaned from the evidence contained in the hearing record certainly establishes this fact?

10) Did the hearing commissioner err in failing to find that, notwithstanding the presence of various stressors, including family illness, death of parents, etc., Ms. Rummage remained sufficiently functional to maintain employment, engaged in household chores and perform essentially all activities of daily living when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably verifies this fact?

11) Did the hearing commissioner err in failing to find inspection of her hearing testimony reveals Ms. Rummage did not deny receipt of any treatment documented in records generated by Dr. Fred D. McQueen, Jr. when the only reasonable inference which may be gleaned from the evidence contained in the hearing record certainly verifies this fact?

12) Did the hearing commissioner err in finding Ms. Rummage's current psychiatric/psychological symptoms do not proximately result from the aggravation of a preexisting condition by the consequences of her May 18, 2012 compensable accident when this determination is: (a) wholly inconsistent with the only reasonable inference

which may be gleaned from the evidence contained in the hearing record; and (b) the product of not only an arbitrary, capricious and unlawful adjudication process, but also an unusual finesse of reasoning?

13) Did the hearing commissioner err in finding Ms. Rummage, "is not remotely credible" when: (a) this determination is substantially the product of a personal, subjective lay assessment ("observations", "delivery of her testimony", "evasiveness" "selective memory"); (b) given the statutory requirements relative to the standard of proof governing compensability of psychiatric/psychological conditions (as well as associated treatment needs), this subjective determination constitutes a legally insufficient basis upon which to assess credibility in the context of mental illness and cognitive loss, areas that are reserved to expert opinion; (c) the substantial weight afforded these personal, subjective lay impressions in this instance is reflective of an arbitrary, capricious and unlawful adjudication procedure; and (d) these findings are inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

14) Did the hearing commissioner err in finding Ms. Rummage "appears wily and manipulative" when: (a) this statement is substantially the product of a personal, subjective lay assessment ("observations", "delivery of her testimony", "evasiveness" "selective memory"); (b) given the statutory requirements relative to the standard of proof governing compensability of psychiatric/psychological conditions (as well as associated treatment needs), this subjective determination constitutes a legally insufficient basis upon which to assess credibility in the context of mental illness and cognitive loss; (c) the substantial weight afforded these personal, subjective lay impressions in this instance is reflective of an arbitrary, capricious and unlawful adjudication procedure; and (d) these findings are inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

15) Did the hearing commissioner err in failing to find both Dr. Donna Schwartz Watts-Maddox and Dr. Amanda B. Salas were clearly aware of Ms. Rummage's "longstanding" preexisting psychological symptoms (as outlined in Finding of Fact Number 8) when the only reasonable inference which may be gleaned from the evidence contained in the hearing record unquestionably establishes this fact?

16) Did the hearing commissioner err in failing to find Ms. Rummage "would not volunteer (or admit) to her preexisting" conditions when the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her hearing testimony, unquestionably establishes her repeated acknowledgement of any preexisting conditions outlined in previously generated medical records?

17) Did the hearing commissioner err in finding Ms. Rummage "suggested" in sworn testimony that her psychological treatment was "episodic/'in the past' instead of ongoing" when the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her hearing testimony, reflects her acknowledgment of this pre-injury course of treatment?

- 18) Did the hearing commissioner err in failing to find Ms. Rummage repeatedly clarified any prior discrepancies created by her deposition testimony through candid acknowledgement of the nature/degree of her pre-injury course of treatment when the only reasonable inference which may be gleaned from the evidence contained in the hearing record undoubtedly establishes this fact?
- 19) Did the hearing commissioner err in finding Ms. Rummage “fail[ed] . . . to be forthright” in the delivery of her hearing testimony when this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, especially her repeated acknowledgement of extended receipt of treatment through Dr. Fred D. McQueen, Jr.?
- 20) Did the hearing commissioner err in finding Ms. Rummage “did not redeem herself by her inconsistent presentation, her selective memory, her evasiveness, her outright denial of pre-existing conditions” during the course of the November 7, 2016 hearing when this finding is wholly inconsistent with the only reasonable inference may be gleaned from the evidence contained in the hearing record, particularly her repeated acknowledgement as to the nature/degree of treatment obtained through Dr. Fred D. McQueen, Jr. prior to sustaining the May 18, 2012 compensable accident?
- 21) Did the hearing commissioner err in finding the medical condition of Ms. Rummage’s husband “has caused a hardship” sufficient to independently produce her current level of psychiatric/psychological symptoms when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) is the product of a personal, subjective lay assessment of conditions (mental illness and cognitive loss) which are legally reserved to expert opinion; (c) constitutes an impermissible medical opinion generated by the Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?
- 22) Did the hearing commissioner err in similarly finding other “situational stressors” (involving her son and parents) independently constituted the source of her current level of psychiatric/psychological symptoms when: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) is the product of a personal, subjective lay assessment of conditions (mental illness and cognitive loss) which are legally reserved to expert opinion; (c) constitutes an impermissible medical opinion generated by the Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?
- 23) Did the hearing commissioner err in finding Ms. Rummage’s current headaches were not “different” from those she was experiencing prior to the May 18, 2012 trauma when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) likewise ignores the contrary opinions expressed by Dr. Fred D. McQueen, Jr., who unquestionably possessed the most reliable knowledge as to the nature of Ms. Rummage’s pre-injury and pos-injury symptom level; (c) constitutes an impermissible medical opinion generated by the

Commission; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

24) Did the hearing commissioner err in essentially finding Ms. Rummage had deliberately misrepresented the pre-injury presence of "dizziness" when: (a) this finding is premised upon an isolated reference contained on a January 23, 2011 diagnostic test report; (b) inspection of treatment records contemporaneously generated by her long time physician Dr. Fred D. McQueen, Jr., do not identify dizziness as symptom/complaint; (c) Dr. McQueen's records do reflect the presence of migraine headaches, which is also referenced on the January 23, 2011 diagnostic report; (d) the presence of this record is hardly indicative of an attempt to conceal any purported dizziness associated with prior migraines; (e) the nature of this evidence does not justify the emphasis (displayed through the use of bold type) afforded this relatively innocuous reference; and (f) reliance on this isolated finding as justification to either question Ms. Rummage's credibility or deny the causal relationship of her current psychiatric/psychological symptoms to the consequences of her compensable accident is reflective of an arbitrary, capricious and unlawful adjudication procedure?

25) Did the hearing commissioner err in finding Ms. Rummage has attempted to lead "providers . . . [to] believe" she did not encounter some degree of sleep difficulties prior to the May 18, 2012 trauma when: (a) Drs. Donna Schwartz Watts – Maddox and Amanda B. Salas were clearly aware of any pre-injury sleep difficulties through review of records generated by Dr. Fred D. McQueen, Jr.; (b) neither of these independent evaluators identified sleep loss as a significant basis for their diagnosis of aggravated preexisting psychiatric/psychological symptoms; (d) the absence of this nexus renders this finding irrelevant to the current dispute; (d) given this lack of relevance, the focus on sleep difficulties is not only unwarranted, but prejudicial; and (e) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

26) Did the hearing commissioner err in finding Ms. Rummage's attempt to continue working following her compensable accident deserves "great weight as to the severity of her condition" when this finding: (a) clearly constitutes the unlawful rendering of a medical opinion by the Commission; (b) conflicts with the applicable standard of proof requiring medical evidence on issues of this nature; (c) seeks to substitute a personal, subjective, speculative lay opinion for the legally requisite medical evidence; (d) is inconsistent with the only reasonable inference which may be gleaned from the evidence of record; and (e) reflects the use of an arbitrary, capricious and unlawful adjudication procedure?

27) Did the hearing commissioner err in finding a June 1, 2012 report of Dr. Fred D. McQueen, Jr. warranted "the greatest weight . . . [o]f all the post-accident evidence" when: (a) Ms. Rummage obviously developed a sufficient level of symptoms to warrant referral to a specialist; (b) the neurologist designated by Defendants subsequently confirmed she exhibited the "typical symptoms of closed-head injury"; (c) after continuing to follow her for the consequences of this injury, Dr. McQueen acknowledged the fact her May 18, 2012 trauma had produced "a concussion"; (d) Dr. McQueen further

confirmed a worsening of her pre-injury headache symptoms to a level which warranted neurological evaluation; (e) after reviewing the report of Defendants' designated neurologist, Dr. McQueen concurred with his assessment; (f) this long time primary care physician similarly verified Ms. Rummage's increased headaches were "most probably the product of a post-concussive syndrome", which had also increased her pre-injury cervical and psychological symptoms, to the extent they required further treatment; (g) this finding is consequently wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (h) the hearing commissioner's determination on this point likewise constitutes a legally impermissible medical opinion; and (i) the nature of this finding, which seeks to ignore Dr. McQueen's recognition of the material consequences of Ms. Rummage's injury is reflective of an arbitrary, capricious and unlawful decision making process?

28) Did the hearing commissioner err in characterizing Ms. Rummage's hearing testimony as a "performance" when this finding: (a) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) impermissibly ignores Ms. Rummage's repeated acknowledgements of preexisting medical conditions, treatment, etc. throughout her hearing testimony; (c) constitutes a highly subjective, impermissible medical opinion by the Commission on a subject (mental illness and cognitive loss) that has been legally reserved for qualified experts; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

29) Did the hearing commissioner err in finding Dr. Fred D. McQueen, Jr.'s June 1, 2012 references to certain preexisting elements to deserve "great weight" when this finding: (a) constitutes a legally impermissible medical opinion; (b) substitutes personal, subjective lay impressions for the medically technical standard of proof governing the current circumstances; and (c) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

30) Did the hearing commissioner err in finding Dr. C. Thomas Gualtieri's impressions of Ms. Rummage were accurate or worthy of any weight when the only reasonable inference which may be gleaned from the evidence contained in the hearing record establishes: (a) this designated evaluator substantially generated his initial report prior to ever meeting Ms. Rummage; (b) Dr. Gualtieri likewise utilized self-serving testing mechanisms that are not considered acceptable tools in either psychiatric or neuropsychological circles; (c) this physician similarly does not possess the training/expertise to interpret neuropsychological test data; and (d) this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record?

31) Did the hearing commissioner err in finding Ms. Rummage "appears to have very selective memory" when this finding: (a) constitutes a legally impermissible medical opinion; (b) circumvents the governing standard of proof through reliance on personal, subjective lay impressions, as opposed to the legally mandated medical evidence required

in the context of mental illness and cognitive loss; and (c) is reflective of arbitrary, capricious and unlawful adjudication procedure?

32) Did the hearing commissioner err in finding Dr. Daniel L. Collins' December 17, 2012 statement that Ms. Rummage "has not tried Lyrica or Neurontin at this point", as well as his January 11, 2013 notation that "[s]he had not tried Neurontin or Lyrica in the past" constituted "more evidence that she is not credible" when: (a) this finding completely ignores the context of these statements, which relate to her post-May 18, 2012 treatment course; (b) likewise assumes this physician even ask about the **pre-May 18, 2012 usage** of these medications, an inquiry which is certainly not reflected in this physician's records; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

33) Did the hearing commissioner err in questioning Ms. Rummage's need for speech therapy, purportedly due to a personal, subjective lay impression that she "had no difficulty expressing herself at the hearing" when this finding: (a) constitutes a legally impermissible medical opinion; (b) incorrectly seeks to create an issue which had never been raised by the respective parties, contrary to any notion of due process; (c) similarly seeks to not only ignore the admitted/acknowledged medical consequences of Ms. Rummage's May 18, 2012 trauma, but also generate additional rationale for challenging her credibility through focus on elements that were not deemed material by either Dr. Donna Schwartz Watts-Maddox or Dr. Amanda B. Salas in determining the causal connection of her current psychiatric/psychological symptoms; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

34) Did the hearing commissioner err in focusing on certain elements in Dr. Daniel L. Collins' March 13, 2014 deposition testimony, while effectively ignoring this authorized treater's subsequent opinions confirming the absence of "any evidence of malingering, symptom magnification or secondary gain", when: (a) utilization of Dr. Collins' deposition in this fashion does not constitute an accurate representation of Ms. Rummage's authorized treating physician's opinions relative to the nature/degree or legitimacy of her current symptoms; (b) this rather narrow preoccupation with Dr. Collins' March 13, 2014 statements unfairly rejects the positive evolution of this authorized treating physician's impressions of Ms. Rummage; (c) the generation of findings based on Dr. Collins' deposition testimony, as opposed to various opinions which were subsequently developed after numerous evaluations, results an in inaccurate and prejudicial characterization of material evidence; and (d) these findings are reflective of an arbitrary, capricious and unlawful adjudication procedure?

35) Did the hearing commissioner err in finding Dr. Amanda B. Salas was unaware of Ms. Rummage's "pre-existing problems" when this finding: (a) is contrary to the only reasonable inference which may be gleaned from the evidence contained in the hearing record, including Dr. Salas' acknowledged review of records generated by Dr. Fred D. McQueen, Jr.; (b) these records not only reference physical and psychological symptoms,

but also sleep disturbance; (c) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

36) Did the hearing commissioner err in basing her finding Ms. Rummage “was not candid, forthright, and honest with Dr. Amanda Salas”, to any extent on a purported denial of “a history of severe depression, treatment for mood anxiety or anxiety problems” contained on page 4 of her report (Claimant’s APA Exhibit 2, p. 85) when: (a) even a cursory review of Dr. Salas’ entire report reveals references to prior depression, medication use for this mood disorder, the absence of pre-May 18, 2012 treatment by a mental health professional and no history of suicide attempts; (b) the reference contained in Finding of Fact Number 24 of the hearing commissioner’s March 14, 2017 order relates to “family members”; (c) given this misconception, the finding Ms. Rummage was not candid/forthright/honest with Dr. Salas is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (d) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

37) Did the hearing commissioner err in finding Ms. Rummage “was not candid and forthright with Dr. Tora Brawley” when this finding: (a) ignores the fact Dr. Brawley specifically referenced “a prior history of depression”; (b) similarly overlooks Dr. Brawley’s role as neuropsychological evaluator per referral of Dr. Donna Schwartz Watts-Maddox who not only reviewed the extensive pre-May 18, 2012 treatment notes generated by Dr. Fred D. McQueen, Jr., but also referenced the presence of depression, with associated use of psychotropic medication, prior to her accident date; (c) incorrectly/speculatively presumes Ms. Rummage simply “told Dr. Tora Brawley only what Claimant wanted her to know, instead of fully disclosing all of her prior medical history and extensive treatment”; (d) is unsupported by the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (e) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

38) Did the hearing commissioner err in rejecting Ms. Rummage’s contention of causally related memory loss “based upon the lack of Claimant’s credibility . . . selective memory at the hearing, and temporal records documenting both normal recent and normal remote memory” when this finding: (a) is premised upon a personal, subjective lay assessment of symptoms attributable to complex medical conditions (mental illness and cognitive loss); (b) ignores the governing standard of proof, which requires expert opinion as to all pertinent issues surrounding these medical conditions; (c) constitutes an unlawful medical opinion by the Commission; (d) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

39) Did the hearing commissioner err in giving “little weight” to the opinions expressed by Drs. Donna Schwartz Watts-Maddox, Tora Brawley and Amanda B. Salas when: (a) the opinions expressed by these experts are clearly consistent with the pertinent medical evidence of record; (b) the attempts to dismiss and/or minimize the impact of

these opinions are the product of an unusual finesse of reasoning and personal, subjective lay misconstruction of the evidence relative to issues (mental illness and cognitive loss) legally reserved for expert opinion; (c) the findings relative to the lack of weight afforded these experts' opinions are not only wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but also indicative of a summary rejection stemming from personal, subjective lay assessment of Ms. Rummage's condition in a fashion which is inconsistent with the governing standard of proof; and (d) these finds are reflective of an arbitrary, capricious and unlawful adjudication procedure?

40) Did the hearing commissioner err in failing to find Ms. Rummage's post-May 18, 2012 psychiatric/psychological symptoms most probably result from the aggravation of a preexisting condition by the consequences of her compensable accident when the only reasonable inferences may be gleaned from the evidence contained in the hearing record firmly establishes this fact?

41) Did the hearing commissioner err in failing to find the causally related psychiatric/psychological symptoms identified by Drs. Schwartz Watts-Maddox, Amanda B. Salas, Tora Brawley and Daniel L. Collins require focused treatment that is medically reasonable, necessary and intended to lessen the period of disability produced by the consequences of her May 18, 2012 compensable accident when the only reasonable inferences may be gleaned from the evidence contained in the hearing record firmly establishes this fact?

42) Did the hearing commissioner err in finding the pre-May 18, 2012 treatment Ms. Rummage received from Dr. Fred D. McQueen, Jr., her primary care physician, constituted treatment obtained through a pain management center when the only reasonable inference which may be gleaned from the evidence contained in the hearing record clearly does not support this finding?

43) Did the hearing commissioner err in finding Ms. Rummage's utilization of Facebook reflects either a lack of causally related psychiatric/psychological symptoms or cognitive loss when: (a) conditions of this nature (mental illness and cognitive loss) are medically technical; (b) resolution of issues relating to medically technical issues hinges upon opinions expressed by appropriate medical experts; (c) the hearing commissioner's finding constitutes a legally impermissible medical opinion of the Commission stemming from the personal, subjective impressions of the lay person; (d) this finding is also inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (e) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

44) Did the hearing commissioner err in finding the medical opinions which support Ms. Rummage's contentions as to the causal relationship of her current psychiatric/psychological symptoms and cognitive loss to the consequences of her compensable accident were flawed due to unfamiliarity with her pre-May 18, 2012 medical history when: (a) these supportive opinions were not generated in a vacuum, but

rather with awareness of her lengthy treatment history through Dr. Fred D. McQueen, Jr.; (b) after considering her preexisting conditions, Drs. Donna Schwartz Watts-Maddox and Amanda B. Salas each verified not only the causal relationship of these symptoms to the consequences of her May 18, 2012 trauma, but also Ms. Rummage's need for treatment; (c) unlike Defendants' evaluator, these medical experts did not begin the process of generating substantive opinions prior to ever examining Ms. Rummage; and (d) this finding is not only inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but also reflective of an arbitrary, capricious and unlawful adjudication procedure?

45) Did the hearing commissioner err in finding Ms. Rummage declined to admit the presence of her preexisting physical and emotional problems when: (a) the only reasonable inference which may be gleaned from the evidence contained in the hearing record, including hearing testimony replete with admissions of this nature, simply does not support this finding; (b) this determination also ignores not only Ms. Rummage's contrition on various points following the deposition, but also extensive medical evidence supporting her contention as to the causal relationship of her current depressive symptoms and cognitive loss; and (c) this finding is reflective of an arbitrary, capricious and unlawful adjudication procedure?

46) Did the hearing commissioner err in finding Ms. Rummage did not acknowledge the presence of headaches, neck problems and depression prior to May 18, 2012 when this finding: (a) is contrary to the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) ignores her repeated acknowledgements as to the presence of these conditions; and (c) is reflective of an arbitrary, capricious and unlawful adjudication procedure?

47) Did the hearing commissioner err in characterizing Ms. Rummage as untrustworthy when this finding: (a) is premised, in large part, on a personal, subjective lay assessment of mental illness and cognitive loss, which are medically technical areas reserved to expert opinion; (b) constitutes a legally impermissible medical opinion; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

48) Did the hearing commissioner err in finding several statements referenced in Finding of Fact Number 34 were purportedly inconsistent with Ms. Rummage's current level of memory loss when this finding: (a) is premised, in large part, on a personal, subjective lay assessment of mental illness and cognitive loss, medically technical areas reserved to expert opinion; (b) constitutes a legally impermissible medical opinion; (c) is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

49) Did the hearing commissioner err in finding Ms. Rummage's "sick husband with a need to care for him plus all her pre-existing health issues which were escalating" were

"very key in this case" when this finding: (a) is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) seeks to create an issue that has never been raised by the respective parties, in violation of due process; (c) is founded upon subjective lay conjecture and surmise; and (d) reflects an arbitrary, capricious and unlawful adjudication procedure?

50) Did the hearing commissioner err in rejecting the various expert opinions supporting Ms. Rummage's contentions as to the causal relationship of her current psychiatric/psychological symptoms and cognitive loss due to her subjective lay impressions of Ms. Rummage's "demeanor/presentation at the hearing" and lack of "review of the entirety of her deposition testimony" when: (a) the record contains no objections as to either the qualifications or foundations of the opinions expressed by these experts; (b) this finding constitutes the *sua sponte* creation of an "issue" which had never been raised by the respective parties, in violation of due process; (c) the hearing commissioner did not identify similar flaws in the opinions expressed by Defendants' designated evaluator (who likewise did not attend the hearing or reference review of the deposition transcript); (d) this finding is not only inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, but it is also the product of a personal, subjective lay assessment of medically technical conditions (mental illness and cognitive loss) reserved to expert opinion; (e) it constitutes a legally impermissible medical opinion; and (f) this finding is similarly reflective of an arbitrary, capricious and unlawful adjudication procedure?

51) Did the hearing commissioner err in characterizing the nature of Ms. Rummage's testimony as "prevarication" when: (a) this finding presumes equivocation stems from dishonesty, as opposed to mental illness or cognitive loss; (b) it is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record, particularly Ms. Rummage's repeated acknowledgements of preexisting physical and psychological symptoms through her hearing testimony; (c) this finding, which makes no mention of any expert opinion, stems from the personal, subjective lay assessment of two medically technical conditions, mental illness and cognitive loss; (d) this finding consequently constitutes a legally impermissible medical opinion; and (e) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

52) Did the hearing commissioner err in finding Ms. Rummage "is using the workers' compensation system for purposes of secondary gain" when: (a) this finding is inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) given the nature of the hearing commissioner's determinations, this finding likewise stems from her personal, subjective lay assessment in the context of conditions (mental illness and cognitive loss) which are medically technical in nature; and (c) this finding constitutes a legally impermissible medical opinion generated by the Commission; and (d) it is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

53) Did the hearing commissioner err in finding Ms. Rummage has sought "to require Defendants to subsidize her need to care for family members who rely upon her for

support, or because of a host of myriad and escalating problems unrelated to the accident on issue" when this finding: (a) is wholly inconsistent with the only reasonable inference which may be gleaned from the evidence contained in the hearing record; (b) the product of an unusual finesse of reasoning, as well as a personal, subjective lay assessment of medically technical conditions involving mental illness and cognitive loss; (c) necessarily constitutes a legally impermissible medical opinion of the Commission; and (d) is likewise reflective of an arbitrary, capricious and unlawful adjudication procedure?

54) Did the hearing commissioner err in failing to conclude Ms. Rummage's receipt of treatment for her aggravated psychiatric/psychological symptoms will tend to lessen her period of disability within the meaning of S.C Code Ann. Section 42-15-60 (2007), when the only reasonable inference which may be gleaned from the evidence contained in the hearing record warrants this conclusion?

55) Did the hearing commissioner err in concluding Ms. Rummage "has failed to prove an aggravation of her pre-existing psychological condition" per the provisions of S.C. Code Ann. Section 42-9-35 (2007) when consideration of the only reasonable inference arising from the evidence of record, in light of the provisions of this statute, establish she has satisfactorily proven her entitlement to rulings: (a) the consequences of her compensable accident have materially aggravated the preexisting psychiatric/psychological condition; and (b) she requires focused treatment of this condition per Section 42-15-60?

56) Did the hearing commissioner err in determining the crux of the parties' current dispute (causal relationship between Ms. Rummage's current psychiatric/psychological symptoms and the consequences of her compensable accident) based upon a personal, subjective lay assessment of Ms. Rummage's appearance/presentation/demeanor/body language when: (a) the focal issue involves mental illness and cognitive loss, which are each medically technical subjects; (b) an individual's presentation/appearance/demeanor/body language are unquestionably impacted by mental illness and cognitive loss; (c) the Legislature, as well as our Appellate Courts, have consequently required that determinations as to the source and consequences of these conditions in the current context must be premised upon expert opinion; (d) despite this fact, the hearing commissioner unquestionably determined this medically technical issue based upon personal, subjective lay criteria; (e) while there was reference to opinions expressed by Defendants' designated evaluator, these opinions were not followed/relied upon to reach a conclusion, but rather noted to "mirror the undersigned's" personal opinions; (f) this use of expert opinion runs completely counter to the legal standard, which demands that medical evidence guides the fact finder to a determination, rather than using the medical evidence to validate a personal/objective/lay assessment; (g) the fact finding mechanism utilized in this instance clearly began and ended with the formulation of an impermissible medical opinion by the Commission, as opposed to truly analyzing the expert evidence; and (h) this arbitrary, capricious and unlawful adjudication procedure resulted in a determination premised on personal/subjective/lay standards, rather than the requisite medical criteria?

57) Did the hearing commissioner err in determining the crux of the parties' current dispute (causal relationship between Ms. Rummage's current psychiatric/psychological symptoms and the consequences of her compensable accident) based upon a personal, subjective lay assessment of Ms. Rummage's appearance/presentation/demeanor/body language when: (a) the focal issue involves mental illness and cognitive loss, which are each medically technical subjects; (b) an individual's presentation/appearance/demeanor/body language are unquestionably impacted by mental illness and cognitive loss; (c) the Legislature, as well as our Appellate Courts, have consequently required that determinations as to the source and consequences of these conditions in the current context must be premised upon expert opinion; (d) the analysis/decision making process utilized by the hearing commissioner focuses on personal/subjective/lay standards of conduct, which neither comport with the applicable legal criteria nor adequately assess the impact of medically technical conditions (mental illness and cognitive loss) on Ms. Rummage's conduct; (e) this manner of assessment likewise lacks the objectivity which the governing medical standard (identified by both the Legislature and our Appellate Courts) is designed to promote; (f) this decision making process, which involves the impermissible generation of a medical opinion by the Commission, is unavoidably premised upon personal standards/views/feelings/ideologies, rather than the objective criteria required by the Legislature and our Appellate Courts; and (g) the ultimate determination Ms. Rummage's psychiatric/psychological symptoms are not causally related to the consequences of her compensable accident results from an arbitrary, capricious and unlawful adjudication procedure?

STATE OF SOUTH CAROLINA)

COUNTY OF FLORENCE)

Vickie Rummage,)

Employee,)

vs.)

BGF Industries, Inc.,)

Employer,)

and)

Great American Alliance Insurance Co.,)

Carrier.)

BEFORE THE
SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION.
W.C.C. FILE NUMBER: 1215681

**CLAIMANT'S MEMORANDUM
IN SUPPORT OF
APPLICATION FOR REVIEW**

STATEMENT OF THE CASE

This is an appeal from the March 14, 2017 Order of the Honorable Susan S. Barden, which: (a) found Claimant, Vickie Rummage, was "not remotely credible", notwithstanding confirmations from multiple examiners, **including her three year authorized treater**, as to the absence of malingering, symptom magnification, etc.; (b) focused on this perceived lack of credibility, while effectively **dismissing five contrary expert opinions** (offered by two forensic psychiatrists, a neuropsychologist and the **treating physiatrist, as well as and the primary care physician who actually provided pre-accident psychotropic medications and the only doctor familiar with both her preexisting and post-accident psychological conditions**) in determining Ms. Rummage had not proven the consequences of her admittedly compensable May 18, 2012 head and neck injuries "aggravated her pre-existing psychological condition; and (c) adopted the flawed conclusions of the **lone dissenting medical evaluator** (whose report

referenced an evaluation date four months prior to Ms. Rummage's actual assessment) because his "impressions of Claimant mirror[ed] . . ." her belief five seasoned professionals, including Defendants' designee, had been "fooled and manipulated by Claimant."

In this regard, Ms. Rummage respectfully submits: (a) the sole issue in dispute constitutes a subject that has been statutorily **reserved for medical experts** in this context; and (b) the opinions expressed by Drs. Donna Schwartz-Watts (Maddox), Tora L. Brawley, Amanda B. Salas and Fred D. McQueen (who was intimately aware of her pre and post-accident psychological state), coupled with the endorsement of these opinions by her **long time authorized treater** (Dr. Daniel L. Collins), **reliably establish a compensable aggravation in this instance**. Additionally, review of the Hearing Commissioner's highly structured findings, which have a figuratively disemboweling effect, reflect a ruling which: (a) was the product of non-medical factors (personal/lay observations), **as opposed to the legally mandated process of resolving a medically complex issue through weighing of the respective medical opinions, as well as promoting this Commission's consistent policy of affording deference to providers who had more than a cursory (one-time) exposure to the patient**; (b) wholly ignores Ms. Rummage's repeated/consistent acknowledgement, through hearing testimony, that the content of pre-injury medical records was accurate; (c) similarly overlooks material inconsistencies in the medical opinions of the lone dissenter, whose opinions were adopted solely because the other 5 experts' views were inconsistent with the fact finder's honest, yet undeniable, distaste for Ms. Rummage; and (d) is unquestionably motivated by the fact finder's personal/lay impressions, which, while sincerely developed, constitute the generation of a medical opinion in a situation that statutorily demands a different process.

FACTS

On May 18, 2012, Ms. Rummage sustained compensable injuries when she fell backwards, striking her head against a doffing machine with sufficient force to produce a laceration that was closed (through use of glue) on site. Although she continued to work following this trauma, Ms. Rummage developed symptoms involving her head, neck and upper back that prompted a May 30, 2012 referral to the company physician (Dr. John F. McLeod, III) who “suspected **some element of concussion.**” (See, Claimant’s APA Exhibit No. 10, p. 161). This physician similarly noted the presence of continued “ . . . [t]enderness over the posterior scalp with mild edema over the si[t]e . . . of previous laceration” in conjunction with continued headaches, which he **again characterized as the “suspected” residual “concussion,”** during a June 6, 2012 follow-up visit.

Inspection of notes generated during the ensuing weeks by **Dr. McQueen (her long time primary physician)** indicates: (a) his provision of Fioricet for “severe headaches **since the fall**”; (b) his **endorsement of a neurological assessment**, which was subsequently performed per Defendants’ authorization on September 5, 2012. (See, Claimant’s APA Exhibit 8, p. 138).

After examining her on that date, Dr. Jeff Benjamin, **an authorized neurologist** affiliated with Grand Strand Specialty Associates, advised examination revealed **“typical symptoms of closed-head injury.”** (See, Claimant’s APA Exhibit 9, p. 152). In fact this physician’s final (November 14, 2012) note **confirmed his belief her constellation of symptoms were reflective of “Traumatic Brain Injury”**. (See, Claimant’s APA Exhibit 9, p. 158).

Ms. Rummage was then directed by Defendants to Dr. Daniel L. Collins, a physiatrist, who likewise **identified post-concussive symptoms**, for which he recommended speech therapy.

(See, Claimant's APA Exhibit 1, pp. 2 and 4). During the early stages of his treatment, Dr. Collins was also informed of depressive symptoms, including the fact Ms. Rummage had used psychotropic medication "in the past" for pre-accident depression. (See, Claimant's APA Exhibit 1, p. 5).

In this connection, it is **undisputed Ms. Rummage had a long history of depression/anxiety**, for which: (a) she was prescribed several psychotropic medications by Dr. McQueen over an extended period of time; but (b) she never received either psychological/psychiatric assessment or treatment. Ms. Rummage likewise **does not contest** the fact she **did not recall all details** of her medication use while under Dr. McQueen's care during her December 9, 2013 deposition.

Given the nature/duration of Ms. Rummage's pre-injury use of psychotropic medication and the relevance of her prior medical history to any determination as to the source of her current depression, the undersigned sought input from Dr. McQueen the medical expert who obviously knew more about her pre-injury condition than any other. Pursuant to questionnaire responses dated March 13, 2014, this physician (whose treatment spanned approximately 14 years prior to the May 18, 2012 accident) confirmed; (a) "Ms. Rummage's **current headaches are most probably the product of a post-concussive syndrome**, as opposed to the tension headaches for which [he] provided treatment prior to the May 18, 2012 trauma"; (b) "the nature/intensity of Ms. Rummage's psychological disturbance have also increased in a manner consistent with post-concussive syndrome"; (c) "each of these components has been materially aggravated by the consequences of Ms. Rummage's May 18, 2012 work related fall"; and (d) the **treatment modalities** he had provided for the

“depression and headaches **prior** to her May 18, 2012 work related fall . . . allow[ed] Ms. Rummage to remain employed. . . .” (See, Claimant’s APA Exhibit 8, pp. 147-149).

As Dr. Collins had recommended not only psychological evaluation, but also neuropsychological testing, for which no authorization was tendered, the undersigned ultimately directed (May 15, 2014) Ms. Rummage to Dr. Brawley, a neuropsychologist, who: (a) noted the presence of psychological stressors that included not only the consequences of her compensable accident, **but also family issues** (e.g., “her son attempting suicide this past November”); (b) indicated Ms. Rummage acknowledged having “a prior history of depression”; (c) found she exhibited “**severely impaired** speed and accuracy . . . of attention and concentration”; (d) administered the “Test of Memory Malinger”, which “did not indicate malingering of cognitive symptoms”; (e) nonetheless believed “her psychiatric symptoms were significantly interfering with cognition and therefore invalidating the test results”, to the extent neuropsychological testing was discontinued; (f) **recommended psychiatric evaluation** in conjunction with counseling for these symptoms; and (g) concluded that “ . . . [w]hile Ms. 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 . . . [, while reiterating] . . . [f]ormal assessment of effort did not reveal attempts to malingering.” (See, Claimant’s APA Exhibit 3, pp. 97-98).

During the course of her November 10, 2015 deposition, Dr. Brawley, a **seasoned neuropsychologist who had served on the University of South Carolina School of Medicine’s faculty for many year**, verified: (a) “Mr. Safran . . . told me he wanted me to . . . see if she was legit . . . to make sure that . . . [Ms. Rummage] was legitimate with her complaints” (See, Dr. Brawley Deposition, pp. 5, 15 and 24); (b) her review of “a lot of . . .

medical records” indicating Ms. Rummage’s use of antidepressants for “quite a while” (referencing records from the 90’s) (See, Dr. Brawley Deposition, pp. 10-11 and 21); (c) acknowledged her awareness Ms. Rummage had encountered “lots of stressors . . . throughout her life” (See, Dr. Brawley Deposition, p. 10); (d) the Test of Memory Malinger was administered “to look and see if she was giving the effort because it was clear she just wasn’t - - her cognition was significantly slowed at that time and she was severely impaired on those couple of short tests that I gave her at the beginning” (See, Dr. Brawley Deposition, p. 14); (e) Ms. Rummage “passed the test of Memory Malinger . . . [.] a formal assessment that looks at effort” (See, Dr. Brawley Deposition, pp. 15 and 17); and (f) “ . . . [h]ad Ms. Rummage not passed the malinger test, . . . [she] would . . . have said so” (actually recalling a prior incidence where one of Mr. Safran’s clients “didn’t pass the malinger test” (See, Dr. Brawley Deposition, pp. 23 and 43).

Following her April 9, 2015 encounter with Dr. Thomas Gualtieri (Defendants evaluator), the undersigned directed Ms. Rummage for a forensic psychiatric evaluation (April 27, 2015) by Dr. Amanda B. Salas, who: (a) reviewed extensive records from several facilities, including McQueen Medical Center (See, Claimant’s APA Exhibit 2, p. 82); (b) recognized her prior history of depression; (c) noting these “. . . [m]edical records document history of treatment with” Prozac, Lexapro, Wellbutrin XL, Cymbalta, Elavil, Serzone, Desryl and Ambien (See, Claimants APA Exhibit 2, p. 84); (c) further referenced her prior use of anti-anxiety medications (Ativan and Xanax) (Id.); (d) identified the presence of various depressive symptoms, as well as clinical evidence of this condition (See, Claimant’s APA Exhibit 2, pp. 84-86); (e) “to a reasonable degree of medical certainty, . . . Ms. Rummage meets the diagnostic criteria for major depressive disorder” (See, Claimant’s APA Exhibit 2, p. 88); (f)

“ . . . [a]lthough 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” (Id.); (g) the current Major Depressive Disorder “is most likely related to her work injury” (Id.); (h) “Ms. Rummage is not at maximum medical improvement in regards to her mood symptoms and memory impairment” (See, Claimant’s Exhibit 2, p. 89); and (i) **treatment of this aggravated depressive condition was required.** (Id.)

Inspection of Dr. Salas’ report also identified various **flaws in Dr. Gualtieri’s methodology and conclusions**, to wit: (a) reference in the report to an evaluation date (December 11, 2014), which was four months prior to her actual visit in April, 2015; (b) test selection bias, noting his use of “the Pediatric Neurocognitive Test, test designed for a pediatric population,” rather than adults (See, Claimant’s APA Exhibit 2, p. 87); (c) his administration of/reliance upon “the Neuropsych Questionnaire (NPQ) . . . [,] **an internet-based computerized symptom checklist developed by Dr. Gualtieri himself** . . . [which b]y his own publication, . . . ‘**was not developed as a diagnostic test**’”; (d) conflicting descriptions of Ms. Rummage” (noted his report states “she appeared his/her stated age”; characterizing her as “**pleasant, well related, cooperative and compliant**”, while concluding, without explanation, she exhibited a “non-credible clinical presentation, with dramatic inconsistency”); (e) failure “to acknowledge or offer explanation as to **why he dismissed**” **psychomotor retardation, which “is typical of severe depression . . . from being a valid part of his assessment and interpretation**”; and (f) “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”, which conflicts with the assessments of multiple medical providers (Drs. McQueen, Benjamin and Collins) (See, Claimant’s APA Exhibit 2, pp. 87-88).

Dr. Brawley similarly questioned the propriety/reliability of Dr. Gualtieri's testing process and conclusions, explaining: (a) "... [i]t is unclear who administered and interpreted these tests. This should be done **only by a qualified psychologist, or by a trained psychometrician under the supervision of a qualified psychologist**" (recalling this physician's report simply bore his signature, while noting the participation of a physician's assistant); (b) "review of the raw data ... [raises] concerns about the accuracy of scoring and interpretation, (identifying, as an example, that the scoring and interpretation in connection with a test involving Ms. Rummage's copying of "complex figure **were both incorrect**"; "simply because someone cannot recall any details on a delayed recall does not render the test 'invalid'"; use of the "pediatric neurocognitive test" on a 55 year old is "curious"; (c) the inconsistency of his ignoring the fact Ms. Rummage's clinical presentation was consistent with Major Depressive Disorder, "the number one diagnostic consideration listed in the interpretive report ... [o]n the Personality Assessment Inventory administered by his office"; and (d) the arbitrariness of his acknowledging the "sedating" effects of Ms. Rummage's medications, yet ignoring their impact on her clinical presentation. (See, Claimant's APA Exhibit 3, p. 100).

Significantly, after being provided with copies of the various reports generated by Drs. G, Salas and Brawley, Dr. Collins, who evaluated Ms. Rummage on numerous occasions over a two year period, concluded: (a) Ms. Rummage had "never exhibited any evidence of malingering, symptom magnification or secondary gain"; (b) she "has consistently exhibited clinical evidence of depression and anxiety throughout [his] ... period of treatment"; (c) "Drs. Salas' and Brawley's observations/opinions/conclusions as to the legitimacy of Ms. Rummage's presentation, the source of her psychological/psychiatric symptom and current treatment needs are consistent with ... [his] own"; (d) "Ms.

Rummage's current psychological/psychiatric symptoms most probably result from the aggravation of her preexisting depression/anxiety by the consequences of her May 18, 2012 compensable accident; (e) she "requires treatment of the nature identified by Drs. Salas and Brawley"; (f) Ms. Rummage has not reached the point of maximum medical improvement "relative to her psychological/psychiatric injury components"; (g) "Drs. Salas' and Brawley's opinions as to Ms. Rummage's rather serious need for psychological/psychiatric care are consistent with [his] . . . repeated recommendations for authorization of this treatment"; and (h) her receipt of this psychological/psychiatric treatment is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by the consequences of her May 18, 2012 compensable accident, including the causally relates psychological/psychiatric injury component identified by these evaluators. . . ." (See, Claimant's Exhibit 1, pp. 79-81).

Ms. Rummage was also evaluated on two occasions by Dr. Donna Schwartz-Watts (Maddox), a forensic psychiatrist, who: (a) unquestionably reviewed medical records dating back to 1991 clearly noted her receipt of "extensive treatment with Dr. McQueen pre-injury" (See, Claimant's APA Exhibit 4, pp. 102-103); (b) certainly referenced the fact psychotropic medication was being provided by Dr. McQueen prior to the May 18, 2012 head injury (See, Claimant's APA Exhibit 4, p. 103); (c) referenced various symptoms that were consistent with depression, as well as the fact she was engaging in various strategies to assist her cognitive function" (identify "Luminous, crosswords and . . . Candy Crush") (See, Claimant's APA Exhibit 4, pp. 104) ; (d) "found no evidence that Ms. Rummage was exaggerating or feigning symptoms"; (e) concluded, to a reasonable degree of medical certainty, that Ms. Rummage "had a pre-existing history of depression which was

worsened by her work-related injury” (See, Claimant’s APA Exhibit 4, pp. 105); and (f) recommended psychiatric treatment (including medication management) in conjunction with psychotherapy for the “Major Depression resulting from the aggravating effects of her May 18, 2012 compensable accident.” (Id.).

After **reevaluating** Ms. Rummage in the fall of 2016, Drs. Salas and Schwartz-Watts (Maddox) conferred/reiterated Ms. Rummage had **not “exhibited any evidence of malingering, symptom magnification or secondary gain during [their] . . . evaluations”**; (b) “ continues to exhibit symptoms reflective of Major Depression and cognitive impairment”; (c) is experiencing **“major depression and cognitive impairment . . . [that] most probably result from the consequences (direct cause and/or aggravation) of her May 18, 2012 compensable accident”**; and (d) “requires treatment of nature identified in [their] respective reports” (See, Claimant’s APA Exhibit 2, pp. 94-96; Claimant’s Exhibit 4, pp. 110 – 111).

These forensic psychiatrists likewise agreed: (a) Ms. Rummage’s receipt of psychological/psychiatric treatment modalities of the nature they had recommended **“is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced the consequences of her May 18, 2012 compensable accident”** (b) their respective opinions were also consistent with Dr. Brawley’s observations/opinions/conclusions as **the legitimacy of Ms. Rummage’s presentation, the source of her psychological/psychiatric symptoms and cognitive impairments**, as well as her current treatment needs; and (c) the nature/degree of Ms. Rummage’s causally related Major Depression and cognitive impairment most probably prohibits her from currently engaging in/sustaining any form of work activities. (Id.).

Finally, inspection of the hearing transcript reveals Ms. Rummage: (a) **did not “deny . . . [having] struggled with depression” prior to May 18, 2012** (See, Hearing Transcript, p. 21); (b) **acknowledged not only receipt of medication for this condition through Dr. McQueen, but also the fact she continued to utilize these medications leading up to her May 18, 2012 accident** (See, Hearing Transcript, p. 22); (c) also identified headaches as a pre-accident symptom (See, Hearing Transcript, p. 26); (d) recalled the presence of nausea associated with her pre-injury headaches (See, Hearing Transcript, p. 28); (e) admitted her post-accident headaches were improved through Botox injection (See, Hearing Transcript, pp. 30-31); (f) **never attempted to hide her pre-injury depression or use of psychotropic medication from her medical examiners** (See, Hearing Transcript, pp. 39-40); (g) **clearly acknowledged the presence of “other stressors involving family members before this accident”** (See, Hearing Transcript, pp. 44-45); (h) agreed her use of psychotropic medication dated back to at least 2005 (See, Hearing Transcript, pp. 51-52); and (i) **repeatedly/consistently accepted, as fact, the content of prior medical records if/when she could not remember particular detail of her lengthy pre-injury medical history**. (See, Hearing Transcript, pp. 53 - 57, 70, 73 and 78).

In this regard, Defendants also sought to introduce a March 5, 2008 Order issued in connection with a prior workers' compensation claim for the purpose of impeachment. While the undersigned, relying upon the South Carolina Supreme Court's decision in Mizell v. Glover, 351 S.C. 392, 370 S.E. 2d 176 (2012), objected to inclusion of this document, the Hearing Commissioner overruled the objection, allowing entry of this extrinsic evidence into the hearing record.

LEGAL ANALYSIS

1. DENIAL OF TREATMENT FOR PSYCHIATRIC/PSYCHOLOGICAL INJURY COMPONENT IS ACTUALLY PREMISED UPON A LEGALLY INAPPROPRIATE LAY OPINION RELATIVE TO A PURELY MEDICAL ISSUE.

S.C. Code Ann. Section 42-9-35 (2015) requires the use of medical evidence to establish aggravation of a preexisting condition by a subsequent injury. In an effort to comply with this statutory requirement, Ms. Rummage submitted medical evidence containing confirmatory opinions as to the causal relationship of her current psychiatric/psychological distress to the aggravating effects of her May 18, 2012 compensable accident from **no less than four medical experts, as well as a seasoned neuropsychologist**. Significantly, these medical opinions were offered by not only two forensic psychiatrists, but also: (a) Dr. McQueen, who uniquely possessed a keen awareness of Ms. Rummage's extensive pre-accident treatment course; and (b) Dr. Collins, Defendants' designated physician, who personally assessed her on essentially a monthly basis for three years.

In response, Defendants a psychiatrist whose involvement was so desperately desired that they agreed to pay much of the cost incidental to any potential discovery. (See. February 22, 2016 Order of the Honorable T. Scott Beck). This expert ultimately produced a report which not only bears the indicia of a "canned" document, but also disturbingly appears to have been generated, to some extent, long before Ms. Rummage was actually evaluated.

Frankly, consideration of the discrepancies, peculiarities and inconsistencies of this dissenter's opinions would lead even a jaded mind to question their objectivity, legitimacy or reliability. When they are viewed in the context of the opinions expressed by Drs. Schwartz-Watts (Maddox), Salas and Brawley, one has even greater reason to take pause. Once the

corroborative determinations of Drs. Collins and McQueen, who possess the most extensive personal experience with Ms. Rummage and certainly have no dog in this fight, are added to the mix, reasonable minds feel compelled to question how the preponderance of evidence does not support the notion Ms. Rummage's preexisting psychiatric/psychological condition, though severe at times, was not aggravated in this instance.

The first step of this analysis obliges recognition that while being afforded broad discretion as the fact finder, “. . . [i]t is not the role of the Commission to render expert opinions.” Edmonds v. Fresenius Medical Care, 165 N.C. App. 811, 600 S.E. 2d 501, 506 (2004) (Steelman, J. dissenting, rev'd. *per curium* for reasons stated in dissent), 319 N.C. 313, 608 S.E. 2d 755 (2005); Nale v. Ethan Allen, 199 N.C. App. 511, 682 S.E. 2d 231, 237 (2009). (“It is not for the Commission to render its own expert medical opinion.”). Accord, Burnette v. City of Greenville, 401 S.C. 417, 737 S.E. 2d 200, 206 (Ct. App. 2012).

Given this prohibition, in light of the legislative mandate that the aggravation of any preexisting conditions be established “by a preponderance of the evidence, including medical evidence, . . . [which Section 42-9-35 defines as] “expert opinion or testimony stated to a reasonable degree of medical certainty”], this factual determination begins and ends with the expert opinion stated to this standard. However, inspection of the March 14, 2017 Order verifies precisely the opposite process, as: (a) the focus is clearly on validating the adverse credibility finding, which is the driving force behind the ultimate ruling; (b) while there are certainly discrepancies in the record, the findings also misconstrue portions of the evidence in a fashion which inaccurately states these experts were unaware of salient facts, despite contrary statements contained in their reports **(i.e., nature of pre-accident conditions and treatment that could certainly be identified through their acknowledged review of Dr. McQueen's records)**, for

the purpose of promoting the adverse credibility finding as the rationale for denial; (c) this effort to undermine the corroborative evidence stems from an obvious divergence between the medical experts' assessment of Ms. Rummage's psychological condition and the fact finder's personal impressions, rather than resolution of dispute among professionals; and (d) this fact is borne out by the fact finder's determination to "give great weight to the conclusion of Dr. C. Thomas Gualtieri . . . , whose impression of the Claimant mirror the undersigned's"

Further, a review of the hearing record reveals: (a) Ms. Rummage presented rather overwhelming medical evidence per Section 42-9-35 that convincingly establishes the consequences of her May 18, 2012 compensable accident aggravated her preexisting psychiatric/psychological condition; (b) notwithstanding her contrary finding, there is no competent evidence which supports the fact finder's determination Ms. Rummage did not meet her burden of proof per this statute; (c) the only reasonable inference which may be gleaned from the evidence contained in the hearing record establishes Ms. Rummage introduced conclusive proof of this compensable aggravation; and (d) the fact finder's conclusion 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.

Consequently, Ms. Rummage respectfully submits: (a) she is entitled to a finding that the consequences of her compensable accident aggravated preexisting psychiatric/psychological symptoms, to the extent they require treatment of the nature identified by Drs. Schwartz-Watts (Maddox), Salas and Collins; (b) there is no competent evidence of record which rebuts Ms. Rummage's entitlement to an award of this nature per Section 42-9-35; and (c) Defendants are obliged to authorize her receipt of this causally related psychiatric/psychological care.

**2. THE HEARING COMMISSIONER ERRED IN ADMITTING
COMMISSIONER LYNDON'S PRIOR ORDER INTO EVIDENCE.**

In Mizell, the Supreme Court held an individual's credibility could not be challenged/attacked through the introduction of extrinsic evidence, including judicial factual findings from a prior proceeding. In this regard, the Court recognized the "obvious prejudicial effect that credibility assessments of witnesses by judges have on subsequent" fact finders. Mizell, 570 S.E. 2d at 182. Recognizing this negative impact, the Court determined admission of extrinsic evidence for this purpose "constituted reversible error." (Id.).

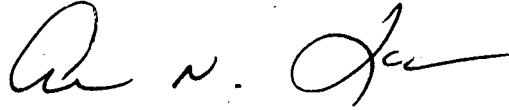
Although the hearing commissioner indicated she did not view Commissioner Lyndon's Order, a statement which the undersigned clearly does not question, she nonetheless: (a) heard argument from counsel as to admissibility; and (b) is more than sufficiently perceptive to recognize this extrinsic evidence was being introduced for the purpose of attacking Ms. Rummage's credibility.

While the undersigned acknowledges the current adverse credibility finding was substantially premised upon the hearing commissioner's personal/lay impressions: (a) it cannot be assumed commencing a hearing with a dispute over introduction of a prior Order had no impact on the tone of the proceeding; and (b) the bell cannot be "unrung". In view of this fact, introduction of this extrinsic evidence warrants reversal.

Accordingly, Ms. Rummage respectfully requests the Panel to: (a) vacate the March 14, 2017 Order; (b) enter findings that the only reasonable inference which may be gleaned from the medical evidence of record verifies she has fully satisfied the requirements of Section 42-9-35; (c) designate a treating psychiatrist per Section 42-15-60; and (d) require Defendants to accept

financial responsibility for the treatment plan outlined by Drs. Schwartz-Watts (Maddox) ,Salas and Collins.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "A. N. Safran", written over a horizontal line.

Andrew N. Safran, Esquire
Post Office Box 12089
Columbia, South Carolina 29211
Attorney for Employee/Claimant

June 15, 2017

STATE OF SOUTH CAROLINA)

COUNTY OF FLORENCE)

Vickie Rummage,)

Employee,)

vs.)

BGF Industries, Inc.,)

Employer,)

and)

Great American Alliance Insurance Co.,)

Carrier.)

BEFORE THE
SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NUMBER: 1215681

CERTIFICATE OF SERVICE

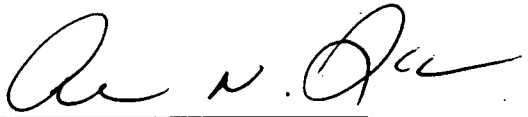
Andrew N. Safran, being first duly sworn, says that on the 15th day of June, 2017, he served the below-referenced documents in the following fashion:

Documents: Claimant's Memorandum in Support of Application for Review

To: **VIA E-CASE**
The Honorable Amy Bracy
Judicial Director
South Carolina Workers' Compensation Commission
1333 Main Street, Fifth Floor
Columbia, South Carolina 29201

VIA FIRST CLASS MAIL AND EMAIL
Michael A. Farry, Esquire
Horton, Drawdy, Ward, Mullinax & Farry, P.A.
307 Pettigru Street
Greenville, South Carolina 29601

This 15th day of June, 2017


Andrew N. Safran
Post Office Box 12089
Columbia, South Carolina 29211
(803) 256-6689

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

STATE OF SOUTH CAROLINA	)	
	)	
COUNTY OF FLORENCE	)	W.C.C. FILE NO.: 1215681
	)	
Vickie Rummage,	)	
	)	
Claimant/Appellant,	)	
	)	
v.	)	BRIEF OF RESPONDENTS
	)	
BFG Industries, Inc.,	)	
	)	
Employer,	)	
	)	
and	)	
	)	
Great American Alliance Insurance Co.,	)	
	)	
Carrier.	)	
_____	)	

STATEMENT OF THE CASE

Claimant, Vickie Rummage, has appealed the March 14, 2017 Decision and Order of Commissioner Susan S. Barden ("Decision and Order"). Claimant seeks additional treatment with a specialist for pre-existing psychological symptoms that Claimant claims were aggravated by the admitted accident. In the Decision and Order, Commissioner Barden held that Claimant had failed to prove a "compensable aggravation of her pre-existing psychological condition" and that Claimant was "not entitled to any workers' compensation benefits for any medical treatment for her psychological condition." Decision and Order, p. 27, ¶ 3. Because these findings and conclusions are supported by the reliable, probative, and substantial evidence in the record, the Decision and Order of the hearing commissioner should be affirmed in its entirety.

FACTUAL BACKGROUND

Claimant began working for Employer BFG Industries, Inc. in 2010. (Rummage Depo, p. 15). On May 18, 2012, Claimant was injured at work when she tripped and fell backwards onto the ground. (*Id.* at 22-23). She testified that she hit her head, had a cut on her scalp, and a lump on her neck. (*Id.* at 24). She did not visit the doctor that day, but she did get some first aid assistance and received some glue for the laceration on her head. (*Id.* at 24-25). Claimant finally sought medical treatment twelve days later when she saw Dr. John McLeod for intermittent headaches, neck pain, and back pain. (APA # 10, p. 161). She also continued working for another three months after the accident.

A. Claimant's Medical Issues Prior to the May 2012 Accident

Claimant had significant medical issues prior to the accident in 2012. She admitted that she had suffered from neck pain, low back pain, and depression as far back as 2005. (Tr., p. 51). She had been diagnosed with cervical disc disease in September 2005, and she had been on medication for pain and depression since at least 2005, including Lorcet, Xanax, Ambien, and Prozac. (Tr., pp. 51-52).

In 2008, Claimant was treated for major depression and chronic pain by Dr. Fred McQueen, her family doctor. (Tr., p. 55). In 2009, Claimant was treated with medication for chronic pain, chronic migraines, chronic anxiety, and depression. (Tr., p. 55). In 2010, Dr. McQueen stated that he "did not know how much longer [Claimant] could continue in the work field, because her body is breaking down." (Tr., p. 54). In January 2011, Claimant underwent a CT scan due to her dizziness and headaches, and her migraines were so severe that it affected her ability to go into work. (APA #14, p. 225). In May 2011, Claimant was still being treated for chronic pain via a prescription for Percocet. (Tr., p. 56). In September 2011, Claimant was being treated for chronic

pain and depression, and as of February 2012, was taking Percocet, MS Contin, Morphine Sulfate, and Xanax. (Tr., p. 58). At the hearing, Claimant claimed to not remember much of her medical history or the medication that she was prescribed. (Tr., p. 58).

B. Claimant's Medical Treatment after the May 2012 Accident

1. Claimant's Treatment by Dr. Daniel Collins

In December 2012, Claimant was referred to Dr. Daniel Collins by the workers' compensation insurance carrier. (Collins Dep., p. 6). Dr. Collins treated Claimant with trigger point injections, Botox, and medication, which Claimant alleged were helpful, particularly with her headaches (Tr., pp. 29-31). She stated that Dr. Collins prescribed antidepressants, pain medication, Lyrica, and Cymbalta to try to help with the pain. She also admitted that Dr. Collins prescribed Xanax and Fioricet for headaches, Effexor for anti-depression, and Amivert for dizziness. She stated these medications did help (Tr., p. 32).

However, Dr. Collins developed serious concerns about Claimant's credibility during the time he treated her. On one occasion, he discovered that Claimant had lied to him about whether she had ever taken Lyrica; she had, but she told Dr. Collins that she had not. (Collins Dep., p. 23). Additionally, Dr. Collins noted that Claimant failed to tell him that many of the physical problems she was complaining about to him had pre-existed her 2012 accident. (Collins Dep., p. 26). Claimant also failed to tell Dr. Collins that she had ever been treated by Dr. McQueen, nor did she tell Dr. Collins that she had been prescribed Lyrica, Flexeril, Percocet, Xanax, and Nuvigil as recently as four days prior to the 2012 accident. (Collins Dep., p. 30). Claimant also failed to tell Dr. Collins that she suffered from headaches, chronic pain, major depression, trouble sleeping, and degenerative disc disease prior to the 2012 accident. (Collins Dep., pp. 33-34). Dr. Collins himself admitted that it would be "impossible to tell . . . how much or how little the work injury from May

2012 played into symptoms that [Claimant] had, apparently, been experiencing for a few years" already. (Collins Dep., p. 35).

Claimant also failed to tell Dr. Collins that she had been prescribed a narcotic pain reliever by another doctor at the same time that Dr. Collins was prescribing her narcotics, which Dr. Collins noted was sufficient grounds to terminate her as a patient. (Collins Dep., pp. 41-42). Regarding Claimant's credibility, Dr. Collins noted that, "I have more than concerns about her honesty in the past, and there is always an issue now whether she is 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." (Collins Dep., p. 46).

Dr. Collins's concerns are reinforced by the fact that Claimant testified that she had not suffered from headaches, dizziness, neck problems, or depression (i.e., all of the symptoms noted repeatedly above) before her 2012 accident, a position that is demonstrably false. (Rummage Dep., p. 53).

2. Claimant's Examination by Dr. Thomas Gaultieri

In April 2015, Claimant saw Dr. Thomas Gaultieri, a psychiatrist, at Defendants' request. Dr. Gaultieri has been practicing medicine for nearly fifty years, and he has spent much of his career in the field of neuropsychiatry. He has published numerous peer-reviewed journal articles related to his field of expertise. (*See, generally*, APA #20). In 1988, Dr. Gaultieri founded NC Neuropsychiatry, which is where he first saw Claimant as a patient.

In addition to his personal observations of Claimant during their meeting and interview, Dr. Gaultieri also reviewed all of Claimant's medical records since the date of her accident in 2012. (APA #20, p. 266). Specifically, Dr. Gaultieri reviewed the records from the following medical providers: Dr. John Mcleod in 2012; Dr. Jeff Benjamin in 2012; and Dr. Daniel Collins in

2012 to 2014. Additionally, Dr. Gaultieri had the opportunity to review Dr. Salas's report critiquing Dr. Gaultieri's findings. (*Id.* at 274). Dr. Gaultieri also administered multiple neurological and cognitive tests on the Claimant during his examination.

Dr. Gaultieri reported that Claimant "demonstrated a non-credible clinical presentation, with dramatic inconsistencies," and he found "clear evidence of symptom exaggeration" by Claimant. (*Id.* at 265). He noted that Claimant's pre-accident symptoms were remarkably similar to those she claimed to suffer from after the accident. (*Id.* at 270). Dr. Gaultieri also recognized the inherent difficulties in evaluating Claimant's condition since the medical provider had to rely fully on Claimant's self-reporting, which is suspect "in cases where compensation is involved" (*Id.* at 272). In stark contrast to Claimant's deposition testimony and her testimony at the hearing, Claimant was suddenly able to recall a "detailed history of complicated medical problems and present them with lucidity," a task she was unable to replicate when questioned by an opposing attorney at her deposition and at the hearing in front of Commissioner Barden. (*Id.* at 274). Claimant's "overt memory performance, and indeed general appearance, fluency and lucidity [was] quite a variance with her claimed symptomology," Dr. Gaultieri noted. (*Id.* at 270).¹

Ultimately, Dr. Gaultieri concluded, based on his nearly fifty years of experience, his observations of Claimant, and his extensive and thorough review of Claimant's medical records, that there was "no reason to believe that her current problems are related to a head injury," such as the accident in May 2012. (*Id.*). He also concluded that Claimant had already reached maximum medical improvement. (*Id.* at 270).

¹ Claimant's attorney makes several references to what he terms Dr. Gaultieri's "canned report," which Claimant's attorney bases solely on a typo of the date on which Dr. Gaultieri examined Claimant. However, a simple review of Dr. Gaultieri's report reveals the extensive testing, interaction, and medical record review that Dr. Gaultieri undertook in reaching his conclusions.

3. Other Medical Evaluations of Claimant

In May 2014, Claimant hired Dr. Tora Brawley, Ph.D. to create a report based on an interview with Claimant. (APA # 3, p. 97-98). Claimant's attorney also later asked Dr. Brawley to refute Dr. Gaultieri's report, which Dr. Brawley dutifully did. (*Id.* at 99-101).

In April 2015, Claimant hired Dr. Amanda Salas of the Palmetto Center of Psychiatry for purposes of refuting Dr. Gaultieri's damning report. (APA #2, p. 82). Dr. Salas spent less time with Claimant than did Dr. Gaultieri (*id.*), yet she was unsurprisingly able to come to a conclusion in support of Claimant and in opposition to Dr. Gaultieri's conclusions. (*Id.* at 89). Dr. Salas, it should be noted, has less than a quarter of the years of experience in her field as does Dr. Gaultieri.

In 2014, Claimant hired Dr. Donna Schwartz-Watts (Maddox) to interview Claimant and provide another report in support of Claimant's case. Dr. Schwartz-Watts issued the report nearly two years later and concurred with Claimant's other hired doctors as to the validity of Claimant's conditions. (APA #4, p. 102).

ARGUMENT

I. Does Commissioner Barden, as the initial factfinding, have the authority to weigh the credibility of the Claimant and other expert witnesses, and to believe one expert witness over another?

Simply put, Commissioner Barden believed Dr. Gaultieri, an expert in the field of neuropsychiatry, over the testimony of other witnesses, including the Claimant. The Claimant pays lip service to Commissioner Barden's discretion as factfinder to determine the credibility of witnesses, but otherwise is simply incredulous that Commissioner Barden would fail to find for Claimant. Yet the legal standard is clear that Commissioner Barden does not have to accept the medical opinion of a claimant's expert simply because the Claimant presents such testimony at a hearing. If that were the standard, we would not need factfinders at all. The Court of Appeals

firmly states that, “[a]lthough medical evidence ‘is entitled to great respect,’ the Commission is not bound by the opinions of medical experts and may disregard medical evidence in favor of other competent evidence in the record.” *Burnette v. City of Greenville* 401 S.C. 417, 427–28, 737 S.E.2d 200, 206 (Ct. App. 2012), citing *Potter v. Spartanburg Sch. Dist. 7*, 395 S.C. 17, 23, 716 S.E.2d 123, 126 (Ct. App. 2011). “[T]he possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency’s finding from being supported by substantial evidence.” *Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm’n*, 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984). The ultimate question for this Commission is whether Commissioner Barden’s determination that Dr. Gaultieri’s expert opinion, along with the Claimant’s overall lack of credibility, provided “other competent evidence in the record” to support the hearing commissioner’s decision. We argue that it does.

Claimant’s alleged symptoms, because they are neurological in nature, are different from a broken arm or injured spine. The difference is that a broken arm can be objectively determined through an x-ray or visual observation. Claimant’s symptoms, such as feeling depressed or suffering from memory loss, are purely subjective and cannot be objectively observed by medical providers. The doctors that Claimant saw had to rely solely on the Claimant’s word that she was suffering from depression, or headaches, or memory loss, or sleep issues. Thus, Claimant’s case rises and falls on her credibility and honesty. Some of her doctors found her credible. Defendants’ doctor did not. And, most importantly, the hearing commissioner did not.

In fact, Commissioner Barden found that Claimant was “**not remotely credible**,” a conclusion that the hearing commissioner based on her observations of the Claimant at the final hearing, “the inconsistencies in her delivery of her testimony, her evasiveness, and on her very ‘selective’ memory at the hearing and at her deposition” Order, p. 13 (emphasis added).

Commissioner Barden determined that Claimant was “wily and manipulative,” a key determination by the factfinder that must guide this entire appeal. (Order, p. 14).

Although the Full Commission is the ultimate factfinder in workers’ compensation cases, “[i]t is logical for the [Appellate Panel], which [does] not have the benefit of observing the witnesses, to give weight to the Hearing Commissioner’s opinion.” *Fishburne v. ATI Sys. Int’l*, 384 S.C. 76, 90, 681 S.E.2d 595, 602 (Ct. App. 2009). It is “within the single commissioner’s discretion, and ultimately that of the Appellate Panel, to assess the witnesses’ credibility and weigh their testimony in reaching a decision.” *Brunson v. Am. Koyo Bearings*, 395 S.C. 450, 459, 718 S.E.2d 755, 760 (Ct. App. 2011). (“Because the single commissioner had the benefit of observing [the claimant] before reaching her decision, we cannot say the Appellate Panel and the circuit court erred in adopting the single commissioner’s finding on this issue.”). Moreover, unlike the blind adherence to expert witnesses that Claimant demands in her brief, “[t]he Appellate Panel is not bound by the opinion of medical experts” *Sanders v. MeadWestvaco Corp.*, 371 S.C. 284, 292, 638 S.E.2d 66, 70 (Ct. App. 2006). Of course, the question remains whether Commissioner Barden’s determination was based on “other competent evidence in the record.” *Burnette*, 401 S.C. at 427-28, 737 S.E.2d at 206.

Commissioner Barden did not pull her determination out of the ether. Instead, she based her conclusions on the following evidence, among other things:

- Claimant’s longstanding chronic depression and anxiety disorders, which predated her May 2012 accident (Order, p. 14, ¶ 8);
- Claimant’s selective memory when it came to her pre-accident symptoms and treatment, including medications she had been prescribed just a few days or months prior to the accident (*Id.* at pp. 15, 19, 21, 22, ¶¶ 8, 20, 22);

- Claimant's longstanding chronic migraines and sinus headaches, which predated her May 2012 accident (*Id.* at p. 16, ¶ 11);
- Claimant's longstanding sleep difficulties, which predated her May 2012 accident (*Id.* at p. 16, ¶ 14);
- The expert opinion of Dr. Gaultieri, as detailed *supra* (*Id.* at p. 18, ¶ 19);
- Claimant's longstanding situation stressors that caused her depression and anxiety for many years prior to the accident (*Id.* at p. 19-20, ¶ 21);
- Claimant's dishonesty with Dr. Collins in failing to inform him of her extensive pre-existing chronic pain, anxiety, depression, and trouble sleeping (and accompanying medication for treatment) (*Id.* at p. 22, ¶ 23); and
- Claimant's selective memory and selective disclosure of prior medical history with a series of doctors that she hired to evaluate her (*Id.* at p. 23-24, ¶¶ 24-27).

Again, as factfinder, Commissioner Barden had access to valuable information that the expert witnesses proffered by Claimant did not. Commissioner Barden was able to directly observe Claimant's demeanor when she testified, especially when Claimant was cross-examined about her pre-existing conditions. Commissioner Barden also had access to a transcript of Claimant's testimony at her deposition and could compare Claimant's responses at her deposition and the hearing to what Claimant told her various doctors in the years leading up to the final hearing. Based on this holistic view, Commissioner Barden made her conclusions.

In *Fishburne v. ATI System International*, 384 S.C. 76, 90, 681 S.E.2d 595, 602 (Ct. App. 2009), the court of appeals noted that "[t]he reliability of the documents and [the claimant's] statements were matters of credibility for the Appellate Panel, which, in upholding the Single Commissioner's order, discounted [claimant's] credibility because she exaggerated her

symptoms and made inconsistent statements at the hearing and to her treating physicians.”

Id. The claimant’s “inconsistent statements[] caused the Single Commissioner to question [the claimant’s] credibility. Therefore, substantial evidence supports the Appellate Panel’s decision that [the claimant’s] testimony was not credible.” *Id.* In this case, as has been discussed in detail above, Dr. Gaultieri found clear evidence of symptom exaggeration by Claimant, and the hearing commissioner, in her extensive and detailed findings of fact, described the multitude of inconsistent statements that Claimant made to her various doctors, as well as to the hearing commissioner herself. That, taken in hand with the hearing commissioner’s finding that Claimant lacked credibility in her presentation at the hearing, provides ample evidence that Claimant lacks credibility in key matters. And, since the nature of her alleged condition depends solely on self-reporting, Claimant’s lack of credibility casts a shadow over her entire case.

Commissioner Barden’s Order is predicated on a plethora of competent and substantial evidence to support the Order’s holding. The Order should be affirmed.

II. The prior workers’ comp Order was not admitted for that commissioner’s opinion of Claimant’s credibility, but rather was admitted to establish that Claimant’s testimony in the current case (that she had little recollection of her previous worker’s comp claim) was further evidence of her selective memory and lack of credibility.

Claimant argues that Commissioner Barden erred in admitting a prior hearing commissioner’s order into evidence, because Commissioner Lyndon had found Claimant to lack all credibility in that hearing as well. (Claimant’s Brief, p. 15). However, as a review of the hearing transcript reveals, Defendants’ counsel was not entering the prior order into evidence to show that Claimant had been deemed without credibility in the prior hearing. Rather, Defendants’ counsel was illustrating yet another example of Claimant’s convenient lapses in memory of events that happen to undermine her case, as well as Claimant’s well-established propensity for prevarication.

At her deposition in the present case, Claimant admitted that she'd had a prior workers' compensation case for an accident in 2007. (Claimant's Dep., p. 11). However, when asked in 2013 whether her prior case had gone to a hearing, Claimant said she didn't remember. (*Id.* at 12). Of course, her case *had* gone to a hearing, and Claimant had testified at that hearing extensively, as did many other witnesses. (APA # 23). When asked at her deposition in 2013 whether she'd ever had her deposition taken before, she denied it. (Claimant's Dep., p. 4). Of course, her deposition *had* been taken before and had been entered as an exhibit at her prior hearing. (APA # 23, p. 313). When asked at her deposition in 2013 whether she'd had an attorney for her 2007 claim, she affirmatively stated that she did not have a lawyer. (Claimant's Dep., p. 12). Of course, she *did* have a lawyer, Steven Haymond of Harris & Graves, for her 2007 claim, who represented her case at trial. (APA # 23, p. 312).

A review of the hearing transcript reveals that Defendants' counsel was clearly using the prior order for the sole purpose of impeaching Claimant's credibility on her answers to questions about whether she'd had a hearing on her prior case, whether she'd ever had her deposition taken before, and whether she'd had a lawyer in the previous case. (Tr. pp. 58-62). Defendants' counsel made no arguments that Commissioner Lyndon's determination of credibility in the prior hearing should be used as a basis for finding that Claimant was not credible in the present case. Rather, Defendants' counsel was able to demonstrate that Claimant could not be trusted to tell the truth on even simple matters, such as having a lawyer in a prior case. Ultimately, Commissioner Barden notes that she used Commissioner Lyndon's order simply to compare with Claimant's testimony at her deposition in the present case, and Commissioner Barden found that "Claimant's sworn deposition testimony—regarding her prior workers' compensation claim—is untrue and evasive." Order, p. 26.

Far from being reversible error, Claimant's argument on this point simply further proves Defendants' case: Claimant has a penchant for prevarication, which further shreds her credibility in this case.

CONCLUSION

Claimant's request for additional and continuing treatment for conditions that she had been treated for in the years prior to the 2012 accident should be denied. Claimant's own inability to offer any consistent testimony, whether at her deposition, the hearing, or to any of her multiple doctors over the years, provides substantial competent evidence to support Commissioner Barden's Order denying Claimant's request for continuing treatment. Additionally, Dr. Gaultieri's testimony and report provide additional substantial evidence to support Commissioner Barden's Order. Commissioner Barden, as factfinder, concluded that she believed Dr. Gaultieri over the Claimant and Claimant's expert witnesses, which is the prime function and privilege of a factfinder. Commissioner Barden's finding that Claimant had failed to prove aggravation of her prior medical issues also finds support in Dr. Gaultieri's report and other medical evidence in the record. Therefore, because Commissioner Barden's findings are supported by reliable, probative, and substantial evidence on the record, her Order should be affirmed.

Respectfully submitted,



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Attorneys for Defendants/Respondents

July 12, 2017

Vickie Rummage, Employee,

Claimant/Appellant,

v.

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

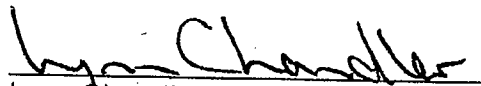
Defendants/Respondents.

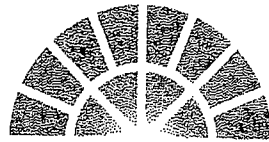
W.C.C. FILE NO.: 1215681

CERTIFICATE OF SERVICE

I, Lynn Chandler, an employee with the firm of Horton Law Firm, P.A., do hereby certify that on July 12, 2017, I served Brief of Defendants/Respondents on the following person(s) via email addressed as follows:

Andrew N. Safran: msa6631@aol.com


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July 12, 2017

VIA ECASE

Ms. Amy Bracy
Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

Re: Vickie Rummage v. BGF Industries, Inc.
W.C.C. File No.: 1215681

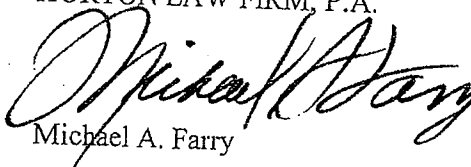
Dear Ms. Bracy:

Enclosed you will find Brief of Defendants/Respondents regarding the above-captioned claim. By copy of this letter via email to Claimant's attorney, Andrew Safran, we are forwarding a copy of Brief of Defendants/Respondents to him.

With kind regards, we remain,

Yours very truly,

HORTON LAW FIRM, P.A.


Michael A. Farry

MAF/lc
Enclosure

cc: Andrew N. Safran (with enclosure)
Strategic Comp Services, 564584091 (with enclosure)

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1215681

Vickie Rummage,)
)
Claimant,)
)
v.)
)
BGF Industries,)
)
Employer,)
)
and)
)
Great American Alliance,)
)
Carrier/Defendants.)
)
-----)

COPY

FULL COMMISSION HEARING

Monday, September 18, 2017
2:06 p.m. - 2:31 p.m.

The Full Commission Hearing was heard before Commissioners Gene McCaskill, Mike Campbell and Avery Wilkerson at the Workers' Compensation Commission, 1333 Main Street, Suite 500,, Columbia, South Carolina, on the 18th day of September, 2017, before Amanda Creel Godfrey, Court Reporter and Notary Public in and for the State of South Carolina.



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P120

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Also Present:

Patricia Kline, Strategic Comp
Jennifer Proctor, Strategic Comp
Tina Reiff, Strategic Comp

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EXHIBITS

(There were no exhibits marked during the hearing.)

STIPULATIONS

It is stipulated and agreed that this deposition is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.



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1 COMMISSIONER McCASKILL: All right, Madam Court
2 Reporter, please call the case.

3 CALL TO ORDER:

4 COURT REPORTER: Today is September the 18th, 2017.

5 This is South Carolina Workers' Compensation
6 Case Number 1215681. This is the case of
7 Vickie Rummage, Claimant versus BGF Industries,
8 Employer, and Great American Alliance, Carrier.
9 The Appellant is the Claimant, represented by
10 Andy Safran, and the Respondent is represented
11 by Michael Farry. Each side is allowed ten
12 minutes for oral argument and the Appellant
13 three minutes in reply. You are requested to
14 argue the grounds of exception and stay within
15 the record.

16 COMMISSIONER McCASKILL: All right, thank you, ma'am.
17 Mr. Safran?

18 ARGUMENT BY MR. SAFRAN:

19 MR. SAFRAN: Yes, if Your Honors, please. I see
20 you're all looking at the computers and, you
21 know, I took the liberty of paper primarily
22 because the record is pretty thick. And
23 because I'm trying to make this what I think it
24 really is, which is a pretty straight forward
25 question, handing you these things, I think



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1 will kind of guide you to exactly where I'm
2 coming from; what did we all agree to. This
3 accident occurred, included a head injury.
4 This lady had an extensive history of pre-
5 injury receipt of medications for depressive
6 symptoms. She complained of depression prior
7 to this. And I'm not talking about a month,
8 I'm talking about years, maybe a decade. So,
9 there's no dispute about that. What do we end
10 up having? Well, we ultimately have her going
11 to receive treatment from several doctors who
12 early on -- these are all authorized doctors
13 who used the word post concussive syndrome,
14 traumatic brain injury. She eventually gets to
15 a physiatrist, Dr. Collins, who follows her for
16 roughly four years. What does Dr. Collins --
17 kind of the same thing. He starts requesting
18 a psychological eval, not authorized. He
19 ultimately gets to a point of doing a --
20 wanting a neuropsychological eval, not
21 authorized. So, you know me well enough, I
22 ultimately said fine. Now, let me take a step
23 back here. This lady was deposed by prior
24 counsel. And to be honest with you, I had
25 grave concerns after reading that deposition



1 and looking at some of the prior medical
2 records. As I said, there's some
3 inconsistencies here. So, what do you do?
4 Personally I decided I wanted to know whether
5 or not this case warrants the time that I'm
6 gonna put into it going forward. So what I did
7 was, 'cause it wasn't authorized, I sent her to
8 Dr. Brawley. I don't know how many of you are
9 familiar with Dr. Brawley, but at the time I
10 think she was affiliated with the medical
11 school, or shortly after, as a
12 neuropsychologist, been doing it for 30 years.
13 If you look at the highlighted portion of her
14 deposition, what did counsel ask her? Not Mr.
15 Farry, prior counsel. What did Mr. Safran ask
16 you about when you saw this lady? He wanted to
17 know whether she was legit, whether she was
18 malingering or not. He wanted to know if what
19 she was presenting was something that was
20 valid, up front, no question about it. And
21 what you'll also find in those highlighted
22 portions is that I wanted somebody who also did
23 a bunch of defense work. And then she said in
24 there, I do probably 65, 70 percent for the
25 defense side. And at the time McAngus was



1 involved and I do them for their office, and
2 done at least as many as I have for you. So I
3 wanted to know, is this lady telling something
4 straight in terms of her symptoms. She
5 administered something that she's explained,
6 it's call the TOMM, Test of Memory Malinger.ing.
7 The lady passed it. However, she said she's
8 too emotionally distraught to be able to go any
9 further with neuropsych testing. So guess
10 where we were? They're treating her physical
11 symptoms and ultimately we need an answer. You
12 know where this case is going, nobody -- it's
13 no secret. Does she ultimately have something
14 that would be a compensable brain injury or
15 not? In order to get there we have to have the
16 test results. In order to get there, you have
17 to get the psych under control. Your Honors,
18 because she had treated for so long with a
19 particular doctor who had given her these
20 different psychotropics, I went to him. And I
21 said, is there any difference in what's going
22 on now, post head injury, to what was going on
23 before. The answer was yes. You've got a
24 questionnaire in front of you that says, most
25 probably to a reasonable degree of medical



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1. certainty, there was an aggravation.
2. Basically, in response to what I had at the
3. time, they chose to send her to this doctor in
4. Charlotte who frankly, you know, I've never had
5. much use for. And what was really telling is
6. when we went in front of Dr. -- or Commissioner
7. Beck on this thing, I pointed out that I'm
8. going into North Carolina and this guy's got a
9. fee scale that basically he charges almost a
10. thousand dollars an hour for deposition. He
11. charges five or 600 dollars an hour for record
12. review, none of which complies with here. Now
13. what happens? Somebody jumps up and waives
14. their hands and says, we'll pay for it. Now,
15. think about that. They want to pay extra for
16. me to do the discovery. They want to pay for
17. me to take the deposition. So, obviously, I
18. didn't fall off the turnip truck yesterday, I'm
19. starting to obviously think maybe my
20. preconceptions are pretty valid. Well, I won't
21. digress any further than to say, they got what
22. they paid for. In fact, he said exactly what
23. they wanted five months before he ever saw her
24. because if you look at the report, he's dating
25. the report in December of '14, he don't see her

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1 until April of '15. And I know my friend here
2 had gone to great pains to even, you know,
3 wanted to put it in the Order that this was
4 just a typo. I couldn't conceded that, and
5 I'll tell you why. He went back and got
6 another letter from him that's in the record
7 from 2016. To look at the letter, quote, he
8 says, there's nothing that I've seen that
9 changes the opinions I expressed on December
10 11, '14, five months before he ever saw her.
11 It had every indication of a can report. But
12 here's the bigger question; before we get into
13 the evidence, I don't think, you know, in terms
14 of what was in it is as important as what was
15 not. If you read that statute, I've handed it
16 up, the medical evidence is necessitated by
17 aggravation of conditions statute, 42-9-35. It
18 says that you will prove by a preponderance of
19 the evidence, including medical evidence of the
20 aggravation. If you read Michau, which I've
21 also handed you, they took the same language in
22 the repetitive trauma statute and said, if
23 you're gonna send somebody as a defendant to
24 the other doctor to get an opinion and rebut
25 what's here, you've got the same standard. I

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1 have read Dr. Gualtieri's reports multiple
2 times. There ain't no to a reasonable degree
3 of medical certainty contained in either one of
4 them. How is that important? I think it's
5 fatal in the sense that it's not competent
6 evidence which we've said throughout. My
7 appeal said there's no competent evidence to
8 support this decision. And, Your Honors,
9 here's the thing, I would be a fool if I sat
10 here and tried to tell you that this Order did
11 not absolutely disembowel my client in terms of
12 the issue of credibility. It was pretty
13 brutal. And do I think that the opinions that
14 were expressed by the single Commissioner are
15 honestly their own, absolutely. I'm not
16 questioning that. I don't doubt that they're
17 motivated by what they felt was the right
18 intention and the right determination.
19 However, in these cases, legislature has said
20 they are medically driven, they require medical
21 evidence both for and against if you meet your
22 burden. I've handed you, in addition to what
23 Dr. McQueen, the guy who saw her both before
24 and after said, I've handed you Dr. Salas,
25 forensic psychiatrist; Dr. Watts Maddox,

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1 forensic psychiatrist. Dr. Collins who saw her
2 for four years, and I gave him Gualtieri's
3 report too, said you pick, you tell me which
4 one is more in line with what you have come to
5 determine. He went with them and said, no,
6 there's an aggravation and she's been credible.
7 Everyone of them was asked if she evidence
8 anything, malingering, symptom magnification,
9 no. So where are we? Well, she screwed up in
10 her first deposition, no doubt about it. My
11 question is, are you damned from that point on
12 or do you get some opportunity to have, you
13 know, a little bit of repentance. Well, she
14 certainly repented enough to Dr. Collins to
15 where he went from in a deposition that prior
16 counsel took where he said I'm questioning her
17 and I may not keep her as a patient, to where
18 he ultimately became her biggest advocate and
19 ultimately said, this lady's got legitimate
20 symptoms, she's got an aggravation. I agree
21 with these people who say the aggravation
22 occurred because of this. So here we are,
23 three medical doctors of specialty have all
24 said exactly what the statute demands. Dr.
25 McQueen is still a medical doctor and his



1 unique aspect in this case is, he was the one
2 seeing her for 10 years before. He's the only
3 one that's gotta before and after picture
4 because he actually treated her as an
5 authorized doctor for a brief period after this
6 accident happened. He said, aggravation. So,
7 you know, what's the point. If I'm going to go
8 to the trouble as I think I'm legally,
9 ethically obliged to do, to see if I can show
10 to myself that this is somebody who is being
11 honest at least in terms of what the medical
12 aspect is, and then I get that. And then I get
13 multiple doctors to validate it. So where am
14 I supposed to go. I mean, candidly, I think
15 from a purely legal standpoint you can't
16 support the determination in the context of
17 this medical statute when you don't have
18 medical that meets the requirements of the
19 statute. And as I said, Michau says, it's
20 gotta say to a reasonable degree of medical
21 certainty. It doesn't. My opinion, I believe,
22 is this. If you have a medical question that
23 is supposed to be ultimately dispositive to
24 some degree by what the medical shows, and you
25 as a Commissioner certainly have a right to



1 waive the medical, I don't question that. But
2 I don't think you can basically give an opinion
3 that effectively supercedes it. So what's
4 happened here is this, I have, as I say,
5 somebody who honestly did not like this client,
6 absolutely called them every name in the book.
7 I mean, it was as I said, it was brutal. But,
8 the point being is this -- I'd like to finish
9 the thought if I could?

10 **COMMISSIONER McCASKILL:** Okay.

11 **MR. SAFRAN:** Is that despite those statements,
12 you're supposed to go where the medical leads
13 you to reach an outcome. Here there was
14 already determination that this lady was not
15 credible and credibility was effectively
16 substituted for the medical evidence that the
17 statute demands. I'll pick that up on the
18 reply. Thank you.

19 **COMMISSIONER McCASKILL:** Thank you, sir. Mr. Farry?

20 **ARGUMENT BY MR. FARRY:**

21 **MR. FARRY:** May it please this Commission. The sole
22 issue on appeal before this appellate panel is,
23 does the record contain competent substantial
24 evidence to support a determination by the
25 hearing Commissioner that there was no



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1 aggravation of a preexisting condition. Now,
2 what do we know? May 18, 2012 the claimant has
3 a compensable accident. She tripped over a
4 car, fell backwards onto the ground, she struck
5 her head, cut her scalp and had a lump on her
6 neck. Required no medical treatment. They did
7 administer first aid, closed the wound on her
8 scalp. Twelve days later is the first time she
9 seeks any medical treatment and that's
10 treatment for intermittent headaches, neck pain
11 and back pain. Importantly, this claimant
12 worked three months from the date of the
13 accident without any compensable lost time at
14 her job. Now, what do we know about the
15 medical is -- issues prior to the date of the
16 accident that are in the hundreds of pages of
17 medical submitted as a part of the APA, many of
18 which never got to some of these opinion
19 doctors until after the fact. We've got neck
20 pain, back pain and depression as far back as
21 2005. Cervical disc disease in 2005.
22 Medication for pain and depression at least
23 since 2005. She takes Lorcet, Xanax, Ambien
24 and Prozac since at least 2005. She was
25 treated for major depression, chronic pain by

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1 Dr. McQueen, her family doctor. Treated for
2 chronic migraines, chronic anxiety, depression
3 and psychotropic medication for that. Dr.
4 McQueen stated in 2010, this is her doctor, did
5 not know how much longer the claimant could
6 work, excuse me, because, quote, her body is
7 breaking down. Claimant underwent a CT scan
8 due to her dizziness and headaches and migraine
9 that were so painful it was preventing her from
10 being able to work regularly at that time.
11 This is in 2011. Now, that's important because
12 claimant denied any prior dizziness or
13 migraines or headaches of this seriousness.
14 February 12, claimant was taking Percocet, MS
15 Contin, morphine sulfate and Xanax. This is
16 prior to the date of the accident. Now, you've
17 heard about Dr. Cox who treated the claimant
18 for a number of years following the accident
19 and then left the practice, I'm not sure why or
20 where he went, but he was no longer available
21 to treat the claimant. He learned that
22 claimant had lied to him about whether or not
23 she had taken Lyrica in the past. Claimant
24 failed to tell the doctor, Collins, about many
25 of the problems she was complaining of that

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1 preexisted her accident of May 18, 2012, same
2 problems she was complaining of post-accident;
3 did not tell Dr. Collins she had been treated
4 by Dr. McQueen; did not tell Dr. Collins that
5 she had been prescribed Lyrica, Flexeril,
6 Percocet, Xanax as recently as four days prior
7 to the date of the accident. And these are for
8 conditions for which she's claiming now are
9 caused by the accident, or aggravated by the
10 accident. Dr. Collins admitted that it's
11 impossible to tell how much or how little the
12 work injury of May 18, 2012 played into
13 symptoms that Claimant had been experiencing
14 for years. Claimant failed to tell Dr. Collins
15 she was taking pain relievers prescribed by
16 another doctor at the same time Dr. Collins was
17 prescribing narcotics, and he noted that was
18 sufficient grounds to terminate her as a
19 patient. I will quote now from Dr. Collins'
20 deposition. I have more than concerns about
21 her honesty in the past and there is always an
22 issue now whether she is being honest with me.
23 She's definitely not been honest in the past.
24 So I would say a lack of honesty in the past
25 makes me worrisome about a lack of honesty at



1 present. You've heard mention of Dr. Gualtieri
2 in North Carolina, a neuropsychiatrist with
3 almost 50 years of experience. He reviewed
4 claimant's entire medical history, including
5 medical history that Dr. Collins was not aware
6 of when he began treating post-accident. He
7 met with the claimant and interviewed the
8 claimant. He administered multiple
9 neurological and cognitive tests during the
10 exam. His conclusions, claimant demonstrated a
11 non-credible clinical presentation, dramatic
12 inconsistencies, clear evidence of symptom
13 exaggeration, pre-accident symptoms were
14 remarkably similar to those she claimed to
15 suffer after the accident and noted that the
16 medical providers and evaluators had to rely on
17 claimant's self-reporting. So that's important
18 because these experts that were hired by the
19 claimant's counsel to render an opinion to
20 rebut Dr. Gualtieri's opinion had to rely on
21 what claimant told them. Some of them were
22 provided additional medical records after
23 claimant's deposition, but they had to rely
24 upon what the claimant was telling them. Dr.
25 Gualtieri noted in his report, Claimant's overt



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1 memory performances and indeed general
2 appearance, fluency and lucidity was quite a
3 variance from her claimed symptomatology. Dr.
4 Gualtieri concluded based upon almost 50 years
5 of experience, his observations of the
6 claimant, his extensive and thorough review of
7 the claimant's medical records and the
8 diagnostic testing that he administered, that
9 there's no reason to believe the claimant's
10 current problems are related to a head injury
11 such as an accident in May of 2012. Remember,
12 this is the claimant that worked three months
13 without any lost time after the accident.

14 **COMMISSIONER McCASKILL:** Does Dr. Gualtieri opine to
15 a reasonable degree of medical certainty?

16 **MR. FARRY:** I don't believe he actually used those -
17 - that terminology in there, but I would submit
18 even without Dr. Gualtieri's opinion stating
19 specifically a reasonable degree of medical
20 certainty the record is complete with
21 substantial evidence to support this single
22 Commissioner's decision. And I say that based
23 upon the fact that the hearing Commissioner had
24 the opportunity to observe this claimant
25 testify; had the opportunity to observe her



1 demeanor; had the opportunity, unlike Dr.
2 Gualtieri or the experts that were hired by
3 claimant's attorney, to make opinions to review
4 the claimant's deposition testimony and compare
5 that to her testimony at the hearing, to note
6 the myriad of inconsistencies and lack of
7 credibility. That alone I think is sufficient
8 to support the decision by the single
9 Commissioner that there was no aggravation of
10 a preexisting condition, it was simply the same
11 condition for which claimant had been treated
12 for years and years and years with psychotropic
13 medication as recently as a weeks prior to the
14 accident that she sustained that rendered her
15 able to continue working for another three
16 months. The hearing Commissioner did find that
17 claimant's not remotely credible. And she
18 relied upon her observations, the inconsistency
19 in her delivery of testimony, her evasiveness,
20 her very selective memory at the hearing, and
21 in her deposition testimony. And she
22 determined that the claimant was simply not
23 credible in her testimony and in her
24 presentation. In reaching that opinion, I
25 would note, and now referring to the single

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1 Commissioner's specific findings and reason for
2 her conclusions, claimant has a long standing
3 chronic depression/anxiety disorder which
4 predated her May 2012 accident. Selective
5 memory when it came to pre-accident symptoms
6 and treatment, including medications she had
7 been prescribed just a few days or months prior
8 to the accident. Claimant's longstanding
9 chronic migraines and sinus headaches which
10 predated her May 2012 accident. Longstanding
11 sleep difficulties which predated her May 12
12 accident. And the expert opinion of Dr.
13 Gualtieri has described claimant's longstanding
14 situational stressors caused her depression and
15 anxiety for many years prior to the accident.
16 Her dishonesty with Dr. Collins in failing to
17 inform him of extensive preexisting chronic
18 pain. Her anxiety, her depression, trouble
19 sleep, and the accompanying medications that
20 she professed she was not taking or had not
21 taken. And her selective memory and selective
22 disorder of prior medical history with a series
23 of doctors she hired to evaluate her. Again,
24 Commissioner Barden was the fact finder in this
25 case. It was her charge to make a decision



1 based upon the evidence presented. We all know
2 the cases, if the Commission can consider some
3 of the evidence, all of the evidence, weigh the
4 evidence, part of one witness, none of the
5 other, and you're not blindly compelled to
6 accept the opinions of any of the experts.
7 Another issue on appeal that counsel didn't
8 mention was the fact that an order was admitted
9 into evidence from a 2007 claim by a prior
10 Commissioner that denied claimant's 2007
11 accident claim, the Order was issued in 2008.
12 It was submitted not for the purpose of
13 specific findings of fact in the Order, one of
14 which being that the complaint was found not to
15 be credible in that case, but the fact that
16 claimant denied at the hearing and denied in
17 the deposition that she had been deposed
18 before. She denied that she had a lawyer at a
19 prior hearing, and she denied that the
20 medication she was taking was for the same
21 condition. The purpose of that admission was
22 simply to establish the claimant's credibility,
23 not any specific findings of fact as to
24 credibility.

25 COMMISSIONER McCASKILL: All right. Thank you, sir.



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1 MR. FARRY: Thank you..

2 COMMISSIONER McCASKILL: All right, Mr. Safran.

3 REPLY BY MR. SAFRAN:

4 MR. SAFRAN: If Your Honors please, let me just do a
5 couple of quick things. I want to dispel any
6 notion that these folks, Dr. Watts, Dr. Salas,
7 didn't have these records from way back when.
8 If you look at Dr. Watt's report, it actually
9 goes into detain listing records that she had
10 from Dr. McQueen all the way back to 1991. So
11 the notion as counsel has, I think, mistakenly
12 suggested and that the hearing Commissioner
13 apparently expressed that somehow these folks
14 were in the blind or duked is just wrong. Dr.
15 Salas, likewise, in her report references
16 having read all of those records from Dr.
17 McQueen. Your Honors, basically I agree that
18 this is a single issue. The issue is whether
19 there's an aggravation. The statute, which
20 I've handed up is crystal clear. It says,
21 including medical evidence, and it defines
22 medical evidence as to a reasonable degree of
23 medical certainty. And as my friend candidly
24 said, it's not in that report. This is not a
25 case basically that we go under, you know, the



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1 old law that basically says you can just pull
2 it out of the air, it doesn't matter what's in
3 the record medically. '07 was specifically
4 changed in order to make these cases ones that
5 have to rest on medical evidence and Michau
6 says it has to go both ways. That's why, in
7 and of itself, that's fatal in this situation.
8 The hearing Commissioner in this statutory
9 context is not at liberty in a medically
10 mandated case to say, I'm just gonna say
11 they're not credible. And let's be honest,
12 that's what it was because if you read the
13 Order, what it says is, bam, bam, bam, bam,
14 bam. I mean, like I said, whipped 'em. And
15 then, by the way, because Dr. Gualtieri agrees
16 with me, I'm gonna go with him. It wasn't a
17 matter of I believe Gualtieri and this is where
18 he took me. This is, this is where I'm at and
19 he agrees with it so he's gonna become the
20 basis medically of my Order. You can't do it
21 backwards and that's ultimately what happened
22 here. The evidence has to take you to a
23 conclusion. And what we have here is, we have
24 an absolutely battering credibility. And think
25 about this, that deposition was -- this was a

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1 hearing at the end of '16, that deposition was
2 done, I believe, three years prior. The
3 deposition he's alluding to from Dr. Collins,
4 same thing. So, yeah, in the early stages,
5 there were some real doubts in this thing, but
6 ultimately, as I've handed up to you, Dr.
7 Collins is checking this stuff off, some of
8 them with multiple checks indicating that this
9 is an aggravation. I believe her. I don't
10 have any issue that this is related. He's the
11 guy that frankly did a complete about-face from
12 what that deposition said to where he was
13 giving her medications, as these records show,
14 he was her biggest advocate and supporter.
15 Why? Because I think she earned that from him.
16 Your Honors, basically we're looking at a
17 situation where they simply did not put in
18 evidence that's going to comply with what the
19 statute says. And I think again, credibility,
20 and I'm not in any way, shape or form doubting
21 the, you know, the honesty of the findings
22 based from the perspective of one person who
23 heard it. On the other hand, you cannot
24 substitute credibility when the legislature has
25 said, you've gotta have medical to do it. And



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1 I appreciate it. I think this has to be
2 reversed based on that because it does not meet
3 the statutory requirement.

4 COMMISSIONER McCASKILL: All right. Thank you both.

5 COMMISSIONER CAMPBELL: Thank y'all.

6 COMMISSIONER McCASKILL: Good to see y'all.

7 (There being nothing further, the full commission
8 hearing concluded at 2:31 p.m.)
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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1215681

EMPLOYEE/CLAIMANT: VICKIE RUMMAGE
EMPLOYER: B.G.F. INDUSTRIES
INSURER: GREAT AMERICAN ALLIANCE INSURANCE
COMPANY

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

PURSUANT TO NOTICE OF WORKERS' COMPENSATION HEARING, THE
WITHIN HEARING WAS TAKEN ON THE 7TH DAY OF NOVEMBER, 2016,
COMMENCING AT THE HOUR OF 2:29 P.M., IN HARTSVILLE, SOUTH
CAROLINA, BEFORE THE HONORABLE SUSAN S. BARDEN, ATTENDED BY
COUNSEL AS FOLLOWS:

SALLYE DEANNE NELSON
VERBATIM REPORTER

JAN L. WHITWORTH
COURT REPORTING SERVICES
POST OFFICE BOX 551
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ATTENDING:

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LEROY RUMMAGE
VICKIE RUMMAGE

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BY COMMISSIONER BARDEN:

(OFF THE RECORD)

WE'RE BACK ON THE RECORD, AND AS FAR AS AVERAGE WEEKLY WAGE AND COMPENSATION RATE, CURRENTLY THE

1 CLAIMANT'S -- THOSE FIGURES HAVE BEEN STATED ON THE
2 FORM 20 AS 578.23 AND 385.51 RESPECTIVELY FOR
3 AVERAGE WEEKLY WAGE AND COMPENSATION RATE. SHE, THE
4 CLAIMANT THAT IS, IS GOING TO BE CONTINUED TO BE
5 PAID AT THE 385.51, BUT THE ATTORNEYS ARE GOING TO
6 GET TOGETHER TO DETERMINE WHETHER OR NOT THAT IS IN
7 FACT AN ACCURATE AVERAGE WEEKLY WAGE AND
8 COMPENSATION RATE, AND IF IT IS, THEN THEY WILL SO
9 STIPULATE, AND IF IT'S NOT, PERHAPS THEY CAN
10 STIPULATE TO ANOTHER FIGURE; AND IF THEY CANNOT
11 STIPULATE, THEN THAT ISSUE WILL BE ADJUDICATED LATER
12 OR UPON AGREEMENT OF THE PARTIES. SO SHE WILL BE
13 CONTINUED TO PAY THAT PAY -- BE PAID AT 385.51, AND
14 THAT WILL SERVE AS HER CURRENT COMP RATE UNTIL
15 FURTHER ORDER OF THE COMMISSION OR AGREEMENT OF THE
16 PARTIES. THE DATE OF THIS ADMITTED ACCIDENT, WHEN I
17 SAY ADMITTED, THAT IS TO THE HEAD AND NECK ONLY, WAS
18 MAY 18TH, 2012.

19 BEFORE I ASK IF THERE ARE ANY OBJECTIONS TO
20 APAS, I WILL PREEMPT MR. SAFRAN. HE DOES HAVE AN
21 OBJECTION ON BEHALF OF HIS CLIENT, AND THAT IS AN
22 OBJECTION TO APA 23 I BELIEVE IT IS OF THE
23 DEFENDANTS' SUBMISSIONS, WHICH IS AN ORDER OF
24 COMMISSIONER LYNDON, AND I HAVE DISCUSSED THAT WITH
25 THE PARTIES IN THE PREHEARING CONFERENCE, BUT IT IS

1 AN ORDER OF THE COMMISSION. IT DEALS WITH A PRIOR
2 INJURY. IT'S NOT DISPOSITIVE AS TO ANY ISSUE BEFORE
3 ME, AND ANY FINDINGS MADE BY A COMMISSIONER, WHETHER
4 THAT'S TO CREDIBILITY OR OTHERWISE, ARE NOT BINDING
5 UPON ME, AND I DON'T -- AND I'VE TOLD BOTH
6 ATTORNEYS, I DON'T THINK IT'S ANYBODY'S -- THE
7 LYNCHPIN OF ANYBODY'S CASE, BUT IT IS IN OVER MR.
8 SAFRAN'S OBJECTION. HE HAS A RUNNING OBJECTION TO
9 THAT DOCUMENT AND ANY TESTIMONY RELATING TO IT. ARE
10 THERE ANY FURTHER OBJECTIONS TO APAS, JURISDICTION,
11 VENUE, OR ANY OTHER ITEMS?

12 BY MR. SAFRAN:

13 NONE. THE ONLY THING I WOULD ADD JUST FOR THE
14 RECORD IS JUST I'M RELYING THE -- THE CASE ---

15 BY COMMISSIONER BARDEN:

16 AND MY ---

17 BY MR. SAFRAN:

18 --- MIZELL VERSUS GLOVER.

19 BY COMMISSIONER BARDEN:

20 OKAY.

21 BY MR. SAFRAN:

22 WHICH IS CITED AT 351 S. -- S.C. 392, 57 S. PER
23 D. -- PER 2D 176, IT'S 2002 BY THE SUPREME COURT.
24 AND ALSO THE CONTENT OF RULE OF EVIDENCE 608, WHICH
25 I THINK THEY DISCUSSED, BUT THE CASE ITSELF HAS A

1 COUPLE OF DIFFERENT GROUNDS THAT THEY ASSIGN TO THE
2 REASON ---

3 BY COMMISSIONER BARDEN:

4 DOES MR. FARRY HAVE A COPY OF THIS?

5 BY MR. SAFRAN:

6 YEAH. I HANDED HIS ---

7 BY COMMISSIONER BARDEN:

8 OKAY.

9 BY MR. FARRY:

10 YES. HE DID ABOUT SIX-AND-A-HALF MINUTES AGO,
11 SO.

12 BY COMMISSIONER BARDEN:

13 OKAY. WELL, DO WE NEED TO -- DO YOU WANT TO
14 TAKE SOME TIME, GO OFF THE RECORD AND...?

15 BY MR. FARRY:

16 NO, THANK YOU.

17 BY COMMISSIONER BARDEN:

18 OKAY. GO AHEAD, MR. SAFRAN.

19 BY MR. SAFRAN:

20 YEAH. AND IT -- IT THE BASICALLY THEY -- THEY
21 ---

22 BY COMMISSIONER BARDEN:

23 WELL, AND IF I'M WRONG AND IN ERROR ABOUT IT,
24 THEN I'LL ADMIT IT.

25 BY MR. SAFRAN:

1 AND THAT'S ONLY REASON. I -- I -- I THINK I
2 HAD TO ---

3 BY COMMISSIONER BARDEN:

4 I'LL READ IT.

5 BY MR. SAFRAN:

6 --- PUT MY WHAT I -- WHAT I WAS RELYING ON AS
7 OPPOSED TO SIMPLY JUST SAYING I OBJECT. SO I -- I'M
8 RELYING REALLY ON THE CONTENTS OF THAT CASE TO
9 REASON.

10 BY COMMISSIONER BARDEN:

11 WELL, AND I'LL HAVE TO READ THIS CASE, AND
12 QUITE HONESTLY, I'M NOT FAMILIAR WITH IT. IT'S A
13 2002 CASE. SO I WILL READ IT. AND IF I FEEL LIKE I
14 NEED TO ADJUST WHAT I'VE SAID OR DONE, THEN I'LL DO
15 SO. BUT, MR. FARRY, DO YOU WANT TO RESPOND TO THIS?

16 BY MR. FARRY:

17 I'LL BE HAPPY TO. APA 23, THE DECISION BY
18 COMMISSIONER LYNDON IS NOT INTRODUCED TO ESTABLISH A
19 CREDIBILITY ISSUE. IT WILL BECOME RELEVANT
20 THROUGHOUT CROSS-EXAMINATION AS TO WHY THAT CASE HAS
21 BEEN ADMITTED.

22 BY COMMISSIONER BARDEN:

23 OKAY. ALL RIGHT. FAIR ENOUGH. ALL RIGHT.
24 ANY FURTHER OBJECTIONS?

25 BY MR. SAFRAN:

1 NONE.

2 **BY COMMISSIONER BARDEN:**

3 ALL RIGHT. WITHOUT FURTHER OBJECTION OTHER
4 THAN THE ONE THAT'S PENDING, THE COMMISSION FILE
5 BECOMES A PART OF THE RECORD WITH THE EXCEPTION OF
6 SELF-SERVING DECLARATIONS AND UNSTIPULATED MEDICAL
7 REPORTS.

8 PRIOR TO GOING ON THE RECORD, WE HELD A
9 PREHEARING CONFERENCE. IT'S THE POSITION OF THE
10 CLAIMANT THAT SHE HAS SUSTAINED A COMPENSABLE
11 AGGRAVATION OF HER PRE-EXISTING PSYCHOLOGICAL
12 CONDITION, THAT SHE IS NOT AT M.M.I. FOR THAT
13 PSYCHOLOGICAL CONDITION, AND SHE SEEKS TREATMENT
14 WITH A SPECIALIST. IT IS HER POSITION THAT THE
15 AUTHORIZED-TREATING PHYSICIAN DR. COLLINS WHO
16 TREATED HER FROM 2012 TO 2016 STATED REPEATEDLY I
17 UNDERSTAND THROUGH THE RECORDS, AND OF COURSE, I'VE
18 BEEN JUST HANDED THESE RECORDS, SO I DO NOT KNOW
19 WHAT THEY SAY, BUT THAT DR. COLLINS HAS STATED THAT
20 THE CLAIMANT NEEDS PSYCHOLOGICAL OR PSYCHIATRIC
21 TREATMENT AND HAS SAID THIS ON A NUMBER OF TIMES.
22 FURTHER, DR. COLLINS DOES NOT BELIEVE THAT THERE IS
23 ANY MALINGERING OR SYMPTOM MAGNIFICATION AS FAR AS
24 THE CLAIMANT IS CONCERNED, AND THE CLAIMANT WOULD
25 CONTEND THAT DR. COLLINS' OPINIONS AND REPORTS

1 SHOULD BE GIVEN GREAT WEIGHT AS THAT HE HAS TREATED
2 HER THE LONGEST AND FOR A FOUR YEAR PERIOD. THE
3 CLAIMANT CONCEDES THAT SHE HAD A PRE-EXISTING
4 CONDITION BUT WOULD CONTEND THAT SHE HAS VARIOUS
5 SPECIALISTS AND PROVIDERS WHO HAVE LINKED HER WORK
6 INJURY TO AN AGGRAVATION OF HER PRE-EXISTING
7 CONDITION. SO THEREFORE, SHE FINDS -- WOULD CONTEND
8 THAT SHE READILY MEETS HER BURDEN OF PROVING AN
9 AGGRAVATED PSYCHOLOGICAL -- PRE-EXISTING
10 PSYCHOLOGICAL CONDITION. THERE ARE SOME OTHER
11 ISSUES RELATED TO PHYSICAL INJURIES AS WELL, BUT
12 BECAUSE THERE IS A PENDING APPOINTMENT WITH DR.
13 WILLIAMS ON DECEMBER 5TH, MY UNDERSTANDING IS THE
14 PSYCH ISSUE IS WHAT IS IN FRONT OF ME TODAY.

15 CONVERSELY, IT IS THE POSITION OF THE
16 DEFENDANTS THAT CLAIMANT HAS A SIGNIFICANT PRE- 2
17 EXISTING PRIOR HISTORY OF PSYCHOLOGICAL PROBLEMS, A
18 TEN YEAR OR MORE HISTORY FOR WHICH SHE RECEIVED
19 SIGNIFICANT MEDICATION, AND THAT SHE HAS A MYRIAD
20 SITUATIONAL STRESSORS THAT SERVE TO CONTRIBUTE TO
21 HER CONDITION, AND THEREFORE, IT CANNOT BE FOUND
22 COMPENSABLE OR SHOULD NOT BE FOUND COMPENSABLE. AND
23 THAT SHE WAS TREATED BY HER FAMILY DOCTOR MCQUEEN
24 AND RECEIVED APPARENTLY WHAT I'M ADVISED, AND AGAIN
25 I HAVEN'T READ THE RECORDS, BUT A COURSE OF TEN

1 YEARS OF PSYCHOTROPIC MEDICATION FOR HER PRE-
2 EXISTING CONDITION. SO THE DEFENDANTS WOULD CONTEND
3 THAT THE CLAIMANT CANNOT MEET HER BURDEN OF PROOF
4 THAT THE PRE-EXISTING CONDITION HAS BEEN AGGRAVATED.
5 ALL RIGHT. THAT'S -- AND THE DEFENDANTS WOULD POINT
6 TO MY ATTENTION THE OPINION OF DR. GUALTIERI. I'M
7 NOT GOING TO GET INTO -- I'VE BEEN -- I KNOW THERE
8 ARE MULTIPLE OPINIONS ON OR OPINIONS ON THE
9 CLAIMANT'S SIDE, AND THERE'S THAT OPINION, AND, OF
10 COURSE, THE PARTIES DISAGREE WITH THE -- THEIR --
11 THE OPPOSING SIDE'S EXPERTS AND WOULD ASK ME TO GIVE
12 GREATER WEIGHT TO THEIR EXPERT, THEIR RESPECTIVE
13 EXPERTS, BUT I WILL LEAVE IT AT THAT RIGHT NOW. I'M
14 NOT GOING TO GET INTO THAT. I WILL DISCUSS ALL THAT
15 IN MY FINDINGS.

16 SO, GENTLEMEN, IS THAT A FAIR SUMMARY OF YOUR
17 RESPECTIVE POSITIONS? AND I PROMISE YOU YOU CAN ADD
18 TO, CORRECT, CLARIFY, CHANGE, AMEND, MODIFY,
19 WHATEVER YOU WOULD LIKE.

20 BY MR. SAFRAN:

21 THAT ---

22 BY COMMISSIONER BARDEN:

23 YOU'RE THE MOVING PARTY, MR. SAFRAN.

24 BY MR. SAFRAN:

25 THAT'S FINE.

1 BY COMMISSIONER BARDEN:

2 I'LL START WITH YOU UNLESS ---

3 BY MR. SAFRAN:

4 THAT'S FINE.

5 BY COMMISSIONER BARDEN:

6 ALL RIGHT. MR. FARRY.

7 BY MR. FARRY:

8 AS TO ANY OPINION RENDERED BY DR. COLLINS BY
9 WAY OF A QUESTIONNAIRE, WE WOULD MAINTAIN IS NOT
10 ACCURATE. BASED UPON DR. COLLINS' OWN TESTIMONY IN
11 HIS DEPOSITION BETWEEN PAGES 7 AND 46 AND ALSO
12 BETWEEN PAGES 68 AND 77 WHERE HE BASICALLY SAID
13 GIVEN THE FACT THAT THE CLAIMANT HAD NOT DISCLOSED
14 TO HIM THE YEARS OF MEDICATION THAT SHE WAS TAKING
15 FOR ALL THESE MYRIAD OF PROBLEMS, IT WOULD NOT BE
16 POSSIBLE FOR HIM TO OPINE AS TO WHETHER OR NOT THERE
17 HAD BEEN AN EXACERBATION OF A PRE-EXISTING
18 CONDITION.

19 BY COMMISSIONER BARDEN:

20 SO YOU'RE SAYING HE RETREATED FROM HIS ORIGINAL

21 ---

22 BY MR. FARRY:

23 NO. I'M SAYING THE QUESTIONNAIRE THAT WAS DONE
24 AFTER HIS ---

25 BY COMMISSIONER BARDEN:

1 OH, AFTER?

2 BY MR. FARRY:

3 --- DEPOSITION. YES, MA'AM.

4 BY COMMISSIONER BARDEN:

5 OH, IT WAS AFTER THE DEPOSITION?

6 BY MR. FARRY:

7 YES, MA'AM.

8 BY COMMISSIONER BARDEN:

9 OH, OKAY.

10 BY MR. FARRY:

11 BUT THE -- THE DEPOSITION ---

12 BY COMMISSIONER BARDEN:

13 NOT BEFORE.

14 BY MR. FARRY:

15 --- WAS TAKEN MARCH OF 2014, ---

16 BY COMMISSIONER BARDEN:

17 OH, OKAY.

18 BY MR. FARRY:

19 --- AND THE QUESTIONNAIRE IS FAIRLY RECENT.

20 BY COMMISSIONER BARDEN:

21 OKAY.

22 BY MR. FARRY:

23 BUT BY HIS OWN TESTIMONY, HE'S ESTABLISHED THAT

24 HE CAN'T MAKE AND FORM THE OPINIONS THAT HE

25 SUBSEQUENTLY FORMED.

1 BY COMMISSIONER BARDEN:

2 OKAY.

3 BY MR. SAFRAN:

4 YOUR HONOR, IF I COULD RESPOND TO THAT QUICKLY?

5 BY COMMISSIONER BARDEN:

6 YEAH. THAT'S, OKAY, NOT THE USUAL.

7 BY MR. SAFRAN:

8 THE DEPOSITION WAS DONE IN ---

9 BY COMMISSIONER BARDEN:

10 AND USUALLY THE DEPOSITION FOLLOWS THE
11 QUESTIONNAIRE.

12 BY MR. SAFRAN:

13 WHAT HAPPENED IS ULTIMATELY, AND I TO BE FAIR,
14 I SENT THE REPORTS FROM NOT ONLY THE EXPERTS THAT I
15 HAD -- HAD SENT HER TO, BUT ALSO DR. GUALTIERI TO
16 DR. COLLINS AND ASKED HIM TO TELL ME BASED UPON HIS
17 PERIOD OF TIME WITH MS. RUMMAGE, WHICH OF THOSE DID
18 HE FIND TO BE MORE CONSISTENT WITH HIS OBSERVATIONS.
19 HE SAID, DR. BRAWLEY, DR. SALAS, NOT DR. GUALTIERI.
20 SO, YOU KNOW, I THINK FRANKLY HE HAS BEEN THROUGHOUT
21 THIS PROCESS ADVOCATING THE PSYCH TREATMENT.
22 ULTIMATELY HE WAS ASKED IN A THE QUESTIONNAIRE, JUST
23 FOR THE PURPOSES OF THE RECORD, AND YOU CAN
24 CERTAINLY TAKE A LOOK AT IT IS PAGES ---

25 BY COMMISSIONER BARDEN:

1 I WILL. AND I DON'T KNOW THAT I ---

2 BY MR. SAFRAN:

3 --- 77 THROUGH PAGE 81.

4 BY COMMISSIONER BARDEN:

5 UH-HUH.

6 BY MR. SAFRAN:

7 AND HE WAS GIVEN ALL OF THAT AND ASKED, BECAUSE
8 AGAIN, I WASN'T NECESSARILY SOLICITING A CAUSATION
9 STATEMENT FROM HIM BECAUSE HE'S NOT A PSYCHIATRIST.
10 HE, INSTEAD, IS A PHYSIATRIST WHO'S BEEN SEEING HER;
11 HOWEVER, HE HAS CONSISTENTLY BEEN CHARACTERIZING HER
12 SYMPTOMS TO BE REFLECTIVE OF POST-CONCUSSIVE
13 SYNDROME, AND WHEN GIVEN THE OPPORTUNITY TO REVIEW
14 EVERYTHING, INCLUDING DR. GUALTIERI'S FINDINGS, HE
15 CAME DOWN AFTER TWO MORE YEARS OF HAVING AN
16 OPPORTUNITY TO OBSERVE HER AND SAID I SEE THIS,
17 WHICH IS IN LINE WITH WHAT DR. SALAS AND DR. BRAWLEY
18 SAID.

19 BY COMMISSIONER BARDEN:

20 OKAY.

21 BY MR. FARRY:

22 AND -- AND DEFENDANTS DO NOT DENY THAT MS.
23 RUMMAGE MAY NEED PSYCHOLOGICAL TREATMENT. WE'RE
24 JUST SAYING IT'S THE SAME PSYCHOLOGICAL TREATMENT
25 SHE GOT FOR YEARS AND YEARS AND YEARS PRIOR TO THIS

1 ACCIDENT AND EVEN DAYS BEFORE THIS ACCIDENT.

2 BY COMMISSIONER BARDEN:

3 OKAY. ALL RIGHT. AND OUR FIRST WITNESS IS MS.
4 RUMMAGE. NOW, MS. RUMMAGE, IF YOU'LL RAISE YOUR
5 RIGHT HAND, PLEASE? DO YOU SWEAR OR AFFIRM THE
6 TESTIMONY YOU'RE ABOUT TO GIVE IN THIS PROCEEDING IS
7 THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE
8 TRUTH?

9 BY MS. RUMMAGE:

10 I DO.

11 * * * * * * * * * *

12 THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE
13 WHOLE TRUTH, AND NOTHING BUT THE TRUTH CONCERNING THE
14 MATTER HEREIN:

15 VICKIE RUMMAGE,

16 BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS
17 FOLLOWS:

18 BY COMMISSIONER BARDEN:

19 Q. ALL RIGHT. PLEASE, STATE YOUR FULL NAME FOR THE
20 RECORD.

21 A. VICKIE W. RUMMAGE.

22 Q. ALL RIGHT. AND YOU'RE GOING TO HAVE TO TURN UP THE
23 VOLUME ON YOUR VOICE. THIS IS A HUGE ROOM. YOUR
24 VOICE HAS TO PROJECT OVER TO MR. FARRY. IT HAS TO
25 PROJECT OVER HERE TO MS. -- TO MS. NELSON, ME, AND

1 MR. SAFRAN. SO YOU'RE GOING TO HAVE TO JUST TURN UP
2 THE VOLUME. OKAY?

3 A. YES, MA'AM. YES, MA'AM.

4 Q. ALL RIGHT. AND THEN IF I HAVE TO, I MIGHT HAVE TO
5 TELL YOU TO DO THAT PERIODICALLY. I'M NOT PICKING
6 ON YOU. IT'S JUST THAT WE -- WE NEED TO BE ABLE TO
7 HEAR EVERY WORD YOU'RE SAYING.

8 A. YES, MA'AM.

9 Q. I'M GOING TO ASK YOU ONE ADDITIONAL THING. MR.
10 SAFRAN'S GOING TO BE ASKING THE QUESTIONS, BUT I
11 WOULD LIKE FOR YOU TO DIRECT YOUR RESPONSES TO ME AS
12 BEST YOU CAN. I WILL BE TAKING NOTES AND LOOKING
13 DOWN, BUT JUST AS BEST YOU CAN, LIKE YOU'RE TELLING
14 ME THE ANSWERS. I KNOW THAT'S A LITTLE BIT AWKWARD
15 AND A LITTLE BIT ODD. JUST DO THE BEST YOU CAN.

16 A. YES, MA'AM.

17 Q. THANK YOU.

18 BY COMMISSIONER BARDEN:

19 ALL RIGHT. MR. SAFRAN.

20 DIRECT EXAMINATION BY MR. SAFRAN:

21 Q. MS. RUMMAGE, TELL ME BASICALLY SOME BACKGROUND
22 INFORMATION. HOW OLD ARE YOU SITTING HERE TODAY?

23 A. I AM 56 YEARS OLD.

24 Q. ALL RIGHT. AND WHERE DO YOU CURRENTLY LIVE?

25 A. IN WALLACE, SOUTH CAROLINA.

1 Q. ALL RIGHT. AND IS THIS GENTLEMAN BACK IN THE BACK
2 YOUR HUSBAND?

3 A. YES, SIR, HE IS.

4 Q. AND HOW LONG HAVE Y'ALL BEEN MARRIED?

5 A. FORTY-THREE YEARS, SIR.

6 Q. OKAY. AND YOU'VE GOT CHILDREN?

7 A. YES, SIR, I DO.

8 Q. AND AS I UNDERSTAND IT WHAT IS YOUR LAST GRADE YOU
9 FINISHED IN SCHOOL?

10 A. I FINISHED TWELFTH GRADE, AND I WENT BACK AND DID
11 FURTHER EDUCATION AT N.E.T.C.

12 Q. OKAY. ALL RIGHT. E.T.C. IS WHAT?

13 A. NORTHEASTERN TECHNICAL COLLEGE.

14 Q. OKAY. AND WHAT KIND OF EDUCATION DID YOU GET THERE?

15 A. I DID C.N.A., PHLEBOTOMY, A NUMEROUS, A ---

16 Q. OKAY.

17 A. --- A MULTI -- MULTI SKILLS.

18 Q. ALL RIGHT. I DON'T ---

19 **BY COMMISSIONER BARDEN:**

20 Q. AND SO DID YOU GET YOUR C.N.A. CERTIFICATE?

21 A. YES, MA'AM.

22 Q. OKAY.

23 **DIRECT EXAMINATION RESUMED BY MR. SAFRAN:**

24 Q. AND -- AND I DON'T WANT TO GO THROUGH YEAR BY YEAR
25 OR ANYTHING, BUT JUST LET'S TALK FAIRLY GENERALLY.

1 BEFORE YOU GOT HURT, LET'S JUST SAY JUST BASICALLY
2 WHERE YOU HAVE WORKED. OKAY? AT THE TIME OF YOUR
3 INJURY, HOW LONG HAD YOU BEEN WORKING WITH B.G.F.?

4 A. I'M NOT SURE HOW LONG I HAD BEEN FULL-TIME, BECAUSE
5 I WORKED SEVERAL YEARS AS A TEMPORARY, FOUR.

6 Q. OKAY. WHERE ARE -- WHAT ARE THE OTHER PLACES THAT
7 YOU ---

8 BY COMMISSIONER BARDEN:

9 Q. SEVERAL YEARS AS A TEMPORARY, AND THEN FOUR MORE AS
10 A REGULAR EMPLOYEE FOR THIS EMPLOYER THAT WE'RE HERE
11 FOR TODAY?

12 A. AND I GUESS IT WAS ONE OR SO TEMPORARY AND OR MAYBE
13 TWO. I CAN'T REMEMBER.

14 Q. I MISUNDERSTOOD. I JUST WANT TO MAKE SURE THE
15 RECORD'S RIGHT. I THOUGHT YOU SAID SEVERAL YEARS AS
16 A TEMPORARY. THAT'S NOT WHAT YOU SAID, JUST ---

17 A. I SAID SEVERAL YEARS TEMPORARY THROUGH ANOTHER
18 COMPANY FOR B.G.F.

19 Q. RIGHT. AND ---

20 A. I'M SORRY.

21 Q. AND THEN -- NO. THAT'S OKAY.

22 A. AND THEN THEY MADE ME PERMANENT. AND I'M NOT SURE,
23 YOU KNOW, I CAN'T REMEMBER HOW IT WAS SPLIT UP THE
24 YEARS ALL TOGETHER.

25 Q. OKAY.

DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

Q. OKAY.

A. I'M SORRY.

Q. WHAT OTHER PLACES DID YOU WORK BEFORE?

A. I'VE WORKED AT COOPER TOOLS.

BY COMMISSIONER BARDEN:

Q. AND WHAT DID YOU DO AT COOPER TOOLS?

A. I WAS AN ASSEMBLER.

Q. OKAY. AND WHERE ELSE?

A. I WORKED FOR MODERN CLEANERS.

Q. AND WHAT DID YOU DO THERE?

A. I WAS AN ASSISTANT MANAGER.

Q. OKAY.

A. I'VE WORKED FOR THE SCHOOLHOUSE.

Q. AND WHAT DID YOU DO FOR THE SCHOOL?

A. I WORKED IN THE LUNCHROOM, PREPARING MEALS FOR KIDS.

Q. OKAY.

DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

Q. OKAY. NOW, LET'S TALK A LITTLE BIT ABOUT JUST SOME
PRE -- WHAT I'M SAYING, BEFORE THIS ACCIDENT
HAPPENED, AND I BELIEVE THIS ACCIDENT WE'VE ALL
AGREED IS 2012; IS THAT WHAT YOU REMEMBER?

A. YES, SIR.

Q. ALL RIGHT. BEFORE 2012, AND SPECIFICALLY LET'S TALK
MEDICALLY, WHO WAS YOUR FAMILY DOCTOR FOR SOME

1 PERIOD OF YEARS?

2 A. DR. FRED MCQUEEN.

3 Q. OKAY. AND DR. MCQUEEN IS LIKE A G.P. OR SOME KIND
4 OF A PRIMARY-CARE DOCTOR?

5 A. YES, SIR. I THINK SO.

6 Q. OKAY.

7 A. JUST A MEDICAL DOCTOR.

8 Q. AND YOU SAW HIM FOR A GOOD WHILE?

9 A. YES, SIR. I DID.

10 Q. ALL RIGHT. NOW, I'M ASSUMING HE SAW YOU FOR A LOT
11 OF DIFFERENT TYPES OF PROBLEMS?

12 A. AND, YES, SIR.

13 Q. DID HE SEE YOU BECAUSE OF HAVING EMOTIONAL PROBLEMS
14 AND FOR THINGS LIKE DEPRESSION?

15 A. YES, SIR. I'M NOT GOING TO DENY I HAVE STRUGGLED
16 WITH DEPRESSION, BUT IT WAS NOTHING THAT I COULD
17 OVER -- NOTHING THAT I COULDN'T OVERCOME WITH HELP,
18 BUT NOW IT'S TOTALLY DIFFERENT.

19 Q. AND LET ME ASK THIS. WHEN YOU SAY "OVERCOME,"
20 OBVIOUSLY YOU WERE WORKING?

21 A. YES, SIR.

22 Q. OKAY. AND WERE YOU DOING THINGS AROUND THE HOUSE,
23 CLEANING UP?

24 A. OH, YES, SIR.

25 Q. GOING OUT?

1 A. YES, SIR.

2 Q. NOW, YOU TOOK MEDICATION?

3 A. YES, SIR.

4 Q. AND DR. MCQUEEN PROVIDED THAT?

5 A. YES, SIR.

6 Q. ALL RIGHT. NOW, DURING THOSE YEARS THAT YOU SAW DR.
7 MCQUEEN, DID YOU EVER GET SENT OR SEE A
8 PSYCHIATRIST?

9 A. NO, SIR.

10 Q. OKAY. DID YOU EVER TO YOUR RECOLLECTION EVER GO SEE
11 A PSYCHOLOGIST BECAUSE OF ANY DEPRESSION OR ANY
12 SITUATION IN TERMS OF YOUR EMOTIONAL?

13 A. NO, SIR.

14 Q. ALL RIGHT. SO YOU DID SEE AND DR. MCQUEEN
15 REGULARLY?

16 A. YES, SIR.

17 Q. AND IS IT FAIR TO SAY AS MR. FARRY ALLUDED THAT
18 BEFORE THIS ACCIDENT, SHORTLY BEFORE, YOU WERE STILL
19 GETTING MEDICATION, WEREN'T YOU?

20 A. YES, SIR.

21 Q. ALL RIGHT. AND I GUESS THE OTHER THING IS THIS
22 THOUGH; YOU'RE NOT DENYING THAT YOU STRUGGLE WITH
23 IT?

24 A. NO, SIR. I'M NOT.

25 Q. AND I THINK YOU STILL THOUGH WERE ABLE TO DO THE

1 THINGS OUT -- WORKING, TENDING TO WHAT YOUR CHORES
2 WERE?

3 A. YES, SIR, I COULD.

4 Q. I MEAN, DID YOU STILL SOCIALIZE WITH PEOPLE?

5 A. YES, SIR, I DID.

6 Q. ALL RIGHT. SO YOU ENDED UP HAVING AN INJURY OVER
7 HERE BACK IN 2012. COULD YOU JUST DESCRIBE VERY
8 BRIEFLY TO THE COMMISSIONER JUST KIND OF WHAT
9 HAPPENED?

10 A. AS I CAN REMEMBER, I HAD STOPPED THE MACHINE ALL AT
11 -- AT THE POINT TO DOFF IT, YOU KNOW, THE MINIMUM
12 NUMBER OF YARDS, AND I WAS STANDING BEHIND THE
13 MACHINE, CLEANING WASTE FROM THE ROLL OF YARN,
14 BECAUSE IT WAS MY BREAK TIME, AND I WAS JUST GOING
15 TO WAIT 'TIL AFTER BREAK TO DOFF, YOU KNOW. AND I
16 DIDN'T KNOW THAT A DOFF TRUCK HAD BEEN PLACED BEHIND
17 ME WHILE I WAS REMOVING THE WASTE FROM THE DOFF,
18 AND I WENT TO STEP BACK, AND WHEN I DID, I CAN
19 REMEMBER THAT THE BOTTOM OF MY LEG CAUGHT THE DOFF
20 TRUCK, AND IT THREW ME BACKWARDS, AND THE DOFF TRUCK
21 WAS DOWN ON THE VERY BOTTOM OF THE GROUND, AND I HIT
22 IT IN HOPING THAT I COULD BREAK MY FALL WHEN I HIT
23 IT WITH MY REAR END, BUT I COULDN'T. AND IT THREWED
24 ME BACKWARDS INTO THE CHAIN AND THE METAL PART THAT
25 -- OF THE DOFF TRUCK.

1 Q. ALL RIGHT. LET ME ASK THIS. DID YOU ACTUALLY
2 STRIKE YOUR HEAD?

3 A. YES, SIR, I DID.

4 Q. AND AS A RESULT OF STRIKING YOUR HEAD, DID YOU HAVE
5 ANY TYPE OF SOMETHING OCCUR ON THE BACK OF YOUR
6 HEAD, ANY LUMP OR ANY TYPE OF BLEEDING OR ANYTHING
7 LIKE THAT?

8 A. YES, SIR, I DID. I HAD A CUT IN MY HEAD, AND I ALSO
9 HAD A LUMP AND CUT ON MY NECK.

10 Q. OKAY. NOW, YOU DIDN'T GO TO THE DOCTOR AT THAT
11 POINT?

12 A. NO, SIR, I DIDN'T.

13 Q. OKAY. AND AT LEAST PEOPLE WERE AWARE YOU HAD THE
14 INJURY?

15 A. YES, SIR, THEY WAS.

16 Q. DID SOMEBODY HELP YOU, I GUESS, WITH SOME GLUE ON
17 YOUR -- YOUR LACERATION?

18 A. YES, SIR.

19 Q. ALL RIGHT. NOW, EVENTUALLY YOU SAW A DR. MCLEOD?

20 A. YES, SIR, I DID.

21 Q. ALL RIGHT. AND I LOOKED IN HIS NOTE THAT SOMETHING
22 ABOUT HIM LOOKING AT THE LACERATION. SO DID YOU
23 SHOW IT TO HIM?

24 A. YES, SIR, HE SEEN IT.

25 Q. NOW, I ALSO SAW RECORDS THAT AT LEAST EARLY ON YOU

1 WERE TREATING WITH AND DR. MCQUEEN FOR THIS PROBLEM?

2 A. ALL ---

3 BY COMMISSIONER BARDEN:

4 FOR WHICH PROBLEM?

5 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

6 Q. FOR AFTER YOU FELL.

7 A. YES, SIR. HE SEEN ME.

8 Q. OKAY.

9 A. HE DID.

10 Q. SO HE ---

11 A. I MEAN, ---

12 Q. --- ACTUALLY SAW YOU BOTH BEFORE YOU HAD THIS
13 ACCIDENT AND AT LEAST FOR SOME PERIOD OF TIME AFTER
14 YOU HAD THIS ACCIDENT?

15 A. YES, SIR, HE DID.

16 Q. OKAY. SO AT THAT POINT, HE WAS PRESCRIBING
17 MEDICINE; HE ACTUALLY LOOKED AT YOU; IS THAT ---

18 A. YES, SIR, HE DID.

19 Q. ALL RIGHT. NOW, AS FAR AS AFTER THAT, DID WORKERS'
20 COMP EVENTUALLY SEND YOU SOMEWHERE ELSE?

21 A. YES, SIR, THEY DID.

22 Q. AND I SAW IN THE RECORDS THAT THERE WAS A -- EXCUSE
23 ME -- A -- A DR. BENJAMIN AT THE BEACH?

24 A. YES, SIR.

25 Q. ALL RIGHT. AND I KNOW I'M NOT ASKING DATES AND ANY

1 OF THAT STUFF, BUT DO YOU RECALL SEEING A DR.
2 BENJAMIN?

3 A. YES, SIR, I DO.

4 Q. ALL RIGHT. AND I'M LOOKING AT RECORDS, AND -- AND
5 I'M JUST ASKING, WERE YOU TELLING HIM ABOUT ANY
6 PHYSICAL PROBLEMS THAT YOU WERE HAVING SINCE THIS
7 FALL?

8 A. YES, SIR, I DID.

9 Q. ALL RIGHT. NOW, I AM LOOKING SPECIFICALLY AT SOME
10 REPORTS FROM HIM ABOUT SOME OF THE THINGS THAT YOU
11 WERE TALKING ABOUT. WHAT WERE THOSE KIND OF
12 SYMPTOMS AFTER THE FALL THAT YOU WERE NOTICING THAT
13 WEREN'T SOMETHING THAT YOU WERE HAVING PROBLEMS OR
14 AS MUCH PROBLEMS WITH BEFORE?

15 A. THE TYPE OF HEADACHES THAT I HAD.

16 Q. OKAY. DID THE -- YOU HAD HEADACHES BEFORE, DIDN'T
17 YOU?

18 A. YES, SIR.

19 Q. ALL RIGHT. HOW DID THE HEADACHES CHANGE?

20 A. IT CAME AS A DIFFERENT TYPE OF HEADACHE AND IS STILL
21 A DIFFERENT TYPE OF HEADACHE, AND YOU NEVER KNOW
22 WHERE IT'S GOING TO START, BUT IT'S LIKE SOMEBODY
23 TAKING A KNIFE AND JABBING IT IN YOUR HEAD.

24 Q. OKAY.

25 A. I HAVE DIZZINESS.

1 Q. UH-HUH.

2 A. I HAVE NAUSEA.

3 Q. UH-HUH.

4 A. I HAVE PROBLEMS WITH MY SPEECH STILL.

5 Q. AND ALONG THOSE LINES, DID YOU ACTUALLY GET REFERRED
6 TO A SPEECH THERAPIST?

7 A. YES, SIR, I DID.

8 Q. AND WERE YOU GIVEN SOME SPEECH THERAPY OVER A PERIOD
9 OF TIME?

10 A. YES, SIR, I WAS.

11 Q. AND AS FAR AS THE SPEECH, WAS THE SPEECH AN ISSUE
12 FOR YOU BEFORE THIS ACCIDENT HAPPENED?

13 A. NO, SIR.

14 Q. OKAY. AND I -- I'M LOOKING IN THE RECORDS. I MEAN,
15 YOU SAW THE SPEECH THERAPIST FOR OVER SOME PERIOD OF
16 MONTHS?

17 A. YES, SIR.

18 Q. ALL RIGHT. AND DID THAT HELP YOU SOME?

19 A. YES, SIR.

20 Q. ALL RIGHT. BUT YOU DIDN'T GO ON YOUR OWN, YOU GOT
21 REFERRED OVER THERE?

22 A. YES, SIR, I DID.

23 Q. AND I ALSO NOTICED THAT AGAIN ---

24 **BY COMMISSIONER BARDEN:**

25 Q. DID YOU EVER HAVE NAUSEA BEFORE?

1 A. OH, WHEN I WOULD HAVE HEADACHES, BUT IT'S NOTHING
2 LIKE IT IS NOW, BECAUSE I HAVE RINGING IN THE EARS,
3 AND I CAN, YOU KNOW, IT CAN GO ON FOR LIKE DAYS AT
4 THE TIME.

5 Q. OKAY.

6 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

7 Q. IS THAT ---

8 A. AND DIZZINESS.

9 Q. AND WAS THE DIZZINESS A REGULAR THING BEFORE THIS
10 ACCIDENT?

11 A. I NEVER HAD IT BEFORE.

12 Q. AND THEN THE NAUSEA YOU HAD BEFORE THE ACCIDENT;
13 WHEN YOU WOULD HAVE BAD HEADACHES, YOU COULD GET
14 NAUSEOUS?

15 A. YES, SIR.

16 Q. DOES THE NAUSEA COME MORE FREQUENTLY NOW?

17 A. YES, SIR.

18 Q. OKAY. AND WAS THE RINGING IN THE EARS A REGULAR
19 THING FOR YOU BEFORE YOU HAD IT?

20 A. I NEVER HAD IT. I NEVER HAD NO RINGING IN MY EARS.

21 Q. ALL RIGHT. NOW, AT SOME POINT, DID YOU GET SWITCHED
22 OVER TO DR. COLLINS?

23 A. YES, SIR, I DID.

24 Q. AND AGAIN, DID YOU HAVE ANYTHING TO DO WITH PICKING
25 DR. COLLINS OR, YOU KNOW, CHOOSING HIM OR ANY WAY

1 HOW YOU GOT TO HIM?

2 A. NO, SIR, I DIDN'T.

3 Q. ALL RIGHT. NOW, WE'VE SUBMITTED RECORDS FROM DR.
4 COLLINS. EARLY ON IN YOUR TREATMENT, I GUESS AT
5 TIMES, I GUESS DID YOU FEEL LIKE NECESSARILY HE WAS
6 LISTENING OR DID YOU ---

7 BY MR. FARRY:

8 OBJECT TO LEADING THE WITNESS.

9 BY COMMISSIONER BARDEN:

10 SUSTAINED.

11 BY MR. SAFRAN:

12 I'LL REPHRASE IT.

13 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

14 Q. WHEN YOU FIRST STARTED TREATING WITH DR. COLLINS,
15 WAS HE ADDRESSING ALL OF YOUR SYMPTOMS OR JUST SOME
16 OF THEM?

17 A. ACTUALLY, I CAN'T REMEMBER, BECAUSE AT FIRST I CAN
18 REMEMBER I DID -- I -- I WASN'T FOR SURE, YOU KNOW,
19 HE WAS THE DOCTOR THAT WAS GOING TO HELP ME OR WHAT.

20 Q. OKAY.

21 A. BUT LATER ON DOWN THE ROAD, I REALIZED THAT HE WAS
22 DOING EVERYTHING IN HIS POWER THAT HE COULD TO HELP
23 ME AND TRY TO GET ME HELP.

24 Q. OKAY. AND WERE YOU TELLING DR. COLLINS ABOUT THE
25 PROBLEMS THAT YOU WERE HAVING?

1 A. YES, SIR, I DID.

2 Q. ALL RIGHT. AND AS A RESULT, AT SOME POINT -- LET ME
3 ASK THIS: DO YOU REMEMBER WHETHER EARLY ON YOU WERE
4 EVEN ALLOWED TO GET TREATMENT FOR YOUR NECK WHEN YOU
5 FIRST STARTED SEEING HIM?

6 A. NO, SIR.

7 Q. AND WERE ---

8 A. WELL, I DID HAVE A NERVE BLOCK IN MYRTLE BEACH.

9 Q. OKAY. WHEN YOU FIRST WENT TO DR. COLLINS, WAS HE
10 DOING -- DO YOU REMEMBER IF HE WAS DOING ANYTHING
11 SPECIFICALLY WITH YOUR NECK AT FIRST?

12 A. NO, SIR. BUT HE STARTED TRIGGER POINTS AND BOTOX
13 AND MEDICATION.

14 Q. OKAY.

15 A. I MEAN, HE WAS ---

16 Q. OVER TIME, DID HE DO THINGS THAT WERE HELPFUL?

17 A. YES, SIR, HE DID.

18 Q. ALL RIGHT. NOW, YOU MENTIONED THE BOTOX. DID THAT
19 HELP?

20 A. YES, SIR, IT DID.

21 Q. AND HE WOULD GIVE YOU BOTOX INJECTIONS?

22 A. YES, SIR.

23 **BY COMMISSIONER BARDEN:**

24 Q. WAS THAT FOR YOUR HEADACHES?

25 A. YES, MA'AM.

1 BY MR. SAFRAN:

2 AND ---

3 BY COMMISSIONER BARDEN:

4 Q. SO IT WOULD MAKE YOUR HEADACHES ---

5 A. IT ---

6 Q. --- A LOT BETTER?

7 A. IT MADE THEM A LOT BETTER.

8 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

9 Q. AND IS THAT WHY YOU KEPT GETTING THEM?

10 A. YES, SIR, IT WAS.

11 Q. ALL RIGHT. AND I THINK THAT YOU HAD THEM SEVERAL
12 TIMES, IS THAT RIGHT?

13 A. YES, SIR.

14 Q. ALL RIGHT. AND I THINK AT SOME POINT WAS THAT
15 REALLY WHAT HE WAS DOING AS FAR AS SHOTS, BOTOX AND
16 TRIGGER POINTS?

17 A. YES, SIR. THAT WAS WHAT HE WAS DOING.

18 Q. DID HE ALSO PRESCRIBE YOU WITH DIFFERENT
19 MEDICATIONS?

20 A. HE DID.

21 Q. NOW, WE GOT RECORDS THAT OBVIOUSLY SHOW THINGS, BUT
22 I GUESS WHEN I LOOKED AT THE LAST TIME THAT HE WAS
23 SEEING YOU, THERE WERE DIFFERENT MEDICINES THAT HE
24 APPARENTLY HAD BEEN GIVING YOU UP UNTIL THE TIME YOU
25 LAST SAW HIM?

1 A. YES, SIR.

2 Q. IT WASN'T JUST ONE OR TWO?

3 A. OH, IT WAS ANTI-DEPRESSANTS. IT WAS -- HE GAVE ME

4 MY PAIN MEDICATION, AND HE GAVE ME LYRICA, CYMBALTA,

5 TO TRY TO HELP THE PAIN.

6 Q. I SEE HERE THAT HE GAVE YOU XANAX?

7 A. YES, SIR, HE DID.

8 Q. ALL RIGHT. HE ALSO GAVE YOU, IT LOOKS LIKE

9 FIORICET?

10 A. YES, SIR, FOR HEADACHES.

11 Q. AND HE GAVE YOU EFFEXOR?

12 A. YES, SIR, FOR ANTI-DEPRESSANT.

13 Q. ALL RIGHT.

14 A. AND HE ALSO GAVE ME MEDICATION FOR THE DIZZINESS.

15 Q. OKAY. ANTIVERT?

16 A. YES, SIR.

17 Q. ALL RIGHT. SO AGAIN, YOU WERE GETTING ALL THESE

18 MEDS FROM HIM?

19 A. YES, SIR.

20 Q. AND WERE THEY HELPING YOU?

21 A. YES, SIR.

22 Q. NOW, WHEN DR. COLLINS LEFT, WAS THERE A GAP PERIOD,

23 I GUESS, WHERE YOU REALLY WEREN'T GETTING MUCH OF

24 ANYTHING?

25 A. OH, YES, SIR. NOTHING.

1 Q. JUST STOPPED?

2 A. STOPPED.

3 Q. NOW, YOU WERE SEEING HIS PARTNER BRIEFLY?

4 A. HE GAVE ME THE BOTOX ONE TIME.

5 Q. OKAY. HOW ABOUT MEDICINES?

6 A. NOTHING.

7 Q. SO REALLY AFTER ALL THESE MEDS THAT YOU HAD BEEN ON,

8 THEY JUST STOPPED?

9 A. THEY STOPPED.

10 Q. EVENTUALLY DID YOU GET TO SEE DR. SINGH?

11 A. YES, SIR.

12 Q. AND HAS HE STARTED YOU BACK ON SOME MED?

13 A. HE -- HE STARTED ME BACK ON THE PERCOCET FOR PAIN

14 AND THE FIORICET FOR HEADACHES.

15 Q. WHAT ABOUT ALL OF THESE OTHER ONES THAT WERE HELPING

16 YOU THAT DR. COLLINS HAD BEEN GIVING YOU?

17 A. NO, SIR.

18 Q. SO NOT GETTING ANY OF THOSE?

19 A. WELL, I ACTUALLY HAD TO GO TO MY PRIMARY-CARE DOCTOR

20 FOR MY THYROID AND BLOOD PRESSURE, AND I WAS REALLY

21 REALLY SICK, AND SHE TRIED TO GET ME SOME HELP TO

22 GET ME ON MY ANTI-DEPRESSANTS AND STUFF TO ---

23 Q. OKAY.

24 A. --- TRY TO HELP ME OUT.

25 Q. SO HAS THAT HAPPENED YET?

1 A. YES, SIR. I'M BACK ON THE ANTI-DEPRESSANTS.

2 Q. OKAY. ALL RIGHT. BUT AT LEAST WHEN YOU WERE
3 GETTING THEM THROUGH DR. COLLINS, WAS THAT STUFF YOU
4 WERE -- THAT WAS -- WORKERS' COMP WAS -- WAS PAYING
5 FOR?

6 A. YES, SIR.

7 Q. AND NOW THEY'RE NOT?

8 A. NO, SIR.

9 Q. ALL RIGHT. DID THE MEDICINES, AND I'M TALKING ABOUT
10 ALL OF THEM, THAT DR. COLLINS WAS GIVING YOU, I
11 GUESS, MAKE YOUR OVERALL CONDITION BETTER THAN IT IS
12 TODAY?

13 A. OH, YES, SIR.

14 Q. AND THE BOTOX SHOTS?

15 A. WERE WONDERFUL.

16 Q. OKAY. NOW, HAVE YOU ASKED ABOUT BOTOX SHOTS WITH
17 DR. SINGH?

18 A. I DID.

19 Q. AND I DON'T WANT TO HEAR WHAT HE SAID, BUT MY
20 QUESTION IS HAS HE GIVEN YOU BOTOX SHOTS?

21 A. NO, SIR.

22 Q. HAS HE REFERRED YOU ANYWHERE FOR BOTOX SHOTS?

23 A. NO, SIR.

24 Q. NOW, AS FAR AS -- AS THE SHOTS THAT DR. SINGH GAVE,
25 ARE THEY DIFFERENT TYPES OF SHOTS THAN WHAT DR.

1 COLLINS HAD GIVEN YOU?

2 A. YES, SIR. HE DOES EPIDURALS.

3 Q. OKAY. AND YOU'VE HAD AT LEAST A COUPLE OF THOSE?

4 A. I -- I HAD AN EPIDURAL, AND THE LAST ONE WAS CALLED

5 -- I CAN'T REMEMBER.

6 Q. WAS IT ---

7 A. I'M SO SORRY.

8 Q. WAS IT A DIFFERENT KIND, THE LAST ONE HE GAVE YOU?

9 A. IT WAS AN EPIDURAL TYPE, BUT IT WAS CALLED SOMETHING

10 DIFFERENT.

11 Q. OKAY. THAT'S FINE. WE'VE GOT RECORDS THAT -- THAT

12 SHOW THAT.

13 A. RIGHT HERE.

14 Q. SO HE'S DONE DIFFERENT SHOTS ON YOU?

15 A. YES, SIR.

16 Q. ALL RIGHT.

17 A. TO THE ---

18 Q. AND THEN I GUESS BASICALLY AT THIS POINT WHAT YOU'RE

19 GETTING THERE IS NOT THE SAME AS WHAT YOU WERE

20 GETTING FROM DR. COLLINS?

21 A. NO, SIR.

22 Q. AND EVEN WITH NEW SHOTS, IS THAT REALLY GIVING YOU

23 THE HEADACHE RELIEF THAT YOU WERE HAVING WITH THE --

24 THE BOTOX?

25 A. NO, SIR.

1 Q. ALL RIGHT. NOW, LET'S TALK A LITTLE BIT JUST IN
2 TERMS OF -- OF YOUR -- YOUR EMOTIONAL SITUATION.
3 RIGHT NOW, DO YOU STILL HAVE ISSUES WITH CRYING?

4 A. ALL THE TIME.

5 Q. NOW, YOU CRIED BEFORE THIS ACCIDENT THOUGH, DIDN'T
6 YOU?

7 A. NOT LIKE THIS.

8 Q. OKAY.

9 A. I WASN'T A CRYING PERSON, UNLESS IT REALLY HURT MY
10 HEART.

11 Q. BUT I GUESS DESCRIBE AS BEST YOU CAN, KNOWING THAT
12 YOU WERE TAKING MEDS BEFORE THE ACCIDENT, KNOWING
13 THAT YOU WERE SEEING AND DR. MCQUEEN OVER A LOT OF
14 YEARS, KNOWING THAT THERE WERE TIMES THAT THINGS
15 WERE REALLY BAD FOR YOU BEFORE THIS ACCIDENT, WHAT'S
16 DIFFERENT NOW AS OPPOSED TO BEFORE YOU HIT YOUR HEAD
17 AND FELL?

18 A. BECAUSE I DON'T HAVE A LIFE ANYMORE. I CAN'T
19 CORRESPOND AMONG A CROWD. I CAN'T KEEP MY HOUSEWORK
20 DONE. I FORGET -- IF I GO TO DO SOMETHING, I CAN'T
21 REMEMBER. IT'S JUST SO MUCH.

22 Q. AND AS FAR AS THE -- THE MEMORY ISSUES, WAS THAT
23 SOMETHING THAT WAS A BIG PROBLEM BEFORE THIS
24 ACCIDENT?

25 A. NO, SIR.

1 Q. AND, NOW THEY'VE HANDED IN SOME STUFF, THESE THINGS
2 FROM YOUR FACEBOOK. WHY ARE YOU ON FACEBOOK?

3 A. I DID FACEBOOK A LITTLE BIT PRIOR, BUT A THERAPIST
4 THAT I SEEN, SHE TOLD ME SINCE I WAS NOT OUT ---

5 BY MR. FARRY:

6 OBJECT TO WHAT ---

7 BY COMMISSIONER BARDEN:

8 SUSTAINED.

9 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

10 Q. ALL RIGHT. LET ME REPHRASE, OR LET ME ASK YOU THIS.
11 YOU GOT SENT TO A SPEECH THERAPIST?

12 A. YES, SIR, I DID.

13 Q. ALL RIGHT. AND YOU WERE GIVEN TREATMENT FROM THE
14 SPEECH THERAPIST?

15 A. YES, SIR.

16 Q. AS A RESULT OF THE TREATMENT YOU WERE GIVEN, WHERE I
17 GUESS THEY -- WERE THEY TRYING TO TEACH YOU HOW TO
18 CHANGE OR IMPROVE YOURSELF?

19 A. YES, SIR. SHE ---

20 Q. WAS ONE OF THE TEACHINGS TO GET ON FACEBOOK?

21 A. YES, SIR, SHE TOLD ME TO.

22 Q. ALL RIGHT. NOT WHAT SHE TOLD YOU, BUT WAS THAT PART
23 FO THE TREATMENT?

24 A. YES, SIR.

25 Q. ALL RIGHT.

1 A. AND ---

2 Q. SO AFTER THAT, DID YOU INCREASE YOUR *FACEBOOK*
3 PARTICIPATION?

4 A. I DID, BECAUSE I HAD NO CONTACT.

5 Q. IS *FACEBOOK* KIND OF YOUR CONTACT WITH THE OUTSIDE?

6 A. IT IS.

7 Q. AND, YOU KNOW, I'VE LOOKED AT THESE THINGS. I MEAN,
8 YOU TELL ME, WHAT DO YOU EVER COMMENT ON? I MEAN,
9 WHAT'S THE POINT?

10 A. THE MAIN THING I COMMENT ON IS WHEN PEOPLE ASK FOR
11 PRAYER. I LOVE TO PRAY FOR PEOPLE, 'CAUSE I LOVE
12 THEM TO PRAY FOR ME.

13 Q. OKAY.

14 A. AND I LOVE TO SEE PICTURES OF PEOPLE, AND I DON'T
15 GET TO SEE MY GRANDKIDS AND STUFF A LOT, AND THEY
16 HAVE A LOT OF PICTURES ON *FACEBOOK*.

17 Q. AND WHY ARE YOU SEEING YOUR GRANDKIDS LESS?

18 A. BECAUSE I'M NOT AN OUTGOING PERSON ANYMORE.

19 Q. THEY COME TO YOUR HOUSE THOUGH, DON'T THEY?

20 A. YES, SIR, BUT I DON'T GET TO GO VISIT THEM LIKE I
21 DID.

22 Q. OKAY. WELL, THAT'S -- AND I MEAN, IT'S NOT LIKE
23 YOUR HUSBAND CAN'T TAKE YOU THOUGH, IS IT?

24 A. NO. JUST I'M NOT UP TO GOING.

25 Q. OKAY. NOW, YOU SAW DR. WATTS, I BELIEVE, DONNA

1 WATTS; DO YOU REMEMBER HER?

2 A. YES, SIR.

3 Q. AND I'M LOOKING HERE, I THINK A COUPLE OF TIMES?

4 A. YES, SIR.

5 Q. ALL RIGHT. AND DID SHE GO THROUGH THESE THINGS WITH

6 YOU AS FAR AS WHAT'S GOING ON WITH YOU, THE TYPE OF

7 PROBLEMS YOU'RE HAVING?

8 A. YES, SIR, SHE DID.

9 Q. DID YOU EVER HIDE FROM HER THE FACT THAT YOU HAD

10 DEPRESSION GOING ON BEFORE THIS ACCIDENT?

11 A. NO, SIR, I HAVEN'T HID IT FROM ANYBODY. I DON'T TRY

12 TO HIDE STUFF.

13 Q. ALL RIGHT. AND LET ME ASK YOU ALSO, I THINK AT SOME

14 POINT, DID YOU GET MORE OR LESS TOLD TO GO TO DR.

15 BRAWLEY TO HAVE SOME TESTS DONE?

16 A. YES, SIR.

17 Q. DO YOU REMEMBER HER, DR. BRAWLEY, KIND OF TALL, DARK

18 HAIR?

19 A. YES, SIR.

20 Q. AND DID YOU TRY ON THE THINGS THAT SHE TRIED TO

21 ALLOW YOU TO DO?

22 A. YES, SIR.

23 Q. AND I'M LOOKING IN HER REPORT, AND IT SAYS THAT

24 Y'ALL HAD TO STOP AT SOME POINT?

25 A. YES, SIR.

1 Q. ALL RIGHT. WAS IT -- DID YOU ASK TO STOP?
2 A. NO, SIR.
3 Q. ALL RIGHT. THAT WAS HER DECISION?
4 A. YES, SIR.
5 Q. ALL RIGHT. NOW, YOU ALSO SAW DR. SALAS A COUPLE OF
6 TIMES?
7 A. YES, SIR.
8 Q. DO YOU REMEMBER HER?
9 A. YES, SIR.
10 Q. ALL RIGHT. AND AGAIN, Y'ALL SAT TOGETHER. YOU WENT
11 OVER THINGS, TOLD HER HOW YOU WERE FEELING?
12 A. YES, SIR.
13 Q. AGAIN, DID YOU EVER TRY TO HIDE FROM HER THAT YOU
14 HAD SEEN DR. MCQUEEN IN THE PAST, THAT YOU HAD
15 GOTTEN MEDICATION FROM DR. MCQUEEN IN THE PAST?
16 A. NO, SIR.
17 Q. ALL RIGHT. BUT AS I UNDERSTAND IT, EVEN WITH THOSE
18 PROBLEMS, THEY WERE SOMETHING THAT YOU STAYED, WERE
19 ABLE TO TREAT WITH DR. MCQUEEN, NOWHERE ELSE?
20 A. YES, SIR.
21 Q. NO PSYCHIATRIST, NO PSYCHOLOGIST?
22 A. NO, SIR.
23 Q. AND AS I -- WAS THERE EVER ANY ISSUE AS FAR AS THESE
24 THINGS BEING BECAUSE OF ANY HEAD INJURY BEFORE 2012
25 WHEN YOU FELL?

1 A. NO, SIR.

2 Q. AND, MS. RUMMAGE, LET ME ASK, ARE YOU INTERESTED IN

3 TREATMENT?

4 A. YES, SIR, I AM.

5 Q. AS -- AS I UNDERSTAND IT, WHAT YOU WOULD BE GETTING

6 AS FAR AS TREATMENT IS NOT SOMETHING YOU'VE HAD

7 BEFORE, COUNSELING?

8 A. I'M INTERESTED.

9 Q. ALL RIGHT. YOU HADN'T HAD PSYCHOLOGICAL COUNSELING?

10 A. NO, SIR, NEVER.

11 Q. AND YOU HADN'T HAD PSYCHIATRIC COUNSELING?

12 A. NO, SIR.

13 Q. OKAY. YOU ALSO WENT UP TO CHARLOTTE. YOU -- I

14 THINK YOU GOT TAKEN UP THERE?

15 A. YES, SIR. MY HUSBAND WAS SICK, AND I CAN'T DRIVE,

16 AND THE SITUATION IS THEY ARRANGED FOR A DRIVER TO

17 PICK ME UP AND TAKE ME AND STAY WITH ME AND TO BRING

18 ME BACK.

19 Q. OKAY. NOW, I'M NOT ASKING A LOT OF DETAILS ABOUT

20 THAT, BUT LET ME JUST ASK THIS: YOU WERE ORIGINALLY

21 SET TO GO, AND IT TOOK SOME MONTHS BEFORE ACTUALLY

22 YOU GOT UP THERE?

23 A. YES, SIR.

24 Q. OKAY. BUT YOU ACTUALLY, IT LOOKS LIKE YOU WERE SEEN

25 IN AROUND APRIL OF -- OF 2015?

1 A. I CAN'T REMEMBER A DATE.

2 Q. OKAY. AND I MAY BE WRONG. I APOLOGIZE IF I SAID
3 '15 OR '14, BUT YOU GOT SEEN -- THERE WAS A GAP FROM
4 WHEN YOU WERE ORIGINALLY SUPPOSED TO GO?

5 A. YES, SIR.

6 Q. ALL RIGHT. WAS -- DO YOU REMEMBER DURING THE TIME
7 OF THAT VISIT WITH THAT DOCTOR HAVING TO DO
8 SOMETHING ON THE COMPUTER?

9 A. YES, SIR. THAT'S WHAT I DID MOST OF THE TIME WAS
10 SIT IN FRONT OF A COMPUTER THAT...

11 Q. AND JUST ANSWER QUESTIONS?

12 A. YES, SIR.

13 Q. ALL RIGHT. DID YOU GET -- AND AGAIN, I'M NOT ASKING
14 SPECIFICS, BUT FROM YOUR BEST RECOLLECTION, DID YOU
15 HAVE A LOT OF WHAT WE CALL FACE TIME WITH DR.
16 GUALTIERI?

17 A. NO, SIR.

18 Q. NOW, YOU OBVIOUSLY HAD FACE TIME WITH DR. WATT?

19 BY MR. FARRY:

20 OBJECT TO LEADING, WHEN IT'S ---

21 BY MR. SAFRAN:

22 ALL RIGHT.

23 BY COMMISSIONER BARDEN:

24 SUSTAINED.

25 DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

1 Q. EXCUSE ME. DID YOU HAVE FACE TIME WITH DR. WATTS?
2 A. YES, SIR, I DID.
3 Q. TWICE?
4 A. YES, SIR.
5 Q. AND DID YOU HAVE FACE TIME WITH DR. SALAS?
6 A. YES, SIR.
7 Q. AND I THINK YOU'VE TESTIFIED YOU WERE DOING SOME
8 TESTS WITH DR. BRAWLEY, AT LEAST UP TO A POINT?
9 A. YES, SIR.
10 Q. ALL RIGHT. DID SHE ALSO -- DID SHE ALSO KIND OF
11 INTERVIEW YOU?
12 A. FACE TO FACE.
13 Q. OKAY. ALL RIGHT. THERE HAS BEEN, I THINK YOU MAY
14 HAVE HEARD THE STATEMENT THAT YOU'VE GOT ALL THESE
15 TERRIBLE THINGS GOING ON IN YOUR LIFE RIGHT NOW THAT
16 ARE WHAT WE CALL STRESSORS, AND THAT THAT'S WHY
17 YOU'RE DEPRESSED, IT DOESN'T REALLY HAVE ANYTHING TO
18 DO WITH YOUR HEAD. YOUR HUSBAND'S SITTING BACK
19 HERE. HE HAS ISSUES HEALTH WISE?
20 A. YES, SIR.
21 Q. HAS HE HAD ISSUES HEALTH WISE BEFORE 2012?
22 A. YES, SIR.
23 Q. ALL RIGHT. AND DID HE HAVE ISSUES WITH HIS HEALTH
24 GOING BACK SOMETIME BEFORE 2012?
25 A. YES, SIR.

1 Q. SO WAS THAT SOMETHING THAT WAS THERE, THAT YOU HAD
2 TO BE AWARE OF AND CERTAINLY LIVE WITH BEFORE YOU
3 EVER HAD THIS ACCIDENT?

4 A. YES, SIR.

5 **BY COMMISSIONER BARDEN:**

6 Q. WHAT ARE THE HEALTH ISSUES?

7 A. HE HAS HEART PROBLEMS. HE HAS DIABETES. HE SERVED
8 IN IRAQ. HE HAS P.T.S.D. BUT HE -- HE HAS HEALTH
9 ISSUES, AND I HAVE DEALT WITH THEM A LONG TIME
10 BEFORE MY ACCIDENT.

11 **DIRECT EXAMINATION RESUMED BY MR. SAFRAN:**

12 Q. OKAY. DID YOU HAVE OTHER STRESSORS INVOLVING FAMILY
13 MEMBERS BEFORE THIS ACCIDENT?

14 A. I -- YES, SIR, I HAVE.

15 Q. OKAY.

16 A. I WAS AN ONLY CHILD. I TOOK CARE OF MY MOM AND MY
17 DAD THROUGH THEIR DEATHS.

18 Q. HOW ABOUT ONE OF YOUR SONS?

19 A. YES, SIR.

20 Q. AND AGAIN, WAS THAT SOMETHING THAT YOU HAD TO DEAL
21 WITH BEFORE YOU EVER HURT YOURSELF?

22 A. YES, SIR.

23 Q. HAS YOUR -- THE SON CONTINUED TO HAVE, I GUESS,
24 SOMETHING IF IT CAN CAUSE YOU TO BE UPSET?

25 A. YES, SIR.

BY COMMISSIONER BARDEN:

Q. NOW, WHAT IS THAT? WHAT -- WHAT'S GOING ON WITH YOUR SON?

A. MY SON HAS A BAD KIDNEY, AND HE BACK SOME MONTHS AGO HE ASPIRATED, BUT ---

Q. I'M SORRY?

A. HE ASPIRATED.

Q. OH, ASPIRATED.

A. BUT HE'S DOING MUCH BETTER.

Q. OKAY.

A. SO...

DIRECT EXAMINATION RESUMED BY MR. SAFRAN:

Q. ALL RIGHT. AND I GUESS MY QUESTION IS YOUR SON HAD ISSUES THAT WERE IN A NORMAL SITUATION WOULD HAVE BEEN STRESSFUL BEFORE THIS ACCIDENT EVER HAPPENED?

A. YES, SIR.

Q. AND HE STILL HAS ISSUES?

A. YES, SIR.

Q. ALL RIGHT. SO I GUESS WHAT I'M SAYING IS YOU'VE ALREADY TALKED ABOUT THERE'S A CHANGE?

A. YES, SIR.

Q. HAS CONTINUING HEALTH ISSUES OF YOUR HUSBAND OR YOUR SON, HAVE THOSE CHANGED, OR HAVE THEY BEEN PRETTY MUCH CONSTANT?

A. IT'S BEEN AN ONGOING THING. I MEAN, IT WAS THERE

1 BEFORE, AND IT'S STILL THERE, I MEAN...

2 Q. DO YOU LOOK AT THAT AS SOMETHING THAT SOMEHOW THAT
3 YOU CAN SAY IS WHY YOU'RE FEELING SO MUCH WORSE NOW,
4 YOUR SON OR HUSBAND?

5 A. NO, SIR.

6 Q. OKAY. LET ME ASK. AS FAR AS -- AS IN YOUR LIFE,
7 KNOWING I GUESS THAT YOU'VE ALREADY SAID "I HAD
8 DEPRESSION BEFORE; I TOOK MEDICINE BEFORE."

9 A. YES, SIR, I DID.

10 Q. WHAT'S CHANGED TO MAKE YOU FEEL THE WAY YOU DO NOW
11 AND IT'S, YOU SAY, WORSE, SOME OF THESE DOCTORS SAY
12 WORSE? WHAT IS IT BASICALLY THAT -- THAT'S MAKING A
13 DIFFERENCE?

14 A. THE FACT THAT I CAN'T COME BACK TO WHERE I WAS
15 BEFORE IT HAPPENED. I CAN'T DO THE THINGS THAT I
16 DID BEFORE IT HAPPENED. I CAN'T COPE WITH BEING IN
17 THE PUBLIC BEFORE IT HAPPENED. I TRY TO, BUT WHEN I
18 TRY TO COME OUT AND TRY TO HOLD CONVERSATIONS WITH
19 OTHER PEOPLE, I USUALLY END UP SAYING THE SAME THING
20 OVER AND OVER OR SAYING SOMETHING THAT JUST REALLY
21 EMBARRASSES MYSELF, AND YOU CAN SEE IT IN THEM, YOU
22 KNOW, THAT THEY NOTICE IT.

23 Q. LET ME ASK THIS: THERE IS RECORDS THAT TALK ABOUT
24 WHAT WE CALL COGNITIVE DEFICITS, IT'S MEMORY,
25 CONCENTRATION. NOW ---

1 A. I STAY IN A FOG.

2 Q. OKAY. NOW, YOU WERE DEPRESSED BEFORE THE ACCIDENT?

3 A. YES, SIR, I WAS.

4 Q. AND I'M SURE THERE MAY HAVE BEEN SOME TIMES THAT
5 WERE WORSE THAN OTHERS?

6 A. YES, SIR, IT WAS.

7 Q. BUT I GUESS WHAT I'M ASKING NOW IS -- IS WHAT WE
8 JUST MENTIONED, THE MEMORY, THE FOCUS, ARE THOSE
9 THINGS DIFFERENT NOW THAN WHAT YOU HAD BEFORE THE
10 ACCIDENT?

11 A. YES, SIR, IT IS. I COULD ALWAYS FOCUS AND BRING
12 MYSELF BACK AND DO WHAT I NEEDED TO DO.

13 Q. OKAY. NOW, THERE WERE TIMES THOUGH THAT YOU WERE
14 CHALLENGED BEFORE THE ACCIDENT?

15 A. OH, YES, SIR, VERY MUCH SO.

16 Q. WERE THERE TIMES YOU TOLD DR. MCQUEEN THAT YOU KIND
17 OF HAD REACHED THE END OF THE ROPE?

18 A. AND PROBABLY NUMEROUS TIMES.

19 Q. OKAY. BUT KEPT ON WORKING?

20 A. YES, SIR, I DID.

21 Q. KEPT ON DOING WHAT YOU HAD TO DO FOR THE FAMILY?

22 A. YES, SIR, I DID.

23 Q. OKAY. JUST A COUPLE OF QUICK THINGS. IN THE EVENT
24 SURGERY IS NOT SOMETHING THAT'S RECOMMENDED, SO
25 LET'S -- JUST FOR THE SAKE OF MY QUESTION, JUST

1 ASSUME THAT THERE'S NO SURGERY THAT ANYBODY WOULD
2 WANT TO DO ON YOU, OKAY, ARE YOU GETTING AS MUCH
3 RELIEF OUT OF WHAT'S BEING PROVIDED TO YOU NOW BY
4 DR. SINGH AS YOU WERE FROM DR. COLLINS?

5 A. NO, SIR.

6 Q. ALL RIGHT. SO IF IN FACT THERE'S NO SURGERY OUT
7 THERE, YOU WANT TO BE ABLE TO GET THESE THINGS THAT
8 YOU'RE NOT GETTING NOW BUT THAT YOU WERE GETTING
9 AUTHORIZED THROUGH DR. COLLINS OR OBVIOUSLY THROUGH
10 SOMEONE TO BE ABLE TO GET THAT GREATER LEVEL OF
11 RELIEF THAT YOU WERE GETTING BEFORE?

12 A. YES, SIR, I WOULD.

13 Q. OKAY.

14 BY MR. SAFRAN:

15 I DON'T HAVE ANYTHING ELSE.

16 BY COMMISSIONER BARDEN:

17 ALL RIGHT. PLEASE, ANSWER ANY QUESTIONS MR.

18 FARRY HAS.

19 BY MR. FARRY:

20 THANK YOU.

21 BY THE WITNESS:

22 WOULD YOU LIKE ME ---

23 BY COMMISSIONER BARDEN:

24 YOU CAN ---

25 BY THE WITNESS:

1 FACING HIM OR ---

2 BY COMMISSIONER BARDEN:

3 HE'S COMING OVER HERE TO MAKE IT EASY.

4 BY MR. FARRY:

5 I'M GOING TO MAKE IT EASY ON EVERYBODY OR TRY
6 TO.

7 BY THE WITNESS:

8 --- TO ANSWER TO YOU?

9 BY COMMISSIONER BARDEN:

10 I SAID JUST BEST YOU CAN DIRECT YOUR RESPONSES
11 TO ME.

12 BY THE WITNESS:

13 THAT'S WHAT I'M SAYING DO I ANSWER TO YOU OR
14 ANSWER TO HIM?

15 BY COMMISSIONER BARDEN:

16 NO, I DIDN'T SAY ANSWER TO ME.

17 BY THE WITNESS:

18 I'M SORRY. I'M SORRY.

19 BY COMMISSIONER BARDEN:

20 I SAID JUST DIRECT YOUR RESPONSES TO ME.

21 BY THE WITNESS:

22 OKAY.

23 BY COMMISSIONER BARDEN:

24 AND, MR. FARRY, YOU CAN PULL UP A CHAIR IF
25 YOU'D LIKE.

1 BY MR. FARRY:

2 THANK YOU.

3 CROSS-EXAMINATION BY MR. FARRY:

4 Q. AFTER YOUR ACCIDENT, MS. RUMMAGE -- AND WE HAVEN'T
5 MET, BY THE WAY. I'M NEW TO THIS CASE IN THE LAST
6 FEW MONTHS. A DIFFERENT LAWYER TOOK YOUR DEPOSITION
7 AND HAS BEEN INVOLVED FOR A NUMBER OF YEARS. SO I
8 MUMBLE SOMETIMES. SO YOU BEAR WITH ME.

9 A. PLEASE, BEAR WITH ME TOO.

10 Q. AND THAT'S -- THAT'S A DEAL. AFTER YOUR ACCIDENT
11 MAY 18, 2012, YOU WERE OFFERED THE OPPORTUNITY TO GO
12 TO THE DOCTOR OR HOSPITAL, BUT YOU DECIDED NOT TO DO
13 THAT, DIDN'T YOU?

14 A. YES, SIR, I DID.

15 Q. AND YOU FINISHED OUT YOUR SHIFT ON THE DAY THAT YOU
16 WERE HURT AND CAME BACK TO WORK THE NEXT DAY YOU
17 WERE SCHEDULED AND WORKED YOUR REGULAR JOB, DIDN'T
18 YOU?

19 A. YES, SIR, I DID.

20 Q. AND YOU WORKED YOUR REGULAR JOB UP UNTIL SOMETIME IN
21 AUGUST; FROM MAY OF 2012 UNTIL AUGUST OF 2012, YOU
22 WORKED YOUR REGULAR JOB?

23 A. STRUGGLING EVERY DAY.

24 Q. YOU HAVEN'T WORKED ANYWHERE SINCE AUGUST OF 2012,
25 HAVE YOU?

1 A. NO, SIR.

2 Q. NOW, PRIOR TO YOUR ACCIDENT, YOU'VE ADMITTED THAT
3 YOU WERE A PATIENT OF DR. FRED MCQUEEN FOR A NUMBER
4 OF YEARS, TEN OR MORE YEARS?

5 A. YES, SIR.

6 Q. AND HE WAS YOUR FAMILY DOCTOR?

7 A. YES, SIR.

8 Q. HE TREATED YOU FOR WHATEVER AILMENTS YOU HAD THAT HE
9 COULD HANDLE, BASICALLY?

10 A. YES, SIR.

11 Q. NOW, BACK IN 2005, YOU WERE RECEIVING TREATMENT FOR
12 NECK PAIN, LOW BACK PAIN, AND DEPRESSION, CORRECT?

13 A. YES, SIR.

14 BY MR. FARRY:

15 THAT'S APA PAGE 191, COMMISSIONER.

16 BY COMMISSIONER BARDEN:

17 THANK YOU.

18 CROSS-EXAMINATION RESUMED BY MR. FARRY:

19 Q. YOU HAD BEEN DIAGNOSED WITH CERVICAL DISC DISEASE BY
20 SEPTEMBER OF 2005 AFTER AN M.R.I. ON YOUR NECK?

21 A. IT'S IN THE PAPERS. I GUESS SO.

22 Q. OKAY. YOU'VE BEEN TAKING MEDICATION FOR PAIN AND
23 DEPRESSION SINCE 2005 AT LEAST?

24 A. YES, SIR.

25 Q. AND THAT MEDICATION INCLUDES LORCET, BACK IN 2005?

1 A. YES, SIR.

2 Q. IT INCLUDES XANAX?

3 A. YES, SIR.

4 Q. IT INCLUDES AMBIEN TO HELP YOU SLEEP?

5 A. UH-HUH. I'M -- I -- I HAVE HAD IT, YES, SIR.

6 Q. OKAY. PROZAC?

7 A. YES, SIR, I THINK I DID.

8 Q. AND BACK IN 2005, YOU WERE ALSO TAKING CYMBALTA,
9 CORRECT?

10 A. I CAN'T REMEMBER BECAUSE ---

11 Q. OKAY.

12 A. --- THEY...

13 Q. FAIR ENOUGH. NOW, DR. MCQUEEN TREATED YOU FOR THIS
14 PAIN PROBLEM YOU HAD, AND YOUR PAIN PRIMARILY WAS
15 YOUR NECK, CORRECT?

16 A. UM...

17 Q. AT LEAST SINCE 2006?

18 A. YES, SIR.

19 BY MR. FARRY:

20 APA PAGE 193, COMMISSIONER.

21 BY COMMISSIONER BARDEN:

22 THANK YOU.

23 CROSS-EXAMINATION RESUMED BY MR. FARRY:

24 Q. YOU SAW DR. BRENNAN WITH FLORENCE NEUROSURGERY &
25 SPINE IN JULY OF 2007 WITH YOUR CHIEF COMPLAINT

1 ACCORDING TO HIS REPORTS BEING NECK PAIN, LOW BACK
2 PAIN, BILATERAL HIP PAIN, NUMBNESS AND TINGLING IN
3 YOUR HANDS; DO YOU REMEMBER THAT?

4 A. I CAN'T REMEMBER, BUT, YES, SIR, IT'S IN THE
5 RECORDS.

6 BY MR. FARRY:

7 THAT'S AT PAGE 182 AND 181, COMMISSIONER.

8 BY COMMISSIONER BARDEN:

9 THANK YOU.

10 CROSS-EXAMINATION RESUMED BY MR. FARRY:

11 Q. AT THAT TIME, YOU WERE TAKING A NUMBER OF DIFFERENT
12 MEDICATIONS FOR PAIN INCLUDING -- AND DEPRESSION
13 INCLUDING LYRICA AT THAT TIME?

14 A. I CAN'T REMEMBER, SIR.

15 Q. WELLBUTRIN, DO YOU REMEMBER THAT?

16 A. NO, SIR.

17 Q. XANAX, DO YOU REMEMBER THAT?

18 A. I CAN'T REMEMBER THAT INCIDENT AT ALL. I MEAN, ---

19 Q. AVANDIA.

20 A. I'M SORRY.

21 Q. DO YOU REMEMBER THAT MEDICATION?

22 A. NO, SIR.

23 Q. SOMA, DO YOU REMEMBER THAT MEDICATION?

24 A. NO, SIR, I DON'T.

25 Q. SKELAXIN, DO YOU REMEMBER THAT MEDICATION?

1 A. NO, SIR.

2 Q. AND ARTHROTEC.

3 BY MR. FARRY:

4 THAT'S AT PAGE 187 AND 189, APA 12.

5 CROSS EXAMINATION RESUMED BY MR. FARRY:

6 Q. NOW, IN SEPTEMBER OF 2006, DR. MCQUEEN PUT IN HIS
7 REPORT, "I DON'T KNOW HOW MUCH LONGER SHE'S GOING TO
8 BE ABLE TO CONTINUE TO WORK." DO YOU REMEMBER
9 HAVING DR. MCQUEEN TELL YOU THAT?

10 A. NO, SIR, BUT I WORKED.

11 Q. OKAY. APA PAGE 194. DECEMBER OF 2006, YOU WERE
12 CONTINUING TO RECEIVE TREATMENT FOR PAIN AS A MEMBER
13 OF THE PAIN MANAGEMENT PROGRAM THAT DR. MCQUEEN HAD.

14 A. YES, SIR.

15 Q. YOU WERE IN HIS PAIN MANAGEMENT PROGRAM?

16 A. YES, SIR.

17 Q. YOU HAD SEVERE DEGENERATIVE DISC DISEASE ACCORDING
18 TO HIS REPORT, SEVERE MUSCLE SPASMS WITH THAT. APA
19 194. DO YOU REMEMBER THAT?

20 A. HE NEVER DISCUSSED THE DISC DISEASE, BUT IT'S IN THE
21 RECORDS.

22 Q. OKAY.

23 A. AND...

24 Q. NOW, THROUGHOUT 2007, YOU WERE TREATED FOR CHRONIC
25 NECK PAIN AND DEPRESSION BY DR. MCQUEEN. HE

1 CONTINUED TO PROVIDE YOU ALL THESE MEDICATIONS FOR
2 DEPRESSION AND PAIN, CORRECT?

3 A. YES, SIR.

4 Q. 2008, DR. MCQUEEN WAS TREATING YOU FOR DEPRESSION,
5 CHRONIC PAIN, AND WHAT HE CALLED MAJOR DEPRESSION;
6 DO YOU REMEMBER THAT?

7 A. I GUESS, SIR. YES, SIR.

8 BY MR. FARRY:

9 APA PAGE 200, COMMISSIONER.

10 CROSS-EXAMINATION RESUMED BY MR. FARRY:

11 Q. IN 2009, YOU WERE TREATED FOR CHRONIC PAIN, CHRONIC
12 ANXIETY AND DEPRESSION SYMPTOMS WITH MEDICATION,
13 TRUE?

14 A. YES, SIR.

15 Q. APA 201. MAY OF 2009, YOU BEGAN TREATING FOR
16 MIGRAINE HEADACHES; DO YOU REMEMBER THAT?

17 A. YES, SIR.

18 BY MR. FARRY:

19 APA 202 AND 203, COMMISSIONER.

20 BY COMMISSIONER BARDEN:

21 THANKS.

22 CROSS-EXAMINATION RESUMED BY MR. FARRY:

23 Q. AT THAT POINT, YOU'RE ON LORTAB, REFLEX, PROZAC,
24 EFFEXOR, AMBIEN, AND XANAX STILL, CORRECT?

25 A. I CAN'T REMEMBER, BUT IT'S IN THE RECORDS.

1 Q. ALL RIGHT. YOU -- YOU DON'T DOUBT THOUGH THAT DR.
2 MCQUEEN WAS PRESCRIBING THOSE MEDICATIONS ---

3 A. AND, NO, SIR.

4 Q. --- IF IT'S IN THE RECORDS?

5 A. NO, SIR.

6 Q. OKAY. APA PAGE 203, 202. IN NOVEMBER OF 2009, YOU
7 WERE STILL TREATING FOR CHRONIC PAIN AND CHRONIC
8 MIGRAINES AS WELL AS GENERALIZED ANXIETY DISORDER.

9 BY MR. FARRY:

10 THAT'S APA 13 AT PAGE 205, COMMISSIONER.

11 CROSS-EXAMINATION RESUMED BY MR. FARRY:

12 Q. IS THAT TRUE?

13 A. YES, SIR, BUT NOTHING LIKE IT'S BEEN.

14 Q. OKAY. IN DR. MCQUEEN'S REPORT OF NOVEMBER 22, 2010,
15 HE WROTE, "I DON'T KNOW HOW MUCH LONGER SHE WILL BE
16 ABLE TO CONTINUE IN THE WORK FIELD, BECAUSE HER BODY
17 IS BREAKING DOWN." DO YOU REMEMBER THAT
18 CONVERSATION WITH DR. MCQUEEN?

19 A. NO, SIR.

20 Q. APA PAGE 208. MAY OF 2011, ONE YEAR BEFORE THE
21 ACCIDENT YOU WERE STILL TREATED BY DR. MCQUEEN FOR
22 CHRONIC PAIN, AND AT THAT TIME, THE MEDICATIONS WERE
23 PERCOCET, CORRECT?

24 A. I DON'T REMEMBER, BUT IF IT'S IN THE RECORDS, THEN I
25 -- I AGREE WITH HIT.

1 Q. PROZAC, DO YOU REMEMBER TAKING PROZAC?
2 A. YES, SIR, I DO REMEMBER TAKING PROZAC.
3 Q. STILL TAKING XANAX AT THIS POINT IN MAY OF 2011?
4 A. YES, SIR.
5 Q. FLEXERIL?
6 A. I DON'T REMEMBER.
7 Q. ADIPEX?
8 A. I DON'T REMEMBER.
9 Q. AMBIEN, FOR SLEEP?
10 A. IT'S IN THE RECORDS, SIR.
11 Q. OKAY.
12 A. I AGREE.
13 Q. AND AT THAT TIME, YOU WERE BEING TREATED FOR TENSION
14 HEADACHES, CORRECT?
15 A. YES, SIR, IF IT'S IN THE RECORDS, I HAVE.
16 Q. YOU WERE ALSO BEING TREATED FOR DEPRESSION AND
17 ANXIETY IN MAY OF 2011, CORRECT?
18 A. YES, SIR.
19 Q. YOU WERE ALSO BEING TREATED FOR MIGRAINES?
20 A. YES, SIR.
21 Q. YOU ALSO WERE BEING TREATED FOR UNSTABLE ANGINA,
22 CORRECT?
23 A. UNSTABLE?
24 Q. ANGINA, PROBLEMS WITH YOUR HEART.
25 A. I NEVER KNEW ANYTHING ABOUT THAT, SIR.

1 Q. OKAY. YOU WERE DIAGNOSED AT THAT TIME WITH
2 OSTEOARTHRITIS, CORRECT?

3 A. YEAH. YES, SIR.

4 Q. YOU WERE STILL HAVING MUSCLE SPASMS AND DIAGNOSED
5 WITH CERVICAL AND LUMBAR DISC DISEASE BY DR. MCQUEEN
6 IN MAY OF 2011, CORRECT?

7 A. YES, SIR.

8 BY MR. FARRY:

9 THAT'S AT APA PAGE 212, COMMISSIONER.

10 CROSS-EXAMINATION RESUMED BY MR. FARRY:

11 Q. SEPTEMBER OF 2011, DR. MCQUEEN CONTINUES TO TREAT
12 YOU FOR CHRONIC PAIN AND DEPRESSION AND SAID IN HIS
13 REPORT THAT IF PERCOCET DOES NOT HOLD PAIN, MAY HAVE
14 TO SEE ABOUT GETTING YOU TO A PAIN CLINIC; DO YOU
15 REMEMBER THAT IN SEPTEMBER OF 2011?

16 A. I DON'T REMEMBER, BUT IF IT'S IN THE RECORD, SIR, SO
17 THAT'S RIGHT.

18 Q. APA PAGE 215. FEBRUARY 2012, NOW WE'RE IN THE YEAR
19 THAT YOU HAD YOUR ACCIDENT IN MAY, YOU WERE TAKING
20 PERCOCET, M.S. CONTIN, MORPHINE SULFATE, AND XANAX,
21 CORRECT?

22 A. I DON'T REMEMBER, SIR.

23 Q. OKAY. APA PAGE 221. NOW, THIS ISN'T YOUR FIRST
24 WORKERS' COMPENSATION CLAIM. YOU HAD PREVIOUSLY
25 FILED A CLAIM AGAINST THE TOWN OF CHERAW, CORRECT?

1 A. YES, SIR. THERE WAS A CLAIM FILED.

2 Q. DO YOU REMEMBER BEING ASKED IN YOUR DEPOSITION AS TO
3 WHETHER OR NOT YOU HIRED AN ATTORNEY IN THAT CLAIM?

4 A. I CAN'T REMEMBER, SIR. I'M SORRY.

5 Q. YOU DON'T REMEMBER WHAT YOU SAID IN YOUR DEPOSITION
6 ABOUT THAT QUESTION?

7 A. NO, SIR, I DON'T.

8 BY COMMISSIONER BARDEN:

9 DO I HAVE A COPY OF THE DEPOSITION?

10 BY MR. FARRY:

11 NO, MA'AM. IT'S NOT IN THE RECORD YET.

12 BY COMMISSIONER BARDEN:

13 OKAY.

14 BY MR. FARRY:

15 BEAR WITH ME JUST A MINUTE, COMMISSIONER. THIS
16 IS THE ORIGINAL TRANSCRIPT FROM MS. RUMMAGE'S
17 DEPOSITION.

18 BY COMMISSIONER BARDEN:

19 OKAY.

20 BY MR. FARRY:

21 MAY I APPROACH THE WITNESS?

22 BY COMMISSIONER BARDEN:

23 YES. YES, SIR.

24 CROSS-EXAMINATION RESUMED BY MR. FARRY:

25 Q. MS. RUMMAGE, I'M GOING TO ASK YOU TO PUBLISH, THIS

1 IS A PORTION OF YOUR DEPOSITION TRANSCRIPT WHEN IT
2 WAS TAKEN IN 2013, AND I'M GOING TO DIRECT YOU TO A
3 CERTAIN PAGE.

4 A. OKAY.

5 Q. AND WE'RE GOING TO START AT PAGE 11 IN YOUR
6 DEPOSITION AND WHERE IT SAYS "Q," THAT'S THE
7 QUESTION THAT THE ATTORNEY WAS ASKING YOU, AND "A"
8 IS YOUR ANSWER. I'M GOING TO READ WHERE IT SAYS
9 "Q," AND I'M GOING TO ASK YOU TO READ WHERE "A" IS,
10 WHICH WAS YOUR ANSWER. OKAY?

11 A. OKAY.

12 Q. "DID YOU RECEIVE ANY TYPE OF WORKERS' COMPENSATION
13 BENEFITS?" AND YOUR ANSWER WAS? READ THAT.

14 A. "NO, SIR, I DID NOT."

15 Q. "DID YOUR CASE GO TO A HEARING AT ALL BEFORE THE
16 WORKERS' COMP COMMISSIONER?"

17 A. "I CAN'T REMEMBER, SIR. I REALLY CAN'T REMEMBER."

18 Q. QUESTION, "DID YOU HAVE A LAWYER?"

19 A. "NO, SIR."

20 Q. IN FACT, YOU DID HIRE A LAWYER, AND YOUR CASE DID GO
21 TO A HEARING, DIDN'T IT?

22 A. SIR, I CAN'T REMEMBER.

23 Q. OKAY. I KNOW YOU CAN'T REMEMBER NOW, BUT WHEN YOUR
24 DEPOSITION WAS TAKEN DECEMBER 19TH, 2013, THAT WAS
25 ONLY A YEAR AFTER THE ACCIDENT, A LITTLE MORE THAN A

- 1 YEAR, CORRECT?
- 2 A. I'M REALLY NOT SURE, SIR.
- 3 Q. OKAY. BUT WE DO KNOW THAT WHEN YOU WERE ASKED THE
- 4 QUESTION, "DID YOU HAVE A LAWYER?" YOU SAID, "NO,
- 5 SIR"?
- 6 A. YES, SIR.
- 7 Q. AND THAT WAS CLOSER IN TIME TO NOW, TO YOUR PREVIOUS
- 8 HEARING, CORRECT?
- 9 A. I'M NOT SURE, SIR.
- 10 Q. OKAY. NOW, THAT CASE WENT TO A HEARING, DIDN'T IT,
- 11 THE ONE THAT YOU HAD WITH THE TOWN OF CHERAW, WHERE
- 12 YOU HAD TO TESTIFY BEFORE A COMMISSIONER?
- 13 A. I'M NOT SURE, SIR. I CAN'T REMEMBER.
- 14 Q. ALL RIGHT. THERE WAS AN ORDER ISSUED, AND -- AND
- 15 THE ORDER SAID YOU DIDN'T GET ANY BENEFITS FOR YOUR
- 16 SHOULDER, CORRECT?
- 17 A. SIR, ALL I CAN REMEMBER IS MY HUSBAND'S INSURANCE
- 18 PAYING FOR IT, FOR MY SHOULDER TO BE REPAIRED.
- 19 Q. NOW, DO YOU REMEMBER WHEN THIS ATTORNEY TOOK YOUR
- 20 DEPOSITION, AND YOU WERE ASKED IF YOU'D EVER HAD A
- 21 DEPOSITION TAKEN BEFORE?
- 22 A. YES, SIR, I THINK.
- 23 Q. YOUR DEPOSITION HAD BEEN TAKEN BEFORE IN THE OTHER
- 24 CASE, HADN'T IT?
- 25 A. SIR, I -- I CAN'T REMEMBER. I'M SO SORRY.

1 BY MR. FARRY:

2 BEAR WITH ME JUST A MINUTE, COMMISSIONER,
3 PLEASE.

4 BY COMMISSIONER BARDEN:

5 GO AHEAD.

6 BY MR. FARRY:

7 COMMISSIONER, AS AN OFFICER OF THE COURT, THERE
8 IS TESTIMONY WHERE SHE DENIED EVER HAVING HER
9 DEPOSITION TAKEN BEFORE, AND I CAN'T PUT MY FINGER
10 ON IT. I ---

11 BY COMMISSIONER BARDEN:

12 I'VE GOT -- OR YOU MEAN IN ---

13 BY MR. FARRY:

14 IN -- IN THE -- IN THE DEPOSITION.

15 BY COMMISSIONER BARDEN:

16 YEAH. WELL, I'LL READ -- I READ EVERYTHING
17 Y'ALL GAVE ME. SO I WILL -- I'LL READ IT, BUT I
18 WOULD LIKE A POST-HEARING CONFERENCE.

19 BY MR. FARRY:

20 YES, MA'AM.

21 CROSS-EXAMINATION RESUMED BY MR. FARRY:

22 Q. YOUR ATTORNEY WAS ASKING YOU ABOUT OTHER STRESSORS
23 IN YOUR LIFE, AND YOU MENTIONED A SON WITH HEALTH
24 PROBLEMS. IS THAT THE SON THAT RECENTLY HAD TO GO
25 TO CHARLESTON FOR A DRUG ADDICTION PROBLEM?

1 A. HE WENT TO CHARLESTON BECAUSE HE ASPIRATED IN HIS
2 SLEEP.
3 Q. OKAY. IT DIDN'T HAVE ANYTHING TO DO WITH DRUGS?
4 A. SIR, THEY DIDN'T TELL ME.
5 Q. YOU DON'T KNOW WHY HE'S DOWN IN CHARLESTON?
6 A. I KNOW HE'S AT HOME.
7 Q. OKAY. BUT THE REASON HE HAD TO GO TO CHARLESTON?
8 A. THAT'S BECAUSE THAT HE ASPIRATED, AND THEY SAID THAT
9 HE WOULDN'T LIVE. I MEAN, HE ASPIRATED AND LAID --
10 WAS LEFT LAYING FOR JUST HOURS.
11 Q. YOU -- YOU DO CROSSWORD PUZZLES AND OTHER GAMES OR
12 THINGS ON THE COMPUTER, DON'T YOU?
13 A. YES, SIR, I TRY.
14 Q. LUMINOUS?
15 A. YES, SIR.
16 Q. CROSSWORDS?
17 A. YES, SIR.
18 Q. PLAY CANDY CRUSH?
19 A. YES, SIR, I TRY.
20 Q. AND YOU REGULARLY GET ON FACEBOOK NOW, CORRECT?
21 A. YES, SIR.
22 Q. AND WHEN YOU'RE ON FACEBOOK, YOU LOOK AT PHOTOGRAPHS
23 AND VIDEOS?
24 A. PHOTOGRAPHS.
25 Q. BUT YOU ALSO LOOK AT VIDEOS, BECAUSE SOMETIMES YOU

1 READ -- READ POSTS OR -- OR SEND VIDEOS TO OTHER
2 PEOPLE, CORRECT?

3 A. I -- I -- I GUESS, SIR.

4 Q. YOU SHARE LINKS AND PHOTOGRAPHS?

5 A. YES, SIR.

6 BY COMMISSIONER BARDEN:

7 Q. YOU DON'T KNOW WHETHER YOU POST OR NOT, OR DO YOU
8 KNOW?

9 A. YES, MA'AM, I DO POST.

10 Q. OKAY. THAT'S ALL -- THAT'S ALL ---

11 A. YES, MA'AM.

12 Q. --- HE ASKED YOU.

13 A. OKAY. YES.

14 CROSS-EXAMINATION RESUMED BY MR. FARRY:

15 Q. OKAY.

16 A. YES, SIR.

17 Q. AND YOU DO THAT. AND YOU POST ABOUT RECIPES AND
18 SHARE THOSE, DON'T YOU?

19 A. YES, SIR.

20 Q. YOU POST ABOUT PHOTOGRAPHS OF YOUR FAMILY OR
21 GRANDCHILDREN OR YOU AND YOUR HUSBAND OR YOU AND
22 YOUR SONS, AND THEN SEND THOSE OUT TO FRIENDS ON
23 YOUR FACEBOOK PAGE?

24 A. YES, SIR.

25 Q. NOW, IF WE JUST LOOK AT THE FACEBOOK POSTINGS ON

1 YOUR FACEBOOK PAGE ---

2 A. OKAY.

3 Q. --- STARTING IN JULY 3, IT LOOKS LIKE IN JULY YOU'VE

4 POSTED AT LEAST 30 TIMES IN THE MONTH OF JULY; DOES

5 THAT SOUND ABOUT RIGHT?

6 A. I DON'T KNOW A NUMBER, BUT, YES, SIR, I DO POST.

7 Q. OKAY. AND THEN IN AUGUST, YOU GOT AT LEAST 19

8 POSTINGS OF HAPPY BIRTHDAYS OR SHARING VIDEOS OR ---

9 A. YES, SIR.

10 Q. --- SENDING ---

11 A. BECAUSE THAT'S THE ONLY CONTACT I HAVE WITH PEOPLE.

12 SO I DO. IF A -- IF I CAN SEE SOMETHING AND WISH

13 THEM A HAPPY BIRTHDAY, YES, SIR, I DO.

14 Q. AND YOU SAY THAT'S THE ONLY CONTACT YOU HAVE WITH

15 PEOPLE. I'VE SEEN PHOTOGRAPHS OF YOU ON YOUR

16 FACEBOOK WHERE YOU AND YOUR HUSBAND ARE GETTING A

17 NEW CELL PHONE, AND THERE'S A PICTURE TAKEN WHERE

18 Y'ALL ARE GETTING A CELL PHONE; DO YOU REMEMBER

19 THAT?

20 A. YES, SIR. THAT WAS ON MY GRANDSON'S BIRTHDAY.

21 Q. OKAY.

22 A. WE WAS IN THERE WITH THEM.

23 Q. RIGHT. AND I'VE SEEN PICTURES ON YOUR FACEBOOK THAT

24 YOU'VE SHARED WITH PEOPLE WHERE YOU'RE AT A POOL,

25 AND ONE OF YOUR SONS IS IN THE POOL, AND YOU'RE

1 LEANED OVER WITH HIM GETTING YOUR PICTURE MADE?

2 A. YES, SIR. AND MATTER OF FACT, THAT'S THE ONLY
3 PICTURE THAT I CAN REMEMBER THAT I HAVE HAD MADE.
4 IT WAS MY GRANDSON'S 22ND BIRTHDAY.

5 Q. OKAY. YOU DON'T REMEMBER ANY OTHER PICTURES BEING
6 MADE?

7 A. OF ME? NO, SIR.

8 Q. I WANT TO SHOW YOU ---

9 A. MAYBE THEY WERE.

10 Q. --- A POSTING ON YOUR *FACEBOOK* PAGE AT PAGE 420.

11 A. OKAY.

12 Q. IS THAT YOU IN THAT PHOTOGRAPH?

13 A. YES, SIR. ON MOTHER'S DAY, IT SURE IS.

14 Q. OKAY. AND THEN THAT'S -- THAT'S ON YOUR *FACEBOOK*
15 PAGE, YOU'RE OPEN -- OR FIRST PAGE OF YOUR *FACEBOOK*
16 PAGE, ISN'T IT?

17 A. YES, SIR.

18 Q. SO YOU PUT PICTURES OF YOU ON YOUR *FACEBOOK* PAGE
19 ALONG WITH YOUR GRANDCHILDREN, DON'T YOU?

20 A. YES, SIR.

21 Q. AND YOU'VE GOT DOGS THAT YOU POST ABOUT ON YOUR
22 *FACEBOOK* PAGE, DON'T YOU?

23 A. YES, SIR, THAT'S OUR FAMILY.

24 Q. OKAY. AND IT LOOKS LIKE IN SEPTEMBER YOU HAD
25 ANOTHER 22 POSTINGS WHERE YOU'RE SHARING PHOTOS OR

1 SHARING PHOTOGRAPHS OF YOUR GRANDCHILDREN OR HAPPY
2 BIRTHDAY WISHES, CORRECT?
3 A. YES, SIR. I WISH THEM HAPPY BIRTHDAY.
4 Q. AND ---
5 A. I'M PROUD OF MY GRANDCHILD. I WANT THE WORLD TO
6 KNOW.
7 Q. YES, MA'AM. NOW, IN OCTOBER, FROM OCTOBER, THE
8 BEGINNING OF OCTOBER TO THE 23RD, WHICH IS THE LAST
9 DAY WE COPIED, IT LOOKS LIKE YOU GOT ANOTHER 11
10 POSTINGS. SO YOU'RE ACTIVE AS IN -- IN THE MONTH OF
11 OCTOBER UP UNTIL THE 23RD, CORRECT?
12 A. YES, SIR.
13 Q. ON FACEBOOK?
14 A. YES, SIR.
15 Q. NOW, BEFORE YOU STARTED SEEING DR. PAUL SINGH, YOU
16 WERE TAKING, ACCORDING TO HIS REPORT AT APA PAGE
17 178, 240 TABLETS OF PERCOCET A MONTH?
18 A. THAT'S PRESCRIBED, YES, SIR.
19 Q. RIGHT. ALL RIGHT. I'M NOT SAYING YOU WERE ABUSING
20 IT. THAT'S WHAT THE DOCTORS WERE PRESCRIBING TO
21 YOU?
22 A. YES, SIR.
23 Q. OKAY. AND HE REDUCED THAT DOWN TO 75, AND YOU NOTED
24 THAT YOU WERE DOING BETTER WITH THAT?
25 A. I'M DOING OKAY WITH IT.

1 Q. OKAY. YOU'RE DOING BETTER IS WHAT HE PUT IN HIS
2 REPORT. DO YOU DISAGREE WITH THAT?

3 A. I -- I CAN'T -- I DON'T KNOW WHAT THEY PUT IN THE
4 REPORT, SIR.

5 Q. OKAY.

6 A. ALL I KNOW THAT ---

7 Q. ALL RIGHT. LET'S -- LET'S FORGET ABOUT WHAT HE PUT
8 IN HIS REPORT. ARE YOU DOING BETTER TAKING 75
9 PERCOCETS VERSUS 240?

10 A. I NEVER TOOK 240, SIR.

11 Q. ARE YOU DOING BETTER TAKING LESS PERCOCETS AS
12 PRESCRIBED BY DR. SINGH THAN WHAT DR. COLLINS WAS
13 PRESCRIBING?

14 A. I'M DOING -- I'M DOING OKAY.

15 Q. IS IT BETTER ---

16 A. I'M AND I ---

17 Q. --- WORSE, OR THE SAME?

18 **BY COMMISSIONER BARDEN:**

19 Q. YOU NEED TO ANSWER THE QUESTION.

20 **CROSS-EXAMINATION RESUMED BY MR. FARRY:**

21 A. IT'S WORSE.

22 Q. OKAY.

23 **BY MR. FARRY:**

24 APA PAGE 178, COMMISSIONER.

25 **BY COMMISSIONER BARDEN:**

1 THANK YOU.

2 CROSS-EXAMINATION RESUMED BY MR. FARRY:

3 Q. NOW, YOU'VE TESTIFIED IN YOUR DEPOSITION THAT YOU
4 COULD NOT REMEMBER IF DR. MCQUEEN TREATED YOU FOR
5 BACK PAIN; DO YOU REMEMBER THAT?

6 A. NO, SIR, I DON'T.

7 BY MR. FARRY:

8 HERE IT IS.

9 BY COMMISSIONER BARDEN:

10 THANK YOU.

11 CROSS-EXAMINATION RESUMED BY MR. FARRY:

12 A. BUT I ALSO KNOW I HURT MY BACK IN THE FALL, AND I
13 NEVER REQUESTED HELP FOR IT TOO.

14 Q. OKAY. I'M GOING TO READ LIKE WE DID BEFORE WHERE IT
15 SAYS QUESTION, AND THEN I'M GOING TO ASK YOU TO READ
16 WHERE IT SAYS ANSWER.

17 A. YES, SIR.

18 BY MR. FARRY:

19 THIS IS ON PAGE 36, COMMISSIONER.

20 BY COMMISSIONER BARDEN:

21 THANK YOU.

22 CROSS-EXAMINATION RESUMED BY MR. FARRY:

23 Q. LINE 24, QUESTION, "WAS DR. MCQUEEN TREATING YOU FOR
24 NECK OR BACK PROBLEMS?" YOUR ANSWER?

25 A. "I CAN'T REMEMBER, SIR. THE MAIN THING -- THE MAIN

1 THING I CAN THINK OF IS MY LEG."

2 Q. "WHICH ONE?"

3 A. "MY LEFT ONE."

4 Q. BUT YOU TESTIFIED EARLIER, AND CORRECT ME IF I'M
5 WRONG, THAT YOU WERE IN THIS CHRONIC PAIN PROGRAM
6 FOR YOUR NECK PAIN FOR YEARS, DECADE PRIOR TO YOUR
7 JOB INJURY, CORRECT?

8 A. SIR, IT'S IN THE RECORDS. YES, SIR. I -- I -- YES,
9 SIR.

10 Q. AND YOU KNEW THAT TODAY SITTING HERE WHEN ASKED THAT
11 YOU WERE TREATED FOR CHRONIC PAIN FOR TEN YEARS BY
12 DR. MCQUEEN BEFORE THE ACCIDENT, CORRECT?

13 BY MR. SAFRAN:

14 YOUR HONOR, I'M GOING TO OBJECT, BECAUSE I
15 THINK HE'S MISCHARACTERIZING SOME OF THE TESTIMONY.
16 I BELIEVE THE ANSWERS HAVE BEEN ON MANY OCCASIONS,
17 "IF IT'S IN THE RECORD, I'M NOT, YOU KNOW, GOING TO
18 DISPUTE IT." I DON'T THINK SHE'S BEEN GIVING IT AS
19 OF HER OWN INDEPENDENT RECOLLECTION.

20 BY MR. FARRY:

21 DO YOU ---

22 BY COMMISSIONER BARDEN:

23 OKAY. WHY DON'T YOU REPHRASE?

24 CROSS-EXAMINATION RESUMED BY MR. FARRY:

25 Q. DO YOU REMEMBER AS YOU SIT HERE TODAY BEING TREATED

1 FOR CHRONIC PAIN IN YOUR NECK BY DR. MCQUEEN FOR TEN
2 YEARS OR MORE BEFORE YOUR ACCIDENT; DO YOU REMEMBER
3 THAT?

4 A. I CAN REMEMBER BEING TREATED FOR PAIN BUT NOTHING
5 LIKE I'VE HAD SINCE MY ACCIDENT.

6 Q. DO YOU REMEMBER BEING IN HIS CHRONIC PAIN PROGRAM
7 FOR TEN YEARS OR MORE BEFORE THEN?

8 A. SIR, I DIDN'T KNOW IT WAS CALLED CHRONIC PAIN. I'M
9 SORRY. I CAN'T. I CAN'T REMEMBER WHAT YOU JUST
10 SAID.

11 Q. DO YOU REMEMBER BEING IN HIS PAIN PROGRAM WHERE HE
12 TREATED YOU FOR PAIN WITH MEDICATIONS?

13 A. I REMEMBER HIM TREATING ME FOR PAIN WITH
14 MEDICATIONS, YES, SIR.

15 Q. OKAY.

16 A. I DO.

17 Q. NOW, DR. MCQUEEN, UP UNTIL A MONTH OR TWO BEFORE
18 THIS ACCIDENT WAS TREATING YOU WITH PERCOCET,
19 MORPHINE SULPHATE, M.S. CONTIN, XANAX, CYMBALTA FOR
20 DEPRESSION AND PAIN PRIOR TO YOUR JOB ENDED; DO YOU
21 REMEMBER THAT?

22 A. SIR, I CAN'T REMEMBER WHAT HE WAS GIVING. I CAN'T.
23 I'M SORRY.

24 Q. WELL, LET'S ASSUME FOR MY QUESTION THAT THE MEDICAL
25 RECORDS ESTABLISH YOU WERE TAKING ALL THOSE

1 MEDICATIONS FOR PAIN AND DEPRESSION, ANXIETY,
2 MIGRAINES, TENSION HEADACHES, CHRONIC DEPRESSION,
3 AND CHRONIC PAIN, OKAY?

4 A. OKAY.

5 BY MR. SAFRAN:

6 JUST QUICKLY. I APOLOGIZE. I NEED TO OBJECT,
7 BECAUSE I THINK THE WAY THE QUESTION IS BEING POSED
8 IS ALMOST IF THEY WERE BEING ALL TAKEN AT ONCE, AND
9 I KNOW THE RECORDS DON'T SUPPORT THAT. I KNOW THEY
10 HAVE BEEN -- THERE WERE SWITCHES GOING ON.

11 BY THE WITNESS:

12 YES.

13 BY MR. SAFRAN:

14 I JUST WANT THAT CLARIFIED FOR THE RECORD.

15 CROSS-EXAMINATION RESUMED BY MR. FARRY:

16 Q. WELL, WHATEVER YOU WERE TAKING AS OF APA 13, PAGE
17 221 ---

18 BY COMMISSIONER BARDEN:

19 COULD YOU TELL HER WHAT THOSE WERE?

20 BY MR. FARRY:

21 SURE.

22 CROSS-EXAMINATION RESUMED BY MR. FARRY:

23 Q. AS OF THAT MEDICAL REPORT, YOU WERE TAKING PERCOCET,
24 M.S. CONTIN, MORPHINE SULPHATE, AND XANAX ---

25 BY MR. SAFRAN:

1 I OBJECT AGAIN, BECAUSE THAT'S EXACTLY THE
2 CONTRA OF WHAT IT SAYS. IT SAYS THAT "I AM GOING TO
3 DROP HER DOWN TO PERCOCET AND STOP THE OTHER STUFF."
4 SO THE IMPLICATION THAT SHE'S TAKING IT ALL AT ONCE
5 IS NOT ACCURATE.

6 BY MR. FARRY:

7 OKAY. FAIR ENOUGH.

8 CROSS-EXAMINATION RESUMED BY MR. FARRY:

9 Q. YOU -- YOU WERE TAKING ONE, AND HE SWITCHED YOU TO
10 ANOTHER?

11 A. IT'S IN THE RECORDS. I GUESS SO. I CAN'T REMEMBER.

12 Q. THAT'S FINE.

13 A. I'M SORRY. I CAN'T REMEMBER WHAT I WAS GIVEN OR
14 WHAT I WERE ---

15 Q. DR. COLLINS TREATED YOU FOR A PERIOD OF TIME, AND HE
16 GAVE YOU SOME OF THESE MEDICATIONS THAT DR. MCQUEEN
17 HAD BEEN PRESCRIBING BEFORE THE ACCIDENT, CORRECT,
18 FOR YOUR DEPRESSION AND ANXIETY?

19 A. FOR DEPRESSION AND ANXIETY, YES, SIR, HE DID.

20 Q. OKAY. WHO'S GIVING YOU THAT MEDICATION NOW? DID
21 YOU GO BACK TO YOUR FAMILY DOCTOR?

22 A. I WENT -- I'M SEEING A NURSE PRACTITIONER.

23 Q. AT YOUR FAMILY DOCTOR?

24 A. THAT'S MY FAMILY DOCTOR.

25 Q. AND DR. MCQUEEN -- MCQUEEN MEDICAL?

- 1 A. NO, SIR, IT'S NOT.
- 2 Q. YOU WENT TO A DIFFERENT ONE NOW?
- 3 A. I HAVE -- I DON'T HAVE ANY INSURANCE ANYMORE, SIR.
- 4 I GO WHERE I CAN GET ME SOME HELP, SIR.
- 5 Q. OKAY. NOW, WHEN YOU STARTED SEEING DR. COLLINS, YOU
- 6 DIDN'T TELL DR. COLLINS ABOUT THE YEARS OF
- 7 MEDICATION THAT YOU HAD BEEN TAKING FOR CHRONIC
- 8 DEPRESSION, DID YOU?
- 9 A. SIR, I CAN'T REMEMBER BECAUSE IT'S ALL DIFFERENT. I
- 10 CAN'T REMEMBER. I MEAN, WHAT I TOOK PRIOR ---
- 11 Q. OKAY.
- 12 A. --- IS NOTHING WHAT I WAS PRESCRIBED FOR THE
- 13 INCIDENT.
- 14 Q. WELL, IF THE -- IF THE RECORDS SHOW AND DR. COLLINS
- 15 TESTIFIED THAT WHEN HE BEGAN TREATING YOU UP UNTIL
- 16 THE TIME OF HIS DEPOSITION SOME YEAR-AND-A-HALF
- 17 LATER HE WAS NOT AWARE THAT YOU HAD BEEN RECEIVING A
- 18 DECADE'S WORTH OF MEDICATION FOR CHRONIC PAIN, FOR
- 19 ANXIETY, FOR MAJOR DEPRESSION, OSTEOARTHRITIS, FOR
- 20 CERVICAL DISC DISEASE, FOR LUMBAR DISC DISEASE, FOR
- 21 MIGRAINE HEADACHES, AND FOR TENSION HEADACHES; YOU
- 22 WOULDN'T DISAGREE WITH WHAT THAT REPORT SAYS, WOULD
- 23 YOU?
- 24 A. SIR, I DON'T KNOW WHAT'S IN THE REPORTS.
- 25 Q. OKAY.

1 A. BUT HE DIDN'T EVER MENTION ANYTHING TO ME THAT I CAN
2 RECALL.

3 Q. NOW, WHEN YOU WERE DEALING WITH ALL THESE STRESSORS
4 IN YOUR LIFE THAT YOUR ATTORNEY WALKED YOU THROUGH
5 THAT YOU REMEMBERED ABOUT YOUR HUSBAND, YOUR PARENTS
6 DYING, YOUR SON'S HEALTH ISSUES, YOU WERE TAKING
7 MEDICATION FOR ANXIETY AND DEPRESSION AND FOR
8 MIGRAINES AND FOR TENSION HEADACHES?

9 A. NO, SIR. MY ATTORNEY HAS NOT WALKED ME THROUGH
10 ANYTHING ABOUT MY HUSBAND, MY FAMILY. NO, SIR. HE
11 HAS NOT.

12 Q. OKAY. WHEN -- BEFORE THE ACCIDENT, YOU WOULD AGREE
13 THAT YOU HAD TO DEAL WITH LIFE STRESSES LIKE THE
14 REST OF US?

15 A. THAT'S RIGHT, YES, SIR.

16 Q. AND SOME OF YOUR LIFE STRESSES INVOLVE YOUR
17 HUSBAND'S HEALTH AS HE HAD POST TRAUMATIC STRESS
18 DISORDER?

19 A. YES, SIR.

20 Q. SOME OF THEM DEALT WITH YOUR SON'S HEALTH ISSUES?

21 A. YES, SIR.

22 Q. SOME OF THEM DEALT WITH YOUR PARENT'S, HAVING TO
23 CARE FOR THEM AND THEIR DEATH, CORRECT?

24 A. YES, SIR.

25 Q. YOU WERE TAKING MEDICATION CONSISTENTLY FOR ANXIETY

1 AND DEPRESSION, CORRECT?

2 A. AND I WAS COPING.

3 Q. YES, MA'AM. AND YOU WERE TAKING MEDICATION FOR
4 MIGRAINE HEADACHES, CORRECT?

5 A. AND I WAS WORKING.

6 Q. YES, MA'AM. AND YOU WERE TAKING MEDICATION FOR
7 TENSION HEADACHES, CORRECT?

8 A. AND I WAS WORKING.

9 Q. AND YOU WERE TAKING MEDICATION FOR CHRONIC PAIN,
10 CORRECT?

11 A. AND I WAS TAKING CARE OF MY FAMILY AND DOING
12 WHATEVER I NEEDED TO DO.

13 Q. AND YOU WERE TAKING MEDICATION FOR CERVICAL AND
14 LUMBAR DISC DISEASE?

15 A. SIR, I DON'T KNOW WHAT I WAS TAKING MEDICATION FOR.

16 Q. OKAY. ALL RIGHT.

17 A. I'M JUST SAYING, I COULD DO WHAT I NEEDED TO DO
18 PRIOR TO MY FALL. I NEVER STOPPED.

19 Q. AND IT'S ---

20 A. AND NOW I CAN'T EVEN CLEAN MY OWN HOUSE.

21 Q. YES, MA'AM. AT SOME -- DO YOU NEED TO TAKE A BREAK?

22 A. NO, SIR.

23 Q. AT SOME POINT SINCE THE ACCIDENT, YOUR MEDICATION
24 FOR XANAX, YOUR XANAX MEDICATION WAS STOPPED, WASN'T
25 IT?

1 A. YES, SIR. YES, SIR.

2 Q. AT SOME POINT, YOUR MEDICATION FOR DEPRESSION WAS
3 STOPPED, WASN'T IT?

4 A. YES, SIR, IT WAS.

5 Q. AT SOME POINT, YOUR MEDICATION FOR YOUR TENSION
6 HEADACHES WAS STOPPED THAT YOU WERE TAKING, CORRECT?

7 A. YES, SIR.

8 Q. AND AT SOME POINT, THE MEDICATION YOU WERE TAKING
9 FOR YOUR MIGRAINE HEADACHES STOPPED?

10 A. YES, SIR.

11 Q. AND AT SOME POINT, THE MEDICATION YOU'VE BEEN
12 PRESCRIBED FOR YOUR CHRONIC PAIN WAS STOPPED?

13 A. AND IT JUST THROWN ME RIGHT BACK TO WHERE I WAS
14 BUILDING FROM.

15 Q. OKAY. THANK YOU, MA'AM.

16 BY MR. FARRY:

17 I HAVE NO FURTHER QUESTIONS.

18 BY COMMISSIONER BARDEN:

19 MR. SAFRAN, ANYTHING ON REDIRECT?

20 BY MR. SAFRAN:

21 LET ME JUST ASK A COUPLE OF THINGS.

22 REDIRECT EXAMINATION BY MR. SAFRAN:

23 Q. JUST BY WAY OF CLARIFICATION, I THINK I ASKED,
24 BROUGHT THIS UP BEFORE.

25 BY MR. SAFRAN:

1 YOUR HONOR, AT PAGE 221.

2 REDIRECT EXAMINATION RESUMED BY MR. SAFRAN:

3 Q. IT SHOWS HERE DR. MCQUEEN, I GUESS IF IT SAYS IN THE
4 RECORDS THAT HE WOULD SWITCH MEDICATIONS FROM TIME
5 TO TIME, I MEAN WOULD THAT BE ACCURATE?

6 A. YES, SIR.

7 Q. AND IT LOOKS LIKE THE LAST NOTE WE HAVE BEFORE YOUR
8 FALL SAYS THAT HE WAS GOING TO DROP YOU DOWN TO A
9 LOWER STRENGTH PERCOCET AS OPPOSED TO THE M.S.
10 CONTIN AND MORPHINE SULPHATE THAT HE HAD BEEN GIVING
11 YOU. NOW, I'M NOT ASKING THAT YOU REMEMBER THAT.

12 A. RIGHT, SIR.

13 Q. BUT WHAT I'M SIMPLY SAYING IS HE DID SWITCH
14 MEDICINES UP?

15 A. YES, SIR, HE DID SWITCH THEM, BUT I CAN'T REMEMBER.

16 Q. AND BASICALLY, AT -- AT LEAST IF THIS RECORD SAYS
17 SHORTLY BEFORE YOUR ACCIDENT THAT HE WAS TAKING YOUR
18 MEDICATION STRENGTH DOWN, WOULD FROM THE TIMES THAT
19 HE WOULD DO THAT WHEN HE WOULD BRING MEDICATIONS
20 DOWN, DID YOU HAVE PERIODS WHERE YOU WERE DOING
21 BETTER, SO YOU NEEDED LESS MEDICATION?

22 A. YES, SIR.

23 Q. ALL RIGHT. LET ME JUST ASK YOU. WHEN YOU WENT TO
24 THE THERAPIST THAT WE DISCUSSED EARLIER, YOUR SPEECH
25 THERAPIST, ---

1 A. YES, SIR.

2 Q. --- WAS CROSSWORD PUZZLES SOMETHING THAT CAME UP AS

3 FAR AS WHAT YOU'RE SUPPOSED TO DO?

4 A. YES, SIR, IT WAS.

5 Q. LUMINOUS?

6 A. YES, SIR.

7 Q. SO AGAIN, WAS THAT PART OF THE TREATMENT YOU ---

8 A. YES, SIR.

9 Q. --- WERE TOLD TO PURSUE?

10 A. YES, SIR.

11 Q. ALL RIGHT. AND HAVE YOU CONTINUED TO DO THAT?

12 A. YES, SIR, I DO.

13 Q. ALL RIGHT. WHAT'S CANDY CRUSH?

14 A. IT'S A GAME THAT YOU HAVE TO LOG ON *FACEBOOK* TO

15 PLAY.

16 Q. OKAY.

17 A. JUST ---

18 Q. AND I GUESS WHAT I ---

19 A. IT'S REALLY A GOOD MIND GAME.

20 Q. OKAY. SO YOU TRY THOSE?

21 A. YES, SIR, I DO.

22 Q. AND -- AND WHEN YOU WERE ACTUALLY GETTING TREATMENT,

23 WERE THESE THE KIND OF THINGS THAT YOU WERE

24 INSTRUCTED TO DO?

25 A. YES, SIR, IT WAS.

1 Q. ALL RIGHT. I LISTENED TO THE COMMENTS, ABOUT YOUR
2 FACEBOOK POSTS. SO BASICALLY, I THINK I HEARD 30 IN
3 JULY. SO THAT WOULD BE BASICALLY AN AVERAGE OF ONE
4 A DAY?

5 A. IT'S NOT A LOT.

6 Q. ALL RIGHT. SIXTEEN IN AUGUST, SO LESS THAN THAT?

7 A. YES, SIR.

8 Q. TWENTY-TWO IN SEPTEMBER, LESS THAN THAT?

9 A. YES, SIR.

10 Q. SO IT DOESN'T APPEAR LIKE YOU'RE SITTING THERE, JUST
11 ---

12 A. NO, SIR.

13 Q. --- A CHURNING? ARE YOU SITTING -- WELL, LET ME ASK
14 THE QUESTION A DIFFERENT WAY. ARE YOU SITTING THERE
15 CHURNING FACEBOOK POSTS CONSTANTLY THROUGHOUT EVERY
16 DAY?

17 A. NO, SIR. I CAN'T EVEN CONCENTRATE ON A T.V. PROGRAM
18 LONGER THAN BASICALLY 20 MINUTES AT A TIME.

19 Q. OKAY. THE OTHER THING IS THIS, I KNOW THAT MR.
20 FARRY WAS USING THE TERM MAJOR DEPRESSION, AND I
21 ASSUME HE GOT THAT AT SOME POINT FROM WHAT HE READ
22 IN DR. MCQUEEN'S. HAD YOU EVER SEEN A PSYCHIATRIST
23 TO BE DIAGNOSED WITH MAJOR DEPRESSION BEFORE ---

24 A. NO, SIR.

25 Q. --- YOU WERE ---

1 A. I HAVEN'T.

2 Q. OKAY. AND BEFORE YOU SAW DR. WATTS OR DR. SALAS,
3 'CAUSE THEY WERE THE FIRST PSYCHIATRISTS YOU SAW, I
4 BELIEVE?

5 A. THAT'S IT.

6 Q. OKAY. AND SO ANY REFERENCE TO THAT WOULD COME FROM
7 YOUR FAMILY DOCTOR?

8 A. YES, SIR.

9 Q. LET ME JUST ASK THIS, AND WE'LL BE DONE. EVEN WITH
10 THE THINGS THAT YOU REMEMBER OR THAT YOU AGREE IF
11 THEY'RE IN THE RECORD WERE ACCURATE, ---

12 A. YES.

13 Q. --- YOU WERE STILL GOING TO WORK PRIOR TO THE
14 ACCIDENT?

15 A. YES, SIR.

16 Q. YOU WERE STILL TENDING TO YOUR FAMILY?

17 A. YES, SIR.

18 Q. YOU WERE STILL HAVING ALL THESE OTHER THINGS, BOTH -
19 - WHETHER IT BE YOUR HUSBAND, YOUR SON, YOUR
20 PARENTS, STILL DEALING WITH THAT?

21 A. YES, SIR.

22 Q. SINCE THE ACCIDENT, HAS IT BEEN A MATTER OF YOUR
23 HUSBAND HAVING TO TAKE CARE OF YOU?

24 A. YES, SIR.

25 BY MR. FARRY:

1 OBJECT TO THE FORM.

2 BY COMMISSIONER BARDEN:

3 SUSTAINED.

4 REDIRECT EXAMINATION RESUMED BY MR. SAFRAN:

5 Q. ALL RIGHT. DOES YOUR HUSBAND NOW SPEND TIME HELPING
6 YOU?

7 BY MR. FARRY:

8 OBJECT TO THAT LINE OF QUESTIONING.

9 BY COMMISSIONER BARDEN:

10 SUSTAINED.

11 BY MR. FARRY:

12 I DIDN'T GO INTO ANYTHING ABOUT THE HUSBAND AND
13 WHAT SHE COULD AND COULD NOT DO ON CROSS.

14 BY MR. SAFRAN:

15 WELL, I THINK ON YOUR CROSS BASICALLY YOU WERE
16 BRINGING UP THE FACT THAT THE HUSBAND'S SITUATION
17 WAS A STRESSOR, AND THAT SHE ---

18 BY THE WITNESS:

19 AND MY SON.

20 BY MR. SAFRAN:

21 HOLD ON. AND THAT SHE HAD TO BASICALLY HAVE TO
22 TEND TO ALL THAT. I THINK IT'S A FAIR QUESTION TO
23 ASK IF WHETHER OR NOT THE ROLES HAVE REVERSED RIGHT
24 NOW.

25 BY MR. FARRY:

1 IT DIDN'T HAVE ANYTHING TO DO WITH HER
2 CAPABILITY AND PERFORMANCE NOW. IT HAD TO DO WITH
3 HER LIFE PRIOR TO THE DATE OF THE ACCIDENT AND HER
4 ABILITY TO COPE. I DIDN'T BRING INTO ANYTHING ABOUT
5 THE HUSBAND AFTER THE ACCIDENT.

6 BY COMMISSIONER BARDEN:

7 I'D HAVE TO LOOK AT THE TRANSCRIPT TO SEE
8 EXACTLY WHAT WAS ASKED, BUT YOU CAN MOVE ON.

9 BY MR. SAFRAN:

10 ALL RIGHT. THAT'S ALL I'VE GOT. THANK YOU.

11 BY COMMISSIONER BARDEN:

12 ALL RIGHT. ANYTHING ELSE, MR. FARRY?

13 BY MR. FARRY:

14 VERY BRIEFLY.

15 RE CROSS-EXAMINATION BY MR. FARRY:

16 Q. YOUR ATTORNEY ASKED YOU AGAIN ABOUT HOW YOU WERE
17 ABLE TO COPE BEFORE THE ACCIDENT AND YOUR ABILITY TO
18 COPE NOW, BUT WE'VE ESTABLISHED THROUGH YOUR
19 TESTIMONY I BELIEVE, YOU CORRECT ME IF I'M WRONG,
20 THAT BEFORE THE ACCIDENT YOU WERE TAKING MEDICATION
21 FOR DEPRESSION FOR TEN YEARS, THAT OVER THOSE TEN
22 YEARS MAY HAVE BEEN XANAX, MAY HAVE BEEN CYMBALTA,
23 MAY HAVE BEEN -- BEEN PROZAC, MAY HAVE BEEN OTHER
24 FORMS OF PSYCHOTROPIC MEDICATION, CORRECT?

25 A. THAT THEY HAD CHANGED IT ---

1 Q. RIGHT.

2 A. --- THE PRIOR TIMES. YES, SIR.

3 Q. AND AT SOME POINT AFTER THE ACCIDENT, YOU STOPPED
4 GOING TO YOUR FAMILY DOCTOR TO GET THAT MEDICATION,
5 DIDN'T YOU?

6 A. YES, SIR. 'CAUSE THEY WAS GIVING IT TO ME.

7 Q. BECAUSE IT WAS COMING THROUGH DR. COLLINS' OFFICE?

8 A. YES, SIR.

9 Q. AND WHEN DR. COLLINS STOPPED GIVING YOU THAT, YOU
10 DIDN'T GO BACK TO YOUR FAMILY DOCTOR TO GET THOSE
11 MEDICATIONS THAT YOU WERE GETTING BEFORE THE
12 ACCIDENT, DID YOU?

13 A. I DIDN'T HAVE INSURANCE, SIR.

14 BY MR. FARRY:

15 THANK YOU, MA'AM.

16 BY COMMISSIONER BARDEN:

17 GO AHEAD, TAKE A MINUTE.

18 REDIRECT EXAMINATION BY MR. SAFRAN:

19 Q. JUST ONE QUESTION. EVEN AFTER YOU STARTED GETTING
20 THOSE MEDICATIONS FOLLOWING THE ACCIDENT FROM DR.
21 COLLINS, WERE YOU STILL HAVING THE PROBLEMS WITH
22 COPING AND DOING THE THINGS LIKE YOU DISCUSSED WITH
23 US TODAY, EVEN ON THOSE MEDICATIONS?

24 A. FROM MY FALL?

25 Q. WHEN -- WHEN HE STARTED GIVING YOU MEDICINE, WERE

1 YOU STILL HAVING THE PROBLEMS YOU WERE TELLING THE
2 COMMISSIONER ABOUT WHERE YOU'RE NOT ABLE TO COPE
3 LIKE ---

4 A. YES, SIR.

5 Q. --- YOU WERE BEFORE ---

6 A. YES, SIR.

7 Q. --- THE ACCIDENT?

8 A. YES, SIR. I STILL HAVE THEM WITH MEDICATION.

9 BY MR. SAFRAN:

10 THAT'S ALL I GOT. THANK YOU.

11 BY COMMISSIONER BARDEN:

12 MR. FARRY?

13 BY MR. FARRY:

14 MY -- THERE ARE NO FURTHER QUESTIONS. I WOULD
15 DIRECT THE COMMISSION TO PAGE 4, LINE 22 THROUGH
16 LINE 23, WHEN I STUMBLED AND COULDN'T FIND THAT
17 REFERENCE TO "NEVER HAD A DEPOSITION TAKEN BEFORE."

18 BY COMMISSIONER BARDEN:

19 THANK YOU, SIR. ALL RIGHT. THAT'S THE
20 CLAIMANT'S CASE. DO YOU HAVE ANY WITNESSES, MR.
21 FARRY?

22 BY MR. FARRY:

23 NO, MA'AM. WE RELY ON THE SUBMISSIONS.

24 BY COMMISSIONER BARDEN:

25 ALL RIGHT. AND THAT CONCLUDES THIS PROCEEDING.

1 (THERE BEING NO FURTHER QUESTIONS, THIS HEARING WAS
2 CONCLUDED AT THE HOUR OF 3:50 P.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1215681

EMPLOYEE/CLAIMANT: VICKIE RUMMAGE

EMPLOYER: B.G.F. INDUSTRIES

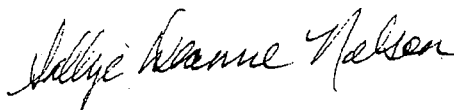
INSURER: GREAT AMERICAN ALLIANCE INSURANCE COMPANY

I, SALLYE DEANNE NELSON, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING 86 PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING HEARING OF VICKIE RUMMAGE, TAKEN ON THE 7TH DAY OF NOVEMBER, 2016.

THAT THE WITNESS WAS DULY PLACED UNDER OATH AND ADMONISHED TO SPEAK THE WHOLE TRUTH. THAT THE ORAL HEARING WAS DULY TAKEN AND TRANSCRIBED AS TO THE QUESTIONS PROPOUNDED AND THE ANSWERS GIVEN.

THAT ALL THE OFFERED EXHIBITS, STIPULATIONS AND OBJECTIONS, IF ANY, INVOLVED IN THIS CASE ARE DULY ATTACHED OR INCLUDED HEREIN.

IN WITNESS WHEREOF, I HAVE SET MY HAND THIS 24TH DAY OF NOVEMBER, 2016.



SALLYE DEANNE NELSON
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 5-08-2022

* THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.

CONDENSED TRANSCRIPT WORD INDEX

Deposition
of
TORA BRAWLEY, PH.D.

VICKIE RUMMAGE v. BGF INDUSTRIES AND GREAT AMERICAN
ALLIANCE INSURANCE COMPANY C/O STATEGIC COMP SERVICES
WCC #1215681

11/10/2015

WILLIAMS REPORTING
803.730.4700
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TORA BRAWLEY, PH.D.

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO.:1215681

Vickie Rummage,	)	
	)	
Claimant,	)	Deposition
	)	
vs.	)	of
	)	
BGF Industries,	)	Tora Brawley, Ph.D.
	)	
Employer,	)	
	)	
Great American Alliance	)	
Insurance Company c/o	)	
Strategic Comp Services,	)	
	)	
Carrier.	)	

Deposition of Tora Brawley, Ph.D., pursuant to the Rules of the South Carolina Workers' Compensation Commission, commencing at 9:09 a.m. Tuesday, November 10th, 2015, at the office of McAngus, Goudelock & Courie, LLC, 1320 Main Street, 10th Floor, Columbia, South Carolina.

Reported by:
Cheri B. Williams, CVR-M

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Stipulations

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Tora Brawley, Ph.D., being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

Direct Examination

By Mr. Lockhart:

Q Dr. Brawley, good morning.

A Good morning.

Q My name, again, is Jason Lockhart. I'm a lawyer here in Columbia. I represent a company called BGF Industries and their workers' compensation insurance company in a workers' comp claim that's by a lady named Vickie Rummage. It's my understanding that you've met with Ms. Rummage, and so this morning I'm here to take your deposition just to ask you some questions about your interactions with her. If any point during the deposition I ask you a question that is confusing to you, please let me know and I'll be more than happy to repeat myself, clarify the question. I'm

Appearances

For the Claimant: Andrew N. Safran, Esquire
Safran Law Offices
Post Office Box 12089
Columbia, SC 29211

For the Employer/
Carrier: Jason W. Lockhart, Esquire
McAngus, Goudelock & Courie, LLC
1320 Main Street, 10th Floor
Post Office Box 12519
Columbia, SC 29211

Reported by: Cheri B. Williams, CVR-M

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Exhibits

No exhibits marked.

Court Reporter's Note: This transcript may contain quoted material. Such material is reproduced as read or quoted by the speaker. Double hyphens (--) denote interruption of speech, incomplete sentence/phrase, or trailing off. [ph] denotes phonetically written. [sic] denotes written as 'spoken.

4

going to be really working from your letter to Mr. Safran from September 16th of 2015, so -- and I'll be referencing that throughout the course of your deposition. Of course, you and I are looking at one another so even if you give a nonverbal response to my questions, I would ask that you speak your answers, if at all possible. It makes it easier for the court reporter to make a record of everything you and I are talking about this morning, okay?

A That's fine.

Q And, again, if any point during the deposition you need to take a break, let me know and we'll stop everything we're doing.

A Okay.

Q I'll let you take whatever breaks, okay? Dr. Brawley, when were you initially contacted by Safran regarding Ms. Rummage?

A I don't have the initial -- let me look. I don't have the initial. I know that I evaluated her in May of 2014 so it was probably shortly before then I was contacted.

Q Okay. And did he contact you by phone or email or letter?

A I don't recall.

5

1 Q Do you generally schedule the -- an evaluation,
2 like the one you conducted on Ms. Rummage, yourself
3 or do you have staff that do that?
4 A I do all of my own scheduling.
5 Q Now, the evaluation, according to your letter to
6 Mr. Safran of September 16th, 2015, the evaluation
7 of Ms. Rummage took place on or about May the 15th
8 of 2014, is that correct?
9 A That's correct.
10 Q Did you speak to Mr. Safran prior to the evaluation
11 of Ms. Rummage?
12 A I did.
13 Q How many times do you think y'all spoke?
14 A We probably spoke just initially when he was asking
15 me to do the evaluation and then we spoke the
16 morning of the evaluation.
17 Q And what did you all speak of or discuss during the
18 morning of the evaluation?
19 A He, I believe, basically just gave me some
20 background information on her and told me he wanted
21 me to check it out and see if she was legit and had
22 some issues that needed to be addressed.
23 Q When you say if she was legit, what do you mean?
24 A He had indicated, you know, that she had some
25 unusual presentation, lots of psychological

6

1 symptoms, and he wanted to make sure that she was
2 adequately representing her situation.
3 Q Which was?
4 A The injuries sustained after her accident at work.
5 Q How many times have you spoken with Mr. Safran
6 since seeing Ms. Rummage on or about May 15th,
7 2014?
8 A Oh, maybe half a dozen times.
9 Q And what were the purposes of those communications?
10 A He had asked me to write a follow up letter after
11 my evaluation, which I did. I believe one time he
12 called me to tell me he was going to send me
13 reports from Dr. Gualtieri and then a report from
14 Dr. Salas, and then I spoke with him before the
15 deposition.
16 Q Okay. And what did you all talk about prior to
17 your deposition?
18 A This morning he called me. He had some questions
19 about one of the tests in Dr. Gualtieri's -- that
20 he had listed in his report.
21 Q And which test was that?
22 A It was one that I wasn't familiar with. It's not a
23 neuropsychological measure. The MCG, maybe. I
24 just told him I wasn't familiar with that and that
25 I would leave that test to Dr. Salas.

7

1 Q It's my understanding the Dr. Salas has evaluated
2 Ms. Rummage as well, correct?
3 A I believe so.
4 Q Have you had any communications with Dr. Salas?
5 A I have had a consultation with her.
6 Q How many times have you spoken with her?
7 A I spoke with her on August 26th for 15 minutes. Of
8 this year.
9 Q Okay. And what did you all discuss?
10 A She had my report and she wanted to discuss my
11 report and make sure she was adequately
12 interpreting that.
13 Q What was your fee for your evaluation of Ms.
14 Rummage?
15 A I don't have that with me. It was probably -- do
16 you have that bill? I don't keep my bills in the
17 report, in my file. It was for maybe three or four
18 hours so it was under \$1,000 for that evaluation.
19 And then I did some additional record review of
20 approximately two and a half hours so that would be
21 about \$600.
22 Q Do you have an hourly rate that you typically
23 charge?
24 A I do charge \$250 an hour. That changed this year
25 and I can't remember -- if this case originated in

8

1 '14, it would be on the old rate of 200. I don't
2 increase my rate -- here it is. For the initial
3 evaluation it was \$700.
4 Q May I take a look at that? And was the fee for
5 your evaluation, was that paid in advance of the
6 evaluation itself or following the completion of
7 the evaluation?
8 A No. I bill following my evaluations because I
9 don't know how long -- how much time is going to be
10 required.
11 Q Okay. In looking back at your letter of September
12 16th, 2015, you indicated that this letter was
13 generated at the request of Mr. Safran?
14 A That's correct.
15 Q Had you planned on preparing a report prior to
16 being asked for the production of this letter by
17 Mr. Safran?
18 A I had already prepared a report.
19 Q Okay. Is that report -- has that been provided to
20 Mr. Safran or anyone else?
21 A Yes, it has.
22 Mr. Safran: And for the record, I think I
23 sent it to you previously, too.
24 Q Okay. Yeah. Where was this evaluation of Ms.
25 Rummage conducted?

9

1 A In Mr. Safran's office.
2 Q Who was present during the evaluation?
3 A She was present and I believe her husband was
4 present for the interview portion, but not for the
5 testing.
6 Q Was there anyone else present during any portion of
7 the evaluation?
8 A No, there was not.
9 Q As part of the evaluation, did Ms. Rummage complete
10 any documentation like an intake form or other
11 documentation that she then provided to you as part
12 of the evaluation process?
13 A No.
14 Q So how did you, I guess, learn of her condition
15 prior to the evaluation, aside from reviewing
16 records and communicating with Mr. Safran?
17 A Well, that was it prior to the evaluation. Then
18 during the evaluation, I take -- I do what I call
19 an extended clinical interview that proceeds my
20 testing.
21 Q Tell me a little bit about that interview process.
22 A I have an interview form. You're welcome to look
23 at my notes here. I, basically, go through my form
24 and take a history of their current complaints. I
25 ask about vegetative symptoms, ask about physical

10

1 symptoms, changes in personality, physical
2 symptoms, stressors. I ask about past medical
3 history including emotional and psychological
4 history, medications, alcohol and drug use, family
5 history, social history.
6 Q What information, if any, were you provided by Ms.
7 Rummage regarding any prior psychological problems
8 or psychological history?
9 A She told me that she had depression in her 30s when
10 her father died. She was put on medications. She
11 said throughout her life she's had lots of
12 stressors. Her mother died. Her husband was in
13 Iraq and subsequently developed PTSD, she said, but
14 she had it under control until the accident and
15 that she had no prior suicidal ideation.
16 Q When she indicated that it was under control, did
17 she indicate to you that was as the result of
18 medication or counseling or both?
19 A I don't believe she had any counseling. I believe
20 it was just medication.
21 Q Did she indicate to you that at the time of her
22 work accident she was utilizing any type of
23 psychological medications?
24 A She gave me a list of medications at the time that
25 I saw her. I have looked at her medical records.

11

1 She's been on and off the antidepressants for quite
2 a while.
3 Q And when you say quite a while, we're talking about
4 more than five, more than ten years?
5 A I think the earliest I -- it's been a little while
6 since I've looked at the records. I think maybe
7 1991 or 1994.
8 Q Dr. Brawley, I'm going to take a look at your
9 report --
10 A Sure.
11 Q --and start with the second paragraph. You
12 indicated that Ms. Rummage was fully cooperative
13 and answered all questions. The question and
14 answer portion of your exam, generally how long of
15 a period of time does that take?
16 A Usually about an hour.
17 Q All right. And the questions that you would have
18 asked to Ms. Rummage, those would have been verbal
19 or she would have been answering questions on a
20 written document? How would you go about having
21 those questions asked and answered?
22 A It's an interview. So I ask her the question and I
23 record her responses.
24 Q And, again, I know you told me a little bit about
25 the information you gleaned from her during the

12

1 evaluation, but when you say all questions, you're
2 taking -- you're taking a clinical history,
3 correct?
4 A Correct.
5 Q All right. And then you're asking her questions
6 about her current condition, correct?
7 A Correct.
8 Q What other types of topics are you covering with
9 her during this one hour question and answer
10 session?
11 A I ask for -- I asked her to tell me about the
12 accident, what happened with that. I ask her to
13 tell me what symptoms she was having then, what
14 symptoms she's having now. I asked her about
15 vegetative symptoms, kind of all the things that we
16 reviewed before.
17 Q Okay. You indicated in your letter that she was
18 fully cooperative in answering all questions, but
19 exhibited a slow response time. Is that correct?
20 A Yes. Yes.
21 Q How do you measure response time?
22 A Her delay in responding.
23 Q And, again, how -- is there a standard that you
24 expect someone to respond by, and how do you
25 measure hers relative to what you expect?

13

1 A I don't have a stopwatch, but it's kind of normal
2 rate of conversation, like you and I are conversing
3 now. She would have a delayed response. It would
4 take her a while to formulate what I had asked.
5 She would oftentimes look to her husband, but I had
6 instructed them that I wanted her to attempt to
7 answer the questions first.

8 Q Do you know if she was taking any medications or
9 under the influence of medications during the
10 course of your interview with her?

11 A She was on -- she told me that she had taken -- I
12 asked her for a list of her medications. She had a
13 fairly long list of medications. She told me she
14 had just her Lisinopril that morning.

15 Q And what is that medication designed to treat, do
16 you know?

17 A I'm not a medical doctor. I believe that's blood
18 pressure, but I'm not certain.

19 Q Did you have any concerns that her response time
20 may be impacted by her utilization of medications
21 prior to your evaluation of her?

22 A Well, that's always something that you should take
23 into account, which is why I asked her, but she was
24 not taking any of those that would slow her down
25 like the Xanax or the Flexeril.

14

1 Q In your -- in your third -- I guess the third
2 paragraph of your letter to Mr. Safran you
3 indicated that Ms. Rummage's psychiatric symptoms
4 were interfering with cognition and invalidating
5 test results?

6 A Correct.

7 Q So you have test results, I presume, but in your
8 opinion they aren't valid based on her presentation
9 at the time of your interview?

10 A I don't do that. I consider that a waste of money
11 to do that. So if I get into the clinical
12 interview and I've done a couple of tests -- I did
13 the interview with her. I asked her some
14 orientation questions. I asked her to do a couple
15 of sustained attention tasks, things like tell the
16 ABCs, go backwards from 20 to one. She was clearly
17 struggling. She was having severe impairments. At
18 that point, I gave a malingering assessment to look
19 and see if she was giving me effort because it was
20 clear she just wasn't -- her cognition was
21 significantly slowed at that time and she was
22 severely impaired on those couple of short tests
23 that I gave to her at the beginning. So at that
24 time I administered the test of memory malingering
25 because Mr. Safran had, you know, said he wanted to

15

1 make sure that she was legitimate with her
2 complaints. She passed the test of memory
3 malingering. So at that point, I discontinued
4 testing. Because of the information that I
5 obtained in the clinical interview and the
6 behavioral observations that I had with her during
7 the testing, I believed that her psychiatric
8 symptoms were so severe I wasn't going to get
9 accurate cognitive results and so I stopped testing
10 at that time.

11 Q If you were to look at the neuropsych testing that
12 you would normally perform as, let's say, 100
13 percent of the testing, what percentage of the
14 testing were you actually able to get through with
15 her before you made the decision to discontinue the
16 testing?

17 A Ten percent.

18 Q All right. And I believe in your letter to Mr.
19 Safran you recommended that the testing be
20 reattempted when her psychiatric symptoms have
21 become more effectively managed?

22 A That's correct.

23 Q Okay. And is that still your opinion?

24 A Yes.

25 Q Okay. Now, in the fourth paragraph of your letter,

16

1 you note that while Ms. Rummage does have a
2 previous history of depression, it was clear that
3 her symptoms worsened significantly following the
4 accident. How did you reach that conclusion?

5 A Part of it was based on self report. Part of it
6 was based on information obtained in the clinical
7 interview. You know, she had been able to work
8 effectively with her depression for all of those
9 years. Part of it was also based on the record
10 review. I looked at a questionnaire from her --
11 her general practitioner who stated, in his
12 opinion, that he felt that her depression had
13 gotten worse as a result of the accident.

14 Q And who is that?

15 A McQueen, I believe. Let me double check that.
16 Yes. Fred D. McQueen.

17 Q But the primary basis for that conclusion, I think
18 you told me, was self -- the self report or the
19 information Ms. Rummage provided to you, correct?

20 A And also review of the records of Dr. McQueen's
21 report.

22 Q His questionnaire?

23 A Yes.

24 Q In this same paragraph of your letter of September
25 16th, you talk about formal assessment of effort

17

1 did not reveal attempts to malingering. Can you --
 2 can you tell me a little bit more about that --
 3 what that assessment -- how that assessment
 4 operates just from a clinical standpoint?
 5 A Sure. It's called the test of memory malingering.
 6 Q Okay.
 7 A It is a formal assessment that looks at effort. It
 8 has been fully standardized.
 9 Q By whom?
 10 A The test manufacturer and the test author, Tom
 11 Tombaugh. Interesting it's called the TOMM. But
 12 it is, by Dr. Tombaugh. He has -- he and his team
 13 and the test manufacturers have fully assessed the
 14 test on different patient populations to find out
 15 what tests are considered indicative of poor effort
 16 and what tests are within normal limits, what
 17 scores are within normal limits. So the way the
 18 test of memory malingering works is you show them a
 19 series of 50 pictures and you tell them they're
 20 going to have to remember all 50 pictures. That
 21 sounds pretty difficult. And then you tell them
 22 you're going to come back and show them two
 23 pictures, one that they've seen before and one that
 24 they've not seen before. So while it sounds like a
 25 test of memory, it's actually a test of

18

1 recognition. And even if you flipped a coin to
 2 answer the questions, you know, just by chance
 3 because either A or B is right or -- right, you
 4 know, chance levels are between 18 and 34 out of
 5 50. So the way that test works is you go through,
 6 you do that for trial one. Then you do the same
 7 thing again for trial two. And then 20 minutes
 8 later you do a retention trial.
 9 Q Is there raw data from the testing you administered
 10 to Ms. Rummage, this formal assessment of effort?
 11 A I have the test form.
 12 Q And is that, for a better term, the raw data,
 13 basically?
 14 A Yes. Yes.
 15 Q Okay. All right. Dr. Brawley, I don't think I've
 16 done this yet, but if I were send a subpoena to
 17 you, the file that you have before you today, is
 18 that what would be produced to me pursuant to a
 19 subpoena?
 20 A I cannot send you the raw data. What I can do is I
 21 can send the raw data to another neuropsychologist.
 22 Also in my letter I address the whole issue of test
 23 security. That's standard protocol. I've worked
 24 with several attorneys in your firm and they're
 25 familiar with this and recognize that there is this

19

1 issue of test security. The raw data can go to
 2 another neuropsychologist or psychologist of your
 3 choosing that is bound by the same ethical
 4 principals to protect the raw test data so it
 5 doesn't get out into the public domain.
 6 Q Is that a federal or state law that prohibits you
 7 from producing the raw data?
 8 A There's some test manufacturer and copyright laws.
 9 The main thing that guides us are the APA ethical
 10 principals and also the National Academy of
 11 Neuropsychology. Now, if you had got a court order
 12 from a judge, would I have to turn it over? Yes.
 13 But I would ask that it be sealed and that it would
 14 be destroyed after the court proceedings. I've
 15 never had it come to that. The attorneys have
 16 always worked with me and allowed it to go to
 17 another neuropsychologist or clinical psychologist.
 18 Q Okay. Are you aware of a subpoena from the South
 19 Carolina Workers' Compensation Commission is, in
 20 essence, an order of the court commanding a
 21 physician or medical provider to produce
 22 information at the request of the party?
 23 A Like I said, it's never come to that. The
 24 attorneys have always worked me. It's -- the
 25 analogy that I give to the attorneys is it's like

20

1 if the questions to the bar exam got out to the
 2 public domain, it wouldn't be an effective measure
 3 anymore. So they're just protecting. We're not
 4 trying to hide anything from attorneys. We're not
 5 trying to be difficult. You know, I used to do
 6 evaluations for the FAA and the pilots wanted to do
 7 really well so they would get onto the computer and
 8 try to research these tests so they could study for
 9 them. You know, so we really try to keep these
 10 test questions protected so that they -- they spent
 11 millions of dollars developing these tests.
 12 Q All right. So even today, I wouldn't have the
 13 ability to review the raw data sitting before you
 14 here?
 15 A You can look at anything in my file. I just can't
 16 let you make a copy of it.
 17 Q Okay. Fair enough. Okay. I'm flipping over to
 18 page two of your letter to Mr. Safran. In the
 19 first paragraph, the raw data of Dr. Gualtieri's
 20 report is discussed. And in that paragraph, you
 21 mentioned an email from Mr. Safran's office dated
 22 May 7th of 2015. What was discussed in that email?
 23 A I had told him that I wanted Dr. Gualtieri's raw
 24 data and that he would have to send it directly to
 25 me as by standard protocol and the email just said,

21

1 I believe, -- I'm going from memory -- he said he
 2 needs a separate release, but he had a release from
 3 me so he went ahead and sent it to me. Here's the
 4 raw test data.
 5 Q How many emails do you think you've exchanged with
 6 Mr. Safran throughout the course of evaluating Ms.
 7 Rummage?
 8 A He sent me a lot of the records via email so maybe
 9 ten, eight or ten.
 10 Q Is Ms. Rummage the first client of Mr. Safran's
 11 you've ever evaluated?
 12 A No.
 13 Q How many of his clients do you think you've
 14 evaluated?
 15 A Maybe a half a dozen.
 16 Q Okay. And have most of those occurred within the
 17 last, say, 12 to 18 months?
 18 A No. I think his first client he sent to me has
 19 been at least ten years ago. That one didn't work
 20 out so well for you.
 21 Q Do you have any evaluations of his clients
 22 scheduled at the present time that you're aware of?
 23 A Not that I'm aware of.
 24 Q Dr. Brawley, let me look through my notes. I think
 25 I've asked you all the questions I need to.

22

1 Mr. Lockhart: Thank you for your time. I
 2 don't have any further questions of you now,
 3 but I know Mr. Safran has some and I may have
 4 some follow up to his questions. So thank
 5 you.
 6 Cross-examination
 7 By Mr. Safran:
 8 Q I just have a few. Let's start kind of where you
 9 just left off. Over the course of, roughly, ten
 10 years, you've evaluated somewhere in the
 11 neighborhood of about half a dozen people for me?
 12 A And it may be more than that.
 13 Q No. I understand that.
 14 A Yeah. And then -- I mean, not more patients. More
 15 years because I was still at USC when you first --
 16 when I first saw the patient.
 17 Q Okay. And let me ask this question. You just
 18 mentioned that I sent you somebody and, as you
 19 said, it didn't work out well for me. Exactly what
 20 do you mean by that, just for the record?
 21 A It was a workers' comp case that you sent to me and
 22 same thing happened. Well, not the exact same
 23 thing, but I did the malingering test early on in
 24 the evaluation because I was seeing some red flags
 25 and he did not pass the malingering test so I

23

1 stopped. I didn't -- some -- some
 2 neuropsychologists will continue to give the full
 3 battery, but, for me, that's a waste of time and
 4 money if you already know you're not getting
 5 adequate effort. So I stopped and told the patient
 6 we were finished and I called you and told you he
 7 didn't pass the malingering test.
 8 Q Okay. And let me ask this. In your experience in
 9 doing these types of testing, is malingering
 10 something that you are always sensitive to try to
 11 assess?
 12 A Anytime there's secondary gain. I mean, I do more
 13 criminal cases than I do civil cases, but there's -
 14 - anytime there's secondary gain, either, you know,
 15 a financial settlement or a lighter prison
 16 sentence, you have to assess for effort. Our tests
 17 are completely dependent upon effort.
 18 Q Okay. And you mentioned earlier on when we started
 19 that when I met with you to, more or less, kind of
 20 introduce you to Ms. Rummage and have you do the
 21 testing that I at least told you, I guess,
 22 confidentially that I wanted to know whether she
 23 was legitimate or not.
 24 A You said you weren't sure what was going on and you
 25 wanted for me to meet her.

24

1 Q And in other cases, have I also asked you to tell
 2 me whether or not people are presenting in a valid
 3 way as opposed to something that they are feigning
 4 or malingering or somehow embellishing?
 5 A Yes.
 6 Q Is that pretty standard with what you and I do?
 7 A You've known that from the first patient that you
 8 sent me that that's what I'm going to do.
 9 Q Okay. And in this situation, I specifically wanted
 10 to make sure that what we were seeing was, in your
 11 estimation, valid as opposed to something that was
 12 not valid or was somehow contrived?
 13 A Correct.
 14 Q Okay. And let me ask this. You don't just do that
 15 for me. You do it in all of your assessments?
 16 A The only assessments that I didn't routinely
 17 administer malingering tests in were the FAA
 18 evaluations that I had mentioned to you before
 19 because they were not going to fake. They were
 20 trying to get back into the cockpit after going
 21 through treatment for alcohol and drugs so --
 22 Q Okay.
 23 A -- they were trying to study for the test. Not
 24 fake them.
 25 Q Let me ask you this. Basically from what I think

25

1 you said, your practice involves doing work in both
2 criminal and civil arenas?
3 A Correct.
4 Q All right. And in the civil arena, if you were to
5 break it down in terms of employee or plaintiff
6 versus carrier, employer, defense attorneys, how
7 does it break down in terms of percentages,
8 roughly?
9 A I do more defense work. I'm probably 65 to 70
10 percent defense work.
11 Q Okay. And I think you alluded earlier in response
12 to a question that having done for Mr. Lockhart's
13 firms?
14 A Correct.
15 Q Have you done various cases for them?
16 A I've done a few cases for McAngus, yes.
17 Q I mean, in terms of comparing, have you done more
18 for them than you have for me over that time?
19 A At least equal, if not more.
20 Q Okay. And they have retained you, I assume, in the
21 context of the defense side?
22 A Correct.
23 Q All right. And, I guess, have you ever gotten any
24 feedback from them that they were not satisfied
25 with your services or the quality of your work or

26

1 anything like that?
2 A No. I have one attorney in the Myrtle Beach office
3 who has referred to me several times.
4 Q Okay. All right. Let me just ask you a few other
5 things. If you are doing an assessment, does it
6 really matter who's paying for it in order to
7 determine, you know, somebody's legitimacy?
8 A No.
9 Q I mean -- and you're not reluctant to say to
10 whoever refers either yes, this is legitimate, or
11 no, it's not?
12 A That's correct.
13 Q I don't think Mr. Lockhart went into your
14 background. Could you just briefly kind of talk
15 about your education and training in terms of the
16 area of neuropsychology?
17 A My undergraduate is from the University of Texas at
18 Austin. I obtained a master's and a doctorate from
19 California School of Professional Psychology. And
20 it was at that time that I started the emphasis on
21 neuropsychology.
22 Q Okay.
23 A I did a pre-doctoral internship at Baylor College
24 of Medicine in Houston, Texas. And then had my
25 clinical experience within the department of

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1 neurology there at Baylor College of Medicine and
2 worked there for several years. I also went back
3 after I got married and we moved to the Carolinas.
4 I did a post-doctoral fellowship in neuropsychology
5 at Duke University Medical Center in Durham.
6 Q Okay.
7 A Work history: Wake Med Rehab; USC here, Department
8 of Neuropsychiatry for many years. I initially
9 came here and was performing evaluations for the
10 Department of Mental Health in their forensic unit.
11 I was the only neuropsychologist in the unit so I
12 got all of the gunshot wounds to the head, you
13 know. We did all of the capital evaluations for
14 competency, capacity to stand trial.
15 Q Okay. How long were you, I guess, some -- a member
16 of the department over at USC in neuropsychology?
17 Or psychiatry. Excuse me.
18 A Gosh, I just gave up my appointment there a couple
19 of years ago and we -- so 12 years, maybe.
20 Q Okay. So you were actually a member of the staff
21 there?
22 A I was on the faculty, yes.
23 Q And, in addition to being a faculty member, you
24 also did evaluations independently?
25 A That's correct.

28

1 Q Okay. And during that time frame, you have
2 performed neuropsychological evaluations on a
3 pretty high number of people?
4 A Thousands.
5 Q Okay. So this is not your first rodeo?
6 A No.
7 Q Let me ask you, also. You've had an opportunity
8 over time to not only review what I've asked you to
9 comment on in terms of Dr. Gualtieri, but other
10 neuropsychologists in this state and outside of the
11 state?
12 A Correct.
13 Q And are you familiar with what are accepted
14 neuropsychological test batteries that are
15 routinely used among people who are your peers?
16 A Very familiar.
17 Q Okay. I think the question I had asked you that
18 you mentioned earlier is I had brought up something
19 that was in the raw data. And I've got a copy of
20 that, I think, for you just in case you need to
21 review it.
22 A Yeah. I did not print that up and I would ask that
23 you destroy that after.
24 Q I understand. This is basically, I think, what I
25 sent you.

29

1 A Yes.
2 Q All right. And, again, you didn't give that to me,
3 correct?
4 A No.
5 Q That was something that was sent to me directly by
6 Dr. Gualtieri's office?
7 A Correct.
8 Q And, I believe, you were referencing an email --
9 I'm more than happy to find it and produce it to
10 Mr. Lockhart -- that I actually sent you this data
11 for your inspection?
12 A Correct.
13 Q Okay. There's a test that was used in that thing
14 and I think that the actual label on it or the name
15 of it -- I'm going to make sure I get this right --
16 it's an NPQ. You're not familiar with an NPQ?
17 A I've never heard of NPQ.
18 Q And I saw in a report that I did share with you
19 from Dr. Salas that this is something that is an
20 Internet based computerized system checklist
21 developed by Dr. Gualtieri himself.
22 A Okay.
23 Q Now, you mentioned earlier that in the TOMM
24 somebody, obviously, had to develop that?
25 A Correct.

30

1 Q But there has been a great deal of research
2 associated with the perfection of it --
3 A (Nods head).
4 Q -- and I'm assuming there is a -- you nodded your
5 head. Is that a yes?
6 A That's correct.
7 Q And I'm assuming in that test, like any other one
8 that you use as part of your standardized battery,
9 that that same type of development, research,
10 validation, et cetera kind of across the board has
11 to happen in order for people like you to use it?
12 A That's correct.
13 Q That, to your knowledge, has never happened with
14 this neuropsych questionnaire, NPQ?
15 A I am not familiar with that test. I don't know.
16 Q Even though you are not still, I guess, on staff at
17 USC, I'm assuming you still keep up in terms of
18 what is necessary in order to remain a viable
19 person to perform the type of testing you do?
20 A Correct.
21 Q Okay. I mean, there's -- whatever requirements for
22 updated education, et cetera, you still do that?
23 A That's correct.
24 Q And in any of your experiences along those lines,
25 have you ever run into the NPQ before?

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1 A I have not.
2 Q Okay. Let me ask you, also. You made some
3 comments, and I'm not going to go into them, you
4 know ad infinitum, but there were just a few things
5 in the report I wanted to ask you about. As far as
6 this situation, did it kind of strike you as odd
7 that there was a date of testing that was not
8 compatible with the actual date that the testing
9 occurred?
10 A I'm assuming that was a typo, but it was -- I did
11 note that in my report.
12 Q Is it another explanation that this report had
13 already begun to be generated prior to him ever
14 seeing this lady?
15 A That's possible.
16 Q Now, I think the other thing is this. Don't you
17 have to go through a very specific and involved
18 degree of training in order to be able to
19 administer a test like this and interpret them from
20 a, as you put it, psychometric standpoint?
21 A Yes.
22 Q I mean, that's not something you just do over the
23 weekend as far as a course?
24 A No.
25 Q I mean, is that something that's taught in medical

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1 school or is that something that's taught in a
2 different way?
3 A It starts in graduate school. You have tests on
4 psychometrics and psychological assessment. You
5 learn how to administer them, how to interpret, how
6 to score them. You are supervised for a certain
7 period of time administering those tests. I've
8 been administering these tests since 1987. And at
9 the time that I started doing them, I was
10 supervised by a licensed clinical neuropsychologist
11 who looks over your work, sits in with you and
12 makes sure that you're administering them
13 correctly. It's a pretty tedious process to be
14 able to administer, score and interpret the tests.
15 Q I mean, from what I'm gathering, this is a process
16 of learning and experience that, you know, spans
17 more than, you know, just maybe taking one class or
18 something?
19 A That's correct.
20 Q Okay. And having been affiliated with, you know,
21 some medical schools -- I think you were affiliated
22 with Duke, you were affiliated with Baylor -- is
23 that a routine type of course that just a medical
24 student would be taking? You know, just a doctor?
25 A No. They occasionally would want to sit in and

33

1 watch the testing, but that didn't last for long.
 2 They got pretty bored watching.
 3 Q And I think -- so, basically, in order to do that
 4 type of interpretation to the standard that you
 5 have come to understand as the norm and the
 6 appropriate, it takes somebody who is specifically
 7 trained in the areas that you have been trained in
 8 over the course of time as well as the experience
 9 you've gained in 30 years, basically?
 10 A That's correct.
 11 Q Let me ask you, also. Did you find it -- you made
 12 a comment about it. Why would somebody who is 55
 13 years old be administered a pediatric
 14 neurocognitive test?
 15 A I'm not sure.
 16 Q Are you familiar with pediatric neurocognitive
 17 tests?
 18 A I do not test children. I refer those out to
 19 someone else.
 20 Q No. I understand. But, I mean, are you familiar
 21 with what it is?
 22 A I've not given that instrument. I'm not that
 23 familiar with it because as soon as I hear that
 24 somebody is 17 or younger, I give out a different
 25 name for a provider.

34

1 Q Well, let me ask it this way. Are you familiar
 2 enough with what it's for to know that if you're
 3 testing an adult, you wouldn't be using it?
 4 A That's correct.
 5 Q Okay. So, again, when we're looking at the normal
 6 standard of -- or battery of tests that you have
 7 more or less formulated to use and gleaned through
 8 nearly 30 years of experience, that is not a test
 9 you would administer to a 55-year-old woman?
 10 A No. It is not.
 11 Q Okay. Let me ask this. You also went through --
 12 and, I mean, you had the opportunity not only to
 13 review the raw data, but also Dr. Gualtieri's
 14 report, correct?
 15 A That's correct.
 16 Q And you mentioned in another paragraph on that
 17 second page of your report, talking about symptoms
 18 that she reported; headaches, unpleasant thought,
 19 lack of appetite, crying easily. Are those very
 20 similar to the symptoms that you documented when
 21 you met with her?
 22 A Yes.
 23 Q Okay. And when you saw her and heard that
 24 constellation of symptoms being reported as well as
 25 observing her, did you find that they were

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1 compatible, what she was telling you and what she
 2 was exhibiting?
 3 A Yes.
 4 Q Did you also feel like that they supported a
 5 diagnosis of some form of psychological and/or
 6 psychiatric condition?
 7 A Yes.
 8 Q And did you confirm that at that point when you saw
 9 her?
 10 A Yes.
 11 Q Did you feel like that condition needed to be
 12 treated?
 13 A Yes.
 14 Q And I think from your standpoint as someone who is
 15 focused on giving neuropsychological testing, was
 16 the treatment of that condition necessary in order
 17 for you to ultimately do what you were asked to do
 18 in terms of performing a full battery of neuropsych
 19 testing?
 20 A Well, I could have performed a full battery of
 21 testing on her, but I wouldn't have been able to
 22 reliably count on those numbers because they would
 23 be reflecting depression.
 24 Q Okay. And so I'll rephrase my question. Same
 25 question only to ultimately perform a valid battery

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1 of neuropsych testing that could be reliable and
 2 people could use as a legitimate indicator of what
 3 this lady's condition was?
 4 A Correct.
 5 Q Okay. I think you mentioned in here that he also
 6 used the PAI Inventory. It says on that the number
 7 one diagnostic consideration listed in the
 8 interpretive report is major depressive disorder,
 9 correct?
 10 A Where are you?
 11 Q That's right here. It's the fourth --
 12 A Yes.
 13 Q So you looked at the standardized test. You looked
 14 at what the results were. And if -- what her
 15 actual presentation on that test was what the test
 16 would say is indicative of major depressive
 17 disorder?
 18 A Correct.
 19 Q He never offered that diagnosis, to my
 20 understanding?
 21 A No.
 22 Q Okay. So, I mean, if you were correctly applying
 23 that test, the answer would be she's got major
 24 depressive disorder based upon the PAI?
 25 A Well, the interpretive report. On page nine of the

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1 interpretive report, it comes up with diagnostic
2 considerations and that was the number one.
3 Q Okay. And, again, when you're learning how to
4 administer these tests, I'm assuming that if you're
5 going to do it appropriately that if it says this
6 is what we're trying to identify and the top
7 diagnosis based upon the results that you obtained
8 would be that, is that something you pay attention
9 to?
10 A It definitely needs to be considered, absolutely,
11 and combined with your other results.
12 Q Would that PAI result be consistent with your
13 clinical interview?
14 A Yes.
15 Q And would you support that diagnosis?
16 A Yes.
17 Q Okay. Given what her presentation was based upon
18 your review of the raw data and as well as what she
19 reported at the time of Dr. Gualtieri's exam, was
20 she still, in your estimation, manifesting enough
21 psychological or psychiatric disruption to
22 invalidate testing?
23 A Yes.
24 Q So would you consider his test results in terms of
25 trying to formulate a diagnosis as to

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1 neurocognitive deficits attributed to head trauma
2 to really be valid at this point given her, you
3 know, unstable emotional state?
4 A I would not have administered the tests that he
5 administered.
6 Q And -- but, again, based upon what you saw, based
7 upon what these tests show, based upon what you've
8 diagnosed in terms of her condition, really is
9 anybody going to be able to get valid
10 neuropsychological results at this stage, absent
11 her receipt of treatment, stabilization, and more
12 or less being able then to proceed in a valid
13 fashion?
14 A She needs to be -- her psychiatric symptoms need to
15 be under much better control before you're going to
16 get valid test results and be able to tell is this
17 all depression, is there something else going on
18 with the depression, is it post-concussion. When
19 there's this many things clouding it, you just
20 can't -- you can't tell.
21 Q And so really whether you had gone forward with the
22 testing or not or the fact that he did, either way,
23 from your estimation, I'm understanding they're not
24 valid results in terms of neuropsychological
25 testing?

39

1 A I would not interpret these results that he got.
2 Q Okay.
3 A That's a clinical decision.
4 Q All right. Let me ask you this. I want to ask
5 just a couple of other things and I'll be done. I
6 shared, I think, Dr. Salas' report with you?
7 A Yes.
8 Q Are you familiar with Dr. Salas from before getting
9 this report?
10 A Yes.
11 Q All right. And where did you first encounter her?
12 A She was a fellow at USC. I mean, I've known her
13 since she was a fellow.
14 Q Okay. And when you say a fellow, what, for the
15 record, is -- what are we talking about?
16 A She was getting fellowship training in forensic
17 psychiatry.
18 Q Okay. So is that something above, I guess, just
19 becoming a psychiatrist?
20 A Yes. That's additional training.
21 Q All right. And that's an area -- a different area
22 of specialization, forensics?
23 A That's correct.
24 Q Okay. And who was she, primarily, training with
25 over at your facility?

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1 A The times that I saw her in court and for
2 evaluation she was with Dr. Schwartz-Watts
3 Q Okay. And I think Dr. Schwartz-Watts was also a
4 member of the staff for many years?
5 A Yes.
6 Q And also actually had -- I guess she is a forensic
7 psychiatrist?
8 A Correct.
9 Q Okay. Let me just ask a couple quick things. On
10 page two of her report, third paragraph, "Presented
11 as honest and forthcoming." Is there anything
12 about that comment that was different than your
13 impression?
14 A No.
15 Q Okay. It says that she did not present as overly
16 dramatic or exaggerated. And I understand you said
17 one of the concerns was just her presentation when
18 I asked you. But, I mean, once you kind of sat
19 down with her, did you find any pretense in her?
20 A No.
21 Q Okay. Then in the fourth paragraph where it talks
22 about forgetful, anxious, depressed, low energy,
23 problems with speech, are those consistent with
24 what was reported to you?
25 A Yes.

41

1 Q Now, in fact, were you aware that Ms. Rummage was
2 referred for speech therapy after this head trauma?
3 A I believe I read that, yes.
4 Q Okay. And, again, when this document where it
5 talks about treating her for a TI or actually --
6 excuse me. Let me make sure I'm using the word
7 correctly. Just bear with me. I think they used -
8 - instead of TBI they used BI. What does BI
9 normally refer to in this context?
10 A Brain injury.
11 Q Okay. And is speech therapy something that you do
12 see as part of the spectrum of treatment that
13 people can get for a traumatic brain injury?
14 A Yes.
15 Q Okay. Would, after this head trauma, Ms. Rummage's
16 treatment through speech therapy be consistent with
17 a head injury?
18 A Yes.
19 Q And, in fact, is there a diagnostic code here on
20 the very first evaluation?
21 A I've not seen these records before, but you're
22 showing them to me now and it says mild cognitive
23 deficit 331.83.
24 Q Okay. Over the course of time, in addition to
25 doing psychological -- or neuropsychological

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1 testing, you have also done numerous clinical
2 evaluations of people from a psychological
3 standpoint?
4 A I don't do straight psychological. I stick with --
5 I've always done neuropsychological.
6 Q Right. But I guess what I'm saying is in addition
7 to doing the testing, you have to do a clinical
8 interview. You have to make a judgment based upon
9 the clinical assessment?
10 A Yes. Yes.
11 Q So that's part of what you do?
12 A Yes.
13 Q All right. And so are you capable -- and I believe
14 -- or I'm asking you are you capable of diagnosing
15 things like depressive disorder and all the other
16 gambit of psychological conditions that may come
17 across in your examination?
18 A I usually will say that my results are consistent
19 with that and then refer them out to a
20 psychiatrist.
21 Q Okay. All right. And I think Dr. Salas ultimately
22 diagnosed major depressive disorder, I think, on
23 the -- I'm looking for it here.
24 A Page seven.
25 Q Okay. And I guess my question is is that -- again,

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1 is that consistent with your examination, your
2 findings, your interview?
3 A Yes.
4 Q From a standpoint -- obviously, you've seen Dr.
5 Salas over time. I mean, do you consider her to be
6 a competent forensic psychiatrist?
7 A Yes.
8 Q Had Ms. Rummage not passed the malingering test,
9 would you have said so?
10 A Absolutely.
11 Q And had she not passed it, would you be, you know,
12 subject, I guess, to a different diagnosis and
13 potentially different recommendations?
14 A Yes.
15 Q Were you satisfied with your examination, your
16 interview and the results of testing in terms of
17 validity as it related to the malingering test to,
18 you know, render the opinions you've rendered up to
19 this point?
20 A Yes.
21 Q And do you stand by them at this point?
22 A I do.
23 Mr. Safran: That's all I've got. Thanks.
24 Re-examination
25 By Mr. Lockhart:

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1 Q Dr. Brawley, just a few questions. You spoke to
2 the competency of Dr. Salas. Is she a personal
3 friend of yours?
4 A No, she's not.
5 Q Mr. Safran asked you some questions earlier about -
6 - about the notion of brain injury. You're not a
7 medical doctor, correct?
8 A That's correct.
9 Q And so are you in a position to be providing a
10 diagnosis regarding a physical injury to anyone?
11 A What I do is say if my results are consistent with
12 organicity. I don't do the DSM diagnoses like Dr.
13 Salas does.
14 Q Okay. All right. There's been some discussion,
15 again, of Ms. Rummage and a notion of major
16 depressive disorder, correct?
17 A Yes.
18 Q Okay. And at this point -- I believe I think you
19 said this earlier -- you are aware that she was
20 receiving treatment for complaints regarding
21 depression before this accident occurred, correct?
22 A That's correct.
23 Q All right. To your knowledge, had she had any
24 testing done prior to the date of accident at all
25 to either confirm or rule out the presence of major

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1 depressive disorder before the work injury
 2 occurred?
 3 A I have not seen any previous testing, but generally
 4 you don't do testing to diagnosis MDD. That's
 5 usually done by a psychiatrist with clinical
 6 interview.
 7 Q You indicated that you've spoken with Dr. Salas
 8 following her examination of Ms. Rummage, correct?
 9 A Yes.
 10 Q Have you had any conversations with Dr. Gualtieri?
 11 A No.
 12 Q All right. Before speaking to his report, would it
 13 not be prudent to speak to him?
 14 A No.
 15 Q Why not?
 16 A Because I was just asked to review his records.
 17 That's pretty standard protocol in our profession,
 18 and it's not standard protocol to call the
 19 provider.
 20 Q Well, if we're questioning the results of his
 21 evaluation, wouldn't it seem prudent to have
 22 conversations with him about the evaluation itself?
 23 A That's not standard protocol for our types of
 24 evaluation.
 25 Q Let me ask you this question. If someone was

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1 questioning the results of an evaluation you
 2 conducted, wouldn't you like to have the
 3 opportunity to speak to them personally about the
 4 evaluation?
 5 A I'm sure that happens all the time and I've never
 6 had anybody call me to ask questions about my
 7 evaluation in the years I've been doing this.
 8 Q Okay. So as far as your concerned, someone could
 9 evaluate something you've done and do so without
 10 any interaction with you?
 11 A That's correct.
 12 Q Okay. Fair enough. Dr. Guiltier's a psychiatrist,
 13 correct?
 14 A That's correct.
 15 Q So he has additional training that you would not
 16 have received, correct?
 17 A He has different -- he went to medical school and I
 18 went to graduate school so they're different paths.
 19 Q Okay. So, again, he may have additional training
 20 that you have not received?
 21 A If he has been trained in psychological testing,
 22 I've not received information on that.
 23 Q You've neither confirmed or not confirmed whether
 24 or not that's the case, correct?
 25 A That's correct.

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1 Q All right. You were asked if you were familiar
 2 with a test called the NPQ and you said you were
 3 not.
 4 A Correct.
 5 Q Your lack of familiarity with the testing doesn't
 6 invalidate it, does it?
 7 A No.
 8 Mr. Lockhart: Dr. Brawley, those are all
 9 the questions I have. Thank you.
 10 Cross-examination
 11 By Mr. Safran:
 12 Q Just a couple. Let me ask this. Basically, as I
 13 understood it, there are certain tests that are
 14 regularly and standardly used among
 15 neuropsychologists with some deviation, I guess,
 16 that are kind of considered, for lack of a better
 17 word, something along the line of the standard or,
 18 you know, what would be universally accepted in
 19 terms of somebody else looking at your results and
 20 you looking at somebody else's. You look to see
 21 there would be certain tests that you're all
 22 familiar with?
 23 A You look to see what battery they gave, absolutely.
 24 Q Okay. And, again, if somebody is basically using a
 25 battery that they've somehow conceived themselves

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1 that doesn't have any mainstream or broad type of
 2 recognition, would you question, you know, the --
 3 whether that test in and of itself should be part
 4 of the assessment of this nature?
 5 A If I had researched it and found that to be the
 6 case, then yes.
 7 Q Okay. And, in fact, I think I looked at Dr. Salas'
 8 report. And I know you'd want to defer some of
 9 this to her, but, at least based upon what's stated
 10 in her report where it says that she -- I think
 11 this is on page six. Is an Internet based
 12 computerized symptom checklist developed by Dr.
 13 Guiltier himself. By his own publication, the NPQ
 14 was not developed as a diagnostic test. If, in
 15 fact, that's what it says, yet it's being used as a
 16 diagnostic process, would those two things be
 17 inconsistent?
 18 A Yes.
 19 Q Okay. And, again, I think you just answered Mr.
 20 Lockhart that in your profession is actually not
 21 the norm. In fact, it would be unusual for
 22 somebody to call you up to start talking to you
 23 about a critique of what your testing had been and
 24 your findings had been?
 25 A That's correct.

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1 Q And in nearly 30 years of doing this, that's never
2 happened?

3 A Never.

4 Q Not that people haven't critiqued. They've never
5 shared it with you?

6 A I'm sure they've critiqued.

7 Q Okay. And just the last thing. I know Mr.
8 Lockhart mentioned, you know, this question. I
9 guess it's kind of the whole notion of M.D. versus
10 Ph.D. Are there certain areas when it comes to
11 this type of assessment and testing that as a Ph.D.
12 you actually have different training than an M.D.
13 would?

14 A Correct. An M.D. is a medical doctor that can
15 prescribe medication where the psychologist defer.
16 And some M.D.s do do counseling but, generally, the
17 psychologists do the counseling. The psychologists
18 are trained in administering, scoring and
19 interpreting the test.

20 Q Okay. All right. One last thing along those
21 lines. Give me just half a second. Are
22 physician's assistants generally trained to the
23 level of test administration, scoring,
24 interpretation that you would be?

25 A No.

State of South Carolina)
County of Lexington) Certificate

Be it known that the foregoing deposition of
Tora Brawley, Ph.D. was taken before me;
That I was then and there a notary public in
and for the State of South Carolina-at-large;

That by virtue thereof I was duly authorized
to administer an oath;

That the witness was by me first duly sworn to
testify the truth, the whole truth, and nothing but the
truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 50 typewritten
pages represents a true, accurate and complete
transcription of the testimony so given at the time and
place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of
any of the parties hereto, nor a relative or employee of
any attorney or counsel employed by the parties hereto,
nor interested in the outcome of this action.

Signed this 29th day of December, 2015.

Cheri B. Williams, CVR-M

Notary public for South Carolina
My commission expires May 13, 2025.

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1 Q And if, in fact, this says that he was assisted by
2 a Rebecca Krause, P.A.C., the P.A.C. certainly
3 wouldn't be the one that could reliably and really
4 appropriately interpret this stuff, could they?

5 A No. Neuropsychologists sometimes use technicians,
6 but they have been -- or psychometrists, as we call
7 them, to administer our tests, but they've been
8 thoroughly trained on the administration of the
9 tests.

10 Mr. Safran: Okay. All right. Thank you.
11 I don't have anything else.

12 Mr. Lockhart: Dr. Brawley, I don't have
13 any further questions, but I would like to
14 look at your file before you leave.

15 The Deponent: Sure.

16 (Whereupon the deposition was concluded at
17 10:05 a.m.)
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FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 12-17-12

REFERRAL:

Wright Rehabilitation Services, Michelle Estep - Case Manager

PURPOSE FOR EVALUATION:

Evaluate for chronic neck and headache pain.

HISTORY OF PRESENT ILLNESS:

Ms. Rummage is a 53-year-old Caucasian female with history of fall at work on 5-18-12. She was working as a weaver when she was standing behind a loom doffing some material. A doff truck was behind her and caused her to fall backwards hitting a chain and part of the doffing machine itself. She lacerated her right scalp and occipital region and had a "laceration" of her neck. She reports this was "glued together" at the site and she did not go to the hospital at that point.

Approximately one week later the patient was sent to Dr. McLeod for evaluation. At that point, the patient was sent to the hospital for a CAT scan which was done and she was prescribed Fioricet and Lorcet at that point.

On 6-6-12, the patient underwent C-spine x-rays which reportedly showed degenerative disk disease at C4-C7 with multilevel facet arthropathy. Lumbar spine plain films done the same date showed hypertrophic facet arthropathy throughout the lumbar spine most prominent at L1-2, L3-4, and L5-S1. The patient subsequently was referred to Dr. Benjamin, a neurologist, at the beach. The patient saw Dr. Benjamin and was diagnosed with a closed head injury on 9-5-12. There was reportedly a request for an MRI scan. The patient was prescribed Topamax along with Hydrocodone and reported she could reportedly work without restrictions although later on she has not been released to work by Dr. Benjamin. She followed up with Dr. Benjamin on 10-12-12 and had bilateral occipital nerve blocks and trigger point injections.

On 11-4-12, the patient saw Dr. Benjamin in followup and reported the nerve blocks gave her no benefit. She reports she attended therapy minimally over two months. That was two times a week for approximately eight weeks in Cheraw. She was prescribed Roxicodone 50 mg t.i.d. and Phenergan prn. She reports physical therapy did help somewhat. She has tried Trileptal with Dr. Benjamin at 150 mg b.i.d. She reportedly has been taken out of work by Dr. Benjamin and cannot lift more than 50 pounds.

The patient also reports she has been placed on Topiramate in the past but that caused "knots" on her nose along with periorbital edema.

Presently, the patient complains of bilateral pain in the posterior neck sharp on the right heading up to the right scalp and on the left it heads behind her left ear. She reports she has ringing of her ears along with lightheadedness and slight memory loss. She prefers not to drive. She reports the headaches start with knife like sensation of the right scalp and she tries heat at home for the headache pain. She has not tried Lyrica or Neurontin at this point.

Vickie Rummage

12-17-12

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PAST MEDICAL HISTORY:

Sinus troubles.

PAST SURGICAL HISTORY:

Prior cholecystectomy, partial hysterectomy for tumor, and left tib-fib fracture treated with ORIF in 2004.

ALLERGIES:

Penicillin.

SOCIAL HISTORY:

Patient is married with two children. She is not working at present. She does not use alcohol or tobacco.

PHYSICAL EXAM:

Well appearing fit adult female in mild acute discomfort seated in exam room. BP 140/97. Pulse 71. Resp: 18. Ht: 5'2". Wt: 168 pounds. HEENT – normocephalic, nontraumatic. CV – RRR. S1/S2 without murmurs. Abdomen soft, nontender with positive bowel sounds. Cervical range of motion showed some trouble with cervical extension and lateral bending to the left. Bilateral upper extremity exam showed 4+ to 5-/5 strength with normal bulk and tone. Sensation was intact to light touch throughout bilateral upper extremities. Lower extremity showed hip flexion, knee extension, and ankle dorsiflexion at 4+ to 5-/5. Bulk and tone were normal and reflexes were 2+ and symmetrical.

IMPRESSION:

Status post work injury, 5-18-12, with persistent headache, neck pain, ringing in ears, lightheadedness, and reported short term memory loss.

PLAN / RECOMMENDATIONS:

At the present time, I have suggested she try a low dose of Neurontin of 100 mg q. hs. along with Hydrocodone 10/660 1 tablet q.i.d. prn. I asked that she be involved in repeat physical or occupational therapy for modalities along with posterior neck gradual range of motion and strengthening. There is probably also a need for evaluation with speech therapy. At this point, we will plan on seeing the patient in followup in approximately one month. If she cannot tolerate the medication then she should stop the Neurontin and continue with the Fioricet only.

Daniel L. Collins, M.D.

DLC/mhp

CC: Wright Rehabilitation Services 
C/O Michelle Estep, Medical Case Manager

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 1-11-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is a 53-year-old female with history of fall at work on 5-18-12. She was working as a weaver when she was standing behind a loom doffing some material. A doff truck was behind her and caused her to fall backwards hitting a chain that was part of the doffing machine itself. She had scalp laceration of the occipital region along with a "laceration" of her neck. She reports that was "glued together" at the site and she did not go to the hospital at that point. She subsequently went for a cervical spine film which showed degenerative disk disease at C4-7 with multilevel facet arthropathy.

Lumbar spine films done on the same day showed hypertrophic facet arthropathy throughout the lumbar spine most prominent at L1-2, L3-4, and L5-S1. She subsequently saw Dr. Benjamin at the beach who reportedly is a neurologist. She was diagnosed with a closed head injury on 9-5-12. There reportedly was request for an MRI scan but I do not have that result. Dr. Benjamin apparently did trigger point injections along with occipital nerve block bilaterally. The patient reports she gained no significant benefit with the occipital nerve block but had some slight benefit with the trigger point injections.

When I first saw the patient on 12-17-12, we had tried her on Neurontin 100 mg q.hs. She had not tried Neurontin or Lyrica in the past. She subsequently called back saying she had some sort of reaction with facial swelling especially around the nose and she stopped the Neurontin. She does report the Hydrocodone prescribed q.i.d. prn has been helping with her neck pain but nothing helps with her headache pain. She reports the headache pain is fairly severe at present. She is receiving outpatient physical therapy in Cheraw attending twice a week for two to three more weeks. She also receives outpatient speech therapy twice a week for mild cognitive impairments.

The patient reports she has taken Fioricet in the past but that was discontinued because Dr. Benjamin did not want her to be on that for any prolonged period of time. She subsequently was tried on Topamax but that caused "knots" on her nose along with periorbital edema. At this point, she cannot take Topamax or Neurontin. She reports today is a very bad day and she has a significant headache.

CURRENT MEDICATIONS:

Hydrocodone 10/650 1 tablet q.i.d. prn

Vickie Rummage

1-11-13

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PHYSICAL EXAM:

Well appearing fit adult female with pain complaints of her posterior cervical spine with decreased cervical range of motion especially in lateral bending, rotation, and flexion and to some degree extension. She has 4+/5 strength throughout bilateral upper extremities with normal bulk and tone.

IMPRESSION:

Status post work injury, 5-18-12, with persistent headaches, neck pain, ringing in ears, lightheadedness, and reported short term memory loss.

PLAN / RECOMMENDATIONS:

The patient will continue with outpatient physical and speech therapy at this point. We will try her on low dose Lyrica 50 mg q.d. in addition to her Hydrocodone. We also discussed possible trigger point injections and even Botox injections for chronic headaches. We will see how she responds initially to the Lyrica and then probably start with trigger point injections and proceed to toxin injections for headache treatment as necessary. I have explained to her we are probably dealing with chronic injury that seems to be persisting well passed 6 months from her initial injury. She probably is looking at several more months of continued treatment to see if we can get control of her headache pain and overall neck pain. We will plan on seeing her in followup in one month. All of the above was discussed with the patient's case manager, Ms. Estep.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 2-11-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She was originally injured in a fall back on 5-18-12. When I last saw her on 1-11-13, we had her continue in physical and speech therapy. The physical therapist would like to treat her for another two weeks 2 times per week. The speech therapist indicates she is significantly improved in terms of attention and memory during structured treatment. They apparently continue to treat her and are suggesting there may be some depression that they have noticed.

The patient does report some persistent symptoms including ringing of the ears and short term memory loss although that is improved. She also reports persistent headache pain. She reports she is 50% better and she does her home exercise program including neck and shoulder exercises. She is reporting she is not getting any benefit from the Norco or Fioricet used for the headache pain. She does use Lyrica and we have suggested possibly increasing the dose of that to twice a day. She reports she would like to have trigger points performed today in the office. In terms of her depression, she has used Prozac in the past and we could certainly try that although she does report some problems with sleep and I think Remeron might be an option for her at present. We will also give her some Flexeril to be used for nighttime stiffness and pain.

CURRENT MEDICATIONS:

Norco 10/650 1 tablet q.i.d. pm, Fioricet 1 tablet b.i.d. pm

PHYSICAL EXAM:

Reasonably well appearing adult female with persistent complaints of neck stiffness with cervical range of motion especially in flexion and extension. She has significant complaints of pain radiating from the neck through her head bilaterally just off midline bilaterally in her neck. She reports those areas are what she thinks might respond to trigger point injections. She otherwise has 4 to 4+/5 strength throughout bilateral upper and lower extremities with normal bulk and tone.

IMPRESSION:

Status post work injury on 5-18-12 with persistent headaches, neck pain, ringing in ears, lightheadedness, and short term memory loss.

PLAN / RECOMMENDATIONS:

We did have the patient stop her Norco and instead will use Percocet 5/325 1 tablet t.i.d. pm.

Vickie Rummage

2-11-13

Page 2

In terms of her depression, we will start her on Remeron 15 mg q. hs. We will also have Flexeril available 5 mg 1 tablet b.i.d. prn and 2 tablets q. hs. for improved help with sleep. We will increase her Lyrica to 50 mg b.i.d.

In terms of therapy, she will continue in physical therapy for another two weeks, total of 4 visits, and she will continue in speech therapy at present.

In terms of trigger point injections, she did sign the consent for the injections and I prepared a 5 cc. syringe with 1% Lidocaine. I injected 5 areas in the cervical paraspinal muscular bilaterally. Good hemostasis was obtained at each of the 10 injection sites and the patient tolerated the procedure well.

All of this was reviewed with the case manager and the patient continues out of work at present. We will plan on seeing her in followup in approximately one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 3-11-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager and her husband. The patient was originally injured on 5-18-12. I last saw her in this office on 2-11-13.

The patient initially reports she is doing well although she then tells me about numerous problems that she is having. We had tried Remeron during the last clinic visit but she had to stop that because of swelling in her face which she has experienced in the past with various medications. She seems to be very "allergic" to various medicines. She also reports persistent double vision and decreased short term memory. She has finished her physical therapy at this point but the speech therapist is asking for another 12 visits.

We did switch the patient to Percocet during the last clinic visit in place of her Norco and she does report the Percocet gives her better relief. She also reports she has posterior scalp pain that hurts even when she is trying to brush her hair and trying to sleep on the back of her skull as she lays on her back. She wants something for her sleep at the present time. As mentioned above, she has completed her physical therapy and we are ready to proceed with a Functional Capacity Evaluation. She will attend 12 more speech therapy visits.

The patient is also requesting trigger point injections today as she does feel the last trigger point injections done 2-11-13 gave her benefit. We have discussed use of Trazodone for her sleep.

CURRENT MEDICATIONS:

Percocet 5/325 1 tablet t.i.d. prn, Flexeril 5 mg b.i.d. prn (2 at night), Lyrica 50 mg b.i.d. prn.

PHYSICAL EXAM:

Well appearing adult female with persistent complaints of neck stiffness and decreased cervical range of motion. She has 4 to 4+/5 strength throughout bilateral upper and lower extremities.

IMPRESSION:

Status post work injury, 5-18-12, with persistent headaches, neck pain, ringing of ears, lightheadedness, blurred vision, and short term memory loss along with insomnia.

Vickie Rummage

3-11-13

Page 2

PLAN / RECOMMENDATIONS:

She will continue on her Percocet and we have added Trazodone 50 mg 1-2 tablets q. hs. for her sleep. Hopefully, she can tolerate this. She is not interested in any antidepressant medications at present. We will have her continue out of work but continue to finish out her speech therapy visits for another 12 visits. She also will be set up to undergo a Functional Capacity Evaluation to determine what her work abilities are. I am doubtful she can return to her former job in the fabric mill which requires a fair amount of lifting and maneuvering throughout the day. She needs to be able to supply yarn to creels approximately 150 times in an 8 hour shift and lift objects that are approximately 50 pounds in weight. We will plan on seeing the patient in followup in this office in one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 4-10-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager and her husband. The patient was originally injured at work on 5-18-12. She has been evaluated previously by Dr. Benjamin a neurologist near the beach. She was prescribed occipital nerve blocks without significant improvement although she did have trigger point injections with some benefit. I have given her at least one set of trigger point injections if not two and those gave her temporarily relief.

The patient has completed a recent Functional Capacity Evaluation which showed she could function at a light physical demand category. Despite that Functional Capacity Evaluation she reports she was terrible for a few days afterwards as it "threw me for a loop" causing her increased pain throughout. She still has persistent blurred vision complaints along with headaches and tension tightness of the upper back along with ringing of her ears. She has undergone a CT of the brain several months ago without any acute finding noted. At this point, she asks about how long she can expect to have the symptoms and I told her given the fact they have gone on for at least 11 months now, I do not think they are going to resolve in the near future. I think her postconcussive headache symptoms will probably persist for an indefinite period of time. I do think it would be wise to check her vision with her ophthalmologist and I have made a referral to her regular ophthalmologist, Dr. Covington, for that evaluation. She certainly is not able to work at the present time and I am not helpful in that regard. Her symptoms really have not eased any degree over the period of time I have been working with her. We have decided to try some Cymbalta for her to try to help with her overall mood. She reports she has not been using the Lyrica on a daily basis but has been using the Percocet 2-4 times per day and the Flexeril usually twice a day. She has experienced side affects to various medications in the past.

CURRENT MEDICATIONS:

Percocet 5/325 1 tablet t.i.d. prn, Flexeril 5 mg b.i.d. prn (2 at night), Lyrica 50 mg b.i.d. prn (not used regularly).

PHYSICAL EXAM:

Tearful adult female seated on exam table. She complains of neck stiffness with decreased range of motion noted with only minimal flexion, extension, and lateral bending and rotation. She generally has 4 to 4+/5 strength throughout bilateral upper and lower extremities.

Vickie Rummage

4-10-13

Page 2

IMPRESSION:

Status post work injury on 5-18-12 with postconcussive symptoms persisting including headaches, neck pain, ringing in ears, lightheadedness, blurred vision, and short term memory loss with insomnia.

PLAN / RECOMMENDATIONS:

Patient will continue in outpatient speech therapy which is occurring 2-3 times per week to try to help with her cognitive deficits. I have made referral for ophthalmology evaluation with her regular ophthalmologist, Dr. Covington, and we will see if there is any change in her prescription necessary. At this point, we have also started her on Cymbalta 30 mg to be used 1 tablet q.d. for a week and then increase to 2 tablets q.d., i.e. 60 mg. I have refilled her Percocet for her. She understands from our discussion that the prognosis for immediate recovery is very poor and I have explained to her that the recovery will likely be several more months. I think only with gradual time she will likely to experience some diminish in her symptoms although they certainly have not changed over the past year or so. I am concerned about her potential for work now and in the future. I have explained this to her and her case manager today. We will plan on seeing her in followup in one month. We will have her continue with speech therapy and try the Cymbalta along with the ophthalmology evaluation. I am not sure that another neurologist would give us anymore substantial input at this point given her symptoms and negative studies to date. I have explained that usually postconcussive symptoms last weeks to months but hers have lasted almost a year at this point without substantial improvement.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 5-13-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation accompanied by her case manager. The patient does have a note from speech therapy reporting she is making reasonable progress but they still need more time with her. They are working on memory along with organizing thoughts and cognitive retraining. She has also undergone a recent ophthalmology evaluation which reportedly identified no significant change in her acuity although they did identify some dryness of the eyes thought to be secondary to medication.

The patient still reports ringing of her ears along with headaches and muscle spasms in her posterior cervical region. She does report some benefit with the Flexeril and we have decided to increase the frequency of the Flexeril. She also has been taking Percocet up to 6 per day and gaining better benefit although she runs out before the end of the month. She is tolerating the Cymbalta just fine at present at 60 mg q.d. She has restarted the Lyrica and now is up to 50 mg b.i.d. She is not sure if she gets much benefit from the Trazodone used 100 mg q. hs. She wonders about other medications such as nerve pills and/or Ambien.

The patient does request a trigger point injections today.

CURRENT MEDICATIONS:

Percocet 5/325 1 tablet t.i.d. prn (4-6 per day), Flexeril 5 mg b.i.d. prn and 2 at night, Lyrica 50 mg b.i.d., Trazodone 100 mg q. hs., Cymbalta 60 mg q.d.

PHYSICAL EXAM:

Reasonably well appearing adult female with stiffness of her neck reported with tenderness in the posterior cervical region. She generally has 4 to 4+/5 strength throughout. Bulk and tone were normal.

IMPRESSION:

Status post work injury on 5-18-12 with postconcussive symptoms persisting including headaches, neck pain, ringing of her ears, lightheadedness, blurred vision, and short term memory loss with insomnia.

Vickie Rummage

5-13-13

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PLAN / RECOMMENDATIONS:

We did decide to discontinue her Trazodone and instead will try Ambien 5 mg to be used 1-2 tablets q. hs. prn for sleep. We will continue her Cymbalta with no changes. We increased her Percocet up to 6 tablets per day from 3 per day. We also increased her Flexeril up to 5 tablets per day from 4. We did have the patient sign a consent for trigger point injections. I prepared 5 cc. of 0.25% Bupivacaine and injected five sites on each side of her cervical paraspinal musculature into her trapezius bilaterally. We injected a total of 10 sites. The patient tolerated the procedure and good hemostasis was obtained at each of the 10 injection sites.

In terms of work, she remains out of work at present. I have renewed her speech therapy and written repeat out of work for her. We will plan on seeing her in one month with refill of medication at that time as necessary.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 6-18-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is accompanied by her case manager, Ms. Estep.

The patient reports she did see the ophthalmologist and they reportedly told her she had no diagnosable problems involving her eyes. She uses reading glasses and the prescription even remained the same. She reports she has difficulty reading at present. She continues to see the speech therapist on a regular basis working on cognition and memory.

The patient reports she continues to use Percocet approximately 6 per day for severe pain of her upper back and neck. She requests trigger point injections in the office today. There is also a request to see a psychologist and we have decided to have her see Dr. Navey, a local psychologist, to see if we can help with the stress related to her injury and her ongoing problems. She does have a sufficient supply of Cymbalta at this time but needs a refill on her Percocet, Trazodone and Lyrica. She also requests prn Phenergan.

CURRENT MEDICATIONS:

Percocet 5/325 1-2 tablets t.i.d. prn (4-6 per day), Flexeril 5 mg b.i.d. prn and 2 at night, Lyrica 50 mg b.i.d., Trazodone 100 mg q. hs., Cymbalta 60 mg q.d.

PHYSICAL EXAM:

Reasonably well appearing adult female with significant complaints of stiffness of her back and pain of her neck and shoulder region especially on the left. She requests trigger point injections. She has 4 to 4+/5 strength with normal bulk and tone.

IMPRESSION:

Status post work injury, 5-18-12, with post concussive symptoms persisting including headaches, neck pain, ringing in ears, lightheadedness, blurred vision, short term memory loss, and insomnia.

PLAN / RECOMMENDATIONS:

The patient will continue in outpatient speech therapy at present and we will have her see Dr. Navey for coping. We did refill the patient's medications, specifically Percocet, Phenergan, Lyrica, and Trazodone for her.

Vickie Rummage

6-18-13

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She did request trigger point injections and has signed a consent. I prepared a 5 cc. syringe with 4 cc. of 1% Lidocaine. I did cleanse her neck posterior along with her mostly left trapezius and scapula muscles along with rhomboids on the left. Approximately 12 sites were injected with 0.25 to 0.5 cc. of 1% Lidocaine. Each injection site showed good hemostasis. The patient tolerated the procedure well.

We will plan on seeing the patient in followup in approximately one month. She will continue speech therapy and then be referred to see Dr. Navey for coping.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 8-19-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager, Ms. Estep. The patient initially reports if she is not able to return to work she has been told by her employer through a letter that she will need to be terminated over the next day or so. She feels she cannot return to her regular job which involves lifting up to 50 pounds at a time and I am in agreement. The patient still has complaints of ringing in her ears along with dizziness and pain in her back along with pain in her posterior left leg. She also reports shooting pain in her thigh. The patient has gained benefit from trigger points done through this office. She has undergone nerve conduction studies most recently that showed mild borderline bilateral carpal tunnel syndrome probably not related to her original Workers Comp injury. She does have some degenerative disk disease and that may have been worsened by the fall but it is hard to connect the carpal tunnel syndrome that she has at present to the fall. She continues to attend outpatient speech therapy for her cognitive deficits and is making slow but steady improvement. At present, she reports she cannot even do her housework at home without resting and she still has significant memory deficits.

We did discuss the fact that I do not think she will be able to return to her regular job now or in the foreseeable future. I have written a prescription with that comment made. At this point, I am not sure she would qualify for disability. I think she should continue to see what jobs are available and what she may be able to do. I have refilled her medication for her and we have also done trigger point injections today.

CURRENT MEDICATIONS:

Percocet 5/325 1-2 tablets t.i.d. prn, Cymbalta 60 mg q.d., Lyrica 50 mg b.i.d., Flexeril 5 mg 1 tablet b.i.d. and 2 tablets q. hs., Ambien 5 mg q. hs. prn.

PHYSICAL EXAM:

Well appearing adult alert female seated in a regular chair in moderate acute discomfort mostly involving her upper back and neck posteriorly. She has 4/5 strength throughout her bilateral upper and lower extremities and she ambulates without any assistive device.

IMPRESSION:

Status post work injury, 5-18-12, with postconcussive symptoms persisting including headaches, neck pain, ringing of her ears, lightheadedness, blurred vision, short term memory loss, and insomnia.

Vickie Rummage

8-19-13

Page 2

PLAN / RECOMMENDATIONS:

At this point, I think her return to work at her regular job is not likely for this patient. I have refilled her Percocet, Cymbalta, Lyrica, Flexeril and Ambien. I have renewed her prescription for outpatient speech therapy. I do not have a note from the speech therapist when I was seen the patient today but I do have a note subsequent to that which was eventually sent to our office. The nerve conduction studies done showed mild bilateral carpal tunnel syndrome and I do not think treatment is allowed at this point for that through myself as she is under Workers Comp. I have encouraged her to seek attention for the carpal tunnel syndrome with her primary care physician.

We will plan on seeing the patient in followup in this office in one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 9-20-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager, Ms. Estep, along with her husband. The patient still reports a fair amount of neck and cervical pain. She reports the trigger point injections really have not been giving her as much relief as she was hoping. She reports she has continued depressive episodes and continued neck pain. She reports only fair relief with the Percocet although she still wants to continue with it at present. She has a sufficient supply of her Lyrica, Flexeril, Ambien, and Cymbalta.

The patient is due for another 16 treatments with speech therapy. That has already been arranged with Ms. Williams at the Sandhills Regional Medical Rehabilitation Center.

We did discuss referral for depression along with possible facet injections. She has had a prior cervical MRI scan done on 7-17-13 which showed facet joint changes at C4-C7 on the left. She reports she is interested in trying the facet injections and I did review the potential pathology and response. She also is reporting she is willing to see Dr. Rainwater or Dr. Navey for depressive episodes.

CURRENT MEDICATIONS:

Percocet 5/325 1-2 tablets t.i.d. prn, Cymbalta 60 mg q.d., Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 2 tablets q. hs., Ambien 5 mg q. hs. prn.

PHYSICAL EXAM:

Reasonably well appearing slightly anxious, almost tearful adult female seated in a regular chair complaining of discomfort of her upper back and neck posteriorly. She has 4/5 strength throughout bilateral upper and lower extremities. She ambulates without any assistive device.

IMPRESSION:

Status post work injury, 5-18-12, with postconcussive symptoms including persistent headaches, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, and insomnia.

PLAN / RECOMMENDATIONS:

We have referred the patient on for facet injections on the left. We also referred her on for counseling with either Dr. Rainwater or Dr. Navey for her depression.

Vickie Rummage

9-20-13

Page 2

We have refilled her Percocet for her today. We will plan to keep her out of work at present. She reports she is not yet terminated from her job. We will plan on seeing her in followup in approximately one month. She will continue with her outpatient speech therapy.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 10-17-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her husband and her case manager, Ms. Estep.

During the last clinic visit on 9-20-13, we had suggested possible facet injections of her cervical spine. She had an MRI scan done on 7-17-13 which showed facet changes at C4-C7 on the left. At present, the recommendation has not been approved and apparently the Workers Comp carrier is discussing the case with the patient's attorney. Otherwise, we also made a suggestion the patient have psychological counseling with Dr. Rainwater or Dr. Navey for depressive episodes. That also is in the process of being reviewed and has not yet been approved.

The patient reports she is getting minimal relief with the Percocet. She does use two at a time and still gets suboptimal relief. We have discussed other medications or possibly increasing the dose on the Percocet and she is agreeable to the second option. She does request cervical trigger point injections in the office today.

The patient still complains of ringing of her ears and dizzy spells. She reports she has occasional falls. The patient continues to take Lyrica, Flexeril, Xanax and Imitrex and needs refills on those. She is still hopeful to return to work if possible in the future.

CURRENT MEDICATIONS:

Percocet 5/325 1-2 tablets t.i.d. prn, Cymbalta 60 mg q.d., Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 2 tablets q. hs., Ambien 5 mg q. hs. prn, Imitrex 1 tablet b.i.d. prn.

PHYSICAL EXAM:

Anxious occasionally tearful adult female seated in a regular chair complaining mostly of discomfort in her left upper back and neck posteriorly. She has 4/5 strength throughout bilateral upper and lower extremities. She ambulates slowly without any assistive device.

IMPRESSION:

Status post work injury, 5-18-12, with postconcussive symptoms including persistent headaches, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, and insomnia.

Vickie Rummage
10-17-13
Page 2

PLAN / RECOMMENDATIONS:

The patient has completed speech therapy and physical therapy at this point. We are still trying to get approval for cervical facet injections as noted above along with psychological counseling with Dr. Rainwater or Dr. Navey. In the meantime, we will increase the patient's Percocet to 10/325 and allow her to use 1½-2 tablets t.i.d. prn. That will be an increase from 10 to possibly 20 mg of Oxycodone at the time which should give her better relief. We will also give her some Antivert to be used 25 mg t.i.d. prn for her vertigo or dizzy spells. We will hopefully be able to get approval for the counseling and the facet injection as noted above. In the meantime, we will plan on seeing her in followup in one month.

I did perform trigger point injections of the left upper neck and trapezius and scapular region on the left using 4 cc. of 2% Lidocaine and 1 cc. of Kenalog 40. The patient tolerated the trigger point injections which were approximately 15 in number. Good hemostasis was obtained at each of the injection sites.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 11-14-13

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today unaccompanied. Her case manager is due later this morning.

During the last clinic visit on 10-17-13 we had discussed we were still awaiting approval for the psychological counseling with either Dr. Rainwater or Dr. Navey for depressive episodes. The patient reports she still has not heard anything about that approval and referral. She also has not heard anything about potential facet injections that were suggested previously. She does ask about Botox injections and those are discussed below. She has completed speech therapy at this point. She does notice some persistent headache pain that starts at the back of her head that is stabbing and radiates to her temples bilaterally to her forehead. These occur 3-4 times per week and last 5-8 hours at a time. She is very photosensitive and sound sensitive during these episodes. She does use her Imitrex to help to some degree.

In terms of her pain medicine, she does need a refill on the Percocet by about the 18th of the month. She is also requesting a refill on her Phenergan and requests increase in the Xanax to twice a day instead of once a day. She has sufficient supply of the other medications at present. She also requests trigger point injections in the posterior cervical spine especially on the left and those were completed today as noted below.

CURRENT MEDICATIONS:

Percocet 10/325 1½-2 tablets t.i.d. prn, Cymbalta 60 mg q.d., Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 2 tablets q. hs., Ambien 5 mg q. hs. prn, Imitrex 1 tablet b.i.d. prn, Phenergan 25 mg t.i.d. prn, Antivert 25 mg t.i.d. prn.

PHYSICAL EXAM:

Slightly anxious adult female seated in a regular chair. She complains of most of her pain in her upper back and neck on the left side with some persistent headache pain off and on. She has 4/5 strength throughout bilateral upper and lower extremities. She ambulates without any assistive device.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with post concussive symptoms including persistent headache, neck pain, ringing in ears, lightheadedness, blurred vision, short term memory loss and insomnia.

Vickie Rummage
11-14-13
Page 2

- 2) Migraine type headaches occurring 3-4 times per week lasting 5-8 hours at a time.

PLAN / RECOMMENDATIONS:

We are still awaiting approval for the facet injections after the prior MRI scan showed facet changes at C4-C7 on the left. We are also still awaiting referral for psychological counseling for depression. In the meantime, I have refilled the patient's Percocet as of 11-18-13 and also refilled her Phenergan and Xanax as of today. We will increase the Xanax to twice a day.

We did discuss the Botox injections and we will be seeking approval for those for migraine headache treatment.

I did get consent for trigger point injections and I prepared a 5 cc. syringe with 4 cc. of 2% Lidocaine and 1½ cc. of Kenalog 40. I injected approximately 15 sites involving the left cervical, left trapezius, left supraspinatus, and musculature over the spinous process of the scapula on the left side. The patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing the patient in followup in approximately one month.

Daniel L. Collins, M.D.

DLC/mhp

ESQ: ANDY SAKKIAN

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 1-17-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her husband and her case manager.

During the last clinic visit on 12-11-13, we had completed Botox injections for migraine headaches. The patient reports the injections have helped substantially. She reports her life quality is much improved but she still has muscle aches in the posterior cervical region. She would like trigger point injections today.

The patient still reports ringing of her ears which comes and goes independent of the headaches.

I did explain to the patient that her attorney had called me just after the last clinic visit. He wanted me to be aware of "prior treatment" for possible depression and musculoskeletal problems the patient had undergone and he had just reportedly obtained that information. I do not have the information in front of me and it was unclear exactly of the extent and severity of the treatment pre-dating her work injury. In any event, that muddies the picture and apparently is causing some mix up between the Workers Comp carrier and the patient's attorney.

CURRENT MEDICATIONS:

Percocet 10/325 1 ½ to 2 tablets t.i.d., Imitrex 1 tablet b.i.d. prn, Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 10 mg q. hs., Cymbalta 60 mg q.d., Phenergan prn, Antivert prn, Xanax 0.5 mg b.i.d.

PHYSICAL EXAM:

Anxious adult slightly tearful female seated in a regular chair. She does complain of the trigger points of her back and we had her sign a consent to proceed with trigger point injections. I also refilled her medication in the office today.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with post concussive symptoms including persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine type headaches occurring 3-4 times per week, lasting 5-8 hours, status post toxin injections on 12-11-13.

Vickie Rummage

1-17-14.

Page 2

PLAN / RECOMMENDATIONS:

We will plan on repeating toxin injections for her after 3-11-14. In the office today I did prepare a 5 cc. syringe with 4 cc. of 1% Lidocaine and 1 cc. of Kenalog 40. Trigger point injections were identified in the posterior rhomboid and trapezius region along with cervical paraspinals on the left. The injections were done with approximately $\frac{1}{4}$ to $\frac{1}{2}$ cc. into at least 12 injection sites in those muscles. The patient tolerated the procedure and good hemostasis was obtained at each injection site. We will plan on seeing the patient in followup in this office in approximately one month.

Daniel L. Collins, M.D.

DLC/mhp

803-793-0860

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 2-19-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports she has had very severe headaches this past week although she is doing somewhat better with the Botox injections. She does continue to use her Percocet. Her last Botox injections were done on 12-11-13 and therefore, she is due for repeat injections after 3-11-14. She still has not undergone neuropsych testing. Apparently, there is a deposition being set up for early March 2014 pending my schedule. The actual deposition was requested by the insurance company for her employer.

CURRENT MEDICATIONS:

Percocet 10/325 1½ to 2 tablets t.i.d., Imitrex 1 tablet b.i.d. prn, Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 10 mg q. hs., Cymbalta 60 mg q.d., Phenergan prn, Antivert prn, Xanax 0.5 mg b.i.d.

PHYSICAL EXAM:

Slightly anxious adult female seated in a regular chair. She complains of pain throughout her neck and upper back along with the base of her skull.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with postconcussive symptoms including persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine type headaches occurring 3-4 times per week improved with recent toxin injections on 12-11-13.

PLAN / RECOMMENDATIONS:

We will plan to do the deposition with the attorneys over the next several weeks as schedule allows. In the meantime, we will plan on seeing her in followup in one month. We did refill her Percocet and Xanax for her today.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 3-13-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is coming back today for repeat toxin injections for migraine headaches. The last injections were done November 13, 2013. She reports she has gained benefit with those with only some return of her symptoms over the past month or so. She did very well through November and December and part of February.

CURRENT MEDICATIONS:

Percocet 10/325 1½ to 2 tablets t.i.d., Imitrex 1 tablet b.i.d. prn, Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. and 10 mg q. hs., Cymbalta 60 mg q.d., Phenergan prn, Antivert prn, Xanax 0.5 mg b.i.d.

PHYSICAL EXAM:

Slightly anxious adult female seated in a regular chair. She reports pain throughout her upper back and neck along with persistent decreased memory and occasional confusion.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms including persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine type headache occurring 3-4 times per week improved with recent toxin injections, 11-14-13.

PLAN / RECOMMENDATIONS:

The patient signed the consent for Botox injections for migraine headaches. We prepared 3.1 cc. of Botox at the prescribed dilution. The normal 31 injection sites were injected today per protocol. The patient tolerated the procedure and good hemostasis was obtained at each of the 31 injection sites. We will plan on seeing the patient in followup in this office in one month. I will be doing a deposition with an attorney today with her side being represented. The deposition was requested by her prior employers at legal service. Additionally, I refilled the patient's pain medicines for her, specifically Percocet, Cymbalta, Xanax, Antivert, Flexeril, and Lyrica in the office today.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 4-11-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. Her last migraine injections were done on 3-14-14 and she reports her migraine headache pain is improved. She reports she has had flu like symptoms with diarrhea and nausea, and hives, but does not feel this is related as the migraine just recently occurred. She does need refill of her Percocet but has a sufficient supply of her other medications.

I did ask her about the fact that she has seen other physicians since I started seeing her in December 2014. She apparently has seen Dr. McLeod and has been prescribed Hydrocodone on at least five visits. She told her attorney that she did not get those prescriptions filled and her attorney called me reporting the same. The DHEC report on the computer reports she did fill those prescriptions for Hydrocodone ranging from 30-60 tablets dating from 3-23-13 through 8-17-13. I confronted her with that information and she reports she does not understand how that shows up but she does not deny having filled them at this point.

CURRENT MEDICATIONS:

Percocet 10/325 1½-2 tablets t.i.d., Imitrex 1 tablet b.i.d., Lyrica 50 mg b.i.d., Flexeril 5 mg b.i.d. / 10 mg q. hs., Cymbalta 60 mg q.d., Phenergan prn, Antivert prn, Xanax 0.5 mg b.i.d.

PHYSICAL EXAM:

Slightly anxious adult female seated in a regular chair. She is not tearful today as she has been previously. She still reports decreased memory and occasional confusion with slightly decreased headache pain at least today.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring 3-4 times per week, improved with recent toxin injections, 3-13-14.

PLAN / RECOMMENDATIONS:

At this point, I did refill the patient's Percocet for her. I told her if she has any further scripts filled, I will probably have to discharge her from this practice.

Vickie Rummage

4-11-14

Page 2

She needs to get prescription medications, specifically narcotics, only from this office and not from other individuals and that was made very clear to her today. If any other use of other physicians is determined I will need to discharge her at that point. In the meantime, we will set her up for repeat toxin injections after 6-13-14, i.e. three months from her last injections. We will plan on seeing her in followup in one month. Her case manager was made aware of the recommendations at present.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 5-8-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her husband but not her case manager. Her case manager could not make it today. The patient reports she is having some migraine headaches and is agreeable to consider repeat Botox injections mid June 2014. In the meantime, she reports she has applied for disability. After that application, she was sent for a psychological evaluation yesterday but they were not able to assess her secondary to complaints of dizziness by the patient.

The patient continues to have the headaches and is asking for use of Fioricet in place of the Imitrex. She also asked for trigger point injections of the posterior cervical and left trapezius.

CURRENT MEDICATIONS:

Percocet 10/325 1½-2 tablets t.i.d., Imitrex 1 tablet b.i.d., Lyrica 50 mg q.d., Flexeril 5 mg b.i.d. / 10 mg q. hs., Cymbalta 60 mg q.d., Phenergan prn, Antivert prn, Xanax 0.5 mg b.i.d.

PHYSICAL EXAM:

Reasonably well appearing slightly anxious adult female seated in a regular chair. She reports persistent decreased memory with occasional confusion and decreased headaches for the most part although they have started to worsen as she gets further away from her last toxin injections on 3-13-14.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week improved with recent toxin injections on 3-13-14.
- 3) Posterior cervical pain with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

I did refill the patient's Percocet and Lyrica, along with her Cymbalta, Xanax, Phenergan, and Antivert. I started her back on Fioricet 1 tablet t.i.d. prn in place of the Imitrex. We also had her sign a consent for trigger point injections and I performed those in the office today.

Vickie Rummage

5-8-14

Page 2

I used a 5 cc. syringe filling it with 3 cc. of 2% Lidocaine along with 1 cc. of Kenalog 40. I injected five sites in the posterior cervical and left trapezius region on the left with good benefit. Good hemostasis was obtained at each of the five injection sites.

We will plan on seeing her in followup in approximately mid June 2014 when she is due for her next toxin injections.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 6-17-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports recently she had an episode last week when she got very confused. She was at home but thought she was at the mall and had been dropped off there by her husband. Friends came by to check on her and they found her crying and she remains still upset about that episode.

The patient has applied for disability and was sent to see a psychologist and reportedly has been "approved" for disability according to the patient.

The patient does need a refill on each of her medications noted below. She is also coming in for toxin injections for migraine headaches. She has signed the consent for that today.

CURRENT MEDICATIONS:

Percoctet 10/325 1½ tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg b.i.d. prn, Flexeril 5 mg 1 tablet b.i.d. and 2 tablets q. hs., Phenergan 25 mg t.i.d. prn, Antivert 25 mg t.i.d. prn. *Cymbalta 60mg*

PHYSICAL EXAM:

Reasonably well appearing slightly anxious and tearful adult female seated in a regular chair. She reports decreased memory and occasional confusion with forgetfulness. She has at least 4+/5 strength throughout bilateral upper and lower extremities.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms including complaints of persistent headaches, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week improved with toxin injections, 3-14-14.
- 3) Posterior cervical pain treated with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

After patient signed the consent, I prepared the toxin medication. The 31 pre-prescribed injections sites were identified and injected with 0.1 cc. at each site. The patient tolerated the procedure and good hemostasis was obtained at each of the 31 injection sites. I did refill her medications for her and also gave her a slip to be out of work which she has been for an extended period of time. I think gainful employment for her will be very difficult in the foreseeable future. We will see the patient in followup in one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 7-17-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is accompanied by her case manager, Michelle Estep.

The patient reports she has had improvement with her headaches related to the toxin injections done on 6-17-14. She does have some trigger points in her upper back mostly on the left which she would like treated with trigger point injections today. She reports she has been approved for disability but her Workers Comp case is ongoing. Apparently, the patient will be switched over to disability once her Workers Comp case is closed and once she is on disability for two years she will be eligible for Medicare as she is still in her mid 50's.

CURRENT MEDICATIONS:

Percocet 10/325 1½ tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg b.i.d. prn, Flexeril 5 mg 1 tablet b.i.d. and 2 tablets q. hs., Phenergan 25 mg t.i.d. prn, Antivert 25 mg t.i.d. prn, Cymbalta 60 mg q.d.

PHYSICAL EXAM:

Well appearing adult female with trigger points identified in the left upper back. She reports persistent decreased memory with occasional confusion and forgetfulness. She has at least 4 to 4+/5 strength throughout bilateral upper and lower extremities

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of her ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections – 6/17/14.
- 3) Posterior cervical pain treated with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

I did refill the patient's medication for her as noted above. She is to remain out of work at present and has been granted disability.

Vickie Rummage
7-17-14
Page 2

I did perform trigger point injections of the left upper back using 4 cc. of 1% Lidocaine and 1 cc. of Kenalog 40. The areas were identified and injected with approximately ½ cc. of the above noted mixture. The patient tolerated the procedure.

At this point, I feel the patient has reached maximum medical improvement. I will be completing any paperwork that the case manager has for me. We will plan on seeing the patient in followup in this office and continue treatment whether she is under Medicare, Workers Comp or any other insurance.

Daniel L. Collins, M.D.

DLC/mhp

CC: Wright Rehabilitation Services
C/O Michelle Estep, Case Manager

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 8-15-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She does not have her case manager with her today.

The patient reports she has some trigger points that she would like to be treated with injections today. She reports she has not been able to get her Cymbalta since July 2014. Unfortunately, there is some type of mix up with her insurance carrier / Worker's Comp carrier.

CURRENT MEDICATIONS:

Percocet 10/325 1½ tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg b.i.d. prn, Flexeril 5 mg b.i.d. / 2 tablets q. hs., Phenergan 25 mg t.i.d. prn, Antivert 25 mg t.i.d. prn, Cymbalta 60 mg q.d.

PHYSICAL EXAM:

Well appearing adult female with trigger points identified in her upper back on the left. She has approximately 13 trigger points which we will be treating today with local Lidocaine injections.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week improving with toxin injections, 6-17-14.
- 3) Posterior cervical pain treated with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

I did prepare 10 cc. of 1% Lidocaine. The patient's posterior cervical, upper back, and trapezius on the left side were indicated and cleansed with alcohol. The 13 sites received just under 1 cc. each of the 1% Lidocaine. Patient tolerated the procedure and good hemostasis was obtained at each injection site. We will plan on seeing her in followup approximately 9-18-14 for Botox injections for chronic migraine headaches.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 9-24-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager, Ms. Estep.

The patient is very tearful this morning. She is not sure if the Cymbalta is giving her the benefit that she wants. The Cymbalta is already at 60 mg q.d. and we did discuss adjusting the dose versus trying a different medication. I feel more comfortable with switching her to a different antidepressant at this point. I have made suggestions regarding psychological evaluation in the past and those have been ignored or denied by the Workers Comp carrier. I definitely feel the patient would benefit from psychological counseling in addition to the medication. I am very much strongly suggesting she be treated. I am trying the best I can with antidepressant medications but I think ongoing counseling is definitely necessary for this patient.

We did discuss migraine toxin injections and she is willing to proceed with those at present. She has gained gain benefit from those in the past. She wishes to have trigger point injections but I cannot do those today. We will try to set her up for this on Friday, 9-26-14. She does need refill on each of her medications.

CURRENT MEDICATIONS:

Percocet 10/325 1½ tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg t.i.d. prn, Antivert 25 mg t.i.d. prn, Cymbalta 60 mg q.d.

PHYSICAL EXAM:

Tearful adult female with pain of her upper back along with migraine headache pain. She ambulates without any assistive device with antalgic gait.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections.
- 3) Posterior cervical pain treated with periodic trigger point injections.

Vickie Rummage

9-24-14

Page 2

PLAN / RECOMMENDATIONS:

I did perform the 31 injections sites today for the migraine headaches using Botox. I injected 0.1 cc. at each of the 31 sites. The patient tolerated the procedure.

In terms of her antidepressant medication, I will switch her from Cymbalta to Effexor 75 mg q.d. for one week, then increasing to 150 mg q.d. I still strongly recommend she be seen by a psychologist for her ongoing depression. Unfortunately that has been refused in the past but I am making that recommendation again at this time.

We will plan on seeing her in followup this Friday for trigger point injections for her upper back which she has benefited from in the past. We will plan on seeing her in followup for medication refills and monitoring of her symptoms in one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

DATE: 9-26-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for trigger point injections. I just saw her a couple of days ago for Botox injections for chronic migraine headache which she continues to tolerate well. She has not yet gained benefit from the toxin injections but it has only been two days. She would like to have repeat trigger point injections which we have done for her in the past.

We did recently change her from Cymbalta to Effexor and hopefully that will give her some improvement in terms of her depression. I still think she would be best managed with a psychologist is Workers Comp would approve that which they have not in the past.

CURRENT MEDICATIONS:

Percocet 10/325 1½-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg b.i.d. prn, Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg t.i.d., Antivert 25 mg t.i.d. prn, Effexor 75 mg q.d. for one week increasing to 150 mg q.d.

PHYSICAL EXAM:

Reasonably well appearing adult female with trigger points identified in her left trapezius and rhomboids posteriorly.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week improving with toxin injections.
- 3) Posterior cervical pain treated with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

I did prepare 4 cc. of 2% Lidocaine and added 1 cc. of Kenalog. We identified approximately 12 trigger points in her left trapezius and left rhomboid musculature. Each of those 12 injection sites were injected with approximately 0.25 cc. of the above noted mixture. The patient tolerated the procedure well and good hemostasis was obtained at each injection site. We will plan on seeing her in followup for repeat medication adjustment and refills in one month.

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DLC/mhp

FLORENCE REHABILITATION MEDICINE
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(843) 661-4390

NAME: Vickie Rummage

DATE: 10-24-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports she is in desperate need of trigger point injections of bilateral neck and upper back today. She also reports she still has problems sleeping but that may be related to a mistake I made with the pain medicines. I apparently gave her an insufficient supply to cover her until today's appointment. We will correct that today.

The patient did sign the consent for the trigger point injections. She is next due for migraine headache toxin injections after 12-25-14.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. / 2 tablets q. hs., Phenergan 25 mg t.i.d., Antivert 25 mg t.i.d. prn, Effexor 150 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Reasonably well appearing adult female with trigger points identified in the posterior cervical and trapezius regions bilaterally along with rhomboids.

IMPRESSION:

- 1) Status post work injury 5-18-12 with post concussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections.
- 3) Posterior cervical pain treated with occasional trigger point injections.

PLAN / RECOMMENDATIONS:

After the patient signed the consent, I prepared 4 cc. of 1% Lidocaine along with 1 cc. of Kenalog. We identified approximately 15 trigger points sites approximately 10 on the left and 5 on the right. I injected those areas with the above noted mixture. Good hemostasis was obtained at each of the injection sites. We will plan on seeing the patient in followup in one month for consideration of adjustments to her medication and/or further trigger point injections as necessary. As above, she will have repeat migraine injections with toxin after 12-25-14.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
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FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 11-24-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports overall she is doing just fair. She does feel she gets benefit from her Cymbalta in terms of pain relief but minimal help with depression. In terms of her Effexor that she is presently using, she gets help with depression but not really much help with pain. She wonders if she can use a combination of the two medicines. I told her we would have to cut the dose of each in half and see if that would give her adequate relief in terms of pain and benefit from depression. She is agreeable to that at present.

We last did migraine botox injections on 9-24-14. We will need to repeat those probably after Christmas.

She is asking for trigger point injections in the office today and we have done those basically each visit recently. She does gain benefit with those trigger point injections. She does need refills on each of her medicines in the office today.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. pm, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. pm, Xanax 0.5 mg t.i.d. pm, Flexeril 5 mg b.i.d. / 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d. pm, Effexor 150 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Reasonably well appearing adult female with some anxiety reported. She has trigger points identified in the posterior cervical region on the left along with left trapezius and left rhomboids.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with postconcussive symptoms including complaints of persistent headache, neck pain, ringing in the ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections.
- 3) Posterior cervical pain treated with monthly trigger point injections.

Vickie Rummage

11-24-14

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PLAN / RECOMMENDATIONS:

After the patient signed the consent, I prepared 4 cc. of 1% Lidocaine and 1 cc. of Kenalog 40 mg/ml. We identified approximately 20 trigger points in the posterior cervical, left trapezius, and left rhomboid musculature. I cleansed each area and then injected approximately 0.25 to 0.5 of the mixture into the trigger point areas. Good hemostasis was obtained at each trigger point injection site.

In terms of her medication, we will use the Cymbalta again with the dose at 30 mg q.d. and Effexor will be cut from 150 to 75 mg q.d. She will use one of each of those daily to gain some benefit from the depression but also treat pain as noted above. We also refilled her Percocet, Lyrica, Xanax, Antivert, Flexeril, Phenergan and Fioricet medication. We will plan for followup in one month.

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FLORENCE REHABILITATION MEDICINE
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(843) 661-4390

NAME: Vickie Rummage

DATE: 12-23-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. During the last clinic visit she had reported she was getting benefit from the Cymbalta in terms of pain relief but not depression and the Effexor gave her better relief in terms of depression but did not affect her pain to any significant degree. We had decided to use a small amount of both as the combination seems to be working well at this point. She does need refills on those medications along with her other regular medications. She is due for migraine toxin injections early next week. She would like to have trigger points performed on her upper back in the office today.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female with anxiety reported with still persistent problems with memory and now car sickness for any long trips. She does report trigger points in the posterior upper back and cervical region. We will address those today with trigger point injections.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including complaints of persistent headache, neck pain, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections.
- 3) Posterior cervical pain treated with mostly monthly trigger points injections.

PLAN / RECOMMENDATIONS:

After the patient signed a consent, I prepared 4 cc. of 1% Lidocaine and 1 cc. of Kenalog 40 mg/ml. We identified approximately 20 trigger points in the posterior cervical and left trapezius, and left rhomboid musculature with a few areas on the right side also. His skin was cleansed and injected approximately 0.25 cc. of the above noted mixture. The patient tolerated the procedure and good hemostasis was obtained at each injection site.

Vickie Rummage

12-23-14

Page 2

I did refill the patient's Percocet, Lyrica, Flexeril, Xanax, Antivert, Phenergan, Cymbalta, and Effexor. She reports she uses minimal amounts of Fioricet and has a sufficient supply at present. We will plan on seeing her in followup for repeat office visit in approximately one month. We will see her for repeat toxin injections for the migraine headache early next week.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 12-30-14

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is actually here for migraine toxin injections which she has benefited from in the past. Her last injections for the migraine were done on 9-26-14. We do periodic trigger point injections approximately monthly for her and those were done on 12-23-14.

In terms of her medication we had been using a combination of mid dose Effexor and Cymbalta for her. She had initially been on Effexor at 150 mg q.d. but was not getting enough pain relief. We switched her to Cymbalta at 30 mg q.d. and she reported she was getting pain relief but was not getting enough antidepressant affect. Subsequent to that, we decided to cut the Effexor dose to 75 mg q.d. and continued the Cymbalta 30 mg q.d. to gain pain relief from the Cymbalta and the depression benefit from the Effexor. Unfortunately, her insurance carrier has refused to fill the Effexor at present. She is getting Cymbalta refilled. At this point, we have discussed other medications and have decided on Topamax nightly in place of the Effexor which is covered by her insurance. We will also do the migraine toxin injections for her in the office today.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. / 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female with some anxiety reported with still problems with memory, headaches, along with ringing of ears, lightheadedness, neck pain, blurred vision and short term memory loss, along with insomnia.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including complaints of persistent headache, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injection.
- 3) Posterior cervical pain treated with mostly monthly trigger point injections with benefit.

Vickie Rummage

12-30-14

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PLAN / RECOMMENDATIONS:

In terms of medicine, we have started her on Topamax to be used 50 mg p.o. q. hs for three nights then to be increased to 100 mg p.o. q. hs. That is in place of the Effexor and she will continue on the Cymbalta.

In terms of her injections, we did have her sign a consent for the migraine headache toxin injections. We prepared 200 units of the Botox and used 155 units wasting the other 45 units. The usual 31 injections sites were injected with 0.1 cc. of the Botox solution. The patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing the patient in followup next month for regular refill of medication with probable trigger point injections and we will probably plan on doing repeat migraine toxin injections after 3-30-15.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 1-20-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports she has been able to obtain the Cymbalta and Effexor. We had been using a small dose of each as one gave her better relief with depression and one was more effective with pain relief. She had tried Topamax during the last clinic visit but reports it has made her slightly depressed. We have decided to stop the Topamax and continue with the Effexor and Cymbalta since her Workers Comp carrier has allowed her to receive that. She has switched pharmacies and now goes to Wal-Mart. We had decided to continue with trigger point injections using a small amount of Lidocaine and Kenalog in the office today. She has some trigger points identified in the upper back to lower cervical region on the left side. She does need a refill on her medications in the office today.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female with mild anxiety. She has persistent complaints of memory loss, ringing of her ears, headache, lightheadedness, neck pain, blurred vision, and short term memory loss along with insomnia. She does report the Botox continues to give her benefit from the migraine headaches. She has asked for trigger points to be injected and I have agreed to that today.

IMPRESSION:

- 1) Status post work injury 5-18-12 with post concussive symptoms including complaints of persistent headaches, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with Botox injections.
- 3) Posterior cervical pain treated with monthly trigger point injections for symptoms consistent with fibromyalgia.

Vickie Rummage

1-20-15

Page 2

PLAN / RECOMMENDATIONS:

I have refilled her medications today for her in the office, specifically her Flexeril, Lyrica, Percocet, Fioricet, and Xanax. She will continue taking the Effexor for depression relief and the Cymbalta for depression and pain relief. We will stop the Topamax today. We will plan on seeing her in followup in one month.

The patient did sign the consent form for the trigger point injections. I prepared 4½ cc. of 1% Lidocaine with ½ cc. of Kenalog 40 which comes out to 20 mg. I identified approximately 12 trigger point areas of her left upper back to lower neck on the left side. Each of those was injected with approximately 0.3-0.5 cc. of the above noted mixture. The patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing her in followup as noted above.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 2-20-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She reports overall she is doing fair. She is anxious to get the repeat toxin injections for her migraine but those are not due until the end of March. In the meantime, she reports she has some trigger points that she would like to be treated today.

She does need a refill on her Percocet, Lyrica, Fioricet and Xanax but has sufficient supply of her other medications.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. and 2 tablet q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female with mild anxiety. She has persistent ringing of her ears along with headaches, lightheadedness, neck pain, blurred vision and short term memory loss. She does report Botox seems to help with her migraine headaches. She has trigger points identified in the left posterior cervical and trapezius muscle on the left. She did sign a consent for the trigger point injection.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including persistent headaches, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week improved after start of Botox injections.
- 3) Periodic cervical pain posteriorly with monthly trigger point injections for symptomatic relief consistent with fibromyalgia.

PLAN / RECOMMENDATIONS:

I did refill the patient's Percocet, Fioricet, Lyrica, and Xanax in the office. The patient signed the consent and trigger points were done. I prepared 4 cc. of 1% Lidocaine along with 1 cc. of Kenalog 40.

Vickie Rummage

2-20-15

Page 2

We identified approximately 15 areas in her left cervical paraspinals and left trapezius. Each of those were injected with approximately 0.3 – 0.5 cc. of the above noted mixture. The patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing her in followup in approximately three weeks.

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DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 3-11-15

HISTORY OF PRESENT ILLNESS:

Vickie returns to clinic today for followup evaluation. She is due the end of March for repeat migraine toxin injections. She comes in today for refill of her medication related to chronic back and upper neck pain. She has received periodic trigger point injections and she is requesting those today. She does need a refill on the Xanax, Fioricet, Percocet, and Lyrica.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Flexeril 5 mg b.i.d. with 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril/HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female slightly less anxious than normal. She does not really complain of much other than the neck and upper back pain at presently spontaneously. When I asked her about the symptoms regarding the concussive headaches she does report ringing of her ears, lightheadedness, blurred vision, short term memory loss along with migraine headaches.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with postconcussive symptoms consisting of persistent headache, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week improved after starting Botox injections.
- 3) Periodic cervical pain posteriorly with monthly trigger point injections for symptomatic relief consistent with fibromyalgia.

PLAN / RECOMMENDATIONS:

I did refill the patient's Percocet, Fioricet, Lyrica, and Xanax. She will be seen at the end of this month for toxin injections for migraine headaches and we will see her approximately 4-23-15 for refill of her medications. She has been having some problem getting her medication filled on time lately with reportedly a new adjustor with her Workman Compensation case.

Vickie Rummage

3-11-15

Page 2

I did have the patient sign a consent for the trigger point injections. I used 4 cc. of 2% Lidocaine along with 1.25 cc. of Kenalog 40 mg/cc. for a total of 50 mg. We identified approximately 15 trigger point sites in the posterior neck on the left and down her rhomboids and supraspinatus muscle on the left. Those areas were cleansed and injected with approximately ¼ cc. of the above noted mixture. The patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will see her in followup as noted above.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Runnaga

DATE: 4-3-15

HISTORY OF PRESENT ILLNESS:

Vickie returns to clinic today for followup evaluation. She reports for some reason the Workers Comp carrier has finally gotten in touch with her and asked her to see a neuropsychiatrist in Charlotte. The patient reports she has severe trouble riding for any length of time and wonders why she cannot see someone locally or in Columbia. I really have no answer for her at this time. When I was making a referral to a neuropsychologist in the past we had been considering somebody locally. At that time, the Workers Comp refused referral but now they have apparently planned for referral but it is three hours away by car. I recommend she discuss this with her attorney as I really think it is unreasonable to drive that distance for a neuropsychological evaluation that can certainly be done locally.

The patient comes in today for repeat toxin injections for migraine headache. The last injections were done 12-30-14.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. pm, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. pm, Xanax 0.5 mg t.i.d. pm, Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d., Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing slightly anxious adult female. She is in her usual state of health with complaints of pain in the upper back and neck posteriorly. She still has the complaints of lightheadedness, blurred vision, short term memory loss, ringing of ears, and of course migraine headache pain.

IMPRESSION:

- 1) Status post work injury on 5-18-12 with postconcussive symptoms consisting of persistent headache, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week improving with treatment using Botox injections q. three months.
- 3) Periodic cervical pain posteriorly treated with periodic trigger point injections for symptomatic relief of fibromyalgia.

Vickie Rummage

4-3-15

Page

PLAN / RECOMMENDATIONS:

I prepared the Botox, specifically 155 units. We wasted 45 units from a 200 unit bottle. The injections were done in the prescribed routine bilaterally along with the one injection in her area just above her nose on her forehead. The patient tolerated the procedure and good hemostasis was obtained at each of the 31 injection sites. We will plan on seeing her in followup in one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 4-24-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. We had performed toxin injections for migraine headache on 4-3-15. She has done well overall. She still has some minimal headache pain but reports she gets benefit. She did have some slight whelps in her back in the upper cervical region on the right possibly related to the toxin injections although she has had the toxin injections in the past without side affects or any skin irritation. At this point, we will hold off on any further trigger point injections which we typically have done in between her migraine injections. We do need refill her medication.

Patient did see a neuropsychiatrist in Charlotte, NC two weeks ago. No report has been obtained yet and the patient's case manager, Ms. Estep, is planning to get the report of that study. The patient reports she tries to be active around the home doing chores as possible.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d., Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d. prn, Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female who is ambulating without any assistive device. She has minimal erythema of the right posterior neck. She also has what appear to be bug bites in the posterior left leg. She still reports lightheadedness along with blurred vision, short term memory loss, ringing of her ears and migraine headache pain.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms consisting of persistent headache, ringing of the ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improving with toxin injections q. three months.
- 3) Periodic cervical pain treated with periodic trigger point injections for symptomatic relief of fibromyalgia.

Vickie Rummage

4-24-15

Page 2

PLAN / RECOMMENDATIONS:

We did refill the patient's Effexor, Cymbalta, Promethazine, Lyrica, Percocet, Xanax, and Flexeril in the office today. No refill is necessary for Fioricet. We will plan on seeing the patient in followup in one month. She should remain out of work at present. Hopefully, we can get the report from the neuropsychiatrist that she saw in Charlotte and the patient's case manager will try to get that for us as soon as possible. We will plan on seeing her in followup at the end of May.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 5-26-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her husband. Her case manager is not with her today.

The patient reports she has had the whelps we talked about the last time but now she has lesions of her legs, hands, and arms. She was prescribed Prednisone for a few days and gained some benefit and feels if she had a few more days it would clear up the lesions completely. She has noticed some increased swelling with the Lyrica when she uses it twice a day. She sometimes takes it once a day and has noticed less swelling. We discussed possible switch from Lyrica to Neurontin and she is agreeable. She has sufficient supply of her Flexeril, Effexor and Cymbalta but needs refills on the other medication. She would like to try Ambien for insomnia as she had gained benefit from this in the past.

The patient did see the neuropsychiatrist in Charlotte approximately early April 2015. I asked the case manager for a copy of the report but we still have not received anything thus far.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d., Lyrica 50 mg b.i.d., Fioricet 1 tablet t.i.d. pm, Xanax 0.5 mg t.i.d., Flexeril 5 mg b.i.d. and 2 tablets q. hs., Phenergan 25 mg q.d., Antivert 25 mg t.i.d. pm, Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing adult female who ambulates without any assistive device. She has some slightly raised erythematous lesions of her legs and arms. The whelps of her upper back are completely resolved at the present time. She still complains of headaches along with blurred vision, short term memory loss, ringing in her ears, along with migraine headache pain.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms consistent with persistent headache, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.

Vickie Rummage

5-26-15

Page 2

- 2) Migraine headaches occurring a few times per week improved with toxin injections q. three months, next due after 4-3-15.
- 3) Periodic cervical pain trigger point injections for relief of fibromyalgia.

PLAN / RECOMMENDATIONS:

We did switch the patient from Lyrica to Neurontin. We will try Ambien 10 mg q. hs. I did refill her Xanax, Percocet, and Fioricet without change. We also gave her Prednisone 10 mg to be used 1 tablet daily for 7 days for hopeful resolution of her lower extremity lesions. We will plan on seeing her in followup up one month.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 6-18-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. During the last clinic visit on 5-26-15 we had discontinued her Lyrica as she noted some rash and swelling in her lower extremities. We instead started her on Neurontin 100 mg b.i.d. She reports she is tolerating the medication but does not feel significant benefit. I told her at the present time we need to increase the dose as she is on a very low starting dose at present. She is requesting refill on her medications along with trigger point injections in the office today. She is also considering repeat cervical MRI scan. As best I can tell one was done in July 2013 and showed facet changes at C4-7. I have no actual report that the records indicate that at least in my office notes.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d., Neurontin 100 mg b.i.d., Fioricet prn, Xanax 0.5 mg t.i.d. prn, Ambien 10 mg q. hs., Phenergan prn, Antivert prn, Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 mg q.d.

PHYSICAL EXAM:

Well appearing anxious adult female who is requesting trigger point injections to the posterior neck and shoulder region especially on the left. She reports persistent blurred vision, short term memory loss, ringing on her ears along with migraine headache pain.

IMPRESSION:

- 1) Status post work injury 5-18-12 with postconcussive symptoms including persistent headaches, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with toxin injections every three months, next due approximately 7-3-15.
- 3) Periodic cervical trigger point injections for relief of fibromyalgia.

PLAN / RECOMMENDATIONS:

I did refill the patient's Neurontin and increased her to 300 mg b.i.d. We also refilled her Xanax and her Percocet along with her Ambien.

PROCEDURE:

I did perform trigger point injections of her posterior cervical and trapezius regions especially on the left. A total of approximately 12 injections were given, at least 8 on the left and 4 on the right. She tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing her in followup in one month or before her scheduled migraine headache injections with toxin.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE
900 E. CHEVES STREET
FLORENCE, SC 29506
(843) 661-4390

NAME: Vickie Rummage

DATE: 7-30-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today for followup evaluation. She is due for toxin injections for migraine today. She does ask if I ever received the evaluation that she completed with a physician up in Charlotte approximately three to four months ago. We still have not received that and we will need to get in touch with her case manager, Ms. Estep, to try to get a copy of that report. The patient reports overall she is doing fairly well. She still has some of the same problems including memory, concentration, and pain. She does need a refill on her Fioricet, Percocet, and Xanax in the office today.

The patient reports she has stopped the Neurontin because it was causing sore muscles. She would like to have a small dose of Prednisone to be used on a daily basis for lesions of her lower extremities. She would also like to retry the Lyrica at 50 mg b.i.d.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. pm, Fioricet 1 tablet t.i.d. pm, Xanax 0.5 mg t.i.d. pm, Flexeril 5 mg b.i.d. / 2 tablets q. hs., Phenergan q.d., Antivert 25 mg t.i.d. pm, Effexor 75 mg q.d., Cymbalta 30 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d.

PHYSICAL EXAM:

Well appearing slightly anxious adult female in her usual state of health. She has complaints of pain of her upper back and neck region posteriorly. She also has complaints of lightheadedness, blurred vision, short term memory loss, ringing of her ears, and migraine headache pain.

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms consisting of persistent headache, ringing of ears, lightheadedness, blurred vision, short term memory loss, insomnia, and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with treatment including botox injections q. three months.
- 3) Periodic cervical pain treated with periodic trigger point injections.

PLAN / RECOMMENDATIONS:

I prepared botox, specifically 155 units – wasting 45 units from a 200 unit bottle. The injections were done as prescribed bilaterally along with one injection just above her nose in the forehead region.

Vickie Rummage

7-30-15

Page 2

The patient tolerated the procedure and good hemostasis was obtained at each of the 31 injection sites. We will plan on seeing her in followup in one month.

I did refill the patient's Percocet, Xanax, Lyrica, and Fioricet in the office today. I will plan repeat toxin injections after October 30, 2015. We will plan to see her in followup in one month for probable repeat trigger point injections.

Daniel L. Collins, M.D.

DLC/mhp

FLORENCE REHABILITATION MEDICINE

900 E. CHEVES STREET

FLORENCE, SC 29506

(843) 661-4390

NAME: Vickie Rummage

Date: 8-27-15

HISTORY OF PRESENT ILLNESS:

Ms. Rummage returns to clinic today accompanied by her case manager, Ms. Estep.

The patient's reports that she did get some improvement of her headaches with the toxin injections done 7-30-15. She still has some headache pain likely related to muscular tension. She does require we repeat the trigger point injections today in the office.

In terms of her medication, she does not feel the Cymbalta is giving her the pain relief that it was previously. She wants to stop that and continue just the Effexor for the antidepressant affect. She does need refills on multiple medications in the office today.

Patient continues to report significant memory loss. She reports she sometimes leaves fryers or her stove on at home, forgetting she has turned it on. I told her she may need to put a timer on when she is cooking to remind her to go back and check or possibly use the microwave.

The patient does report persistent increased pain of her neck. We did do an MRI scan of her cervical spine in July 2013 that showed moderate central canal stenosis with multilevel spondylitic changes with a small disc bulge and protrusion at C5-6 and C6-7. It probably would be worthwhile to repeat that at this time.

The patient did have an evaluation with a neuropsychologist as best I can tell, in Charlotte approximately four to five months ago. We still have not been able to get a copy of that record. The patient is instructed to try and see if her attorney can get a copy of the record as we really have not received anything and Ms. Estep in the office reports she has not received anything either.

CURRENT MEDICATIONS:

Percocet 10/325 1-2 tablets t.i.d. prn, Fioricet 1 tablet t.i.d. prn, Xanax 0.5 mg t.i.d. prn, Ambien 10 mg q.hs., Flexeril 5 mg b.i.d. and 2 tablets q.hs., Phenergan q.d. prn, Antivert 25mg t.i.d. prn, Effexor 75 mg q.d., Lisinopril / HCTZ 20/12.5 1 tablet q.d., Lyrica 50 mg q.d.

PHYSICAL EXAM

Well appearing slightly anxious adult female who is still complaining of pain in her upper back and neck posteriorly. She also reports persistent complaints of headache, blurred vision, short term memory loss, ringing of her ears, and migraine headache pain slightly improved.

W. Dean Lorenz, M.D.

WDL/mlhp

Vickie Rummage

8-27-15

Page 2

IMPRESSION:

- 1) Status post work injury, 5-18-12, with postconcussive symptoms consisting of persistent headache, ringing of her ears, lightheadedness, blurred vision, short term memory loss, insomnia and migraine headaches.
- 2) Migraine headaches occurring a few times per week, improved with botox treatment q. 3 months.
- 3) Periodic cervical pain posteriorly treated with periodic trigger point injections.

PLAN / RECOMMENDATIONS:

I did refill the medication for her as noted above. We also requested an MRI scan of her cervical spine without contrast and we will try to get Workers Comp approval for that. We also had her sign a consent for the trigger point injections.

I prepared 4 cc. of 1% Lidocaine along with 1 cc. of Kenalog 40. I cleansed her posterior cervical and upper back region and injected approximately 15 sites with 0.1-0.2 cc. of the above noted mixture. Patient tolerated the procedure and good hemostasis was obtained at each of the injection sites. We will plan on seeing her in followup in approximately one month.

Daniel L. Collins, M.D.

DLC/mhp

Florence Rehabilitation Medicine Progress Note

Patient Name: Vickie Rummage
Patient ID: [REDACTED]
Sex: Female
Birthdate: [REDACTED], 1959
Referring Provider: Daniel L. Collins MD

Visit Date: September 25, 2015
Provider: Daniel L. Collins, MD
Location: Florence Rehabilitation Medicine
Location Address: 900 E. Cheves St
 Florence, SC 29506-2704
Location Phone: (843) 661-4390

Chief Complaint

Pain in neck

History Of Present Illness

Terms of her pain she is requesting repeat trigger point injections in the office today. She reports that she did gain some benefit from the migraine headache toxin injections that we performed to 3 months. Her last injections were done July 30, 2015 and she is due for repeat injections at the end of this month or early November 2015. Next para the patient does ask about fibroid which is another anti-depression medication. I think at present she should continue on the Effexor that she is on at present. We had stopped Cymbalta in the recent past. Not sure that the fibroid would be more effective than his Effexor and is at present. of her left arm into her fingertips and drawing up on the left side. We did request an MRI scan of her cervical spine but that is still being worked on by the case manager's past can tell. We have not received approval for that MRI scan at present.

I did prepare a 5 cc syringe with 1 cc of Kenalog 40 and 4 cc of 1% lidocaine. The cleansed posterior cervical and upper back region injected approximately 15 sites with 0.1-0.2mL above the above-noted mixture. Patient tolerated the procedure and good hemostasis was obtained at each injection site.

I did give the patient a refill on her Percocet, Ambien, Floricet and Xanax in the office today. No refill on the other medication is necessary at present. medication was to be refilled as a October 7, 2015. Still trying to get results from the evaluation performed in Columbia on referral from her disability insurance carrier. We still have not seen results of that evaluation although the patient reports that her attorney does have the results. I certainly have not received a copy myself.

We'll plan on seeing the patient in follow-up in this office in early on November 2015 as she'll be due for refill on her medication at that time along with the repeat toxin injections for migraine headaches.

Past Medical History

Disease Name	Date Onset	Notes
Chronic Pain Syndrome	--	Neck
Headache	--	--

Past Surgical History

Procedure Name	Date	Notes
Cholecystectomy	--	--
Hysterectomy	--	--
Open reduction and internal fixation	2004	Left tib-fib fx

Medication List

Name	Date Started	Instructions
Ambien Oral tablet 5 mg		1-2 po q hs
Antivert oral tablet 25 mg	08/31/2015	Take one po Tid prn
cyclobenzaprine oral tablet 5 mg	08/31/2015	Take one po Bid and two qhs
Cymbalta Oral capsule, delayed release (DR/EC) 60	04/24/2015	take 1 capsule (60 mg) by oral route once daily for 30 days

mg		
Effexor XR oral capsule, extended release 24hr 75 mg	08/31/2015	take 1 capsule (75 mg) by oral route once daily for 30 days
Floriset oral capsule 50-300-40 mg	08/31/2015	Take one po Tid prn
Floriset Oral tablet 50-325-40 mg	11/15/2013	--
Imitrex Oral tablet 25 mg		take 1 tablet by oral route 2 times a day as needed
Lyrica Oral capsule 50 mg	08/31/2015	take 1 capsule by oral route 2 for 30 days
Percocet oral tablet 10-325 mg	09/02/2015	Take one to two po tid prn
promethazine Oral	11/15/2013	--
promethazine oral tablet 25 mg	04/24/2015	take 1 tablet by oral route 3 times a day for 30 days
Remeron Oral tablet 15 mg		take 1 tablet (15 mg) by oral route once daily before bedtime
trazodone Oral tablet 100 mg		1.5 po q hs
Xanax oral tablet 0.5 mg	08/31/2015	take 1 tablet (0.5 mg) by oral route 3 times per day for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
PENICILLINS	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Chronic Obstructive Pulmonary Disease	/	--
Congestive Heart Failure	/	--
CVA (Cerebrovascular accident)	/	--
Depression	/	--
Hypertension	/	--
Osteoporosis	/	--

Social History

Finding	Status	Start/Stop	Quantity	Notes
Alcohol	Never	--/--	--	--
Married	--	--/--	--	--
Tobacco	Never	--/--	--	--

Review of Systems**Constitutional**

o * See HPI

Eyes

o * See HPI

HENT

o * See HPI

Breasts

o * See HPI

Cardiovascular

o * See HPI

Respiratory

o * See HPI

Gastrointestinal

o * See HPI

Genitourinary

o * See HPI

Integument

- o * See HPI

Neurologic

- o * See HPI

Musculoskeletal

- o * See HPI

Endocrine

- o * See HPI

Psychiatric

- o * See HPI

Heme-Lymph

- o * See HPI

Allergic-Immunologic

- o * See HPI

All Others Negative**Vitals**

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
09/25/2015	09:16 AM	132/89	Sitting				81 - R	16							

Physical Examination

reasonable appearing anxious and slightly tearful adult female complaining of pain over the upper back and neck region especially on the left side; She has persistent complaints of headache, blurred vision, short-term memory loss, ringing in ears and migraine headaches moderately improved with the Botox injections.

Assessment

- Chronic Pain Syndrome - 338.4/G89.4
- Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus 346.73/G43.711

#1 status post work injury May 18, 2012 with postconcussive symptoms consisting of persistent headache, ringing in her ears, lightheadedness, blurred vision, short-term memory loss, insomnia and migraine headaches

#2 migraine headaches occurring a few times per week improved with toxin injection treatment every 3 months

#3 periodic cervical pain posteriorly treated with periodic trigger point injections

Plan**Orders**

- o Moderate level established patient office visit (99213) - 338.4/G89.4, 346.73/G43.711 - 09/25/2015
- o Initial injection of trigger point (20552) - 338.4/G89.4 - 09/25/2015
- o 4 - Injection, triamcinolone acetonide, not otherwise specified, 10 mg (J3301) - 338.4/G89.4 - 09/25/2015

Disposition

- o Call or Return if symptoms worsen or persist.

Electronically Signed by: Daniel L. Collins, MD -Author on September 30, 2015 08:37:15 AM

Florence Rehabilitation Medicine Progress Note

Patient Name:	Vickie Rummage	Visit Date:	November 17, 2015
Patient ID:	[REDACTED]	Provider:	Daniel L. Collins, MD
Sex:	Female	Location:	Florence Rehabilitation Medicine
Birthdate:	[REDACTED], 1959	Location Address:	900 E. Cheves St Florence, SC 29506-2704
Referring Provider:	Daniel L. Collins MD	Location Phone:	(843) 661-4390

Chief Complaint

- Toxin Injection

History Of Present Illness

Vickie Rummage is a 55 year old Caucasian/White female who presents to the office today for injection.

History:

Vicki returns to clinic today for follow-up toxin injections for migraine headache. Reports that overall she is doing about the same with persistent problems with memory and concentration. Her pain level continues to be high involving her neck and she has noticed some improvement with the migraine injections.

Physical Exam:

tearful and anxious adult female receiving injections today but still worried about her overall health assessment the slow involvement of mental health individuals in her case. I've discussed this with her repeatedly in the past and we have a difficult time getting the case manager to get approval for psychiatric assistance which patient is definitely needs in addition to her chronic pain management. She relates bony assist device. She is proximally 4 minus to 45 strength of the bilateral upper and lower extremities.

Impression:

#1 status post work injury May 18, 2012 with postconcussive symptoms consistent with persistent headache, ringing in her ears, lightheadedness, blurred vision, short-term memory loss, insomnia and migraine headaches for which she receives periodic toxin injections #2 migraine headaches occurring a few times per week improved with toxin therapy every 3 months #3 persistent severe cervical pain treated with periodic trigger point injections #4 chronic pain syndrome

Recommendations:

#1 the patient to receive toxin injections using 155 units of Botox. #200 unit bottle with 45 units wasted. The injections were done in the prescribed injection sites totaling 31. We'll plan on seeing the patient in follow-up in 3 months time for repeat toxin injections for treatment of her migraines. In the meantime we'll see her in follow-up early December 2015 for trigger point injections. I did refill her Fioricet, Lyrica and Percocet in the office today. We actually increased her Percocet to 1-2 tablets 4 times a day from 3 times a day at present and 120 were prescribed for her. She complains of significantly increased pain recently. I did explain to her that I did speak with her attorney just last week he is sending some recent paperwork to complete. There was a significant degree of disagreement between psychologists that the patient saw in the past and an independent medical evaluation completed in Charlotte I plan to see the patient in follow-up in early December and we'll repeat toxin injections for migraines in February 2016.

Procedures:

The skin was prepped with alcohol and 200 units of Onabotulinum Toxin A (Botox) was used and 45 units were wasted. Injections were given in the standard migraine pattern for the patient's safety.

MUSCLE/UNITS BELOW

1. STANDARD MIGRAINE PATTERN
2. MUSCLE / UNITS
3. MUSCLE / UNITS
4. MUSCLE / UNITS
5. MUSCLE / UNITS
6. MUSCLE / UNITS
7. MUSCLE / UNITS
8. MUSCLE / UNITS
9. MUSCLE / UNITS
10. MUSCLE / UNITS

Past Medical History

Disease Name	Date Onset	Notes
Chronic Pain Syndrome	--	Neck.
Headache	--	--

Past Surgical History

Procedure Name	Date	Notes
Cholecystectomy	--	--
Hysterectomy	--	--
Open reduction and internal fixation	2004	Left tib-fib fx

Medication List

Name	Date Started	Instructions
Ambien oral tablet 10 mg	11/10/2015	take 1 tablet (10 mg) by oral route once daily at bedtime for 30 days
Antivert oral tablet 25 mg	10/08/2015	Take one po Tid prn
cyclobenzaprine oral tablet 5 mg	10/08/2015	Take one po Bid and two qhs
Cymbalta Oral capsule, delayed release (DR/EC) 60 mg	04/24/2015	take 1 capsule (60 mg) by oral route once daily for 30 days
Effexor XR oral capsule, extended release 24hr 75 mg	10/08/2015	take 1 capsule (75 mg) by oral route once daily for 30 days
Floriset oral capsule 50-300-40 mg	11/10/2015	Take one po Tid prn
Imitrex Oral tablet 25 mg		take 1 tablet by oral route 2 times a day as needed
Lyrica Oral capsule 50 mg	10/08/2015	take 1 capsule by oral route 2 for 30 days
Percocet oral tablet 10-325 mg	11/17/2015	Take one to two po QID prn
promethazine Oral	11/15/2013	--
promethazine oral tablet 25 mg	04/24/2015	take 1 tablet by oral route 3 times a day for 30 days
Remeron Oral tablet 15 mg		take 1 tablet (15 mg) by oral route once daily before bedtime
trazodone Oral tablet 100 mg		1.5 po q hs
Xanax oral tablet 0.5 mg	11/10/2015	take 1 tablet (0.5 mg) by oral route 3 times per day for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
PENICILLINS	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Chronic Obstructive Pulmonary Disease	/	--
Congestive Heart Failure	/	--
CVA (Cerebrovascular accident)	/	--
Depression	/	--
Hypertension	/	--
Osteoporosis	/	--

Social History

Finding	Status	Start/Stop	Quantity	Notes

Alcohol	Never	--/--	--	--
Married	--	--/--	--	--
Tobacco	Never	--/--	--	--

Review of Systems**Constitutional**

- o * See HPI

Eyes

- o * See HPI

HENT

- o * See HPI

Breasts

- o * See HPI

Cardiovascular

- o * See HPI

Respiratory

- o * See HPI

Gastrointestinal

- o * See HPI

Genitourinary

- o * See HPI

Integument

- o * See HPI

Neurologic

- o * See HPI

Musculoskeletal

- o * See HPI

Endocrine

- o * See HPI

Psychiatric

- o * See HPI

Heme-Lymph

- o * See HPI

Allergic-Immunologic

- o * See HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
11/17/2015	04:47 PM	138/80	Sitting				88 - R	18		160lbs 0oz 5' 2"		29.26	1.78		

Assessment

- Chronic migraine without aura; with intractable migraine 346.73/G43.711
- Chronic pain syndrome 338.4/G89.4

Plan**Orders**

- o Chemodenervation of muscle(s); muscle(s) innervated by facial, t (64615) - 346.73/G43.711 - 11/17/2015
- o 200 - BOTOX 200 units (J0585-2) - 346.73/G43.711 - 11/17/2015

Electronically Signed by: Daniel L. Collins, MD -Author on November 19, 2015 09:11:17 AM

Florence Rehabilitation Medicine Progress Note

Patient Name: Vickie Rummage
Patient ID: [REDACTED]
Sex: Female
Birthdate: [REDACTED], 1959
Referring Provider: Daniel L. Collins MD

Visit Date: December 2, 2015
Provider: Daniel L. Collins, MD
Location: Florence Rehabilitation Medicine
Location Address: 900 E. Cheves St
 Florence, SC 29506-2704
Location Phone: (843) 661-4390

Chief Complaint

- Neck pain
- Left shoulder pain

History Of Present Illness

Vickie Rummage 55 year old Caucasian/White female returns today for a trigger point injection.

She was last here in November 17, 2015 when we did toxin injections for migraine headaches.

Since last clinic visit I did speak with her Turner attorney by phone. We reviewed the fact that she is seen to psychologists and they have both recommended continued psychiatric care for her for severe depression. 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. I still feel that she is in desperate need of continued psychiatric/psychological care for her depression which only is exacerbating her pain. Patient does have some periodic lesions which have responded to prednisone in the past. We'll give her a prescription for 20 days and a gradually decreasing dose. This patient is here today for trigger point injections which have helped her in the past. Will also need refill some of her pain medicines for her today.

medicines include Ambien 10 mg daily at bedtime, Antivert 3 times a day when necessary, second) 5 mg twice a day and 2 daily at bedtime, Effexor XR 75 mg daily, Fioricet 1 tablet 3 times a day when necessary, Lyrica 50 mg daily next Percocet 10/325 one to 2 tablets 4 times a day when necessary, Remeron 1 tablet every at bedtime, Xanax 0.5 mg 3 times a day when necessary

I did prepare for cc of 1% lidocaine along with 1 cc of Kenalog 40. We identify approximate 15 trigger points in her posterior cervical and posterior shoulder region on the left. Those injections were done without problems. She tolerated the procedure.

In terms of medication I did refill her Percocet along with her Fioricet and Ambien. We actually refilled her Effexor and increase to 250 mg daily and also refilled her Xanax for her. I did give her a prescription for prednisone to be used 10 mg 2 tablets daily for 5 days then 1 tablet daily for 5 days then one half tablet daily for 5 days and then stop. We'll plan on seeing her in follow-up in the end of December 2015 and she'll be due for her repeat toxin injections for migraine headaches after February 17, 2016

Past Medical History

Disease Name	Date Onset	Notes
Chronic Pain Syndrome	--	Neck
Headache	--	--

Past Surgical History

Procedure Name	Date	Notes
Cholecystectomy	--	--
Hysterectomy	--	--
Open reduction and internal fixation	2004	Left tib-fib fx

Medication List

Name	Date Started	Instructions
Ambien oral tablet 10 mg	11/10/2015	take 1 tablet (10 mg) by oral route once daily at bedtime for 30 days
Antivert oral tablet 25 mg	10/08/2015	Take one po Tid prn
cyclobenzaprine oral tablet 5 mg	10/08/2015	Take one po Bid and two qhs
Cymbalta Oral capsule, delayed release (DR/EC) 60 mg	04/24/2015	take 1 capsule (60 mg) by oral route once daily for 30 days
Effexor XR oral capsule, extended release 24hr 75 mg	10/08/2015	take 1 capsule (75 mg) by oral route once daily for 30 days
Floriset oral capsule 50-300-40 mg	11/10/2015	Take one po Tid prn
Imitrex Oral tablet 25 mg		take 1 tablet by oral route 2 times a day as needed
Lyrica Oral capsule 50 mg	10/08/2015	take 1 capsule by oral route 2 for 30 days
Percocet oral tablet 10-325 mg	11/17/2015	Take one to two po QID prn
promethazine Oral	11/15/2013	--
promethazine oral tablet 25 mg	04/24/2015	take 1 tablet by oral route 3 times a day for 30 days
Remeron Oral tablet 15 mg		take 1 tablet (15 mg) by oral route once daily before bedtime
trazodone Oral tablet 100 mg		1.5 po q hs
Xanax oral tablet 0.5 mg	11/10/2015	take 1 tablet (0.5 mg) by oral route 3 times per day for 30 days

Allergy List

Allergen Name	Date	Reaction	Notes
PENICILLINS	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Chronic Obstructive Pulmonary Disease	/	--
Congestive Heart Failure	/	--
CVA (Cerebrovascular accident)	/	--
Depression	/	--
Hypertension	/	--
Osteoporosis	/	--

Social History

Finding	Status	Start/Stop	Quantity	Notes
Alcohol	Never	--/--	--	--
Married	--	--/--	--	--
Tobacco	Never	--/--	--	--

Review of Systems**Constitutional**

o * See HPI

Eyes

o * See HPI

HENT

o * See HPI

Breasts

o * See HPI

Cardiovascular

- o * See HPI

Respiratory

- o * See HPI

Gastrointestinal

- o * See HPI

Genitourinary

- o * See HPI

Integument

- o * See HPI

Neurologic

- o * See HPI

Musculoskeletal

- o * See HPI

Endocrine

- o * See HPI

Psychiatric

- o * See HPI

Heme-Lymph

- o * See HPI

Allergic-Immunologic

- o * See HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m ²	BSA m ²	O2 Sat	HC
12/02/2015	08:37 AM	146/92	Sitting				92 - R	16		160lbs 0oz	5' 2"	29.26	1.78		

Physical Examination

Moderately tearful adult female seated in a chair in moderate discomfort involving her back and neck region posteriorly especially on the left. She has 4 minus to 4 or 5 strength at the bilateral upper and lower extremities. Cervical and lumbar range of motion with decreased in all directions.

Assessment

- Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus 346.73/G43.711
- Cervical pain (neck) 723.1/M54.2
- Chronic pain syndrome 338.4/G89.4
- Severe depression 311/F32.9

#1 status post work injury May 18, 2012 but postconcussive symptoms including persistent headaches, ringing in her ears, lightheadedness, blurred vision, short-term memory loss, insomnia, migraine headaches number

#2 migraine headaches occurring a few times per week improved with Botox therapies every 3 months

#3 persistent severe cervical pain treated with periodic trigger point injections with benefit.

#4 chronic pain syndrome

#5 Severe depression with poor coping

Plan**Orders**

- o Injection(s); single or multiple trigger point(s), 1 or 2 muscle (20552) - 723.1/M54.2, 338.4/G89.4 - 12/02/2015
- o 4 - Injection, triamcinolone acetonide, not otherwise specified, 10 (J3301) - 723.1/M54.2, 338.4/G89.4 - 12/02/2015

Disposition

- o Call or Return if symptoms worsen or persist.

Electronically Signed by: Daniel L. Collins, MD -Author on December 3, 2015 10:22:10 AM

Florence Rehabilitation Medicine Progress Note

Patient Name: Vickie Rummage
Patient ID: [REDACTED]
Sex: Female
Birthdate: [REDACTED] 1959
Referring Provider: Daniel L. Collins MD

Visit Date: January 4, 2016
Provider: Daniel L. Collins, MD
Location: Florence Rehabilitation Medicine
Location Address: 900 E. Cheves St
 Florence, SC 29506-2704
Location Phone: (843) 661-4390

Chief Complaint

- Generalized body pain

History Of Present Illness

Vickie Rummage 56 year old Caucasian/White female returns today for a follow up visit.

She reports that she has not heard much from her attorney lately.

Explained to return him by phone that she is in desperate need of psychological care but really not been able to get her worker's comp carrier to get her referred to a psychologist or psychiatrist. She is coming back today for refill of medications along with trigger point injections. She is not due for migraine toxin injections until after February 17.

Exam:

recently tearful adult female seated on the exam table in mild acute discomfort. She does complain of trigger point injections over her upper back and neck which we have used trigger point injections for in the past. We'll repeat that today. She did sign a consent for this trigger point injections.

Impression:

- #1 chronic migraine without aura with intractable migraine
- #2 migraine headaches occurring a few times per week improved with Botox therapies every 3 months
- #3 persistent severe cervical pain treated with periodic trigger point injections with benefit
- #4 chronic pain syndrome
- #5 severe depression with poor coping

Recommendations:

At the present time we did prepare 5 cc of combination of 1% lidocaine along with 1 cc of Kenalog 40. We identified approximately 15 trigger point areas of her left posterior cervical region and trapezius and rhomboid region on the left. Those injections were done with approximately 0.25 cc of the above-noted mixture. The patient tolerated the procedure and good hemostasis was obtained at each injection sites. The patient is due for follow-up migraine toxin injections after February 17 2016

Past Medical History

Disease Name

Date Onset

Notes

Chronic Pain Syndrome
Headache

-- Neck
--

Past Surgical History

Procedure Name	Date	Notes
Cholecystectomy	--	--
Hysterectomy	--	--
Open reduction and internal fixation	2004	Left tib-fib fx

Medication List

Name	Date Started	Instructions
Ambien oral tablet 10 mg	11/10/2015	take 1 tablet (10 mg) by oral route once daily at bedtime for 30 days
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Allergy List

Allergen Name	Date	Reaction	Notes
PENICILLINS	--	--	--

Family Medical History

Disease Name	Relative/Age	Notes
Chronic Obstructive Pulmonary Disease	/	--
Congestive Heart Failure	/	--
CVA (Cerebrovascular accident)	/	--
Depression	/	--
Hypertension	/	--
Osteoporosis	/	--

Social History

Finding	Status	Start/Stop	Quantity	Notes
Alcohol	Never	--/--	--	--
Married	--	--/--	--	--
Tobacco	Never	--/--	--	--

Review of Systems**Constitutional**

- o * See HPI

Eyes

- o * See HPI

HENT

- o * See HPI

Breasts

- o * See HPI

Cardiovascular

- o * See HPI

Respiratory

- o * See HPI

Gastrointestinal

- o * See HPI

Genitourinary

- o * See HPI

Integument

- o * See HPI

Neurologic

- o * See HPI

Musculoskeletal

- o * See HPI

Endocrine

- o * See HPI

Psychiatric

- o * See HPI

Heme-Lymph

- o * See HPI

Allergic-Immunologic

- o * See HPI

Vitals

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI		
												kg/m ²	BSA m ²	O2 Sat HC
01/04/2016	10:48 AM	132/84	Sitting				72 - R	16		160lbs 0oz	5' 2"	29.26	1.78	

Assessment

- Chronic Pain Syndrome 338.4/G89.4
- Chronic migraine without aura, intractable, with status migrainosus 346.73/G43.711
- Cervical pain (neck) 723.1/M54.2
- Severe depression 311/F32.9

Plan**Orders**

- o Moderate level established patient office visit (99213) - 338.4/G89.4, 346.73/G43.711, 723.1/M54.2, 311/F32.9 - 01/08/2016
- o Injection(s); single or multiple trigger point(s), 1 or 2 muscle (20552) - 723.1/M54.2 - 01/04/2016
- o 4 - Injection, triamcinolone acetonide, not otherwise specified, 10 (J3301) - 723.1/M54.2 - 01/04/2016

Disposition

- o Call or Return if symptoms worsen or persist.

Electronically Signed by: Daniel L. Collins, MD -Author on January 11, 2016 12:08:04 PM

ANDREW N. SAFFRAN, LLC
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1400 PICKENS STREET, SUITE 104
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MAILING ADDRESS:
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COLUMBIA, SOUTH CAROLINA 29211

January 14, 2016

Daniel L. Collins, M.D.
Florence Rehabilitation Medicine
900 E. Cheves Street
Florence, South Carolina 29506

RE: Vicki Rummage

Dear Dr. Collins:

This will confirm our conversation of November 12, 2015, during which we discussed several of your opinions as to the current medical status and treatment needs of Ms. Vicki Rummage, who you have followed since December 17, 2012 for various symptoms that developed in the aftermath of a May 18, 2012 work related fall. Specifically, I inquired as to whether: (a) Ms. Rummage continued to exhibit sufficient evidence of depression to warrant focused treatment of this condition; (b) after reviewing reports stemming from several evaluations of these symptoms, you had formulated an opinion as to the likely source of Ms. Rummage's current psychological/psychiatric distress; and (c) you had any question as to the validity/reliability of her complaints or clinical presentation.

In this regard, inspection of your treatment notes reveals: (a) references to short term memory loss since the inception of your treatment on December 17, 2012; (b) an initial notation of depression (identified by another medical provider) on February 11, 2013; (c) your first request for a psychological consult on June 18, 2013; and (d) multiple reiterations of the previously suggested psychological referral during the ensuing months leading up to your March 13, 2014 deposition.

During the course of this deposition, you: (a) learned Ms. Rummage had been periodically treated for depression and anxiety by her primary care physician prior to the May 18, 2012 trauma; (b) acknowledged her symptoms, including emotional lability, were consistent with the post-concussive syndrome you had diagnosed; (c) noted the May 18, 2012 trauma "could have been an aggravating factor" relative to various symptoms, including emotional distress; (d) indicated the nature of her current depressive symptoms would best be addressed by a psychiatrist; and (e) deferred any opinion as to the causal relationship between these symptoms and her May 18, 2012 trauma.

Daniel L. Collins, M.D.
January 14, 2016
Page 2

Following this deposition, you have: (a) routinely reexamined Ms. Rummage on essentially a monthly basis; (b) consistently noted symptoms of decreased memory and some degree of anxiety; (c) observed her to be "tearful" on various occasions; (d) repeatedly recommended that she receive focused psychological/psychiatric care, specifically indicating this treatment was something she "definitely needs in addition to her chronic pain management"; and (e) more recently opined that "she is in desperate need of psychological care" for her depressive symptoms.

In conjunction with our discussion, I provided you with copies of reports generated by C. Thomas Gualtieri, M.D., Amanda B. Salas, M.D. and Tora L. Brawley, Ph.D., who each had the opportunity to evaluate Ms. Rummage's psychological/psychiatric symptoms. As clearly evidenced by their respective reports, Ms. Rummage saw Dr. Gualtieri per the carrier's directive, while Drs. Salas and Brawley (a neuropsychologist) evaluated her at my request.

As you noted in your November 17, 2015 report, there is "a significant degree of disagreement between" the carrier's designee and Drs. Salas and Brawley relative to several material aspects of Ms. Rummage's condition. While I provided you with copies of their respective reports so that you could formulate your own conclusions, after reviewing these reports, it is my understanding Dr. Gualtieri (psychiatrist) believes: (a) Ms. Rummage's current problems are not related to the consequences of her May 18, 2012 accident; (b) no head injury occurred on the date in question; (c) she "demonstrated a noncredible clinical presentation, with dramatic inconsistencies"; and (d) "... [t]here was clear evidence of symptom exaggeration." He also criticized the nature of her treatment, including your prescription of opicoids.

Conversely, Dr. Salas (forensic psychiatrist) verified Ms. Rummage: (a) "presented as an honest and forthcoming individual"; (b) did not deny experiencing "bout of depression prior to the injury"; (c) "did not present as overly dramatic or hysterical"; (d) exhibited impaired attention and difficulty with delayed recall; (e) "meets diagnostic criteria for ... severe ... Major Depressive Disorder"; (f) displays a "constellation of symptoms as verified by collateral information, current mental status examination, and personal history of depression ... [that] are indeed congruent with a major depressive episode, severe in nature, that is most likely related to her work injury"; (g) will continue to experience "depressive mood symptoms ... [which] are likely to worsen and become more resistant to treatment if treatment is delayed and stressors persist"; (h) "is not at maximum medical improvement in regards to her mood symptoms and memory impairments"; and (g) requires two-pronged treatment involving psychotherapy and psychopharmacological care.

Daniel L. Collins, M.D.
January 14, 2016
Page 3

Dr. Brawley similarly observed/concluded: (a) Ms. Rummage "was fully cooperative and answered all questions" during the clinical interview; (b) "[w]hile . . . [she] does have a previous history of depression, it was clear that her symptoms worsened significantly following the accident and needed to be aggressively treated"; (c) "[f]ormal assessment of effort did not reveal attempts to malingering"; (d) Ms. Rummage is not at maximum medical improvement; and (e) "[s]he needs to be treated immediately and aggressively for her psychiatric symptoms."

Based upon our conversation, it is my understanding you feel: (a) Ms. Rummage has never displayed any evidence of malingering, symptom magnification or secondary gain; (b) she has consistently exhibited clinical evidence of depression and anxiety throughout your period of treatment; (c) 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 completely consistent with your own; (d) Ms. Rummage's current psychological/psychiatric symptoms most probably stem from the aggravation of her preexisting depression/anxiety by the consequences of her May 18, 2012 compensable accident; (e) she requires treatment of the nature identified by Drs. Salas and Brawley; (f) Drs. Salas and Brawley have correctly concluded Ms. Rummage has not yet achieved maximum medical improvement relative to her psychological/psychiatric injury component; and (g) their opinions as to Ms. Rummage's rather serious need for psychological/psychiatric care are completely consistent with your repeated recommendations for authorization of this treatment.

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 ever exhibited any evidence of malingering, symptom magnification or secondary gain?

Yes _____ No ☒

2) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage has consistently exhibited clinical evidence of depression and anxiety throughout your period of treatment?

Yes ☒ No _____

Daniel L. Collins, M.D.
January 14, 2016
Page 4

3) 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 ☐

4) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage's current psychological/psychiatric symptoms most probably result from the aggravation of her preexisting depression/anxiety by the consequences of her May 18, 2012 compensable accident?

Yes ☒ No ☐

5) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage requires treatment of the nature identified by Drs. Salas and Brawley?

Yes ☒ No ☐

6) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage has achieved maximum medical improvement relative to her psychological/psychiatric injury components?

Yes ☐ No ☒
(at MMI) (not at MMI)

7) Do you believe, to a reasonable degree of medical certainty, that Drs. Salas' and Brawley's opinions as to Ms. Rummage's rather serious need for psychological/psychiatric care are consistent with your repeated recommendations for authorization of this treatment?

Yes ☒ No ☐

8) Do you believe, to a reasonable degree of medical certainty, that Ms. Rummage's receipt of the psychological/psychiatric treatment modalities identified by Drs. Salas and Brawley is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by the consequences of her May 18, 2012 compensable accident, including the causally related psychological/psychiatric injury component identified by these evaluators?

Yes ☒ No ☐

Jan. 22. 2016 9:28AM

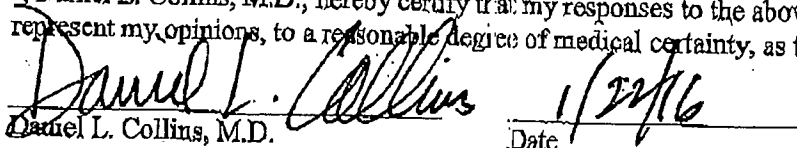
No. 2031 P. 6/6

Daniel L. Collins, M.D.

January 14, 2016

Page 5

I, Daniel L. Collins, 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.


Daniel L. Collins, M.D.

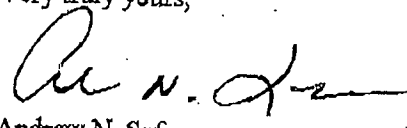
Date 1/22/16

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

ANS/trm