

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F200474/F203347

MAGDALENA HERNANDEZ

CLAIMANT

SUPERIOR INDUSTRIES

RESPONDENT

CROCKETT ADJUSTMENT CO.
INSURANCE CARRIER/TPA

RESPONDENT

OPINION FILED JULY 29, 2004

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Springdale, Washington County, Arkansas.

Claimant represented by RONALD M. MCCANN, Attorney, Fayetteville, Arkansas.

Respondent represented by CURTIS NEBBEN, Attorney, Fayetteville, Arkansas.

STATEMENT OF THE CASE

A hearing was held on May 10, 2004 in Springdale, Arkansas.

A pre-hearing conference was previously held in this claim, and as a result thereof, a pre-hearing order was entered in the claim on March 2, 2004. This pre-hearing order set out the stipulations offered by the parties and the issues to be litigated and resolved at the present time. Prior to the commencement of the hearing, the respondent employer announced by its attorney, that it was not insured for workers' compensation purposes by Fidelity & Guaranty Insurance Company, but was self-insured with Crockett Adjustment Company as its third party administrator. A copy of the pre-hearing order with this amendment noted thereon was made Commission's Exhibit No. 1 to the hearing.

The following stipulations were submitted by the parties and are hereby accepted:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On all relevant dates, including July 1, 1998 and May 30, 2001, the relationship of employee-employer-carrier existed between the parties.

3. The appropriate weekly compensation rates are \$330.00 for total disability and \$248.00 for permanent partial disability.
4. Any and all claims are controverted in their entirety.

By agreement of the parties, the issues to be litigated and resolved at the present time were limited to the following:

1. Whether the claimant sustained compensable injuries to her intrascapular/shoulder area, her cervical spine, and her lumbar spine as the result of specific incident on or about July 1, 1998 and/or May 30, 2001.
2. Whether the claimant sustained compensable injuries to these portions of her body as the result of non specific cumulative trauma from her employment.
3. Whether the claimant is barred from receiving any benefits by the provisions of A.C.A. §11-9-702.

In regard to these issues the claimant contends:

“She sustained compensable injuries on 05/26/1998 (lumbar), then gradual onset which continued through the claimant’s light duties of floor mopping, with the gradual onset ending on her termination date of 01/24/2002 when she was informed that no light duty was available and terminated by respondent’s agents, Linda Wade and Chris Topp. In addition, the claimant sustained an intrascapular/shoulder/cervical injury, both gradual onset, and specific incident with an increase in symptoms and/or aggravation on 05/30/2001.”

The claimant has been temporarily disabled from 01/24/2002 to a date as yet to be determined. As result of one or all of her work related injuries, the claimant has been treated by the following medical providers:

- (a) Cyril A. Raben, M.D.
- (b) William Piechel, D.O.
- (c) Texas Back Institute

- (d) Robert Tomlinson, M.D.
- (e) Arkansas Occupational Health Clinic

Claimant contends entitlement to workers' compensation benefits as set forth in the issues response in the preceding paragraph, and specifically, to the following workers' compensation benefits:

- (a) Reasonable and necessary medical expenses;
- (b) Temporary total disability benefits;
- (c) Permanent partial/total disability benefits (reserved);
- (d) Controverted attorney fees.

All other benefits are reserved under the Act.

In regard to these issues, the respondent contends that the claimant did not sustain an injury arising out of and in the course of her employment.

DISCUSSION

I. ALLEGED INJURY OF JULY 1, 1998.

In her testimony, the claimant describes an injury and onset of back difficulties as a result of a specific employment related incident in May 1998, rather than June 1, 1998. She further stated that she immediately reported this employment related injury and was sent by the respondent on the same date for medical treatment at the Lowell Occupational Health Clinic.

The claimant's testimony, in this regard, is supported by the medical evidence presented. The report of Dr. Kevin G. Baker of the Arkansas Occupational Health Clinic, (dated May 26, 1998, reveals that he saw the claimant on that date), at the request of the respondent employer. At that time, the claimant was complaining only of pain symptoms involving her low back with some pain radiating toward her legs. There is no mention of any symptoms involving the claimant's intrascapular/shoulder area or cervical spine. She did, however, attribute these complaints to a specific employment related incident. During

his initial physical examination Dr. Baker also noted objective findings, in the form of a reversal of the normal lordosis or curvature of the claimant's lumbar spine. The diagnosis of the etiology of the claimant's lumbar difficulties, at that time, was that of a lumbar strain.

Both the claimant's testimony and the medical evidence shows that she was treated for this employment related injury at the Arkansas Occupational Health Clinic through June 15, 1998. She was also placed on light or limited duty during this period. On June 15, 1998, the claimant was released from further medical care by Dr. Gary Moffett of the Arkansas Occupational Health Clinic and returned to full employment duties.

The claimant testified that she experienced no further difficulty with her lower back or had any limitations on her physical activities from June 15, 1998 until some time in December 2000. Both the claimant's testimony and the medical evidence reveal that the claimant neither sought nor received any medical treatment for any difficulties involving her back between June 15, 1998 and June 1, 2001.

Apparently, the respondent paid for the services provided to the claimant for her alleged May 1998 back injury by the physicians at the Arkansas Occupational Health Clinic. However, there is no evidence that the respondent provided the claimant with any other medical services for these complaints after June 15, 1998. It would also appear that the respondent provided the claimant with a light duty employment position, which was within the restrictions imposed by the physicians at the Arkansas Occupational Health Clinic, during the period of May 26, 1998 through June 15, 1998. There is no evidence that the respondent paid or that the claimant was entitled to any temporary or permanent disability benefits for her May 1998 back injury.

A.C.A. §11-9-702 (b) (1) provides that any claims for additional benefits must be filed within two years from the date of the injury or within one year from the last payment of benefits, whichever is greater. Based upon the evidence presented, the claimant had until May 26, 2000 to file any claim for additional benefits attributable to her alleged

compensable injury of May 26, 1998 (erroneously indicated in the pleadings and Prehearing Order as July 1, 1998). No claim for additional benefits attributable to the May 26, 1998 injury was filed by that date. The first claim for additional benefits attributable to this alleged compensable injury was filed on January 28, 2002.

After consideration of all the evidence presence, I find that the claimant has proven that she sustained a compensable injury to her lumbar spine, in the form of a lumbar strain on May 16, 1998. In regard to this injury, she has proven all of the necessary requirements of Ark. Code Ann. §11-9-102(4)(A)(i) and §11-9-102(4)(D).

However, the statute of limitation provided by A.C.A. §11-9-702 (b) (1) bars the claimant's receipt of any additional benefits for this compensable injury. Any subsequent claim for additional benefits attributable to this alleged compensable injury must be denied and dismissed.

II. ALLEGED COMPENSABLE INJURY OF MAY 30, 2001.

In her testimony, the claimant initially stated that her current difficulties with her lower back, upper back, neck, and legs (including tingling and numbness in her left leg) all started in May 2001, when she "was lifting rims that were really heavy, that weighed over 50 pounds." (T7-8). She subsequently testified that she actually began experiencing leg pain and lower back pain in December 2000, when she was "working with really, really, heavy rims, six or seven, up to 12 hours a day." (T8-9). Finally, in regard to the events leading up to her finally reporting employment related difficulties on May 30, 2001, the claimant testified:

"We got into a period of really heavy work and we were working really intensely and I had so many rims to handle, when I would get down and they were so heavy that I felt that my back was going to give out on me and I wouldn't be able to get up and put them on the pallet. I kept going until I just couldn't do it anymore." (T10-11).

The evidence shows that when the claimant finally reported employment related back complaints to her supervisor, she was referred that same day for medical treatment.

On that date, she was seen by Dr. Russell Green of the Arkansas Occupational Health Clinic. In his report of May 30, 2001, Dr. Green records the following history of the claimant's complaints:

"This person presents with history, according to her, of eight months of back pain in the right intrascapular area. She has been an inspector, works days. She says what is happening lately is that she is being required to do more work and harder, heavier work. She states that there is nothing specifically that has happened, it is just that she has now pain between the spine and the right shoulder blade. She has used some Doan's pills without benefit. She has not altered her work activity. She is otherwise well."

On June 1, 2001, the claimant was seen by her family physician at Healthcare North. In a report bearing the date of June 1, 2001, the claimant's complaints are noted as lower abdominal pain and low back pain, which is constant. This report also noted that the claimant has "felt bad for three months" and "does lifting at work." A subsequent report from this facility (dated June 21, 2001), records a history of back pain for four weeks, as well as "problems with breathing." This report also attaches some significance to the claimant "cleaning the floor."

The first mention in the medical evidence of any complaints involving the claimant's neck is not found until the report from the Arkansas Occupational Health Clinic, dated September 10, 2001. At that time, the claimant was noted to be also complaining of pain at the base of her neck. However, no precipitating event or activity is identified in connection with the appearance of these new complaints.

The first mention of any complaints or symptoms or abnormalities involving the claimant's actual shoulder joint is not found until Dr. Rabin's initial evaluation of April 2, 2002. Again no history was recorded of any specific distinguishable event as causing or precipitating any problems with the claimant's actual shoulder joints.

During the course of her evaluation and treatment of her multitude of complaints the claimant has been seen by a multitude of physicians of varying specialties, including a

neurosurgeon, orthopaedic surgeon, a physiatrist, a chiropractor, an anesthesiologist/pain management, and a physical therapist. The various reports and records for these medical providers either record no specific distinguishable event as the cause of any of the claimant's various complaints or record only the specific employment event in 1998.

The evidence presented, including the claimant's own testimony, fails to show that the onset of any of her difficulties involving her neck, intrascapular area of her back, lower back, or shoulders occurred contemporaneously with or was attributable to any distinguishable singular event in May of 2001. Clearly, the term "specific incident", given its common and usual meaning, implies a somewhat singular isolated event that is distinguishable from all other events or acts. In the present case, the evidence is clearly insufficient to prove the existence of a causal relationship between the claimant's various difficulties and complaints with her neck, upper back, lower back, and shoulder with any employment related "specific incident" (as that term is used in the Act) in May of 2001. Thus, she has failed to prove that, on or about May 30, 2001, she sustained a "compensable injury" to these portions of her body within the meaning of A.C.A. §11-9-102 (4) (A) (i).

III. CUMULATIVE TRAUMA INJURIES TO THE CLAIMANT'S INTRASCAPULAR/SHOULDER AREA, CERVICAL SPINE, AND LUMBAR SPINE.

Next, it becomes necessary to address the question of whether the claimant has proven the occurrence of "compensable injuries" to her intrascapular/shoulder area, cervical spine, or lumbar spine which were the result of nonspecific cumulative employment related trauma. In regard to each of these areas of her anatomy, the burden rests upon the claimant to prove all of the requirements for a nonspecific incident "compensable injury" as set out in the Act. These various requirements are found in A.C.A. §11-9-102 (4) (A) (ii), §11-9-102 (4) (B), and §11-9-102 (4) (E) (ii).

This case is clearly made more difficult by the fact that the claimant is not fluent in the English language. However, it is even more complicated by the fact that the claimant has complained of a multitude of injuries to various portions of her anatomy from her head to her feet and has seen numerous physicians.

There is no doubt that all of the evidence presented shows that the claimant's employment activities for this respondent involved rather strenuous use of her back and upper body to lift and move rather heavy objects on a continuous or frequent basis. Although the claimant, in her testimony, may have over estimated the weight of these objects and the number of these objects she was required to lift during a shift, it is undisputed that, until May 26, 1998, the claimant was required to lift, inspect, and move between 45 and 55 vehicle rims per hour during her entire shift and that these rims each weighed up to at least 38 pounds.

Clearly, these strenuous physical activities obviously placed substantial stress on the anatomical components of the claimant's neck, intrascapular area of her back, shoulders, and lower back. This stress could reasonably result in nonspecific cumulative trauma injuries to these portions of her anatomy. However, these facts alone are not sufficient to prove that these activities did, in fact, cause the claimant's various complaints or that the claimant did in fact sustain "compensable injuries" to these portions of her body, as that term is defined by the Act.

First, the claimant must prove that each of these alleged employment related injuries satisfies the requirements of A.C.A. §11-9-102 (4) (D). This subsection of the Act mandates that the actual existence of all "compensable injuries" must be proven by medical evidence. Further, the actual existence of such a physical injury must be supported by "objective findings." The term objective findings is defined as the independent observation of findings beyond the claimant's voluntary control, A.C.A. §11-9-102 (16) (A) (i).

Although the medical evidence reveals that various physicians have diagnosed the existence of a physical injury involving the claimant's neck or cervical spine, this diagnosis is based solely on the claimant's subjective complaints. All of the numerous physical examinations performed on the claimant have failed to note the observation of any supporting "objective findings," such as muscle spasms, atrophy, abnormal reflexes in the upper extremities, etc... Extensive objective testing, in the form of a bone scan, two MRI studies, and multiple x-rays have failed to show any abnormalities involving the claimant's cervical spine.

Thus, the claimant has failed to prove the necessary requirements for a "compensable injury" to this portion of her body that are contained in A.C.A. §11-9-102 (4) (D). Her failure to prove these necessary requirements compels a finding that she has failed to prove the occurrence of a "compensable injury" to this portion of her body, and her claim for benefits for a nonspecific injury to her neck or cervical spine must be denied and dismissed.

I would also note that, although the claimant testified that her cervical difficulties had their initial onset in May 2001. Her testimony in this regard is contrary to all of the other evidence presented. There is no indication in the medical evidence that the claimant complained of any symptoms or in any way exhibited any symptoms with this portion of her body, until September 10, 2001. During this same period of time, she was seen on numerous occasions by Dr. Green (the company doctor) and at Healthcare North (her family physician). Her first complaints of symptoms with this portion of her body were not noted until almost four months after she was placed on light duty and was no longer performing the position requiring the frequent repetitive movement of the tire rims or wheels.

It is my further opinion that the claimant has failed to prove by the greater weight of the credible evidence the existence of a causal relationship between her employment

activities with this respondent and her cervical complaints. As a result, she has also failed to prove the occurrence of a physical injury to this portion of her body that “arose out of or occurred in the course of her employment” with this respondent. This is a necessary requirement for a “compensable injury” under A.C.A. §11-9-102 (4) (A) (ii). Therefore, she has also failed to prove the occurrence of a “compensable injury” to her neck or cervical spine, under the definition of this subsection, and her claim for benefits attributable to her cervical complaints must be denied and dismissed.

In regard to the claimant’s intrascapular/shoulder difficulties, the medical evidence contains a multitude of potential diagnoses. These potential diagnoses cover possible injuries or conditions involving the musculature of the claimant’s upper back, referred radicular complaints from an injury or condition involving the claimant’s cervical spine, injuries or conditions involving the claimant’s thoracic spine, and injuries or conditions involving the claimant’s actual shoulder joints.

The records and reports of Dr. Green reveal that the initial diagnosis for the claimant’s various complaints involving her shoulder and intrascapular area was that of a muscle strain. Dr. James Blankenship subsequently indicated the possibility that these complaints were due to referred radicular pain from a cervical injury or condition. Dr. K. Marty Hurlbut diagnosed myofascial pain syndrome of the cervical brachial area and bilateral shoulder pain of unknown etiology. Dr. Cyril Raben diagnosed a probable shoulder derangement. Dr. Robert Tomlinson diagnosed chronic scapulothoracic myofascial syndrome and mild rotator cuff tendinitis. Finally, Dr. Michael Penney, in his interpretation of an MRI of the claimant’s thoracic spine, indicated that the claimant’s complaints might possibly be attributable to a focal fatty deposit or hemangioma of her thoracic vertebrae.

As previously indicated, there is absolutely no objective evidence (and very little subjective evidence) of any physical injury or condition involving the claimant’s cervical

spine. Plain x-rays and an MRI study of this area were interpreted as essentially normal. No objective evidence of any neurological deficits were noted on repeated clinical examinations. It appears, from the greater weight of the medical evidence, that the potential diagnosis that the claimant's intrascapular and shoulder complaints represented referred complaints from a cervical injury or defect has been abandoned.

The evidence presented also shows a total lack of "objective findings" to support any diagnosis of a physical injury or condition involving the claimant's actual shoulder joints. Except for complaints of pain, there are even very little subjective findings to support the existence of any physical injury or condition involving this portion of the claimant's body. The Initial range of motion test (performed by Dr. Hurlbut) was entirely normal. Dr. Rabin only noted some degree of reduction in range of motion, and then only "on internal rotation with a flexed posture", Dr. Tomlinson appears to note a full range of motion but indicates some degree of decrease on "resisted abduction supraspinous testing and tenderness along the medial supramedial borders scapula and supraspinous." Dr. Tomlinson also indicated that the claimant had a 1+ positive near impingement sign. All of the radiographic studies which were recommended by both Dr. Hurlbut and Dr. Tomlinson, were never performed because the claimant appears to have not bothered to return for these recommended studies. I would note that, in her numerous physical examinations, there is no record of the observation of crepitations, catching, clicking, swelling, atrophy, or other "objective findings" normally associated with injuries or conditions involving the shoulder joints.

The medical evidence presented further shows a lack of objective findings to support the actual existence of an injury or condition involving the musculature of the claimant's upper back, particularly in the intrascapular area. The diagnosis of a soft tissue injury to this portion of the claimant's anatomy is based solely upon the claimant's repeated complaints of pain in this area, "tenderness", on palpitation or pressing of the muscles in

this area and “tightness” of some of the muscles in the right intrascapular (this latter finding was only observed on one occasion by the physical therapist). All of these findings involve matters which are clearly within the claimant’s voluntary control and would not meet the definition of an “objective finding” contained in Ark. Code Ann. §11-9-102(16)(A).

The medical evidence does show the presence of an “objective finding”, in regard to a defect involving the vertebral bodies of the claimant’s thoracic spine. This finding was observed on a thoracic MRI study, performed at the request of Dr. Green on November 13, 2001. Dr. Michael Penney, the radiologist conducting this study makes the following statement:

“IMPRESSION: A 1CM focus of increased T1 and T2 signal within the posterior lateral aspect of the T9 vertebral body that represents a benign process, either focal fatty deposition or hemangioma.

A mark was placed on the patient’s (*sic*) at the sight of her most severe pain that was at the level of T8-9 and intervertebral disc space. It has been reported patient’s (*sic*) can have pain related to hemangiomas of the spine. It is uncertain whether this finding could be the cause of the patient’s pain.

1CM hemangioma involving the T12 vertebral body.”

No other abnormalities were observed during this testing.

Since this MRI study was performed the claimant has been seen and evaluated by a neurosurgeon, three orthopedic surgeons, a physiatrist, a chiropractor, and a general practitioner. None of these physicians have attributed the claimant’s intrascapular/shoulder complaints to this objectively documented defect. Clearly, at least some of these physicians have greater expertise in the area of medicine as associated with the diagnosis of injuries and conditions involving the musculature and bones of the spine, than that possessed by Dr. Penney, the radiologist. Thus, these objective defects would represent only incidental findings unrelated to the claimant’s intrascapular/shoulder complaints.

In summary, I find the claimant has failed to establish, by medical evidence, the actual existence of any physical injury or condition involving her intrascapular/shoulder area that is supported by “objective findings.” The only objectively supported abnormality involving this area are the hemangiomas of two of the claimant’s vertebrae. The greater weight of the medical evidence fails to “establish” this defect as the source of any of the claimant’s intrascapular/shoulder difficulties. Thus, the claimant has failed to meet the statutory requirements of A.C.A. §11-9-102 (4) (D). Failure to meet these requirements prevents the finding of a “compensable injury” to her intrascapular/shoulder area. Her claim for any benefits attributable to such injuries must be denied and dismissed.

Even had the claimant satisfied the provisions of A.C.A. §11-9-102 (4) (D), she has failed to prove the existence of a causal relationship between her intrascapular/shoulder difficulties and her employment activities with this respondent. If the claimant’s intrascapular/shoulder complaints are the result of the objectively documented fatty deposit or hemangiomas (tumors), clearly these are conditions that would not be causally related to physical activities, employment related or otherwise.

In regard to the other diagnosed etiologies, the only direct evidence presented by the claimant to prove the existence of this required causal relationship is her own testimony. In the present case, the claimant’s testimony, concerning the onset and progression of her difficulties with her intrascapular/shoulder area, is contrary to other more credible evidence presented.

The claimant testified that she began experiencing difficulties in her intrascapular/shoulder area in May 2001. She stated that all of these difficulties began at that time and have remained unchanged thereafter.

However, the initial report of Dr. Green notes that when the claimant was seen on May 10, 2001, her complaints only involved an area located between her spine and her

right scapula. He also recorded a history that these complaints had been present for eight months, but had worsened recently.

Curiously, when the claimant was seen by her family physician (Healthcare North), on June 1, 2001, no complaints were recorded involving the claimant's upper back or intrascapular/shoulder area. The claimant continued to be seen at Healthcare North for various complaints involving her lower back, lower abdomen, and respiratory difficulties, but no mention was ever made of any difficulties involving the claimant's upper back or intrascapular/shoulder area.

The records of Dr. Green further indicate that during the claimant's course of treatment, she began to voice complaints of pain involving her lower back and neck. However, her intrascapular/shoulder complaints continued to limit the area initially identified or the area between her thoracic spine and right scapula.

The physical therapist reports, in September 2001, also shows that the claimant's intrascapular/shoulder complaints remained localized in the right scapular area. These physical therapy reports further note a history of onset of these difficulties "two years ago" and to describe an incident similar to the incident in 1998.

This localized nature of the claimant's intrascapular/shoulder complaints is also supported by the radiologist report, concerning the thoracic MRI performed on November 13, 2001. At that time, Dr. Penney, the radiologist, notes that the claimant indicated that her "most severe pain" was in the T8-9 area of her thoracic spine.

On November 15, 2001, Dr. Green attempted to refer the claimant to Dr. Luke Knox, a neurosurgeon, for a second opinion in regard to all of her various complaints, including her upper back or intrascapular/shoulder area. However, this evaluation does not appear to have ever taken place. Instead, the claimant elected, on her own, to seek an evaluation by Dr. James Blankenship, another neurosurgeon.

At the time of his initial evaluation Dr. Blankenship noted that the claimant's reported upper back complaints now included pain radiating from her neck to both her shoulders, pain beneath both shoulder blades, and pain underneath the scapula on the left hand side. He records a history that these complaints had their inception in a work related injury in 1998.

Dr. Blankenship referred the claimant to Dr. Marty Hurlbut, an orthopedic surgeon. In his initial evaluation (on March 12, 2002), Dr. Hurlbut noted complaints of marked sharp pain in the midline thoracic, upper and lower thoracic areas with sharp pain in the lateral areas of both scapula, the bilateral thoracic areas of her back and by the anterior portion of both shoulders. He further recorded a history that all of these complaints began the previous year and that the location of these difficulties has not changed. The claimant failed to return to Dr. Hurlbut for follow up.

On April 2, 2002, the claimant, on her own, consulted Dr. Cyril Rabin, another orthopedic surgeon. Dr. Rabin noted complaints of arm pain. He recorded a history that these complaints began "some eleven months ago." Curiously, there is no mention in Dr. Rabin's initial evaluation of any difficulties involving the claimant's upper back or intrascapular area. Dr. Rabin referred the claimant to Dr. Robert Tomlinson (another orthopedic surgeon) for her arm difficulties, but continued to treat the claimant, himself, for her lower back complaints.

When the claimant was evaluated by Dr. Tomlinson (on April 8, 2002), he noted that she was complaining of bilateral shoulder and neck pain. He also recorded a history that this was of an eleven month duration, but states that her bilateral shoulder and neck pain was "of insidious onset." However, he relates that these difficulties were most noticed by the claimant at work. The claimant scheduled for a follow up appointment, but again for reasons which are not entirely clear, whenever returned to Dr. Tomlinson.

Although the claimant has sought and received extensive evaluations, tests, and treatment for her low back complaints from a number of physicians (last being her family physician), there is no indication that the claimant received or even sought any further medical treatment for her alleged severe complaints involving her intrascapular/shoulder area after her visit with Dr. Tomlinson on April 8, 2002. Clearly, her failure to seek such medical services or even mention any continuing complaints, to her other subsequent treating physicians is clearly inconsistent with her testimony concerning the persistence and magnitude of her intrascapular/shoulder complaints.

The final alleged employment related injury concerns the claimant's complaints involving her low back or lumbar spine and radicular complaints involving her lower extremities. The medical evidence presented clearly shows the existence of objectively documented defects involving the claimant's lumbar spine. However, there is an obvious dispute between the medical experts in regard to which, if any, of these defects may be the cause of the claimant's severe subjective complaints and the existence of a causal relationship between any of these objectively documented defects and the claimant's employment.

First, contrary to the claimant's testimony, the medical evidence shows a progression of both the claimant's subjective symptoms and her objective findings after May 30, 2001. During this time, she was either on light duty for the respondent or was not working for the respondent at all.

Beginning with June 1, 2001, the records of Healthcare North (the claimant's family physician), show complaints only involving the lower area of the claimant's back. There is no note of any radicular complaints or any complaints involving the claimant's lower extremities.

Dr. Green's records show that the claimant's initial lower back complaints involved only the right side of her lower back. No mention was made of any radicular complaints

or any complaints involving the claimant's lower extremities. Throughout his course of treatment of the claimant, the clinical evaluations by Dr. Green do not reveal any radicular difficulty. Straight leg raising tests were continuously noted as negative, the claimant's reflexes remained normal, heel and toe walking continued to be normal, and the claimant's gait continued to be normal. In fact, the only mention of any symptoms involving her lower extremities is found in the September 12, 2001 physical therapy report, in which the physical therapist reports that the claimant is complaining of numbness in both her legs. This same physical therapy report also notes that the claimant's other symptoms are primarily in her upper back.

The evidence shows that x-rays of the claimant's lumbar spine were interpreted as normal. A bone scan, which was performed at that time to detect any increased blood flow that would be indicative of inflammation or healing of a recent musculoskeletal injury, was also interpreted as normal. An MRI was also performed at the request of Dr. Green on November 13, 2001. This test was interpreted by the radiologist (Dr. Penney) as showing the following:

"The alignment of the lumbar spine is normal. The marrow signal is normal and vertebral body height are maintained. The intervertebral discs are normal and there is no disc bulges or protrusions. The neural foramina are widely patent. The conus medullaris is of normal position and appearance.

IMPRESSION: Normal lumbar spine MRI. (emphasis mine)

Based upon his clinical examinations and the various test results, Dr. Green's diagnosis of the etiology of the claimant's lower back difficulties remained that of a muscular strain. He also opined that the claimant's voiced symptoms, complaints, and limitations appear to far outweigh her clinical findings and test results. This latter opinion is clearly supported by the observation recorded in Dr. Green's reports, concerning his personal observations, the results of the test performed at that time.

When the claimant was initially seen by Dr. Blankenship (on February 13, 2002), her voiced lower back complaints were in the form of back pain and bilateral hip pain (after walking 10 to 15 minutes). No mention is made of any complaints with her legs. Another lumbar MRI had been ordered by Dr. Blankenship. This test was performed on January 28, 2002. This test was also reviewed by Dr. Penney and revealed a change from the prior study performed on November 13, 2001. Dr. Penney interpreted the most recent test as showing:

“At L4-5 there is a very small broad based disc bulge that minimally flattens the ventral aspect of the fecal sac with no evidence of spinal canal stenosis or nerve root impingement. There is mild loss of the intervertebral disc height. T-2 signal at this level.

At L5-S1, there is a very small right central disc protrusion that mildly impinges upon the ventral side of the fecal sac with no evidence of spinal canal stenosis nor nerve root impingement. There is moderate loss of the intervertebral disc height and a T-2 signal at this level.

The alignment of the lumbar spine is normal with no fractures or subluxations. The marrow signal is normal and the vertebral body heights are maintained. The conus medullaris is of normal position and appearance.” (emphasis mine)

On his physical examination, Dr. Blankenship found no evidence of any radicular symptoms involving the claimant’s lower extremities. Her sensory and motor examinations were normal for strength and tone. Her lower extremity reflexes were also apparently normal (it is obvious that his reference to “borderline reflexes” or “slightly hyper-reactive” reflexes are in regard to the claimant’s upper extremities, as these findings caused him to order another cervical MRI). In his review of this second MRI study, Dr. Blankenship opined that this study now showed “some straightening of the normal lordosis of the lumbar spine.” Based upon his clinical evaluation and his review of the lumbar MRI, Dr. Blankenship gave the following opinion in regard to the claimant’s lower back difficulties:

“She does have a small disc bulge at the lumbosacral eccentric off to the right and some bilateral disc bulging at L4-5, all of which are clinically asymptomatic. I do believe at

present the lower pain that she is experiencing with ambulation is more musculoskeletal in nature and the MRI findings that are noted on her report are all incidental and fairly normal for a woman her age.” (emphasis mine)

Essentially, Dr. Blankenship concurred with the diagnosis of Dr. Green, even in the presence of the new findings on the second MRI, that the claimant’s lower back problem was in the form of a lumbar strain.

In his report of March 12, 2002, Dr. Hurlbut did not record that the claimant voiced any complaints with her lower extremities, and that her voiced complaints involved only her low back. On physical examination, he observed no findings indicative of the presence of any nerve or radicular difficulties into her lower extremities. Based upon his review of the test results and his physical examination, Dr. Hurlbut diagnosed the claimant’s lower back difficulty as “degenerative disc disease, lumbar spine.”

In the initial office note of Dr. Rabin (dated April 2, 2002), he recorded complaints involving not only the claimant’s lower back, but also some leg pain. On his physical examination, he indicated that various tests for the existence of a radiculopathy or neurological impingement remained normal. However, he does note that the claimant is now showing a “marked “reduction in the range of motion of her lumbar spine (a significant change from her previous physical examinations). He also indicated that he has reviewed the claimant’s MRI study of January 28, 2002.

He apparently concurred with the radiologist interpretation that the defect observed at L4-5 was minimal and further concurred with Dr. Blankenship that this defect is probably an incidental finding and is not the cause of the claimant’s lower back or lower extremity complaints. However, he classified the protrusion at the L5-S1 level to be “mild” rather than very small or minimal. He also disagreed with Dr. Blankenship and opined that this defect was the actual cause of the claimant’s current lower back or lower extremity difficulties. At this point, he ordered a disc space injection at L5-S1.

At the next visit (on April 16, 2002), Dr. Rabin changed his opinion of the cause of the claimant's low back and leg complaints. During his clinical examination, on that date, he apparently observed that the claimant had a discrepancy in the lengths of her legs. In his office note of that date, he stated:

"I think what we are dealing with here perhaps is not related to this tear of the annulus. Perhaps it is related to a sacroiliac abnormality."

Based upon this change in his diagnosis, Dr. Rabin prescribed medication and referred the claimant for evaluation and treatment of her "sacroiliac abnormality" by Dr. Steven Whitelaw, a chiropractor. After a month of adjustments by Dr. Whitelaw, Dr. Rabin concluded that the claimant's pain and difficulties were not coming from her sacroiliac joint and returned to his previous diagnosis that these complaints were attributable to a discal injury. He not only prescribed a CT/Discogram of the L4-5 and L5-S1 intervertebral disc, but in anticipation of the positive results of such a test, referred the claimant to Dr. Harold Chackales, in Little Rock, for a possible IDET procedure.

This discogram was performed on June 14, 2002. A follow up CT scan was performed on July 11, 2002. The discogram was interpreted as showing normal for the L4-5 intervertebral disc, but "fissuring of the posterior aspect of the disc at L5-S1 with contrast extending into the epidural space and into the right neural foramina that would be consistent with a disc rupture." The subsequent CT scan was interpreted as showing only degeneration of the L4-5 disc with no annular disruption and degeneration of the L5-S1 disc with a "small" annular "disruption" in the midline with contrast extending into the right epidural space.

Based upon these tests and the claimant's subjective pain complaints, Dr. Rabin prescribed either an IDET or an artificial disc replacement. Both of these treatment modalities would seem rather extensive and evasive treatment for merely complaints of pain with absolutely no evidence of neurological involvement or structural instability. At

this point, Dr. Rabin also referred the claimant to Dr. William Perschal (a physiatrist) for temporary pain management.

It appears that the claimant was also seen, upon referral from Dr. Rabin by Dr. Carl Covey (an anesthesiologist and now practicing in innovative spine care). In his report of October 4, 2002, Dr. Covey noted that upon physical examination the claimant's lower extremity reflexes were intact and symmetrical, that she has a positive straight leg raising test that was "more on the left than on the right," and that she has a sciatic notch tenderness only on the left. Although he found it somewhat curious that the discogram and CT showed the annular tear to be on the right on the claimant's symptoms on the left, he concurred that an IDET would be appropriate. He also recommended a disc space injection (which had previously been recommended by Dr. Rabin). Although Dr. Covey indicates that this disc injection would be "palliative," these injections are also commonly used for diagnostic purposes to give an insight into whether further, more invasive procedures, such as those recommended would likely be beneficial. The only evidence concerning the outcome of these injections is found in the reports of Dr. Richard Guyer, who relates that the claimant stated that she received no significant benefit from the injections she received.

On April 1, 2003, another lumbar MRI was performed, at the request of Dr. Rabin. This test is interpreted as showing:

- “1. Moderate degenerative disc disease at L5-S1 with desiccation and loss of vertical height (a significant change from the interpretation of the prior MRI studies).
2. Straightening of the normal lumbar lordosis..
3. Mild diffused disc bulging identified from L1 to S1 (another significant change from the previous MRI studies).
4. No demonstration of transligamentous HNP (herniated nucleus pulposis or ruptured disc), extruded disc fragment central canal stenosis or lateral recess stenosis.

5. Mild degenerative facet arthropathy (a new finding and a change from the prior studies).
6. There is asymmetry in the CSF (cerebral spinal fluid) surrounding the exiting nerve roots at L5-S1 with a preponderance of this on the left hand side another new finding and a change from the prior MRI studies and the discogram and follow up CT scan). There is no demonstration of nerve root compression or abnormal soft tissue mass and this is probably on the basis of asymmetric dural ectasia alone.
7. The conus medullaris is not enlarged and there is no pathological marrow signal intensity arising from the vertebral bodies.”

Following this MRI, Dr. Rabin changed his opinion in regard to the IDET procedure and opined that the only appropriate medical treatment for the claimant would either be an anterior interbody fusion of the L5 and S1 vertebrae or the surgical implantation of an artificial disc. While it appears that he would be willing to do the anterior interbody fusion, he felt that (due to the claimant's young age), the surgical implantation of the artificial disc at the Texas Back Institute would be more appropriate. Again, these would appear to be rather extensive and invasive procedures in the absence of any neurological compromise or structural instability and any objective findings to substantiate the magnitude of the claimant's pain complaints (i.e. most of the medical records note that the claimant does not appear to be in any acute distress). Further, a question would also be raised about the L5-S1 disc being the source of the claimant's complaints in light of the fact that injections of local anesthetics directly into this area by Dr. Covey provided little or no relief.

On April 25, 2003, the claimant was seen by Dr. Richard Guyer of the Texas Back Institute in Plano, Texas. Dr. Guyer's reports relate that he reviewed the claimant's most recent MRI study, performed and reviewed plain x-rays, and personally examined the claimant. He concurred that the MRI showed moderate degenerative disc disease at L5-S1 with loss of vertical height, diffused bulging, no evidence of any herniations, mild degenerative facet arthropathy, and a cerebral spinal fluid abnormality about the existing

nerve root at L5-S1, but with no nerve root compression. He interpreted the x-rays performed at his facility as showing narrowing at L5-S1, but with no segmental instability of the lumbar vertebrae. His physical examination of the claimant revealed only paraspinal tenderness at L4-5 and L5-S1, some pain in the back on flexion and extension, only low back pain on left straight leg raising, and equivocal results on right leg straight raising. His neurological assessment of the claimant revealed only normal findings on heel and toe raising, reflex testing, normal results on strength, sensation, and motor testing, and normal pulses in the lower extremity. He also noted that the claimant had not and was not experiencing any difficulties with controlling her bowels or bladder. Curiously, as previously noted, his report contains the only indication that the claimant may have received the intradiscal injection recommended by Dr. Rabin and Dr. Covey, and got only slight relief of her pain.

Although Dr. Guyer can find no evidence of neurological involvement or structural instability of her lumbar spine and in light of the lack of success of the injections, he still indicated that the surgical implantation of an artificial disc at the L5-S1 level would be appropriate to treat the claimant's complaints of chronic severe low back pain. He also indicated that he will be happy to perform this apparently experimental procedure as soon as appropriate financing can be arranged.

In a final report, dated March 29, 2004, Dr. Rabin again restated his diagnosis of a "disc derangement" at the L5-S1 level, as the cause of the claimant's lower back and, presumably, her lower extremity difficulties. Curiously, he further states that the abnormality he noted in the MRI of January 28, 2002, (a hyper intensity at L5-S1 region) not only supported this diagnosis, but was also evidence of an "acute" or recent injury in this location. He also recognized in this and some of his previous reports, that the defect involving the claimant's L5-S1 intervertebral disc space had progressed. However, he

offered no explanation as to why the initial MRI, on November 13, 2001, did not reveal this hyper intensity at L5-S1 or, in fact, any defect at this level.

Although the claimant testified that her lower back and lower extremity difficulties all began at the same time and have remained unchanged thereafter, both her testimony and the medical evidence, record a number of various and conflicting dates in regard to the onset of these complaints. As previously noted, the claimant initially testified that her lower back and lower extremity complaints first appeared in May 2001. She subsequently testified that she experienced some degree of complaints in her lower back beginning in December 2000. She also conceded that she had previously experienced difficulties in her lower back following the alleged employment related injury in 1998.

The medical evidence also contains a number of conflicting onset dates. The initial records of Dr. Green indicate that the symptoms began “eight months ago,” which would have been in September 2000. The records of Healthcare North contain histories that symptoms began three months prior to the visit on June 1, 2001 or four weeks prior to the visit on June 21, 2001. The physical therapy reports contain a history that the claimant’s difficulties began two years prior to her visit on September 12, 2001. The records of Dr. Blankenship record a history that the claimant’s difficulties began with an injury “at work in 1998.” In his report of March 12, 2002, Dr. Hurlbut noted that, in regard to the claimant’s difficulties, “the date of onset is unknown,” but “further notes that it started while she was working last year.” Dr. Rabin noted that the claimant’s symptoms began 11 months prior to his evaluation on April 2, 2002. Dr. Rabin subsequently noted a history that her difficulties began in 1998 and again in May 2001 (Claimant’s Exhibit No. 1, page 34). Dr. Tomlinson recorded a history of an 11 month period of difficulties, preceding his initial evaluation on April 8, 2002. Dr. Perschal noted that the claimant had been having difficulties, in the form of low back pain, for approximately the past 18 months, prior to his visit on November 18, 2002. Dr. Guyer related that the claimant gave a history that the

onset of her complaints occurred on May 30, 2001, when she was lifting heavy wheels. Dr. Whitelaw stated that the claimant gave a history of slight to moderate lumbar spine pain which began three months prior to her visit on April 18, 2002. The various form records of Washington Regional Medical Center (where the claimant was apparently seen by her family physician), noted various histories concerning the claimant's back difficulties. For the most part, these records show a history of onset two years prior to October 2003. However, some of these records do note a history of a work related back injury in May 2001. These records also clearly show periodic subsequent exacerbations or increases in the claimant's symptoms, without any precipitating event or activity.

After consideration of all the evidence presented, it is simply my finding that the claimant has failed to prove by the greater weight of the credible evidence that her low back and leg difficulties represent a compensable injury, within the meaning of A.C.A. §11-9-102 (4) (A) (ii). When the claimant first complained of difficulties with her lower back or lumbar spine, she was obviously performing employment activities which placed considerable stress on this portion of her body. However, the various tests and clinical evaluations, which were performed at that time, failed to objectively show the actual existence of any physical injury or defect involving the claimant's lumbar spine. As a result, the diagnosis of a lumbar strain was based solely on the claimant's subjective complaints. Objective evidence of any physical defect involving the claimant's lumbar spine was not noted until long after she was placed on limited or restricted duty and approximately two months after she had entirely ceased all employment with this respondent. According to Dr. Rabin, this test also revealed this physical damage or defect was acute or recent. Subsequent objective tests showed a further deterioration or increase in the magnitude of this physical damage or defect, long after the claimant had ceased all her employment activities with this respondent. However, this would not be unexpected, in light of the fact the greater weight of the credible medical evidence indicates that the

objectively documented lumbar damage or defect is degenerative in nature and can thus occur and progress with little or no stress or trauma and can be simply a part of the aging process. While I recognize that Dr. Rabin has given his standard opinion that the claimant's employment was the "major cause" of all the claimant's difficulties and defects, I find that the other more credible evidence indicates otherwise.

The claimant has failed to prove, by the greater weight of the credible evidence, the occurrence of a physical injury to her lower back or lumbar spine that satisfies all of the requirements for a "compensable injury" that are imposed by the Act. Her failure to do so requires that her claim for benefits attributable to such an injury must be denied and dismissed in its entirety.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On all relevant dates, the relationship of employee-self-insured employer TPA existed between the parties.
3. On all relevant dates, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$330.00 for total disability and \$248.00 for permanent partial disability.
4. The initial and only claim for benefits, in regard to all of the alleged compensable injuries, was filed on January 28, 2002.
5. Any claim for benefits attributable to an employment related injury in May 1998 (misstated by the claimant as July 1, 1998) is barred by the statute of limitation provided by A.C.A. §11-9-702 (a) (1). Specifically, the evidence shows that the claimant failed to file either an initial claim for benefits or a claim for additional benefits for such an injury within two years of the

date of its occurrence or one year from the last payment of benefits.

6. The claimant has failed to prove, by the greater weight of the credible evidence, that she sustained a “compensable injury,” as that term is defined by A.C.A. §11-9-102 (4) (A) (i) to either her intrascapular/shoulder area, shoulders, cervical spine, or lumbar spine. Specifically, she has failed to prove the occurrence of any physical injury to these portions of her body that were caused by a “specific incident.”
7. The claimant has also failed to prove the occurrence of a “compensable injury”, as that term is defined by A.C.A. §11-9-102 (4) (A) (ii) to her cervical spine or her intrascapular/shoulder area. Specifically, she has failed to prove the actual existence of any physical injuries to her cervical spine or her shoulder joints that are supported by “objective findings,” as required by A.C.A. §11-9-102 (4) (D). She has further failed to prove the occurrence of any physical injuries to her cervical spine, shoulder joints, or her intrascapular area that arose out of or occurred in the course of her employment with this respondent.
8. The claimant has also failed to prove, by the greater weight of the credible evidence, that she sustained a physical injury to her low back or lumbar spine, as that term is defined by A.C.A. §11-9-102 (4) (A) (ii). Specifically, she has failed to prove, by the greater weight of the credible evidence, the occurrence of a physical injury to this portion of her anatomy that arose out

of or occurred in the course of her employment with this respondent.

9. The respondent has denied the occurrence of any compensable injuries to the claimant's intrascapular/shoulder area, cervical spine, or lumbar spine and has controverted the claimant's entitlement to any and all benefits.

ORDER

Based upon my foregoing findings and conclusions, I have no alternative but to deny and dismiss these claims in their entirety.

IT IS SO ORDERED.

MICHAEL L. ELLIG
ADMINISTRATIVE LAW JUDGE