

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F300383

KENNETH PAGE	CLAIMANT
J B HUNT TRANSPORT, INC.	RESPONDENT
AIG CLAIM SERVICES, INC. INSURANCE CARRIER	RESPONDENT

OPINION FILED MAY 11, 2004

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

Claimant represented by NEAL HART, Attorney, Little Rock, Arkansas.

Respondents represented by JOSEPH PURVIS, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on February 24, 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 November 19, 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. On October 18, 2002, the relationship of employee-employer-carrier existed between the parties.

3. The claimant is entitled to the maximum compensation rate for 2002.

4. The claimant was in Lexington on October 18, 2002, and was in Illinois on the morning of October 22, 2002.

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

1. Compensability of the claimant's injury to his neck and left shoulder.

2. Related medical.

3. Temporary total disability from date of last payment to a date to be determined.

4. Attorney's fees.

In regard to the foregoing issues the claimant contends that he is entitled to payment of additional medical expenses, plus payment of additional TTD benefits from the date last paid through a date to be determined. Claimant is entitled to payment of a statutory attorney's fee on all controverted benefits. All other potential issues are expressly reserved for litigation at a later date.

In regard to the foregoing issues the respondents contend that the claimant was employed by the respondent on or about October 18, 2002. At that time, the claimant had an average weekly wage of which would entitle him to receive the maximum disability in the event he had a compensable incident. That on or about October 27, 2002, the claimant reported that some nine days before on or about October 18, 2002, he believed he had injured his left shoulder and arm as well as his neck while jerking open a door on his trailer. He stated that eh felt a muscle pull at that time. Upon reporting

this incident to the respondents, they accepted the claim as compensable to the left shoulder. That several days before, on October 24, 2002, while on leave at home, the claimant reported to Dr. Krall at the Rural Health Center in Illinois for a visit. He was complaining to the doctor at that time of left arm pain. He noted that he had fallen the previous day, injuring his left arm. The doctor noted that the claimant had fallen the day before, presumably October 23, while going up some stairs and caught himself on a railing. He reported that he felt a severe stabbing pain in his arm. Dr. Krall prescribed a massage therapist for some two weeks, as well as some anti-inflammatory drugs. That some four days later on or about October 28, 2002, the claimant returned to the Rural Health Center, continuing to complain of left shoulder pain. He noted that he had no relief since his injury. X-rays of the left shoulder and scapula at that time were normal. The claimant returned to work and during the months of November and December made several visits to the Rural Health Center for inhalers for apparent sinus problems. On or about December 26, 2002, he again returned to the Rural Health Center, complaining of left arm and shoulder pain and also pain into the neck. He was complaining then of a pulling sensation on the left side of the face, and the doctor noted that the pain was at the C6-7 level, as well as pain in the left upper extremity. The doctor also noted the claimant had had previous problems in the deltoid and shoulder area of the left arm. The doctor further noted a history of lumbar spinal fracture in 1970, and that the claimant was complaining that

he had hurt himself while opening the door of a trailer. The doctor likewise noted the claimant smoked one pack per day. That claimant returned to the Rural Health Center on December 28, 2002, at which time it was noted that he was going to physical therapy but needed something for pain. The doctors there referred him to an orthopedist, a Dr. Karolyn Seneca, at the Ortho Center of Illinois in Springfield, Illinois. He initially saw Dr. Seneca on January 17, 2003. At that time, the claimant informed Dr. Seneca that his problems began in October 2002 when he was opening the jammed door of a trailer and jerked his left shoulder. She noted the claimant's history and noted that the shoulder was very tight and stiff. She went on to note a marked decreased motion to the left shoulder, that there was a marked positive impingement sign. She found that the claimant had adhesive capsulitis with a possible rotator cuff tear. On January 25, 2003, the claimant underwent an MRI of the left shoulder which showed mild tendonopathy. The rotator cuff tendons were otherwise negative. There was no rotator cuff tendon tear, no joint effusion or bursa seen. That on January 30, 2003, the claimant returned to Dr. Seneca. She found at that time that he still had significant limitation of the shoulder, and her impression was adhesive capsulitis with evidence of any rotator cuff tear. She noted that the claimant refused a corticosteroid injection. She further noted he was making no progress with physical therapy and determined that the only thing left was closed manipulation of the left shoulder, which she performed on February 14, 2003, along with an injection of the glenohumeral joint. That

Dr. Seneca saw the claimant again on February 20, 2003, at which time she noted that she believed he was doing better. ON March 11, 2003, she saw him and thought that he had an improvement but still had pain. On April 15, 2003, she noted that the claimant still had pain with his left shoulder, especially with exercises and was also complaining of pain in the left forearm and wrist, as well as pain in the left side of then neck and into the ear as well. She noted that it was really not a radicular type pain. X-rays of the claimant taken at that time revealed some disc space narrowing at C5-6 with osteophytes. At that point Dr. Seneca injected the claimant's left shoulder with Celestone and Lidocaine. She also diagnosed the claimant as having cervical degenerative disc disease with narrowing at C5-6 which could be contributing to some of the left arm and shoulder pain. That on April 21, 2003, the claimant underwent an MRI of the cervical spine. This showed a very mild disc bulge at C3-4 with no evidence of any canal or foraminal stenosis. Claimant was unremarkable at C4-5. At C5-6 there was prominent degenerative spurring with some posterior bony osteophytes and moderate bilateral foraminal compromise, more on the left than the right. There was no canal stenosis at that level, however. The claimant was continued on light duty. On April 25, 2003, the claimant returned to Dr. Seneca. Her impression was that while the motion of the left shoulder was quite good, he still had severe shoulder pain. She further opined that he had degenerative disc disease at C5-6 and that a portion of his shoulder and arm pain could be from this neck area. She suggested

that the claimant see a neurosurgeon and noted that she was not sure that any surgery on the shoulder was the answer in light of the negative shoulder MRI. That on June 2, 2003, the claimant saw a Springfield, Illinois, neurosurgeon, Dr. Terrence Pencek, on referral from Dr. Seneca. Dr. Pencek reviewed the claimant, noting his symptoms and likewise noted that the claimant had been smoking two packs of cigarettes a day for some 35 years. Dr. Pencek noted the claimant was not married and lived alone. The doctor noted the claimant's problem was difficulty in sleeping and shortness of breath, left arm numbness and weakness, and he diagnosed the claimant as being a 50 year old with a C5-6 osteophyte disc complex with bilateral foraminal stenosis. He noted that the claimant had some clinical signs of C6 radiculopathy and concluded with a plan that the claimant should have a C5-6 anterior cervical discectomy and fusion. That the respondents accepted the claim involving claimant's shoulder as compensable up to approximately August 11, 2003, at which time they discovered claimant's original medical report made on October 24, 2002, wherein he gave a different history of injury to Katherine Krall at the Menard Medical Center in Petersburg, Illinois. While respondents had accepted and paid all disability payments as well as all outstanding medical up until that time, upon realizing that there had been an unreported incident as the cause of the claimant's problems, the respondents ceased all payments and benefits. That nurse practitioner Katherine Krall in her deposition of January 19, 2004, opined that an incident such as the claimant reported to her of October 24,

2002, namely slipping and catching himself on a rail and resulting in stabbing pain to the arm, could be the cause of the physical problems which he complained. Moreover, Ms. Krall indicated that there was nothing other than that incident which she knew was the cause of his problems. That Dr. Terrence Pencek opined that the cause of the claimant's problems were the preexisting degenerative conditions in his neck. Dr. Pencek also opined that an incident such as the one described by the claimant on October 24, 2002, to Katherine Krall could very well be the cause of his recent surgeon problems and could be the source of his pain. Dr. Pencek testified that the claimant had never told him about such an incident of on or about October 23, 2002.

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 documentation marked Claimant's Exhibit No. 1. The respondents submitted medical information marked Respondents' Exhibit No. 1, the deposition of Dr. Terrence Pencek marked Respondents' Exhibit No. 2 and the deposition of Katherine Krall marked Respondents' Exhibit No. 3. The parties jointly submitted a third amended pre-hearing questionnaire marked Joint Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

There was a preliminary hearing conducted in order to establish jurisdiction. The claimant testified that although he had been in contact with an attorney in Illinois, he was convinced

that jurisdiction was in Arkansas and that he fully understood that if we tried the case on the issues set forth in the pre-hearing order that he would not be allowed to retry these same issues in an Illinois' jurisdiction. The claimant agreed that the case belongs in Arkansas and that he wished to try his case in Arkansas on this date. On cross examination, the claimant testified that he had no wish or desire to pursue his workers' compensation claim under Illinois law. The claimant further agreed that he had no desire nor did he anticipate filing any sort of action in the state of Illinois for this claim.

The claimant testified that he was fifty years old and had been working since he was eight. The claimant testified that several years ago he underwent a lumbar fusion and was in a body cast for approximately ten months. The claimant testified that his physician, Dr. Bacon, did an incredible job and once he was released he began doing concrete work. The claimant agreed that other than the injury he sustained while working for the respondent he has never had any problems with his neck, his shoulders, arms or hands.

The claimant testified that he worked for the respondent in the year 2000 and worked approximately eight or nine months before he got completely burned out. The claimant testified that he then returned to work for the respondent in May 2002 as an over the road truck driver. The claimant testified that his supervisor or fleet manager was Forrest. The claimant explained that he was suppose to call in each day to the fleet manager and that the fleet manager

was to field problems and take care of whatever the drivers' needs. The claimant stated that the fleet manager was the support staff that was furnished to the drivers. The claimant testified that he had never met Forrest nor had he seen where Forrest worked but he understood that he worked in Lowell, Arkansas.

The claimant testified that on October 18, 2002, he was making a delivery and in the process of unloading his cargo the right door of his trailer was hooked and tore off all but one of the hinges. The claimant testified that for safety reasons he did not want to handle the broken door but some of the people working at his delivery point took a hinge off of the left door and put it on the right door. At that point, the claimant testified that he had been instructed by the respondent to go to a repair shop in order to repair the damaged door. The claimant testified that when he got to the repair shop he was given instructions where to pull his truck into a repair bay. The claimant testified that he returned to his truck and went to the back to open the doors. The claimant testified that due to the position of the truck in the driveway the back of the trailer was higher than usual and when he got up on the bumper to open the doors the handles did not break loose and he fell backwards off of the bumper onto the ground. The claimant testified that he felt he had been jarred stating that he fell flat not hitting his head but that he did feel immediate pain go through the left side of his body. The claimant testified that there was a pain that shot right underneath his collar bone and it went down through his arm, face and the left side. The claimant stated that,

"Like it went numb or like, you know, how you get a shot at the dentist or something." The claimant further indicated that he knew something had happened he just did not know for sure what. The claimant testified that he got up, dusted himself off, walked back to the truck, got in and just sat there. The claimant testified that he did not work with the doors any more but he did get the hinges repaired after he had moved his truck into the repair bin. The claimant testified that after the paperwork was filled out he drove to a truck stop to rest, take a shower and change his cloths. The claimant testified that he stayed the night at the truck stop and the next morning he was hurting and had an earache in his left ear. The claimant testified that the left side of his head and other parts of his body on the left side were hurting. The claimant stated that he thought he had broken his collar bone noting that a ball had developed in his left tricep part of his arm. The claimant testified that it was painful to move around and he did not drive that day but did sleep a lot.

The claimant testified that he first reported his injury to Forrest, his fleet manager, and told him that he had hurt his arm after he dropped his trailer in Channahon, Illinois. The claimant testified that he made this report by telephone after he had dropped his trailer and parked his tractor. The claimant testified that after he parked his truck he was going up the stairs behind his tractor to undo his brake lines on the top and he was trying to climb the stairs without using his left arm because it was hurting. The claimant testified that he caught his toe on the rail and had

to reach out and grab the rail to keep from falling on the cat walk. The claimant testified that once he grabbed the rail with his left hand "everything just lit up." The claimant testified that he called Forrest, his dispatcher, and reported that he though he needed to go to the doctor when he got home because he had hurt his arm. The claimant testified that he did not tell him anything about the accident on October 18 and did not in fact tell him about any accident. The claimant testified that Forrest told him that he would have to get back to him as to who to call. The claimant testified that Forrest never did get back with him as to what doctor to go see so he ended up going to the doctor on his own. The claimant testified that he called Forrest and told him that he had been to the doctor who had taken x-rays and that nothing was torn so he assumed he had pulled some muscles but that he wanted to stay home a little longer than he normally would. The claimant was asked if Forrest had talked to him about filling out an accident report and the claimant replied, "No. I didn't want to fill out an accident report or nothing like that. I didn't ask him to fill out any of that stuff." Again the claimant testified that he wanted to find out for sure what was wrong before he made any accident report. The claimant testified that he was home approximately eleven days and was trying to give his arm time to repair so that he could get back to work. The claimant testified that his symptoms did not change during the period of time he was at home.

The claimant testified that the first time he was seen for medical treatment was on October 24, 2002. The claimant testified

that he thought that the person who was examining him was a doctor. The claimant testified that when he gave a history of what had happened to him, he reported that in Channahon he was climbing up the stairs and when he grabbed the rail the left side of his body lit up and that he thought that he had ripped a tendon or tore a muscle. The claimant testified that he also shared with the nurse about the trailer door incident. The claimant stated that he asked the nurse if he could see the x-rays before he filled a workers' comp claim. The claimant indicated that these medical records are incorrect because they set forth that he had been messaging his arm for more than two weeks when in fact it should have been for two days. The claimant agreed that he was complaining of pain in his left shoulder, left deltoid and shooting pain to his finger tips but he also made complaints of an earache. The claimant agreed that he also reported that he was taking over the counter medications such as aspirin, anti-inflammatories and ibuprofen for his symptoms. The claimant testified that the x-ray which was taken indicated that he had no torn ligaments and that the nurse practitioner gave him Celebrex for inflammation. The claimant testified that the Celebrex did not change his symptoms in any way.

The claimant testified that he began driving for the respondent again on November 11, 2002. The claimant stated that he was still sore but he felt that since there was nothing ripped he could work through his sore muscles. The claimant testified that he still had the pain in his arm and his ear aches would come and go. The claimant stated that over time his arm started losing

movement and he tried to work this out by doing stretching exercises. The claimant testified that eventually he could not raise his arm to even hold the steering wheel properly so he, for safety reasons, stopped driving sometime in December. The claimant agreed that he was seen at the Menard Medical Clinic on December 26, 2002. The claimant testified that Dr. Newton diagnosed his frozen shoulder, set up physical therapy sessions and eventually referred him to Dr. Seneca.

The claimant testified that he reported to Forrest that his shoulder was frozen and he was referred to different personnel in the company to answer questions concerning his injury. The claimant testified that the respondent accepted his claim as compensable and began paying medical bills and benefits. The claimant testified that besides medication and therapy, Dr. Seneca also performed a non surgical procedure called arm manipulation to break his shoulder loose. The claimant testified that on the same day that this manipulation was done he was taken immediately to begin physical therapy. The claimant testified that in the weeks following this manipulation, he had movement in his shoulder but the pain was still there and he was still having the same symptoms in the left side of his face, neck, shoulder and down into his arm. The claimant testified that he underwent additional x-rays and even an MRI. The claimant testified that after his MRI he was referred to Dr. Pencek and that he reported about his accident to Dr. Seneca and Dr. Pencek. The claimant testified that Dr. Pencek has

recommended surgery which was scheduled but canceled just a few hours before it was to begin.

The claimant agreed that the respondents paid both medical and temporary total disability benefits through about August 13, 2003. The claimant testified, however, that the medical bills from his initial visits were not paid and are still outstanding. The claimant testified that he is still taking pain medications as prescribed by his physicians but he is not under active treatment other than medications. The claimant testified that he still has pain going down through his side and through his arm and he still has earaches and that the left side of his face feels affected like it is paralyzed. The claimant testified that currently he is not working and that the last time he did work it was for the respondent.

On cross examination, the claimant agreed that after his fall on October 18 he had a pain level between six and eight on a scale to ten. The claimant further agreed that he did not report this injury until after he had returned to the truck terminal in Channahon, Illinois on October 22, 2002. The claimant testified that he reported his injury to Forrest and that Forrest would be lying if he said that the claimant first reported his injury on October 24. The claimant stated that when he talked to Forrest about his injury he told him that he though he had hurt his arm. The claimant testified that he did not report to Forrest that he injured his arm on the job just that he had injured his arm. The claimant agreed that the respondent's drivers' manual and training

sets forth that injuries are to be reported to the fleet manager. The claimant testified that when he was first seen by the doctor on October 24 he reported the incident in Channahon. The claimant testified that he did not report to Mrs. Krall about the event in Lexington when he was trying to open the truck doors and fell because he did not want to report a workers' comp injury at that time. The claimant read from the exhibit marked Respondents' 9A dated October 24, 2002, indicating that he was complaining of left arm pain and he fell yesterday. The claimant agreed that he was not working for the respondent on October 23. The claimant testified that he described to Ms. Krall that he fell going up stairs and caught himself on the railing and felt severe stabbing pain and that this event happened on October 22. The claimant agreed that in his deposition he did not mention anything about a fall at Channahon or hurting himself at Channahon. The claimant testified that he did not have an accident at Channahon but he did grab onto a railing which caused pain in his arm and his accident happened in Lexington, Kentucky. The claimant agreed that he was at home in Havana, Illinois on October 23 and it was not until today's testimony that there has been any mention of an alleged slip at Channahon. The claimant agreed that there is no mention or notification to the respondent of any incident occurring on October 18 involving an accident while opening trailer doors until December 26, 2002. The claimant also agreed that he had delayed telling the respondents about a hernia event which had occurred several months prior to December but did not make them aware of it until after

Christmas in December 2002. The claimant testified that on October 22 while at Channahon he stumped his toe and caught himself but there was no accident. The claimant stated, "I didn't end up falling down and getting hurt or nothing, other than the pain that went through the left side of my body."

The claimant called Forrest Cassell as a witness. Mr. Cassell stated that he had been with the respondent since July 2002 and began with them as a fleet manager. This witness testified that he keeps in contact with his drivers via an OBC, on board computer. Mr. Cassell testified that the preferred protocol when a driver has a work related injury, is that they would report this injury to him directly and he then will pass it on to the workers' compensation department or the safety department. Mr. Cassell stated that sometimes a driver will report directly to the workers' comp department and bypass him. Mr. Cassell testified that when the claimant called him on October 24 he was off work and asked for a couple of extra days off because his shoulder was bothering him. This witness testified that he asked the claimant if he hurt his shoulder on the job and the claimant told him that he did not. Mr. Cassell testified that the claimant did not tell him where he hurt his shoulder. This witness was asked when the claimant had been working and he responded that he believed that the claimant worked up until October 20 or 21. Mr. Cassell testified that the claimant did not report to him on October 22, 2002, that he had injured himself on October 18, 2002, while attempting to open his trailer doors. Mr. Cassell testified that the claimant reported to him

that he had hurt his shoulder but he did not report that he had a work problem. This witness testified that the claimant never told him that he was hurt on October 18, 2002, pulling on doors and that he has no idea how the claim got to AIG. Mr. Cassell testified that he does remember that in late December the claimant called in and filed a workers' comp claim.

On cross examination, Mr. Cassell testified that it was not uncommon for his many drivers to have physical complaints and problems. Mr. Cassell testified that he does not file a workers' compensation claim every time someone makes a complaint and he agreed that it is the drivers responsibility to speak up if he has an on the job injury. Mr. Cassell stated that the respondent puts their drivers through a week long orientation program and that each driver is given a handbook. This orientation as well as the handbook covers workers' compensation claims and how to report such a claim. Mr. Cassell stated that he was aware that the claimant was due for some time off and after he had been in Lexington, Kentucky they began looking for a load to bring him closer to Channahon. This witness testified that they got the claimant a load to Indiana and that he deadheaded into Channahon for his time off. This witness again testified that the claimant did not call him from Channahon and report that he had hurt his arm. Mr. Cassell stated that it was not until October 24 while the claimant was off work that he called in and reported that his shoulder was hurting. Mr. Cassell testified that he asked the claimant if he hurt his shoulder on the job and the claimant said no. Mr. Cassell

testified that from the time the claimant took off work in October until he returned to work on November 8, 2002, he had contacted the claimant several times to see how he was doing and to see when he was going to be able to return to work. This witness testified that he did not hear anything more from the claimant about his shoulder problems. This witness further agreed that it was not until after Christmas of 2002 that he heard about the claimant reporting a workers' compensation claim.

On redirect examination, Mr. Cassell testified that after he learned that the claimant had filed for workers' compensation benefits in December 2002, he let the respondent's workers' compensation department handle the case. This witness was asked why he did not report to the respondent that the claimant had not reported to him a workers' compensation injury and Mr. Cassell testified that no one asked him.

Christy Russell was called to testify on behalf of the respondents. Ms. Russell testified that she was employed with American International Group Claim Services (AIG). Ms. Russell testified that her company handles the claim service for the respondent's workers' compensation claims. Ms. Russell testified that she was not the initial adjuster assigned to the claimant's workers' compensation claim. Ms. Russell testified that the claimant filed his workers' compensation claim on December 28, 2002, and that after some investigation, benefits were paid on this claim. Ms. Russell agreed that in August 2003 the respondent made a decision that this claim was not a compensable action. Ms.

Russell stated that this position was taken based on two pieces of information. The first piece of information, Ms. Russell noted, was the medical report dated October 24, 2002, which indicated that there was a fall and that this report gave all indication that the injury was not work related. Ms. Russell stated that the other piece of information was that the claimant's neck problems were degenerative in nature and the doctor could not say within a reasonable degree of medical certainty that the claimant's problems with his neck for which surgery was recommended were in any way tied to the original alleged injury. Ms. Russell clarified her statement by indicating that it was Dr. Pencek who had made this statement. Ms. Russell testified that she had read Dr. Pencek's notes concerning the claimant and that in his note of June 11, 2003, the doctor had written that the claimant's symptoms are related to his accident.

On redirect examination, Ms. Russell testified that she had read a summary of Dr. Pencek's deposition and was aware that the doctor had testified in his deposition that the condition which he sought to correct by surgery was a result of degenerative pre-existing problems as opposed to any injury that had occurred on or about October 18, 2002. Ms. Russell also agreed that she was aware that the doctor, in his deposition, stated that he could not testify to any reasonable degree of medical certainty that what he would be operating on the claimant for was caused by any event that occurred on October 18, 2002.

Catherine Krall testified by deposition that she was a nurse practitioner. Ms. Krall testified that the first time she saw the claimant was on October 24 for complaints to his left arm which he attributed to a fall the day before. Nurse Krall testified that according to her notes, the claimant had been getting message therapy for his arm for a period of two weeks prior to her seeing him. Ms. Krall agreed that there is nothing in her notes to indicate that the claimant's left arm pain came from any incident involving a trailer or any event that would have occurred on October 18, 2002. Nurse Krall testified that she next saw the claimant on October 28 where he reported that his pain medications were not working, that he had an indention on top of his shoulder with pain and an x-ray was made. Ms. Krall testified that she also prescribed stronger pain medication for the claimant. Nurse Krall testified that after reviewing the claimant's x-ray she diagnosed him with left shoulder sprain. Ms. Krall testified that on October 30 the claimant was contacted and told that his x-ray was normal and asked if he wanted to go to physical therapy. Ms. Krall testified that it was the clinic's policy to always encourage a patient to call or to come back in if there are other problems or if new problems develop. Ms. Krall testified that on November 6 the claimant contacted Dr. Newton's nurse and requested a refill on his pain medication. This witness testified that the next contact the claimant had with the clinic was a telephone call from the claimant on November 23 where he requested inhalers but there was no mention of continued problems with his arm or shoulder. The

nurse testified that the claimant contacted their clinic two other times, once on December 2 and again on December 24 for refills on his inhalers and there was no mention of his shoulder or arm problems. Ms. Krall examined deposition Exhibit No. 6 which was dated December 26, 2002, and testified that the claimant was seen by another nurse practitioner, Kathy Segal, for his complaints of left arm pain. Ms. Krall tried to decipher the hand written note on the December 26 date making out a portion of the note to read, right shoulder injured while opening up both doors of truck.

On cross examination by the claimant's attorney, Ms. Krall testified that on the office notes taken on October 24, 2002, the writing at the top of the first page was not her hand writing but she opined it was the notes of a student practitioner helping her that day. Ms. Krall testified that she certainly would have been present when this information was given and the note written but she had no independent knowledge other than what was written on the note of the event. Ms. Krall testified that she had translated the information set forth by the student practitioner on Exhibit No. 1 at the request of the claimant. Ms. Krall agreed that the note of October 24 indicates that the client was opening semi-trailer doors everyday for a living. Ms. Krall testified that she had no idea whether the claimant intended this information about opening doors to be what was causing his problems. This witness also testified that the claimant did not indicate whether his problems occurred at home or at work. Ms. Krall testified, "He didn't indicate one way or the other." Ms. Krall reviewed the clinic's notes concerning

the claimant and she noted that he was an established patient with the clinic but prior to October 24, 2002, there was nothing in his records concerning neck problems. Ms. Krall testified that she would not advise a patient to work as an over the road truck driver while taking pain medications such as Vicoden. This witness explained that Vicoden would impair a patient's judgement and their driving ability. Ms. Krall agreed that it was reasonable to assume that if the claimant was working as an over the road truck driver, he would not be calling in to get refills for his pain medications. The nurse testified that the complaints which were set forth in the December 26 note sounds like the same thing he was complaining of on October 24, 2002. Nurse Krall testified that she would say that the note written down by the student practitioner on October 24, 2002, was correct because she read the note before she signed off on it that day.

Dr. Terrence Pencek testified in his deposition that he first saw the claimant on June 2, 2003. Dr. Pencek agreed that the claimant related his problems to a work related injury on October 18, 2002, where he described trying to open the door of a semi-trailer. Dr. Pencek agreed that he had reviewed the claimant's MRI and had noted that he saw a C5-6 osteophyte disc complex with bilateral foraminal stenosis. After some discussion, Dr. Pencek also agreed that generally the development of osteophytes and foraminal stenosis are part of the degenerative or aging process. The doctor testified that growing older and physical activities cause osteophytes to develop. Dr. Pencek agreed that the operation

which he has recommended to the claimant is to go in and correct the result of the degenerative process as opposed to any trauma that might have been caused by an accident on October 18, 2002. Dr. Pencek agreed that the claimant had described in length an October 18, 2002, event while he was opening the doors of a trailer but had made no mention of an October 23 event. On cross examination, Dr. Pencek agreed that the injury from which the claimant suffers is consistent with the history which he gave such as jerking on trailer doors. The doctor was asked, "In other words, the problem that he has and the problem that you think I guess he needs treatment for, can that be caused by the incident he described?" Dr. Pencek stated, "Yes, Sir." Dr. Pencek testified that even though the claimant's problems with osteophytes and foraminal stenosis are degenerative in nature, he has reported that he was asymptomatic prior to October 18, 2002, and that due to his work activities, these degenerative problems became symptomatic. Dr. Pencek agreed that some sort of traumatic event such as pulling on trailer doors can cause something that is already there to become symptomatic and then need medical care. Dr. Pencek further agreed that he thinks that that is what has happened in the claimant's case. Dr. Pencek also stated that he can state within a reasonable degree of medical certainty that this is what happened in the claimant's case. On redirect examination, Dr. Pencek agreed that what he found with the claimant is simply the result of the natural aging process as opposed to any particular incident. Dr. Pencek also agreed that he could not say to a reasonable degree of

medical certainty that the so called incident of October 18, 2002, caused the condition that he would be alleviating by surgery. Dr. Pencek indicated that if the claimant's history is correct and accurate he could state within a reasonable degree of medical certainty that the October 18, 2002, event aggravated the claimant's symptoms and caused his need for treatment.

The medical records set forth that the claimant was seen at the Rural Health Center by Katherine Krall on October 24, 2002, for complaints of left arm pain noting that he fell yesterday, caught himself with arm, opening semi-trailer doors every day for a living. Claimant fell going up stairs, caught himself on railing, felt severe stabbing pain. The history further sets forth that the claimant had message therapist messaging arm two weeks that he has complaints of pain in his left shoulder, left deltoid, shooting pain to finger tips for which he is using aspirin and anti-inflammatories and Ibuprofen. Nurse Krall noted that the claimant had crepitus and popping with movements and diagnosed the claimant with shoulder strain and recommended medications and shoulder exercises. The claimant was again seen at the clinic on October 28, 2002, reporting that his medications are not working and he has shoulder pain with an indentation on the top on his shoulder. The x-ray results dated October 29, 2002, sets forth that the claimant's left shoulder and scapula were normal. The medical records reflect that the claimant called in several times in November and early December asking for refills on his inhalers. The claimant was seen again on December 26, 2002, at the Rural Health Center with

complaints of left arm pain as well as pain in his shoulder and neck and left side of face. It is noted that the pain is consistent and rates to be a six to seven on a scale of one to ten. This information sets forth that he was injured while opening up back doors of truck and he has been on the road for twenty-one days. The claimant was seen by Dr. Karolyn Senica on a referral from Dr. Newton for an injury to the claimant's left shoulder. The claimant reports that this incident occurred in October 2002 while he was working for the respondent as a truck driver. The history sets forth that there was a problem with one of the semi doors in October and he went to a repair shop and when he tried to open the door he had to pull on the door because it was jammed and stuck at that time he jerked his left shoulder and arm trying to open the semi door and he did feel a pulling in his shoulder at the time. This history reports that he received medical treatment in the form of medications and physical therapy as well as had x-rays. This history sets forth that gradually he has had increasing pain in his shoulder and that he has not had any previous problems with his shoulder in the past. After examination, Dr. Senica diagnosed the claimant with having adhesive capsulitis of his left shoulder and possible left rotator cuff tear for which she recommended that he continue to go to therapy to work on his range of motion, she prescribed medications and set up an MRI. Dr. Senica writes on January 23, 2003, that she has communicated with the claimant's case manager, Carolyn Waggoner, and that the claimant would have restrictions of light duty work starting January 27, 2003, to

include no use of left arm, no lifting over one to twenty pounds and no at shoulder level or above shoulder level work with left hand until released. On January 30, 2003, Dr. Senica notes that she had reviewed the claimant's MRI of his shoulder and this reveals mild tendonopathy in the supraspinatus tendon but there is no evidence of a rotator cuff tear, no joint effusion or bursa fluid was seen. It is noted that he really has a negative MRI. Dr. Senica continues to write on January 30 that she has recommended manipulation of the claimant's shoulder which he agreed to. The claimant underwent a manipulation of his left shoulder under sedation on February 14, 2003. The claimant continued with follow up treatment with Dr. Senica after his manipulation procedure through March 2003. Dr. Senica writes on April 15 that he has seen the claimant for follow up and x-rays taken that day of this claimant's cervical spine show some disc space narrowing at the C5-6 level with some osteophytes present. An MRI was ordered as well as medications. The medical records set forth that this claimant has continued to be on light duty limited to no use of his left arm and hand. Dr. Senica reviewed the claimant's MRI on April 25, 2003, and notes that the claimant has some degenerative changes at the C5-6 level with bony osteophytes and narrowing of the neural foramina, left greater than right and he also has a mild disc bulge at the 3-4 level. Dr. Senica notes that she thinks a portion of his shoulder pain and arm pain could be admitting from his neck noting that he has degenerative disc disease at the C5-6 level with foraminal narrowing. Dr. Senica notes that the claimant is unable

to do his normal job, therefore, she gave him a slip for light duty.

The medical records continue with a clinic note from Dr. Terrence L. Pencek dated June 2, 2003, where it is noted that he has seen the claimant for a work related injury October 18, 2002, driving a semi-trailer tractor. The claimant's history reports that the claimant was trying to open the doors of his tractor trailer at a repair shop using the two handles and the door did not open. It further notes that the claimant lost his grip and fell hitting the ground and he felt like he had shooting pain in his left arm. The claimant's reported history then goes through his medical treatment and symptoms. After examination and review of the claimant's MRI, Dr. Pencek notes that the claimant has C5-6 osteophyte disc complex with bilateral foraminal stenosis and that he has clinical signs of C6 radiculopathy on the left as well as he may have some myofascial strain. Dr. Pencek recommended a C5-6 anterior cervical discectomy and fusion. Dr. Pencek signed an off work slip for the claimant noting that he should not return to work until twelve weeks after his recommended surgery. Dr. Pencek writes on June 11, 2003, to the claimant's case worker, Ms. Waggoner, stating that in his opinion the claimant's clinical symptoms correlate with the reported date of his accident and they are related. The doctor notes that the claimant never had neck pain before his reported accident and he seems to be honest in his opinion. Dr. Pencek notes that he feels the claimant may have had a flexion extension injury. Dr. Jose Espinosa writes on August 7,

2003, that he has seen the claimant who reports that his symptoms started on October 18, 2002, when he tried to open the doors at a repair shop using the two door handles. It is noted that the doors did not open, he lost his grip and fell head into the ground. The history notes that since then the claimant has felt pain shooting down his left upper extremity then sets forth a brief capsulation of the claimant's medical treatment. After a physical examination and review of the claimant's MRI, Dr. Espinosa writes that the claimant's MRI of his cervical spine does not show significant cervical spine stenosis but some degree of foraminal stenosis. Dr. Espinosa recommended an EMG of the left upper extremity.

After consideration of this entire record, I find that the claimant has failed to prove by a preponderance of the evidence that he sustained a work related injury while working for the respondent on October 18, 2002. Although the claimant seemed, during testimony, to be very credible and a very hard worker, the many variations of the story of his injury causes great concern as to actually what happened. Just because someone does not want to file a workers' compensation claim does not mean that if an injury occurs a workers' compensation claim should not be properly reported. The claimant, by his own testimony, stated that he did not tell his fleet dispatcher, Forrest, that he had experienced a work related injury on October 18, 2002. The claimant also did not report to Nurse Krall when he was seen on October 24 that he sustained a work related injury but rather reported that he hurt himself the day before when he fell going up stairs, caught himself

on railing and felt severe stabbing pain. The claimant reported to Dr. Senica that in October 2002 he tried to open the doors to his tractor trailer and he had to pull on the door because it was jammed and at the time he jerked his left shoulder and arm trying to open the door and he felt a pulling in his shoulder at that time. It is not until the claimant was seen by Dr. Pencek in June 2003 that he reported an injury on October 18, 2002, resulting from him trying to open his trailer doors, losing his grip on the handles and falling to the ground feeling pain. Due to the variety of stories and even variety of dates of possible injury raises too many questions as to when and how this claimant injured his shoulder and neck. Therefore, I find that the claimant has failed to meet his burden of proof by a preponderance of the evidence.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On October 18, 2002, the relationship of employee-employer-carrier existed between the parties.
3. The claimant is entitled to the maximum compensation rate for 2002.
4. The claimant was in Lexington on October 18, 2002, and was in Illinois on the morning of October 22, 2002.
5. This claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury while working for the respondent on October 18, 2002.

ORDER

The claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury while working for the respondent on October 18, 2002. Therefore, this claim for benefits should be denied in its entirety.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE