BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F005538

PAMELA HICKENBOTTOM	CLAIMANT
FAMILY DOLLAR STORES, INC.	RESPONDENT
TRAVELERS INSURANCE CARRIER	RESPONDENT

OPINION FILED APRIL 8, 2004

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by MARK FREEMAN, Attorney, Fayetteville, Arkansas.

Respondents represented by PHILLIP CUFFMAN, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on February 17, 2004, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on October 23, 2003. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

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

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.

2. The relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her neck and head.

4. All medical expenses paid for neck and head.

5. Respondents accepted 6% to the body as a whole.

6. Compensation rates are $103.00 for temporary total disability and permanent partial disability.

By agreement of the parties the issues to litigate are limited to the following:

1. Medical benefits according to Ark. Code Ann. §11-9-113.

2. Temporary total disability according to Ark. Code Ann. §11-9-113.

3. Attorney’s fees.

In regard to the foregoing issues the claimant contends that she is entitled to benefits under Ark. Code Ann. §11-9-113.

In regard to the foregoing issues the respondents contend that they have paid all benefits to which this claimant is entitled and specifically, she is not entitled to benefits under Ark. Code Ann. §11-9-113.

The documentary evidence submitted in this matter consists of the Commission’s pre-hearing order marked Commission’s Exhibit No. 1. The claimant submitted medical records marked Claimant’s Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

It was stipulated and the claimant testified that while she was working for the respondent a case of 409 cleanser fell and hit her on the head and neck knocking her to her knees and dazing her. This injury has been accepted as compensable and all medical expenses have been paid for the claimant’s neck and head as well as the

respondents have accepted a 6 percent whole body impairment and paid it to the claimant. The claimant was asked where she still has pain in relation to her compensable injury and the claimant stated, "I have it in my arms, both arms, my neck, my head. I have headaches, confusion. I just have a lot of problems." The claimant testified that she suffered a concussion as a result of her being hit with the box. The claimant testified that she has had an MRI but has never had a CAT scan of her head even though Dr. Chambers, a psychiatrist, had recommended it. The claimant testified that Dr. Chambers put her through some testing. The claimant testified that she has problems understanding, relating to what is being said as far as comprehending and just trying to remember things. The claimant stated that doing tasks that are simple for other people are major for her and she has problems with house work as well as shopping. The claimant testified that she takes someone to help her with shopping and that all this makes her very depressed.

The claimant testified that she takes Oxycontin, Oxycodone, Previcet, Vistaril, Lorazepam and Tylenol. The claimant testified that these medications were prescribed by a variety of doctor's, some for pain and some are from her psychiatrist. The claimant testified that these medications help some with her pain, her anxiety and her inability to sleep. The claimant testified that before her compensable injury she did not take all of these medications with the exception of an occasional Tylenol. The claimant described her condition as getting worse stating, "I try to overcome it, you know, to put it behind me, but it's there. It's

been dragging on. It seemed like it's always there. It's just there."

The claimant testified that she went to Dr. Burks on her own for pain management. The claimant stated, "I have a lot of pain it's chronic."

The claimant testified that she talks to her mother by phone each day and sees her several times a week. The claimant testified that her mother lives just a couple of miles from her.

The claimant testified that she and her husband have been seen at the Ozark Guidance Center for family counseling. The claimant was asked if during this family counseling if she was suffering the way she is currently and the claimant responded no. The claimant indicated that she had tried to go back to work but was not allowed to return to work and she has applied for social security and is awaiting notification as to that situation. The claimant testified that her hobbies and extra curricular activities are changed since her accident in that she no longer is able to camp, fish, hike and lift weights as she once did.

On cross examination, the claimant testified that the first physician she saw after her accident was Dr. Patterson. The claimant testified at the time of her injury she pretty much lost consciousness but came to on her own. The claimant testified that she drove her self to the doctor and when there she was given muscle relaxers and pain pills but no diagnostic testing was done except for maybe an x-ray. The claimant testified that she went to Dr. Burt Park on her own and that he had her go through an MRI. The

claimant testified that Dr. Park, a neurosurgeon, has not recommended surgery for her but has indicated that there could be surgery in the near future. The claimant testified that she does not have a herniated disc. The claimant testified that before her compensable injury she had no psychological problems and she feels as thought the blow that she took when the case of 409 fell on her has caused her psychological problems. The claimant does not recall reporting to the psychologist that in April 1999 she had a cardiac arrest followed by several days on life supports stating that she died and that before this cardiac arrest she was very organized, and now she has difficulty organizing her thoughts and behavior and she has experienced depression and sleep disturbances. The claimant agreed that this cardiac event happened to her in April 1999. The claimant testified that she was first seen by Dr. Patterson who referred her to Dr. Vowell who in turn sent her to Dr. Park. The claimant testified that Dr. Vowell told her that there really was not anything wrong with her neck and released her to return to work. The claimant testified that she had not tried to work in the past four years or since her injury. The claimant testified that it is hard to find any work that she can do but she has not applied for any jobs because she has got a lot of pain.

