

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F104249

JUDITH ROGERS	CLAIMANT
SERVICEMASTER MANAGEMENT SERVICES	RESPONDENT
ZURICH AMERICAN INS. CO. OF IL INSURANCE CARRIER	RESPONDENT

OPINION FILED JANUARY 22, 2004

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Fort Smith, Sebastian County, Arkansas.

Claimant represented by MICHAEL HAMBY, Attorney, Greenwood, Arkansas.

Respondents represented by LEE MULDROW, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on October 23, 2003, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on June 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. On April 2, 2001, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her right knee.

4. Medical expenses have been paid to date.

5. Temporary total disability has been paid to date.

6. The respondents have accepted and will pay a 9 percent rating.

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

1. Additional temporary total disability from April 29, 2003, to a date to be determined.

2. Has the claimant reached MMI?

3. Is the claimant permanently and totally disabled or entitled to wage loss over and above her 9 percent anatomical impairment rating?

4. Is the claimant's depression disorder a compensable consequence of her compensable injury?

5. Medication for depression.

6. Attorney's fees.

In regard to the foregoing issues the claimant contends that she is entitled to continuing temporary total disability benefits from August 6, 2002, through a date yet to be determined, or alternatively, the claimant is entitled to total permanent disability, or alternatively, wage loss in excess of the 9 percent anatomical rating to her lower extremity. The claimant is suffering from a major depression disorder, and contends that the same is in fact work related to the injury which is the subject matter herein. All reasonable and necessary medical treatment which has been received as a result of the same should be found compensable.

In regard to the foregoing issues the respondents contend that

the claimant has reached MMI, that they have accepted Dr. Bebout's 9 percent rating and that they are entitled to a credit for temporary total disability paid after the claimant's MMI date.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1. The respondents submitted medical reports marked Respondents' Exhibit No. 1. Reports of payment of TTD and PPD marked Respondents' Exhibit No. 2. Medical reports from Dr. Bebout marked Respondents' Exhibit No. 3, a vocational evaluation marked Respondents' Exhibit No. 4 and a report from Thomas Vocational Consulting marked Respondents' Exhibit No. 5. All these exhibits were admitted without objection.

#### DISCUSSION

The claimant testified that she currently was 36 years old, had been married to her current husband for the past ten years and has three children. Her children are ages 17, 16 and 13. The claimant testified that she was 5'9" tall and currently weighs 310 or 311 pounds. The claimant testified that at the time of her compensable injury she weighed 250 pounds.

The claimant testified that on April 2, 2001, while working for the respondent she tripped on a metal rail which was going around a conveyor belt and fell injuring her right knee. The claimant testified that she finished out her shift thinking that it was not that bad and went home over the weekend. The claimant testified that she kept her knee iced and elevated all weekend and when she went back to work, her knee was hurting her so bad that she reported

it to her supervisor who sent her to the emergency room to have it checked out. The claimant remembers that she had x-rays taken and was given medications for pain as well as a four-way brace. The claimant remembered that she was kept off work until she was seen by Dr. Craft and that, at her request, he released her to light duty with no squatting. The claimant testified that after a week she was squatting and bending, felt a pop in her knee and felt excruciating pain immediately. The claimant testified that she went to the emergency room, was taken off work and had follow up treatment with Dr. Craft.

The claimant testified that she was referred to Dr. Bebout who ultimately did two surgeries on her knee. The claimant testified that she continued treatment with Dr. Bebout until August 2002. The claimant testified that she did not return to work during this period of time. The claimant testified that she eventually was referred to Dr. Mulhollan who she saw in early November 2002. The claimant agreed that Dr. Mulhollan prescribed for her a stationary bike as well as pool therapy which the respondent eventually provided for her about August 2003. The claimant testified that Dr. Mulhollan continually got mad at her for not complying with his recommendations but the claimant testified that she did have the money to provide the stationary bike and arrange for pool therapy on her own. The claimant testified that she did not continue with treatment with Dr. Bebout but did continue being treated by Dr. Craft who she would see approximately every month.

The claimant testified that from the time she last saw Dr. Bebout in August 2002 until April 29, 2003, she continued to receive

temporary total disability from the respondents. The claimant testified that she got a progress note from Dr. Bebout which apparently was transcribed at the end of February 2003 but back dated to August 2002 which set forth her permanent impairment rating. The claimant was asked if that was the first time she became aware that Dr. Bebout had awarded her a rating and had released her and the claimant responded, "yes."

The claimant testified that in May 2003, on Mother's Day, she attempted suicide by taking an excessive amount of pain medications. The claimant testified that she was wanting her pain to go away. The claimant testified that she was taken to the emergency room, had her stomach pumped and was subsequently admitted to the hospital and then to the psychiatric ward. The claimant testified that while in Harborview she was treated by Dr. Vadmal who is a psychiatrist and Dr. Johnson who is a psychologist. The claimant testified that she started being treated by Dr. Withers who is a psychologist and conducts the group daily sessions she attends at Harborview. The claimant was asked if she has continued to be treated by Dr. Mulhollan and the claimant responded that she is still being treated by him but Dr. Craft wanted her to hold off returning to Dr. Mulhollan until she can get her depression better under control because when he, Dr. Mulhollan, would infer that she was non-compliant she could not deal with it.

The claimant testified that she has had a history of depression and had talked with Dr. Craft about it prior to April 2001. The claimant testified that she did not take medications to control her depression before April 2001. The claimant testified that after her

injury her depression got significantly worse because she was unable to do the things she was able to do before, unable to work and unable to be a "whole person." The claimant explained that because of her knee injury she cannot do many of the daily activities that she would normally do and has to ask her husband or family to help her and this makes her feel like half a person because she is such a burden on all of them. The claimant testified that her weight gain has also been a problem in that she does not like the way she appears and she cannot bend over as far. The claimant agreed that Dr. Mulhollan's attitude toward her upset her when he implied that she was non-compliant with his recommended treatment plan. The claimant testified that her weight gain affected her personal relationships with her family and children, stating that she started putting herself in her room at night and not doing things with her family. The claimant testified that she could not go to her son's football games because she could not climb into the stands and this made her feel like a terrible mother.

The claimant testified that at the request of the respondent's insurance carrier she began working toward a program of rehabilitation and this program was initially set up for her to go to classes at University of Arkansas at Fort Smith. The claimant testified that she was not able to go through the orientation program because there were too many people which made her sick. The claimant testified that her program has now been modified so that she is currently taking classes over the internet. The claimant testified that this program is going pretty good except for the time she has to go to the college to take tests. The claimant testified

that when she is on campus, she will go to the library and find a cubby hole where no one is around. The claimant testified that she has a 97 percent grade average and is taking an integrated personal computer class.

The claimant agreed that her progress notes from her group meetings indicate that she has, in the past, been subject to sexual abuse and other problems long before she was injured in April 2001. The claimant agreed that she had been able to work every day prior to her knee injury and she did not require any kind of counseling or medical treatment prior to this time but did indicate that she would visit with Dr. Craft about some of her problems.

On cross examination, the claimant agreed that Dr. Mulhollan had recommended that she lose weight. The claimant also agreed that the respondent eventually provided her with diet pills, an exercycle as well as access to a swimming pool for therapy. The claimant agreed that by August 2003 the respondent had complied with the recommendations of Dr. Mulhollan to provide the claimant with her exercycle, pool privileges as well as diet pills. The claimant agreed that in August 2003, she weighted approximately 289 pounds and that currently she has gained approximately 20 pounds. The claimant agreed that at the time of her accident she weighted approximately 250 pounds and since then she has gained 50 to 60 pounds. The claimant agreed that she has been working with Mr. Dale Thomas on her rehabilitation retraining program and that the respondents have been paying her retraining expenses. The claimant agreed that since she has an associate's degree already, her current program is more of a refresher course to brush up her computer

skills. The claimant was asked if working through this rehabilitation program and upgrading her computer skills was helping her become more optimistic about her future employability, the claimant responded, "no."

The respondents' attorney asked the claimant about her suicide attempt. The claimant was asked if she remembered that the records from the hospital following her attempted suicide reflected that she had had a long history of depression although no previous suicide attempts. It was also asked if she remembered being put on Zoloft for treatment of a nervous break down. The claimant responded, "when I found out that my son had been sexually abused. It really wasn't classified as a nervous break down. I just got depressed." The claimant agreed that this event occurred in 1994. The claimant also agreed that her mother had suffered from depression. The claimant testified that she also had some depression following her hysterectomy in 1991. The claimant agreed that prior to her suicide attempt, she was feeling sad, down, helpless, hopeless and she was having difficulty dealing with her son. The claimant was asked if she had expressed the day after her attempted suicide that she had a lot of guilt about her son's problem and he was having trouble with the law at that time. The claimant responded, "I don't remember if he was having trouble with the law at that time. He got arrested for shop lifting, but I think that was after that period." The claimant testified that she had no doubt that she told Dr. Vadmal that she was a rotten mother and not a good wife and she had failed. The claimant testified that one of the factors resulting in her attempted suicide was that her son had told her that he did not like

her and this particularly hurt her since it was on Mother's Day. The claimant testified that she remembered reporting to the doctor on June 24 that she was having difficulties sleeping especially after her son had been arrested for shop lifting, that her son was wanting to be away from her and that this was causing her a lot of stress. The claimant testified that on July 8 she was worried because her husband would not let her go to court with her son because he did not think that she could handle it.

The claimant agreed that after she was released from the hospital following her suicidal attempt, she began attending group sessions at Harborview Mercy Hospital. The claimant testified that she does not remember reporting to the group at her first group session that she was feeling guilty for attempting to end her life because she now realized that her son really did care for her. The claimant testified that she does not remember saying this because she still is suicidal. The claimant testified that she has been married twice before her current marriage and that one of these relationships was abusive which she has discussed in her group. The claimant agreed that she told the group in July 2003 that after her son was released from jail, she was concerned that he might hurt her. The claimant agreed that she shared with her group her fear and depression when she learned that her social security benefits had been denied and also that her workers' compensation carrier was claiming a credit for overpayment in the amount of \$9000.

Dr. Larry Withers was called to testify on behalf of the claimant stating that he was employed as a psychologist with Vista Health which was formerly Harborview Hospital. Dr. Withers

testified that during his employment with Harborview he came in contact with the claimant, remembering that initially she was involved in a day program where she met with a group five days a week. Dr. Withers stated that although the claimant has not improved greatly he does feel as though she is not actively planning a second suicide. The doctor testified that the claimant has been diagnosed with major depression without psychosis. Dr. Withers testified that in his opinion the claimant's on the job injury is the main reason for her current emotional state because she focuses on it all the time and how she is unable to go back to work. Dr. Withers testified that the claimant has mentioned the concerns about her family and her relationship with her son but that 80 percent of her time is spent on her inability to go back to work. Dr. Withers testified that, "there've been a number of sessions where she brought up her son and brought up other family stress, but that never did appear to be, well, the main reason she was so distraught." The doctor testified that in his opinion the claimant would not be able to work on a continual basis due to her inability to be around people. Dr. Withers testified that there were days when she is better than others due to her depression. Dr. Withers acknowledged that the claimant has had some past depression but since her injury he considers her depression to be debilitating. The doctor was asked if the source of the claimant's depression was the fact of her on the job injury and her inability to function as she once did, Dr. Withers responded, "yes."

On cross examination, Dr. Withers testified that he never obtained through his counseling information from the claimant

concerning her long history of depression and her taking Zoloft several years ago for a nervous break down. In explaining why his notes on the claimant's sessions are not more prominent with mention of her concern over her injury and job loss but focused more on her family problems and her relationship with her son, Dr. Withers indicated that if a patient's primary concern is her inability to work, he would not mention it in every note but if she mentioned something new, he would jot that down. Dr. Withers agreed that it was a fair statement to say that the claimant came to these sessions with a lot of emotional baggage such as abusive prior relationships, sexual abuse of her son, things that caused her a lot of concern and hurt. Dr. Withers stated that he did not know whether he would recommend that the claimant have a job that would take her away from the work place and he was not sure at this point if she could even work satisfactorily. Dr. Withers was then asked if he could see the circular nature of the claimant situation in that she is depressed because she is not working and she cannot work because she is depressed and Dr. Withers testified, "hu-huh." Dr. Withers then clarified that the claimant is depressed enough that it would interfere with her performance at work.

Dale Thomas testified on behalf of the respondents stating that he was a vocational consultant and had been contacted by the respondent to evaluate the claimant and her potential for vocational retraining. Mr. Thomas testified that he has interviewed the claimant as well as reviewed her medical records and considering these as well as her age, education, past work history and her stated subjective understanding of her physical and mental

abilities, he formulated his professional opinion. Mr. Thomas testified that considering all of this information, he considered the claimant to be a skilled person and that her skills were transferrable to other jobs. Mr. Thomas stated that since the claimant's training dated back to 1997 she and he agreed that her computer skills were outdated and needed to be upgraded. This witness testified that the claimant indicated that she would require sedentary work and she needed to be able to prop her knee up during the day and that she was depressed and did not want to be around people. Mr. Thomas stated that he listed in his report jobs which he feels the claimant would be capable of performing in the existing job market with her existing job skills. Mr. Thomas agreed that the insurance company had agreed to allow the claimant to upgrade her computer skills so that she could become more marketable in accounting, bookkeeping and computer work and a detailed program for the claimant was established. Mr. Thomas testified that the university worked with the claimant and found a program which she could do at home on her computer. Mr. Thomas testified that the claimant did attempt to attend the orientation session on the university's campus but she had some problems so she has gone through the orientation on line at her home. Mr. Thomas testified that the claimant's first test was taken at home but her last two tests were taken on campus and these are done at a time that is convenient for the claimant. Mr. Thomas testified that each time he has met with the claimant she seems excited about what she is doing and optimistic that this program will lead to some kind of gainful employment which she can do at home. Mr. Thomas indicated that he

thinks that it would be possible for the claimant to work in a small office such as a tax accounting office or a medical billing position and she could do these jobs with her current skills. Mr. Thomas testified that he had no doubt that with the claimant's training which she is currently obtaining that she is going to be more marketable than she would have been without this training. Mr. Thomas testified that what makes him optimistic about the claimant's ability to become gainfully employed is her motivational level in that she expresses a desire to get out of financial distress, go back to work and become more productive.

On cross examination, Mr. Thomas testified that Dr. Bebout had returned the claimant to work several times at light duty and he had looked more for sedentary jobs for the claimant than light duty jobs.

On redirect, Mr. Thomas was asked about the concern of the claimant's inability to concentrate and answering correctly to precise questions. Mr. Thomas replied that from his perspective he had reviewed her work book or her textbooks and she was dealing with complex issues as well as complex computer skills which would indicate to him that she had the ability to concentrate on a subject. Mr. Thomas also agreed that for her to be maintaining a 97 grade point average would further indicate a level of concentration for a period of time.

The medical records set forth and the parties have stipulated that the claimant sustained a compensable injury to her right knee and received extensive medical treatment for her problem. As a result of this injury the claimant was treated by Dr. Craft as well

as Dr. Bebout. Dr. Bebout operated on the claimant's knee on June 21, 2001, performing an arthroscopy with lateral release and shaving of the medial foraminal condyle. The claimant did follow up with Dr. Bebout as well as Dr. Craft noting that she continued to have persistent right knee pain. On August 15, 2001, Dr. Bebout writes that he believes that the claimant should be able to get back to her normal activity level after her healing period following her lateral release. The doctor writes that during the remainder of her healing period she should be able to do a job that requires less strenuous activity as far as avoiding squatting and knelling or climbing up and down stairs or ladders and she should also not do significant lifting but can do more sedentary type activities. The medical records set forth that the claimant continued to have problems with her right knee as well as experiencing abnormal pain. Dr. Bebout performed a second operation on the claimant's right knee on November 5, 2001, this time performing a quadriceps realignment with osteotomy of the tibial tuberosity and the advancement of the VOM, right knee. Following surgery the claimant was followed by Dr. Bebout and underwent physical therapy as well as remained on an off work status. The medical records set forth that the claimant continued to receive medical treatment from Dr. Bebout as well as Dr. Craft for her ongoing discomfort and inability to regain the strength in her injured knee. Dr. Bebout writes on April 16, 2002, that the claimant is now five months following her surgery but she still has complaints of instability symptoms and occasional buckling of her knee. Dr. Bebout writes that the claimant has good range of motion, her wound is nicely healed and there is no significant

effusion. The claimant's medications were continued and it is noted that her quadriceps remain somewhat weak and she has been placed in a new type of brace because of her instability symptoms. Dr. Bebout notes that a three-view x-ray of the claimant's knee looks unchanged and that overall the patella alignment looks to be well maintained. The doctor recommended that the claimant continue with her physical therapy and to be rechecked in six weeks. Dr. Bebout writes on June 12, 2002, that the claimant's most recent physical therapy tests show that her leg has significant quadriceps and hamstring weakness compared to her other leg. The doctor notes that not only have they had her in a physical therapy program but they have had her in a home electrical stimulation unit to try and strengthen her quadriceps and despite all of this she still has a significant problem in this extremity. Dr. Bebout writes that the claimant can do sedentary type work that does not require significant standing or walking and certainly no stair climbing, bending or stooping. On June 25, 2002, Dr. Bebout writes that they are going to discontinue the therapy since it does not seem to be affective but she is to continue with her home therapy program, pool therapy and exercise as well as the E stem exercise using a bike and the weights. Dr. Bebout writes that the claimant may continue working at a light duty status but he does not want her standing over a couple of hours, no lifting greater than ten pounds, no climbing, no squatting or keeling type activities. He recommended that she be seen in six weeks and he continued her medications. Dr. Charles Craft writes on August 7, 2002, that he has seen the claimant for her chronic knee problems noting that Dr. Bebout has released her stating to her that

her condition is basically stabilized and he is currently working on her permanent disability rating. Dr. Craft notes that the claimant has had a significant weight gain over the past fifteen months and she has some significant gastritis complaints. Dr. Craft writes again on September 6 that he has seen the claimant and again notes that she has been released by Dr. Bebout but continues to use her brace and do her home therapy. On October 7, 2002, Dr. Craft saw the claimant again for her instability and right knee pain and at that time filled out a primary physician's status report indicating that the claimant should be off work indefinitely.

The claimant was seen by Dr. James Mulhollan on November 6, 2002, and this doctor writes that the claimant weighs approximately 300 pounds and she is 5'9" tall. Dr. Mulhollan notes that the claimant has profound atrophy of the right thigh, her knee region is palpably warm and she can fully extend her knee and contract the quadriceps muscles. Dr. Mulhollan did an examination of the claimant's knee and writes that the combination of weight excess coupled with insufficient strength was the reason for her knee discomfort. The doctor writes that he does not think that she has any prospect of improving significantly until she becomes stronger or lighter. Dr. Mulhollan writes that, in his opinion, she is misusing the electrical stimulator, that she should discontinue her physical therapy with the assistance of a physical therapist, she should begin swimming on a regular basis, she needs a stationary bike and should peddle it with the involved leg and that she should diet voluntarily and keep track of her weight. The medical records set forth that the claimant continued to be seen by Dr. Craft for

her ongoing knee problems as well as a sprain of her left ankle. The claimant was seen by Dr. Mulhollan on November 26, 2002, where it is note that she has lost ten pounds. Dr. Mulhollan again recommended that the claimant swim on a frequent basis and get a stationary bike for home use. Dr. Mulhollan writes on February 7, 2003, that the claimant is the same and that her knee wants to buckle. It is noted that she is using a cane and that the insurance company has not authorized her swimming or agreed to help purchase a stationary bike. Dr. Mulhollan writes that at this point the claimant's case is going nowhere and without weight loss or an improvement in strength her symptoms will persist. The claimant continued to be seen by Dr. Craft for her chronic right knee pain as well as obesity.

There is an office note from Dr. Bebout with a typed date of February 26, 2003, which has a line drawn through it with 8-6-02 written in above. In this note, Dr. Bebout writes that the claimant has gone through extensive therapy but continues to have significant quadriceps weakness despite the therapy which caused her to have continued leg problems. Dr. Bebout writes that he would rate the claimant with a 9 percent lower extremity impairment based on the A.M.A. Guides for Evaluation of Permanent Impairments. Dr. Bebout sets forth that the claimant will be given a complete release from his office on August 6, 2002.

Dr. Craft writes on March 31, 2003, that the claimant cannot work at all due to her right knee, right hip and a stigmatism. Dr. Craft continued to see the claimant for her ongoing knee problems,

obesity as well as a variety of other physical problems which are unrelated to her compensable injury.

On May 13, 2003, the claimant was seen at the emergency room of St. Edwards Mercy Medical Center after having ingested several Davocets. The claimant reports that she has never attempted suicide before but she does have a long history of depression due to chronic pain. The claimant reported to the ER personnel that she is tired of hurting and her son hates her. The claimant was kept in intensive care on suicide precaution and psychiatric consulting was arranged. Dr. Vadmal writes on May 12, 2003, that the claimant reports that she has had depression since 1991 and was on antidepressants. The claimant further reported that she had had a lot of stress build up including her son's abuse by her exhusband and had an accident at work and was having difficulty with her workers' comp. The doctor's notes set forth that the claimant was feeling sad, down, helpless, hopeless and having difficulty dealing with her son and having lots of guilt. The claimant had reported that she was a rotten mom and not a good wife and she was not helping anyone financially. The claimant reported that her son told her on Mother's Day that he did not like her and this caused her to decide to take the pills. The doctor diagnosed the claimant with major depression disorder with suicide attempt and recommended antidepressants as well as counseling. The claimant began group therapy sessions on June 2, 2003, with Dr. Withers. The initial report indicates that the claimant presented with a dysphoric mood and appropriate affect and stated that she was unsure who she was, however, was attempting to determine this by experimenting with

food. Dr. Withers writes that the claimant felt guilty for attempting to end her life because now she realized that her son really did care for her. On follow up sessions, the claimant expressed interest and desire in bringing her father who lives in Maine to live with her but due to financial restraints, it was currently impossible. It was also expressed that the claimant did not feel that she had resolved any of the issues which brought her to the hospital. It is noted that on June 11 the claimant was very supportive of other group members and gave appropriate advice when needed but was reluctant to accept the gratitude and compliments of the group members. It was noted that the claimant indicated that it was difficult for her to be around people because of her anxiety but she felt safe in a hospital environment. The claimant continued to attend group sessions several days a week and on June 17, 2003, she discussed with her group prior relationships where she and her five-year-old son were sexually abused by the son's father. The notation indicates that the claimant was remorseful and accepted 90 percent of the responsibility for the child's abuse. Follow up sessions would indicate that this matter continued to be discussed within the group. On June 23, 2003, it is noted that the claimant discussed her concern over her seventeen-year-old son being in jail for stealing a magazine and not being clear on how she should handle the matter. On June 24 there was a progress note where the claimant was seen and accompanied by her husband reporting that she was feeling down with increased stress and financial problems and having difficulty sleeping after her son had been arrested for shop lifting. The progress notes indicate that the claimant continued to

participate and be supportive of the other participants in the group throughout her many sessions and that she remained concerned about her son's situation but indicated that she had no thoughts of self harm. On July 2 it is noted that the claimant discussed the difficulty in getting disability from social security. Throughout July the session reports set forth that the claimant had some bad days and reports concern about an upcoming family reunion as well as the status of her son who was in jail. A progress note dated July 22, 2003, indicates that the claimant's seventeen year old son was released from the juvenile detention center and she was in fear that he would harm her and she could hardly sleep. The progress notes through the end of July indicate that the claimant continued to have fear of her seventeen-year-old son and had feelings of guilt for requiring her son and a friend to find another place to stay.

Dr. Larry Withers writes on July 29, 2003, that the claimant is a patient of his and a participant in a group therapy session which meets daily. Dr. Withers writes that the claimant meets the diagnosis criteria for major depression, single episode, severe noting that one factor that significantly contributes to her depressed mood is the job related injury for which she is seeking disability compensation. Dr. Withers writes that her job injury resulted in her inability to work and contribute to the family income which has put additional financial strain on her family because she is not doing her part. It is also noted that her hospital bills have further added financial stress which contributes to her depressed mood. Dr. Withers writes that the claimant reports that she was not depressed before the injury and that her reduced

mobility and change in life style and feelings of unproductivity have resulted in her thinking that she is a burden on her family causing her to be depressed and withdraw socially. Dr. Withers concludes that he believes that the claimant's job injury is the main reason for her current emotional state.

The progress reports from the claimant's group therapy sessions throughout the month of August set forth that she had concerns about her retraining program at the University, concerns about family stress, concern over thoughts that she cannot control, stress created by her husband's exwife and son, stress regarding her sixteen-year-old son and her concern about how others perceive her. These progress notes also set forth that she was supportive in the group and participated occasionally expressing that she was down or had hit bottom. The therapy sessions for the month of September set forth that the claimant again provided good input to the group and expressed concerns over her family and relatives. During September the notes set forth that the claimant developed concerns about her husband's faithfulness, although she had no evidence that he was in fact unfaithful to her. On September 10, 2003, the session note indicates that the claimant was depressed and crying because she was turned down for social security and needed to buy a new car. Throughout the remainder of the sessions in the month of September the claimant expressed support of the group and how much it meant to her, sharing her coping techniques in order to deal with her negative thinking but then at times would express difficulty in coping and not being able to do what she used to do. The claimant

also express concern about a fall which hurt her knee as well as her problems with dealing with a collection agency.

Dr. James Mulhollan writes on September 30, 2003, that based on his last visit with the claimant she was not especially complying with his medical recommendations and her case was going nowhere. Dr. Mulhollan notes that it is safe to assume that the claimant's status is permanent and that the physical impairment assessed by Dr. Bebout is rather high. Dr. Mulhollan writes that he assumes that this rating is based on weakness which is rather marked. There is a brief note from Dr. Bebout dated October 19, 2003, which sets forth that the claimant reached maximum medical improvement in his opinion on August 6, 2002, and this would be irrespective of her ability to lose weight.

Dale Thomas filed a vocational evaluation report on the claimant on July 28, 2003. After meeting with the claimant, reviewing her medical background and acquiring other information from the claimant concerning her past as to education and work experience, Mr. Thomas opines that as a result of the claimant's work related injuries she is restricted to sedentary work and would not be involved in climbing, crouching, crawling, kneeling and bending. It also noted that as per the claimant, in order for her to tolerate her pain she would need to elevate her knee to waist level and alternate sitting and standing while working. Mr. Thomas notes that the claimant indicates that she feels capable of working at a job that primarily involves using a computer. Mr. Thomas recommended retraining to upgrade the claimant's computer skills. The follow up reported dated September 2, 2003, indicates that a

retraining program has been established for the claimant which she is participating in and he remains in contact with the claimant regarding her progress in school and will remain available to assist in helping solve problems should they arise.

After a review of this complete record, I find that the claimant has proven by a preponderance of the evidence that she remained in her healing period and entitled to temporary total disability until February 26, 2003. This February 26 date is the date appearing on the progress note from Dr. Bebout in which he sets forth the claimant's 9 percent impairment rating. Although this report has the February date lined out with a date of August 6, 2002, hand written above it and his note indicates that she was given a complete release from his office on August 6, 2002, this claimant remained under active medical treatment by Dr. Craft as well as by Dr. Mulhollan up at least through her last visit with Dr. Mulhollan on February 7, 2003, when even he indicates that the claimant's treatment program is going nowhere. It is noted that Dr. Craft has indicated that the claimant remains temporarily totally disabled and has not reached her maximum medical improvement to date, however, he is primarily addressing her complaints of pain as well as addressing a variety of problems which the claimant has unrelated to her compensable injury. It is my feeling that Dr. Bebout who was the surgeon who operated on the claimant's knee twice and Dr. Mulhollan who is another knee specialist are better equipped to assess and evaluate the claimant's knee problems rather than Dr. Craft. Therefore, I find that the claimant reached maximum medical improvement on February 26, 2003.

The claimant is contending that her depression is caused by her work related injury. I find that the medical records and even the claimant's testimony indicates that her mental problems are long standing and have even in the past required medical attention. It is not doubted that this claimant's physical injury and subsequent financial concerns have contributed to this claimant's depression but in reviewing all of the group therapy notes as well as her intake when she was admitted to the ER after her suicidal attempt, her main concerns dealt with her family problems, her feelings of guilt and her inability to relate to and help her son with his various problems. There is mention of the claimant's inability to participate in activities that she once did and there are mentions of financial problems, however, the bulk of this claimant's notes do not set forth or indicate that her job injury is the sole and only reason for her depression or even the major reason for her depression. Dr. Withers has testified that, in his opinion, her job injury and her inability to function as she once did as a result of this injury is the major cause of her depression, however, his notes do not reflect her feeling along this line and he admitted that there was information about the claimant's past bouts with depression and treatment which she did not reveal to him and he was unaware of. Therefore, I find that the claimant has failed to prove that her depression is a compensable consequence of her job related injury and no benefits will be awarded for the treatment of this claimant's depression.

I further find, after review of the record, that the claimant has failed to prove by a preponderance of the evidence that she is

permanently and totally disabled. The claimant's physical limitations would not prevent her from working and Mr. Thomas, the vocational counselor, has indicated that even with her current job skills, she could find employment in a sedentary type atmosphere. The indication is that the claimant has transferrable job skills and a high intellect capable of managing complex thinking skills as evidenced by her high grade point average in school. I do find that the claimant is entitled to wage loss over her 9 percent impairment rating in the amount of 9 percent based on her age, education, transferrable job skills and physical limitations. It is not doubted that this claimant is going to have difficulty and limitations in finding work but she is skilled and intelligent as well as young enough to locate employment if she will remain motivated to do so. This additional 9 percent impairment rating will entitle the claimant to a total disability rating of 18 percent to the body as a whole.

#### FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On April 2, 2001, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to her right knee.
4. Medical expenses have been paid to date.
5. Temporary total disability has been paid to date.
6. The respondents have accepted and will pay a 9 percent rating.

7. The claimant reached her maximum medical improvement on February 26, 2003. See discussion above.

8. The claimant is entitled to have received temporary total disability up to February 26, 2003, but is not entitled to receive additional temporary total disability from April 29, 2003, to a date to be date to be determined. See discussion above.

9. The claimant has failed to prove by a preponderance of the evidence that her depression is a compensable consequence of her work related injury. See discussion above.

10. The claimant has failed to prove by a preponderance of the evidence that she is permanently and totally disabled but she has shown that she is entitled to wage loss over her 9 percent impairment rating in the amount of an additional 9 percent entitling her to a disability rating of 18 percent to the body as a whole. See discussion above.

11. The respondents have controverted this claimant's entitlement to additional benefits.

12. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant reached maximum medical improvement on February 26, 2003, and is entitled to temporary total disability to that date.

The claimant has failed to prove by a preponderance of the evidence that her depression is a compensable consequence of her compensable knee injury. Therefore, no benefits will be awarded for treatment of her depression.

The claimant has failed to prove that she is permanently and totally disabled but she has shown by a preponderance of the evidence that she is entitled to wage loss in the amount of 9 percent over her 9 percent impairment rating entitling her to a disability rating of 18 percent to the body as a whole which the respondents should pay.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

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ELIZABETH DANIELSON  
ADMINISTRATIVE LAW JUDGE