..I I.C. NO. 101675, TERRY CAWTHORN, Employee, Plaintiff v. MISSION HOSPITAL, INC., Employer, Defendant. OPINION AND AWARD by GEORGE T. GLENN, II, Deputy Commissioner, N.C. Industrial Commission. Filed 22 September 2009.

This matter was heard before the undersigned in Hendersonville, North Carolina, on March 30 and 31, 2008. Following the hearing the record was held open to allow the parties to submit additional evidence. The depositions, exhibits and medical records of Drs. Daniel Hankley, Margaret Burke, Ralph Loomis and Josh Klaaren, PA, have been received and are hereby made a part of this record. The contentions and proposed Opinion and Awards of the parties have been received. The record closed on July 15, 2009 and this case is now ready for decision.

APPEARANCES

Plaintiff:	Ganly & Ramer, Attorneys at Law, Asheville, North Carolina; Thomas F. Ramer, Counsel of Record.
Defendants:	Brooks, Stevens and Pope, Attorneys at Law, Cary, North Carolina; Joy Brewer, Counsel of Record.

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Pursuant to the Pre-Trial order entered by the undersigned the parties have entered into the following

STIPULATIONS

1. All the parties are properly before the North Carolina Industrial Commission and the Industrial Commission has jurisdiction of the parties and of the subject matter of this case. All parties are bound by and subject to the North Carolina Workers' Compensation Act. All parties have been correctly designated and there is no question as to the misjoinder or nonjoinder of any party.

2. The employer-employee relationship existed between the plaintiff and the defendant-employer at all relevant times herein.

3. Defendant-employer was an approved self-insured, at all times relevant herein.

4. Plaintiff's average weekly wages were $1,456.98 per week, yielding a compensation rate of $786.00 per week.

5. The following exhibits were admitted into evidence at the hearing:

a. Stipulation #1, plaintiff's medical records, IC forms and employment records, pages 1-96;

b. plaintiff's #1, plaintiff's 2006/2007 annual performance evaluation;

c. plaintiff's #2, e-mail from plaintiff to plaintiff's attorney;

d. plaintiff's #3, defendant's response to plaintiff's second set of interrogatories and request for production of documents;

e. plaintiff's #4, Mikos e-mail of 7/25/08 to plaintiff;

f. plaintiff's #5, Mikos letter of 6/4/08 to plaintiff;

g. plaintiff's #6, e-mail between Ms. Carpenter and plaintiff dated 4/13/2008;

h. defendant's #1, 1997 report of injury by plaintiff;

i. defendant's #2, short term disability payments to plaintiff.

6. The issues to be determined from this hearing are as follows:

a. Whether plaintiff sustained an injury by accident while in the course and scope of the employment with defendant-employer on either February 26, 2008, March 7, 2008, March 10, 2008, and/or May 20, 2008?

b. If so, to what, if any, workers' compensation benefits is plaintiff entitled to recovery under the North Carolina Workers' Compensation Act?

c. Whether plaintiff is entitled to attorney's fees?

d. Did defendant unreasonably deny plaintiff's claim(s)?

e. Whether defendant is entitled to any credit as a result of plaintiff being paid short and long term disability payments?

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Pre-hearing Motion

At the hearing and prior to taking evidence defendants argued their motion to disallow consideration of plaintiff's claims for injuries on March 7, March 10, and May 20, 2008. Counsel argued such claims should not be considered as part of this matter as defendants had not been made aware of such claims until plaintiff filed Form 18 Notice of Injuries on March 3, 2009. However, after considering the Stipulated Exhibit No 1, including defendants' Risk Master report of February 26, 2008, the Staff Health medical records which report treatments for such injuries as workers' compensation claims, and the claims journal records of Janet Mikos entered on May 27, 2008 acknowledging these reports of injuries, the undersigned denied defendants motion as their own records make it clear they were aware of such injuries and claims and failed to take any action. Subsequent to the hearing defendants have filed Form 63s admitting liability for medical treatment for such claims. It should be noted that the filings of these Form 63s were late and not as indicated as what should be done per N.C. Gen. Stat. §97-18 in that defendant had actual notice of plaintiff's additional claims shortly after each incident but they did not do anything either to admit or deny the claims and it was more than one year after receiving actual notice of the additional claims that the Form 63s were filed, therefore their filing was untimely and not in accordance with N.C. Gen. Stat. §97-18 or other parts of the Workers' Compensation Act and rules.

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The Pre-Trial Agreement along with its attachments and any additional stipulations are hereby incorporated by reference as though they were fully set out herein.

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Based upon the competent evidence of record, the undersigned makes the following additional:

FINDINGS OF FACT

1. As of the hearing, the plaintiff was a 47 year old mother who had over 20 years of service to Defendant Mission as a registered nurse. As of February 26, 2008 she was earning an average weekly wage of $1,456.98 which yields the maximum compensation rate of $786.00. Plaintiff contributed to the purchase of both her short term and long term disability.

2. On February 26, 2008, plaintiff was assigned to work in the Women's Operating room which was her regularly assigned position. In the early afternoon, when the surgical cases for the day had been completed she was asked to assist in the post surgical recovery and transport for which she had some previous experience. She transported a post surgical patient to a room and at approximately 2:00 PM while assisting transferring the patient from the gurney into the bed she leaned across the bed and reached out her hand to assist the patient while transferring to the bed and felt a pain in her back. She completed the patient transfer and returned downstairs to the women's OR area to complete the rest of her shift.

3. During the remaining hour of her shift plaintiff's back pain became more severe. While driving home her pain further increased and by the time she arrived at home she had to lie on the floor to get relief from her muscle spasms. Due to her severe back pain and spasm she

was not able to enjoy her birthday dinner with her family. She took some muscle relaxers to help relieve her symptoms and rested.

4. On February 27, 2008, immediately upon arriving for her shift at 7:00 AM, plaintiff reported her back injury of the previous day to her supervisor, Beverly Carroway. Ms Carroway, who testified and confirmed plaintiff's report of injury, instructed her to complete an injury report via the computerized system (RiskMaster) and then go to the Staff Health for evaluation.

5. Plaintiff then completed a computerized incident report in which she reported the claim as an employee injury and the cause of her injury was moving a patient, reporting that her pain became worse during the last hour of her shift. The Mission Risk Management Staff then reported the claim fell under the "Workers Comp SIR" insurance policy and listed the type of claim as Medical Only. They further reported plaintiff was not performing her regular job, reported her disability to be from an injury and noted the injury to her Back-Lower (Lumbar).

6. Plaintiff was seen by Josh Klaaren, PA, this visit was scheduled by defendants as a workers' compensation evaluation. Upon examination Mr. Klaaren noted plaintiff had spasms and low back pain and "bilateral SI joint area." In her hand written report of injury, plaintiff noted "sudden onset of low back pain during last hour of my shift." Mr. Klaaren diagnosed plaintiff with a low back and SI joint strain, prescribed some anti-inflammatory medications and restricted plaintiff to light duty work for two days.

7. After her staff health evaluation, plaintiff returned to the OR and again reported to Ms. Carroway. Ms. Carroway in turn advised her supervisors, Samantha Farmer and Renee Carpenter, both of whom came to the OR, where she reported plaintiff's injury and limited

work status. Ms. Farmer confirmed on the witness stand that Ms. Carroway advised her of plaintiff's report of injury shortly after it occurred as well as her work restrictions.

8. Thereafter, plaintiff continued to work on restricted duty until March 7, 2008. On March 7, 2008, plaintiff was required to hold a large panniculus or abdominal apron of a 300 pound patient for approximately 20-30 minutes while a spinal block was administered, during which plaintiff experienced an increase of her low back pain, muscle spasms, and onset of right SI joint pain. Plaintiff continued working and on March 10, 2008, she was attempting to remove the base off an OR table during a procedure when she once again experienced the onset of low back and SI joint pain and spasms. On this date she reported the incident and was instructed to go to Staff Health to be examined.

9. As instructed, plaintiff reported to Staff Health on March 10, 2008 and was seen by Josh Klaaren. This visit was scheduled and reported by defendants as a follow up workers compensation evaluation for plaintiff's February 26, 2008, injury. While there for an evaluation, plaintiff reported both March 7th and March 10th incidents and she noted low back pain with SI joint pain, also noting some secondary spasms. Mr. Klaaren believed that plaintiff's condition was considered by defendant to be related to her workers' compensation injury of February 26, 2008, and he advised plaintiff not to work for 2 days.

10. Plaintiff continued to work on light duty, but continued to suffer from intermittent low back and bilateral SI joint pain and spasms. On March 10, 2008, she consulted Dr. Resa Johnson for chiropractic care at the suggestion of a co-worker, and reported that she had injured herself on February 26, 2008, pulling a 350 pound patient and developed severe back pain 30 minutes later. Dr. Johnson diagnosed plaintiff with right SI pain, lumbar pain and cervical strain.

11. On March 13, 2008, plaintiff e-mailed Renee Carpenter, defendants' Director of OR, to advise her that due to the very strenuous work required of plaintiff in the women's OR that she had re-aggravated her back injury two weeks ago on March 7 and March 10, 2008, and that the re-injuries had set back or worsen her condition.

12. On April 11, 2008, plaintiff was seen by Dr. Paul Martin, MD, of Staff Health for continued right SI joint pain. Plaintiff informed him that she was still working but by doing so, she would experience increasing back pain and spasms by the afternoon as she worked. Dr. Martin noted that her date of injury was February 26, 2008 and that her injury was work related. Plaintiff was given an injection by Dr. Martin and he sent a follow up e-mail to Renee Carpenter the same day re-advising her of plaintiff's continuing SI joint pain since February.

13. On May 20, 2008, plaintiff again injured her back while attempting to move a Book-Walter Ring weighing approximately 50 pounds. She reported this incident to her supervisor and was again directed to go to be evaluated at Staff Health where she was seen on May 22, 2008, by Anne Marie Hawes, PA. Plaintiff reported pain over her sacrum with muscle spasms in her low back. The records from defendants report this visit was scheduled and reported as a follow up visit for plaintiff's February 26, 2008, injury. Ms. Hawes noted that plaintiff suffer from discomfort over the bilateral sacral area and she placed plaintiff on restricted duty, recommended that plaintiff have assistance moving patients and further recommended that plaintiff be seem by Dr. Daniel Hankley at Blue Ridge Bone and Joint Clinic. Ms. Hawes reported this to Mary Silver, the Workers' Compensation administrator for defendant to request authorization for plaintiff to see Dr. Hankley.

14. On or about May 27, 2008, Janet Mikos, defendants' adjuster became aware of the claim and interview plaintiff about her February 26, 2008, incident. Ms. Mikos testified that

she intentionally did not obtain a recorded statement of their conversation but entered a summary of her notes of the conversation into defendants' claims management system, Risk Master, on May 27, 2008. Ms. Mikos had access to plaintiff's initial February 27, 2008, Risk Master report in which plaintiff reported the cause of her injury was moving a patient and in an separate section noted her pain became more severe in the last hour of her shift. Ms. Mikos was further aware this claim had been timely and properly reported and entered into the Risk Master system as a medical workers compensation claim.

15. During their conversation on May 27, 2008, plaintiff explained that she had been asked to assist in transferring a post surgical patient to an upstairs room, which was not her regular job, and reached out across a bed and let the patient grab plaintiff's arm to assist a 300 pound patient transfer into a bed at which time she felt pain in her low back. She also told her that she returned downstairs to her normal work station, sat at a desk during the last hour of her shift, and had increasing back pain until she left for home. That during her ride home her pain became much more severe and upon getting home she had to miss her birthday dinner due to her pain.

16. Ms. Mikos advised plaintiff that since neither she nor the patient she was assisting slipped, tripped or fell such incident did not qualify for workers compensation coverage. This statement is confirmed by Ms. Mikos's Risk Master entry which reported "there is no specific traumatic event, no fall, no trip, no stumbling or either the clmt [claimant] or any patient that she may have been assisting." Ms. Mikos, a claims adjuster with over 20 years of experience with 6 of those years working in North Carolina knew such statement to be untruthful and made such statement to mislead plaintiff and deny her workers' compensation benefits.

17. Rather than honestly and reasonably investigating plaintiff's claim by reviewing the Risk Master report and contact Beverly Carroway, who was listed as plaintiff's supervisor, Ms. Mikos took the suggestion of Barbara Thompson of defendants' Human Resources department, and contacted Renee Carpenter, who was the OR Director. Ms Carpenter reported she was not aware of plaintiff's injury until it was recently reported in the Risk Master system and was not aware of plaintiff's restrictions until May 22nd. She further reported she had seen plaintiff on May 20th in the OR and she did not appear to be injured as she "forcefully pushed Renee aside so the clmt [claimant] could assist a patient" and "may not take the appropriate precautions to abide by the restriction imposed."

18. At the hearing defendants, through arguments of their counsel, argued they were not previously aware of plaintiff's claim of re-injuring her back on March 7 when she was assisting with a large obese patient on March 7, 2008, or when she was moving an OR table on March 10, 2008, or finally while moving a Book Walter Ring on May 20, 2008, and that such claims should not be considered in this matter.

19. Defendants' claims and arguments of counsel are in direct contradiction of all the evidence that defendant retained in its own records of this incident in that plaintiff's supervisor stated that plaintiff had made her aware of each incident and that she had document each of them and on each occasion she had sent plaintiff to Staff Health where plaintiff was treated and Staff Health medical records of plaintiff's visit reflect not only that plaintiff told them of her injuries, they were told that these visits for treatment were to be considered a part of plaintiff continuous treatment from the February 26, 2008 injury by accident, and that Ms. Mikos entered this information into her Risk Master summary on May 27, 2008, more than a year earlier. Further Josh Klaaren, PA of Staff Health testified that the Staff Health evaluations were scheduled by

defendants and entered into the Risk Master system as follow up to her February 26, 2008, injury and such information was available to defendants Risk Management staff immediately. Further Ms. Mikos knowledge of plaintiff's claim of re-injury on May 20, 2008, is confirmed in her own Risk Master notes of May 27, 2008, when she stated reported "she feels she exacerbated her back on 5-20-08 lifting a 50# Book-Walter Ring in the OR."

20. Subsequent to her review of plaintiff's claim, Ms. Mikos spoke to Mary Silver, Defendants' Workers' Compensation Manager, and discussed plaintiff's claim. Ms. Silver was aware Ms. Carroway was plaintiff's direct supervisor and even acknowledged that plaintiff had reported the incident to her on February 27, 2008. However, rather than contacting Ms. Carroway, to confirm plaintiff's Risk Master report of the onset of her back pain while moving a patient, Ms. Silver ignored this portion of the Risk Master report and focused on the portion which reported plaintiff's lower back started hurting during the last hour of her shift which showed intentional actions in reaching the decision to deny the claim.

21. On May 29, 2008, without consulting or interviewing Beverly Carroway, who defendants acknowledged on their Form 19 was plaintiff's supervisor and "first knew of the injury" on February 27, 2008," or interviewing Josh Klaaren of Staff Health who testified in his opinion the February 26, 2008, and subsequent injuries of March 7, March 10th and May 20, 2008, were all valid workers' compensation claims, both Janet Mikos and Mary Silver made the decision to deny plaintiff's claim in spite of the overwhelming evidence to the contrary.

22. By letter dated June 4, 2008, Ms. Mikos advised plaintiff that her claims was being denied based solely on her contentions that plaintiff had not described an injury by accident or a specific traumatic incident, specifically stating "based on our investigation there was no "accident" and your claim is respectfully being denied."

23. In a separate email dated July 25, 2008, Ms. Mikos again confirmed that her sole reason for denying plaintiff's claim was her position that plaintiff had not described an injury by accident, which Ms. Mikos admitted at the hearing was not required by the North Carolina Workers' Compensation Act, and further claimed that "per my conversation with Renee Carpenter, she was not aware of the injury until May 22, 2008, when the event was entered into our claims handling system (Risk Master). Both the statements by Ms. Carpenter as to when she became aware of plaintiff's injury and when the event was entered into the Risk Master system were false statements.

24. On May 30, 2008, plaintiff was seen by Dr. Daniel Hankley of Blue Ridge Bone and Joint Clinic at the referral of defendants' Staff Health, where she reported her injury assisting a patient followed by severe low back pain and SI joint pain 30 minutes later as well as her re-aggravation a week later. On examination Dr. Hankley noted tenderness to palpation over her right PSIS, worse with lumbar extension. He further reviewed X-rays from May 20, 2008, which showed Grade I spondylolisthesis at L5 on S1, and then reported plaintiff has aggravated her SI joint during her two lifting and patient assisting movements which "continues to aggravate it while she is doing full duty." He indicated plaintiff may have some referred pain from her L5-S1 disc and recommended obtaining an MRI scan and a having steroid injections. Dr. Hankley placed plaintiff on a 20 pound limitation with limited bending, stooping or twisting.

25. In spite of denying plaintiff's workers' compensation claim, defendants provided light duty work for plaintiff pursuant to their workers' compensation policy. She continued to work in the OR and continued to have low back and bilateral SI joint pain.

26. Plaintiff returned to Dr. Hankley on June 12, 2008, when he reported she has been working under restricted duty and her pain was getting worse, specifically noting more low back

pain and right SI joint pain. He further reported plaintiff reported significant back pain and spasms after simply lifting a casserole out of the oven and her spasms where so severe she had to lay on the floor, which were the very same complaints she made to Staff Health on February 27, 2008. His diagnosis did not change and he reported her SI joint pain may be referred from her low back and her spondylolisthesis. Dr. Hankley recommended an MRI scan and left plaintiff's restrictions unchanged.

27. On or about June 13, 2008, plaintiff was sent home from work by defendants and advised light duty work was no longer available. On Monday, June 16, 2008, plaintiff was summoned to a meeting with Mission Human Resources and Samantha Farmer at which time she was informed that they had reconsidered her restrictions and light duty work would be made available to her. Thereafter, plaintiff continued to work in the women's OR and continued to suffer from low back and bilateral SI joint pain.

28. On June 24, 2008, plaintiff returned to Dr. Johnson for additional chiropractic treatment at which time she reported worsening pain over the past few days with a "fiery pain over her rt. SI joint". There is no indication that plaintiff suffered any new injury or intervening incident.

29. On June 26, 2008, plaintiff returned to Dr. Hankley at which time she had continued with complaints of severe low back pain and bilateral lower extremity pain, left worse than right. Dr. Hankley reviewed the MRI scan and reported she suffered form bilateral pars defect with Grade I spondylolisthesis and severe left and mild right neuroforaminal encroachment, which confirmed her earlier X-rays of May 20, 2008. No disc herniation or other cause for her leg pain was noted. Dr. Hankley continued work restrictions and recommend an

epidural injection. Dr. Hankley did not indicate that plaintiff had suffered any new injury or intervening incident.

30. On July 16, 2008, plaintiff was evaluated by Dr. Ralph Loomis, a board certified neurosurgeon, at which time she again reported the onset of her symptoms in February when "she was assisting a patient move from a gurney to bedside post surgically and felt a little twinge in her back… about 30 minutes later her low back began hurting" which got progressively worse over the next few hours. It was noted her pain never resolved and at the end of June she began to notice trouble with her left thigh. On exam Dr. Loomis reported diffuse weakness in her left leg and after review of her MRI diagnosed spondylolisthesis at L5-S1, lumbar stenosis and foraminal stenosis, low back pain and left leg weakness and radiculopathy. A nerve root block was recommended which was done on August 14, 2008 which provided significant relief of her symptoms.

31. Throughout the summer, plaintiff continued to work on light duty in the women's OR. She was seen in follow up by Dr. Loomis on September 16, 2008, with continued complaints of low back pain. On exam she was noted to have normal reflexes and gait and negative straight leg raise. Her diagnosis remained unchanged but she was referred for urological exam.

32. On September 9, 2008, defendants notified plaintiff that light duty work was no longer being made available to her and she was taken out of work as of that date.

33. Plaintiff was next evaluated for a second opinion by Dr. Jon Silver, who was Dr. Loomis' partner, on October 22, 2008, at which time she was noted on exam to have "mild tenderness to palpation in the lower lumbar region with moderate left sciatic notch tenderness. She again had normal reflexes and negative straight leg raises. Based on his examination Dr.

Silver opined "I suspect that the lifting injury did aggravate the spondylolisthesis in that she already had some nerve root compression and this irritated the root." Plaintiff was thereafter referred to Dr. Margaret Burke, a specialist in physical medicine and rehabilitation, to undergo rehab to try and avoid a surgical fusion.

34. On October 23, 2008, Dr. Loomis prepared a letter in which he reported his agreement with Dr. Silver that plaintiff's lifting injury aggravated her spondylolisthesis and that she was incapable of performing her duties as a nurse for defendants.

35. Plaintiff ultimately underwent a lumbar interbody fusion at L5-S1 on December 1, 2008 with Dr. Loomis. On December 3, 2008, two days after her surgery, defendants terminated plaintiff's employment after over 20 years of service. Plaintiff then re-applied for other positions with defendant-employer and was offered an alternative position which was rescinded a few days later.

36. Post surgically plaintiff continued under the care of Dr. Loomis and Dr. Burke. She participated in extensive physical therapy. Subsequent to the hearing during their depositions both Dr. Burke and Dr. Loomis indicated that plaintiff had reached maximum medical improvement. Dr. Burke approximated that plaintiff would have a 25% impairment rating and Dr. Loomis did not establish an impairment rating and indicated he would need to see plaintiff again before making that determination. However, both doctors indicated that before they could establish functional work limitations a FCE would need to be performed.

37. Both Dr. Burke and Loomis are of the opinion that plaintiff's back complaints beginning in February, 2008, were a direct result of her lifting incident on February 26, 2008, and her condition was further aggravated by her incidents of March 7, March 10, and May 20, 2008, all of which necessitated her surgery and resulting disability.

38. Josh Klaaren, defendants' own Staff Health physician's assistant, indicated that plaintiff's complaints remained consistent and in his opinion her low back and SI complaints were the same complaints caused by her initial injury of February 26, 2008, and were treated as such during all evaluations by Staff Health personnel.

39. Dr. Daniel Hankley agreed that plaintiff's low back and bilateral SI joint pain and symptoms were referred from the aggravation of her spondylolisthesis. However, Dr. Hankley testified in his opinion such complaints somehow resolved without explanation and her complaints of left legs symptoms were a result of picking up a casserole in late June 2008 and her subsequent symptoms were unrelated to her injury. However Dr. Hankley admitted in reaching such opinion he was not aware of plaintiff's post injury consistent bilateral SI joint pain and could not reach an opinion about the significance of such complaints.

40. Greater weight is afforded to the opinions of Dr. Burke, Dr. Silver and most specifically Dr. Loomis who actually performed plaintiff's surgery and was given the complete history of plaintiff's complaints from February 26, 2008 until his surgical recommendation and confirmed such history was consistent and a direct result of the February 26, 2008 lifting incident at work.

41. While plaintiff's doctors indicated that her impairment rating is only an approximate rating and that she continues to require follow up treatment and a formal functional evaluation to determine her safe working limitations, plaintiff has been and continues to be disabled.

42. According to Ms. Mikos statements to plaintiff and her letters and emails defendants denied this claim based on their assertion plaintiff did not report an accident or specific traumatic injury, and they were not aware of such incidents until May 27, 2008. Their

positions were re-affirmed in their answers to interrogatories filed on March 26, 2009 when they stated "defendants contend that plaintiff has not related her back injury to moving a patient until after the denial of this claim."

43. Defendants position and denial of this matter intentionally disregard information on their own Risk Master report of injury filed on February 27, 2008, their acknowledgment of Ms. Carroway's knowledge of the incident on February 27, 2008 and failure to contact her while they were investigating this claim to determine whether it should be admitted or denied, their failure to contact Josh Klaaren and other Staff Health personnel, and continued disregard of their testimony which was taken at this hearing, as well as the other evidence in defendants own records and the evidence produced at this hearing, the defendants denial of this matter, as reported by Ms. Mikos and Ms. Silver, was and remains unreasonable and based on stubborn, unfounded litigiousness.

44. Defendant-employer has a long and well established history in workers' compensation claims before the Industrial Commission and Court of Appeals wherein they have been found to have unreasonably denied workers compensation cases and sanctioned with attorney fees, and their actions in denying this claim is consistent with such practices and their behavior continues along the line of their established pattern and practice of bad faith in administering workers' compensation claims.

The statements by Ms Mikos, as affirmed by Ms. Silver, to the plaintiff as to the compensability of her incident were made intentionally and constitute fraud in denying plaintiff workers compensation benefits when they knew she was entitled to the same. Such statements and the lengthy history of defendants' prior unreasonable denial of claims show a pattern and practice of bad faith handling of workers compensation claims.

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The foregoing Stipulations and Findings of Fact engender the following

CONCLUSIONS OF LAW

1. Plaintiff sustained a specific traumatic incidents on February 26, 2008, March 7, march 10 and May 20, 2008 while in the course and scope of her employment with defendant-employer. As a direct result, of her injury by accident, plaintiff sustained physical injuries that include aggravation of her spondylolisthesis. N.C. Gen. Stat. §97-2(6).

2. As a result of the February 26, 2008, incident and injury, plaintiff is entitled to have defendants pay ongoing temporary total disability compensation at a rate of $786.00 per week for the period of September 10, 2008, and continuing until further order of the Commission. N.C. Gen. Stat. §97-29. Defendant is not entitled to any credit for plaintiff's short or long term disability.

3. As a result of the February 26, 2008, incident and resulting physical injuries, plaintiff is entitled to have defendants pay for all related medical treatment that is reasonably necessary to effect a cure, give relief, or lessen plaintiff's disability, including expenses associated with treatment provided by Dr. Margaret Burke and Dr. Ralph Loomis, or such treatment or referrals as they deem appropriate. N.C. Gen. Stat. §§97-2(19) and 97-25.

4. Defendants' denial of this matter was undertaken unreasonably, fraudulently and in bad faith which justifies an award of attorney fees and costs.

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Based on the foregoing Findings of Facts and Conclusions of Law, the undersigned enters the following:

A W A R D

1. Subject to the attorney's fees hereinafter approved, defendants shall pay to plaintiff total disability benefits at the rate of $786.00 per week beginning September 10, 2008 and continuing through the date of this hearing and continuing thereafter until such time as plaintiff returns to work at her pre-injury wage or until further order by the Commission.

2. As a sanction for their bad faith denial and fraudulent actions defendants are further sanctioned with a 10% penalty applicable to all indemnity awarded and to be paid to the plaintiff.

3. Defendants shall pay all medical expenses incurred or to be incurred by plaintiff as a result of the compensable injury for so long as such evaluations, treatments and examinations may reasonably be required to effect a cure, give relief and/or lessen plaintiff's period of disability, including but not limited to the expenses associated with treatment from Dr. Burke and Dr. Loomis.

4. A reasonable attorney fee in the amount of 25 percent of the compensation approved and awarded to plaintiff is approved and allowed for plaintiff's counsel, this amount shall not be deducted from the compensation due plaintiff but paid as a part of the cost in this matter. The attorney's fee shall be paid directly to plaintiff's attorney.

5. This case is hereby referred to the North Carolina Attorney General and Department of Insurance for investigation of possible violations of unfair claim handling and settlement practices under Chapter 58 of the North Carolina General Statutes. (*Porter v. Whitley* NCIC No. 298350 filed 6/26/06)

6. Defendants shall pay the costs of this action.

It is further ORDERED that this case be REMOVED from the docket.

S/

GEORGE T. GLENN, II
DEPUTY COMMISSIONER