The claimant’s husband, Emanuel Gale Hickenbottom, testified that they had been married six years in April. Mr. Hickenbottom stated that the claimant, when she was working for the respondent, was always motivated to go to work and to do her job. This witness testified that in the past they have had marital problems for which

they sought counseling at the Ozark Guidance Center. Mr. Hickenbottom testified that since her injury she has had a lot of confusion, skipping from one task to another. Mr. Hickenbottom testified that his wife does complain about pain and has problems lifting things like a gallon of milk. Mr. Hickenbottom agreed that his wife seems depressed and she cries sometimes which is pretty regular since her May 2000 injury. Mr. Hickenbottom testified that between her pain problems and her emotional problems it is a toss up as to which one is worse and they seem to be getting more severe.

The claimant's mother, Zeola Yeager, testified on behalf of her daughter. Ms. Yeager testified that she sees the claimant on a regular basis and talks to her by phone almost every day. Ms. Yeager testified that her daughter is a completely different person since May 2000 in that she is much more child like and does not understand what you are trying to say to her. Ms. Yeager stated that the claimant was a very intelligent person had done well in school and was very industrious before her injury. Ms. Yeager testified that the claimant does not remember what she has been told and you must be very careful when telling her something because she gets it all jumbled up. This witness testified that the claimant was always a good house keeper and now she forgets to clean or that something needs to be cleaned. Ms. Yeager testified that she was aware that the claimant and her husband had been seen at the Ozark Guidance Center for counseling but that counseling was not for the claimant's memory problems. Ms. Yeager testified that her daughter

also has physical problems and that she has had to help her with her shopping.

The claimant was seen by Dr. Vowell on May 11, 2002, where it is reported that she was struck in the upper thoracic area by a case of 409 cleanser on May 8, 2000, while working for the respondent. The doctor's notes indicate that the claimant was seen at the ER by Dr. Patterson and that cervical spine x-rays and thoracic spine x-rays were taken and no fractures were noted at which time she was treated with medications. Dr. Vowell did not note any bruising, swelling or muscle spasms upon physical examination, although the claimant did complain of various pain. Dr. Vowell diagnosed the claimant with a cervical strain, placed her in a soft cervical collar and prescribed medications. On May 22, 2000, Dr. Vowell writes that the claimant continues to complain of headaches and pain in her upper neck as well as tingling in her fingers and into her thumb. Upon physical examination, the claimant had various complaints of pain but the doctor notes that there are no muscle spasms and no motor weakness or sensory defect. The doctor released the claimant to return to work at a sit down job with no lifting, bending, twisting or looking up or down with her neck. The claimant was seen by Dr. Burt Park on June 2, 2000. Dr. Park writes that the claimant reports that she was injured when a box fell off a shelf hitting her on the back of the neck and shoulders and she subsequently had pain radiating up into the neck and down both arms with numbness on the right. Dr. Park writes that physical examination is unrevealing from the standpoint of ongoing

radiculopathy and that the claimant’s cervical spine range of motion is limited due to para spinous spasm. Dr. Park writes that he cannot detect any specific muscle group weakness nor dermatomal hypalgesia. Dr. Park recommended physical therapy, medication and an MRI was scheduled. The claimant underwent an MRI on June 7, 2000, and the results of this MRI indicate that there is minimal changes of degenerative disc disease present at C5-6 and C6-7 and that there is no evidence of disc herniation or significant neural encroachment. On July 10 Dr. Vowell released the claimant to return to work on July 11, 2000, to a sit down job only with no lifting, bending, twisting, looking up or looking down. Dr. Park writes on August 14, 2000, that he has seen the claimant after her four-week trial of physical therapy and the claimant reports that she is worse at the present time in terms of her headaches. Dr. Park writes that he believes that her discomfort is related to soft tissue injury which takes a significant amount of time to heal. Dr. Vowell writes on December 5, 2000, that he has reviewed the claimant’s EMGs which suggest that she has some C5-C6 radiculopathy on the right noting that she is taking Soma and Amitriptyline and that she has been released to a sit down job. Physical examination was unrevealing except for complaints of pain. Dr. Vowell writes that he thinks that the claimant has reached MMI noting that he does not think that she has a surgical condition and he has nothing else to offer her. Dr. Vowell writes that he thinks that the claimant should have a permanent job restriction of no overhead work or jobs that require moving her neck up and down. Dr. Vowell diagnosed the claimant with

having chronic cervical strain with neuralgia and mild neuropathy and assessed her with a 4 percent loss of function to her cervical spine and 2 percent from her loss of motor function from her C6-C7 bilateral radiculopathy giving her a 6 percent whole body impairment as based on the A.M.A. Guides, Fifth Edition.

The claimant was seen by Troy Gray at the Ozark Guidance Center on October 9, 2001, where she reports that she is "really depressed." The information from the claimant sets forth that she has feeling of hopelessness and worthlessness with suicidal thoughts but has resolved not to carry these thoughts out. It is also noted that she has feelings of desperation for some relief noting that she has memory problems, sleeping problems and a noticeable increase in weight gain. The claimant further reports that she forgets things and has comprehension problems although it is noted that she could name the months of the year forward and backward correctly and had other good recall of recent events. The claimant reports that her memory problems started after her heart stopped in April 1999. The claimant reports also that her memory problems trigger panic attacks and she has so many thoughts going through her head she cannot think. It is noted that the claimant has been in a depressed mood for the past year with loss of interest in usual activities, fatigue, ideas of worthlessness and no ambition. The claimant reports that she has headaches from cervical disc damage resulting from an accident at the respondent's business in May 2000 when an object fell on her head also causing nerve damage in both arms and since then she has been unable to work. The claimant was diagnosed

with major depression, dementia due to general medical condition, mood disorder due to medical condition, occupational problems, economic problems and problems with access to health care. The claimant, in her history set forth that her current husband suffers from paranoia which is better now since he is on medications. The claimant reported that this is her third husband and that her second husband cheated on her and was mentally abusive to her. In the interview the claimant reported that a boyfriend was physically abusive and she had a head injury resulting in a hematoma. The claimant also reported that when she was two or three months old she was accidentally dropped on her head and that she and her husband are both living off of his disability.

The claimant was seen by Dr. Jim Moore on December 27, 2002, for an IME. Dr. Moore notes that the claimant gave him a history of being injured while working for the respondent when a box struck her in the lower cervical upper thoracic area and she immediately felt needles and tingling in this region. It is noted that she reports ongoing problems of headaches, muscles jumping, numbness of the left hand, severe numbness of the thumb, that she is easy to develop cricks and spasms of pain in her neck. The doctor gave the claimant a physical examination and reviewed her various tests as well as Dr. Vowell’s rating letter dated December 5, 2000. Dr. Moore assessed the claimant with having a soft tissue problem noting that, in his opinion, he does not see any structural damage nor any nerve involvement. Dr. Moore recommended that the claimant undergo a repeat EMG/nerve conduction velocity study as her current report

apparently did suggest some changes on the right in the C5/6 level. The doctor notes that unless this new study would demonstrate some changes, he did not think anything further would be appropriate in her evaluation and the rating as outlined by Dr. Vowell should stand. Dr. Moore diagnosed the claimant with having post traumatic muscle sprain and strain, subjective radiculopathy without evidence of any compromise of the bone or nerve structures. Dr. Moore writes again on January 17, 2002, that he has reviewed the claimant's new EMG studies which reflect that it was a normal study without evidence of carpal tunnel syndrome or cervical nerve root irritation. It is noted that there were no changes in the C5 nerve distribution, no evidence of involvement at the C7 and the other musculature. Dr. Moore notes that this was a normal study and support his opinions as set forth in his earlier letter of December 27, 2001. Dr. Moore made no further recommendations for this claimant.

The claimant was seen at the Ozark Guidance Center by Dr. Donald Clay on February 21, 2002. At this time the claimant reports that she died in 1999 explaining that her heart stopped in the waiting room of her doctor's office and since that time she had not been the same. The claimant described having cognitive deficits, particularly with short term memory, recall, reading and comprehension and none of these things were present prior to this heart episode. The claimant reported symptoms of depression including decreased sleep, increased irritability, feelings of uselessness and hopelessness and described symptoms of panic

disorder. The doctor notes that the claimant's thought train is logical, coherent and goal directed with no evidence of formal thought disorder, that her judgement is fair to good and her insight is fair to good. Dr. Clay writes that cognitively the claimant is alert and oriented. The claimant underwent another MRI of her cervical spine which again showed degenerative disc disease at the C5-6 and C6-7 noting that there is shallow posterior osteophyte formation at both of these levels but no evidence of significant neural encroachment or herniated disc.

