

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F008816

ODESSIA BASS, EMPLOYEE

CLAIMANT

MCGEHEE PUBLIC SCHOOLS, EMPLOYER

RESPONDENT

RISK MANAGEMENT RESOURCES, CARRIER

RESPONDENT

OPINION FILED SEPTEMBER 4, 2003

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH W. HOGAN on June 6, 2003, at Monticello, Drew County, Arkansas.

Claimant represented by the HONORABLE OSCAR H. HIRBY, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE CAROL L. WORLEY, Attorney at Law, Little Rock, Arkansas.

ISSUES

A hearing was conducted to determine the claimant's entitlement to payment of medical expenses, temporary total disability benefits and attorney's fees.

At issue is whether or not the claimant sustained a compensable injury as defined by Ark. Code Ann. §11-9-102. All other issues are reserved.

After reviewing the evidence impartially without giving the benefit of the doubt to either party, Ark. Code Ann. §11-9-704, I find the evidence does not preponderate in favor of the claimant.

STATEMENT OF THE CASE

The parties stipulated to an employer-employee-carrier relationship during 2000 at which time the claimant was earning sufficient wages to entitle her to a compensation rate of \$101.00/\$101.00, in the event this claim is found to be compensable.

The claimant contends she sustained specific injuries to her neck on January 18, 2000, February 21, 2000, and March 3, 2000. She was diagnosed with an herniated nucleus pulposus at C3-4 and surgical fusion was performed by Dr. Ron Williams on April 24, 2002. As a compensable consequence, the claimant developed a hip fracture at the site of the bone graft. The claimant seeks payment of medical expenses, temporary total disability benefits from March 27, 2000 to a date yet to be determined and attorney's fees.

The respondents contend the claimant did not suffer a specific, compensable injury. Alternatively, there is no evidence of a gradual onset injury, nor an injury supported by objective medical evidence, nor evidence of major cause. Additionally, the medical evidence does not support the claimant's request for unlimited temporary total disability benefits.

The following were submitted without objection and comprise the evidence of record: the parties' prehearing questionnaires and exhibits contained in the hearing transcript.

The following witnesses testified at the hearing: the claimant; her former co-worker and present manager of the cafeteria, Estella Grant, whose testimony was corroborative; Shirley Bolling; and former cafeteria manager, Gay Bartlett.

The claimant, age 60 (D.O.B. June 24, 1943) began work for the respondent-employer in 1987 as a cook. She sustained three workers' compensation injuries in the past which were paid by the respondent-employer. Copies of AR-N forms were submitted showing a 1997 eye injury, a 1997 back injury and a 1999 back injury. The claimant presently receives Social Security benefits. She applied for Social Security in May, 2000 and indicated on the form that she did not plan to file for workers' compensation.

On January 18, 2000, the claimant was cooking using a large pot when she felt a pop in her neck. She mentioned the incident to her supervisor, Gay Bartlett who told her she would be okay. Gradually, the claimant's symptoms worsened and she went to her doctor. She kept her supervisor informed and submitted off-work slips. The claimant testified her neck stiffened and she required the assistance of co-workers to lift pots and pans. She worked one week with her arm in a sling provided by her supervisor.

The claimant came under the care of Dr. Ron Williams. She was treated conservatively with injections until an MRI scan confirmed a cervical herniated nucleus pulposus. Surgery involving a bone graft was performed on April 24, 2002. The claimant developed complications in her hip at the site of the bone graft which prolonged her recovery. The claimant stated that her neck and hip have improved although she remains symptomatic and unable to work.

The claimant applied for a medical leave of absence on August 21, 2000 and filled out an accident report form provided by Shirley Bolling. An AR-N was submitted showing a date of injury of February 21, 2000, with notice to the employer on the same date. The form was signed on September 6, 2000. The claimant testified she made a mistake when she listed the date of injury. She cannot recall any specific injuries in February or March. She stated her condition gradually worsened after the specific incident in January, (Tr. p. 100-104, 110).

Gay Bartlett worked for the respondent-employer seventeen years prior to her retirement. Despite her years of experience she did not seem knowledgeable about workers' compensation policy or reporting procedures. Ms. Bartlett visited the claimant in her home following surgery. Ms. Bartlett testified the claimant's job duties involved lifting six gallon pans, cooking the main dish and cleaning the kitchen. The claimant continued her regular duties until her last day of work in March

2000. Ms. Bartlett was aware of the claimant's complaints of neck pain but stated that the claimant never reported an injury. Ms. Bartlett even provided the claimant with a sling to use but denied providing any other home remedies (such as massages, WD40 or praying Tr. 19-20, 26, 34).

MEDICAL EVIDENCE

The claimant testified she had neck and back problems in 1996, 1997, and 1998 but the medical exhibits provided begin in 1999. Medical records show the claimant has suffered from neck pain and headaches since at least January 18, 1999. X-rays confirmed degenerative disc disease of the cervical spine.

The claimant mentioned no specific injury or general job duties that triggered her symptoms to either her family physicians, Drs. Heder and Gregory or to her surgeon, Dr. Ron Williams or to pain specialist, Dr. Juan Roman.

The claimant saw her family physician on January 21, 2000 with complaints of right shoulder pain and an inability to lift her arm at times. She was prescribed Celebrex. She returned to her doctor on January 24, 2000 with continued complaints of right shoulder pain. On March 6, 2000 the claimant complained of right shoulder pain radiating to the back of her neck for the last three days. X-rays were taken of her cervical and thoracic spine. She was diagnosed with multi-level cervical arthritis – “longstanding”. The claimant returned to the doctor again on March 10, reporting pain in her right shoulder that started last Friday (March 3, 2000). She was given injections and more Celebrex. She returned on March 15, 2000 with numbness in her right arm and hand with shoulder pain. The handwritten clinic notes show, “no recent head or neck injury.” When the claimant returned on March 20, 2000, she was referred to Dr. Ron Williams.

In his report of March 28, 2000, Dr. Williams recorded a sudden onset of neck pain radiating to her right arm and hand one month in duration. He excused her from work from March 28, 2000 to April 6, 2000.

Dr. Juan Roman administered epidural steroid injections to control the claimant's pain upon referral by Dr. Williams.

Dr. Roman's Report of 3-28-00:

She is a 56 year old lady who complains of right arm and neck pain ongoing for about one month. She works in a cafeteria and does not recall any acute traumatic events, but has not had history of neck pain in the past.

Dr. Williams ordered an MRI scan which revealed "degenerative disc disease with bulging discs at multiple levels." There was some impingement of the thecal sac at the C3-4 level. Dr. Williams extended her off-work status until April 17, 2000 and prescribed another steroid injection with Dr. Roman.

Dr. Williams performed surgery on April 24, 2000 fusing the C3-4 level with a bone graft and scheduling a return appointment in six weeks. His report of May 30, 2000 indicates improvement of pain at the donor site and no arm pain.

The claimant began a course of physical therapy and returned to her family physician for follow-up care. She was seen on several occasions from May 2000 to March 2001 complaining of neck, left hip and leg pain. On September 11, 2000 the claimant reported that she hurt her "neck again doing housework, lifting things."

The claimant also contends that she sustained a fractured hip as a compensable consequence of her neck injury. The claimant complained of hip pain to her family physician and said that a

doctor at St. Vincent's told her she had a fractured left hip although no x-rays were taken. In a report dated June 7, 2000 her family physician recommended an x-ray and a follow-up report dated June 21, 2000 indicates the x-ray was reviewed with the radiologist. The x-ray report could not be located in the exhibit packet and the family physician never mentions the results of the x-ray in the medical records. I assume the x-ray was negative or inconclusive because a CT scan was recommended in reports dated July 11, 2000 and August 1, 2000, due to the claimant's continued complaints. Again, the CT report could not be located in the exhibit packet and no mention is made of the results in the doctor's notes. The family physician referred her to Dr. Gober on the assumption that a back injury was causing radiating hip and leg pain. After a negative MRI scan, Dr. Gober ruled out a back injury and advised the claimant to return to Dr. Ron Williams to discuss pain at the surgical donor site. Dr. Gober's expenses do not appear to be reasonably related to the neck injury.

The claimant's complaints of hip and leg pain appear in her family physician's reports from June 2000 to March 2001. There is no objective medical evidence to substantiate any complication to the claimant's hip during surgery, nor evidence of malpractice that would give rise to a claim for a compensable consequence.

With regard to temporary total disability benefits, Dr. Williams released the claimant on May 30, 2000 with no scheduled follow-up appointments. The claimant's general practitioner also authored a note on June 5, 2000 confirming that the claimant had been released by Dr. Williams.

After surgery the claimant used a walker and a cane and took physical therapy. A note from her general practitioner indicates physical therapy was completed by September 1, 2000. Dr. Gregory then scheduled a follow-up visit in one month and continued her off work until the claimant could be evaluated by Dr. Gober. There is no proof to substantiate the claimant's contention that she

is entitled to temporary total disability indefinitely. No physician has recommended any specific work restrictions and the persistence of pain alone does not extend the healing period, Mad Butcher, Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982).

FINDINGS AND CONCLUSIONS

As this claim arose after July 1, 1993, this case is governed by Act 796 of 1993 which must be strictly construed, Ark. Code Ann. §11-9-704, §11-9-717. The claimant has the burden of proving the following requirements, as defined by Ark. Code Ann. §11-9-102, by a preponderance of the evidence of record, which means “evidence of greater convincing force,” Smith v. Magnet Cove Barium Corporation, 212 Ark. 491, 206 S.W2d 442 (1947):

- 1) proof that the injury arose out of and in the course of employment
- 2) proof that the injury caused internal or external physical harm to the body which required medical services or resulted in disability
- 3) proof establishing the injury by objective medical evidence
- 4)(a) proof that the injury was caused by a specific incident identifiable by time and place of occurrence

or

- (b) proof that the injury was caused by rapid, repetitive motion and proof that the injury was the major cause of disability or need for medical treatment.

The Claimant’s testimony is simply not corroborated by the documentary evidence of record. I would not characterize her job as rapid and repetitive and there is no specific incident to correlate with her worsening symptoms and sudden onset of numbness (suggesting herniation of a disc) in

March, 2000. After considering the lay testimony and documentary evidence, I find the evidence of record shows that the claimant has suffered with multi-level degenerative disc disease for many years with progressive bulging and ultimately herniation of a disc in her cervical spine. She periodically complained of pain and needed assistance with her job duties, but she did not report a specific injury to her employer or ask for medical treatment at the respondents' expense despite the fact that she had three previous workers' compensation injuries and knew the procedure. The claimant told her physicians there was no specific injury or job duties that caused the onset of her symptoms. Accordingly, I find the claimant failed to prove by a preponderance of the credible evidence of record that she sustained an injury arising out of and in the course of her employment.

1. The Workers' Compensation Commission has jurisdiction of this claim in which the relationship of employer-employee-carrier existed among the parties during January, February, and March, 2000, at which time the claimant was earning sufficient wages to entitle her to a compensation rate of \$101.00/\$101.00.
2. The claimant has failed to prove by a preponderance of the credible evidence that she sustained a compensable injury, caused by a specific incident, arising out of and in the course of her employment which produced physical bodily harm, supported by objective findings, requiring medical treatment or producing disability, pursuant to Ark. Code Ann. §11-9-102.

This claim is respectfully denied and dismissed.

IT IS SO ORDERED.

ELIZABETH W. HOGAN
Administrative Law Judge