The claimant underwent a psychological assessment on June 17, 2002, by Dr. Robert Huwieler. The claimant again reports that she had a cardiac arrest in April 1999 followed by several days on life supports describing it as having died but has no memory of the actual occurrences. The claimant described that her memory was generally spotty but prior to her cardiac arrest she was well organized but now she has difficulty organizing her thoughts and behavior. The claimant reports that at times she gets lost and that she often cannot recall what she has been doing. Since this event, the claimant explains that she had experienced depression and sleep disturbance. The claimant also reported a head injury at eight months of age when she was dropped on concrete on her head resulting in a scull fracture and she also had an accident in which a box fell on her head striking her neck in May 2000. The claimant was administered a battery of psychological tests as well as screened for psychiatric issues using the clinical systems rating scale. The doctor writes following the claimant's testing that her test reflect

a broad range of intellectual and cognitive impairments typical of a person with histories of brain injury. The doctor notes that because she has had three injuries it is impossible to tell at this time what the precise affect of each injury was. It is noted that the overall pattern of deficiencies suggest defused brain injury with impact across a broad range of brain behavior functions and she will have difficulty adapting to new experiences and situations and she will have difficulty with maintaining occupational functioning. The claimant was seen and tested by Dr. Gene Chambers on November 7, 11 and 13, 2002. Prior to these tests, the claimant underwent an intake procedure on October 30, 2002, where she reports that she sustained an injury while working and that following this injury she developed memory problems and headaches stating that she began to have episodes of being totally confused. The claimant reports that it seems to be getting worse and I get real confused, I start something and instead of finishing four to five things begin to happen in my brain and I get distracted. The claimant also reported that in May 2000 she was struck at the base of the skull while she was bending over and this knocked her to her knees and she had a needle affect in her neck. The claimant reports that when she straightened up she felt weird and received medical treatment that night at the ER. The claimant testified that she has developed bad headaches, that she is plagued with chronic pain and that she began to develop memory changes approximately three to five months after this accident. The claimant reports that Dr. Vowell has been prescribing medications for her and that Dr. Park informed her that

she has bulging discs at C3, 5, 6, and 7 and she has been given so many physical restrictions by her doctor that she has had to go on workers' compensation because there is little that she can do. After evaluating the various tests, Dr. Chambers diagnosed the claimant with post concussion disorder with post concussion depression and headaches and Dr. Chambers writes that the overall outcome of her test results do suggest that she sustained a closed head injury that has resulted in a lowering of neural psychological functioning. The doctor notes that there is also evidence of clinical depression following her head injury and in all probability she did sustain a concussion. Dr. Chambers recommended counseling to assist her in making a better adjustment to her current pain and loss of cognitive functioning and in his opinion she would benefit from possible biofeedback to assist her with managing her headaches and that she could benefit from participating in the traumatic injury group.

The medical records set forth that the claimant began being seen and treated by Dr. David Cannon for pain management on July 16, 2002, up and through November 6, 2003, for her compensable injury.

After a complete review of this record, I find that the claimant has failed to prove by a preponderance of the evidence that she is entitled to medical benefits as well as temporary total disability benefits according to Ark. Code Ann. §11-9-113. It has been testified to and stipulated by the parties that the claimant sustained a compensable injury in May 2000 while working for the respondent to her upper thoracic neck area. The claimant was

treated for her complaints of pain as a result of her injury throughout the years 2000 and 2001 and it was not until a year and a half after her compensable injury that she began to express complaints of depression, hopelessness and worthlessness for which she sought treatment at Ozark Guidance Center on October 9, 2001. During this particular interview with Dr. Gray the claimant also reported a closed head injury as a result of physical abuse and a head injury when she was an infant. In February 2002, the claimant was seen by Donald Clay at the Ozark Guidance Center where she reported at length a cardiac event in 1999 which left her with cognitive difficulties particularly with short memory recall, reading and comprehension. The claimant also reported to Dr. Clay that since this cardiac event she has had depression, sleep depravation, increased irritability and feelings of uselessness, hopelessness and symptoms of panic disorder. It is noted in the extensive report from Dr. Chambers that the claimant did not reveal to him her cardiac event, her head injury or her head injury as a result of an abusive boyfriend nor had she mentioned that she and her current husband had sought counseling at Ozark Guidance Center a short time before her May 2000 upper back injury. It is not questioned that this claimant may have some psychological problems which need to be clinically addressed but in my opinion the May 2000 compensable injury which has been consistently diagnosed as a neck strain is not the initiating factor in this claimant's need for psychological treatment. Therefore, this claimant's claim for

benefits under Ark. Code Ann. §11-9-113 should be denied in its entirety.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.

2. The relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her neck and head.

4. All medical expenses paid for neck and head.

5. Respondents accepted 6% to the body as a whole.

6. Compensation rates are $103.00 for temporary total disability and permanent partial disability.

7. The claimant has failed to prove by a preponderance of the evidence that she is entitled to Ark. Code Ann. §11-9-113 benefits. See discussion above.

ORDER

The claimant has failed to prove by a preponderance of the evidence that she is entitled to medical or temporary total disability under Ark. Code Ann. §11-9-113. Therefore, this claim for benefits should be denied in its entirety.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE