

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F204161

KARAN THOMAS SMITH	CLAIMANT
HEALTHSOUTH OF FORT SMITH	NO. 1 RESPONDENT
PACIFIC EMPLOYERS INS. CO. INSURANCE CARRIER	NO. 1 RESPONDENT
SECOND INJURY FUND	NO. 2 RESPONDENT

OPINION FILED DECEMBER 20, 2004

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

Claimant represented by EDDIE H. WALKER, JR., Attorney, Fort Smith, Arkansas.

Respondents No. 1 represented by DIANE GRAHAM, Attorney, Fort Smith, Arkansas.

Respondent No. 2 represented by DAVID PAKE, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on September 30, 2004, 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 May 13, 2004. 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 February 20, 2002, the relationship of employee-employer-carrier existed between the parties.

3. The claimant's injury was initially accepted as compensable and all benefits are paid to date.

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

1. Compensability of the claimant's low back problems of February 20, 2002.

2. Related medical.

3. Temporary total disability for the period of time she was paid temporary total disability.

4. Impairment of 5 percent.

5. Wage loss over the 5 percent impairment.

6. Second Injury Fund liability.

7. Attorney's fees.

In regard to the foregoing issues the claimant contends that she was in a job related accident on February 20, 2002, and as a result sustained injury to her thoracic and lumbar spine. The claimant contends that she has a herniated disc at L2-3 and was at one time diagnosed as having a defect at T12-L1 and that as a result of those conditions she has permanent disability in an amount to be determined by the Commission. The claimant contends that she is entitled to reasonable and necessary medical treatment since her condition is in fact permanent. The claimant contends that her attorney is entitled to an appropriate attorney's fee.

In regard to the foregoing issues Respondents No. 1 contend that they accepted the claimant's alleged February 20, 2002, injury as compensable, paid medical expenses and temporary total

disability benefits. When the claimant was released to return to work with restrictions, the respondent employer placed her in a position within the restrictions which was admission clerk on July 14, 2002, and increased her hourly wage by twenty-five cents. Claimant continued to work until she was terminated for job performance on March 28, 2003. As a result of discovery, Respondents No. 1 have changed their position and controverted claimant's claim in its entirety. Specifically, Respondents No. 1 deny the incident described by claimant occurred, and alternatively, deny her small herniated disc which has improved over time is a result of the incident. Respondents deny the small herniated disc is the source of her pain and contend it is her pre-existing degenerative disc disease. Respondents raise the Shippers defense and have attached claimant's health questionnaire. Alternatively, if the claimant's claim is ultimately determined compensable, Respondents No. 1 contend the Second Injury Fund has liability for wage loss disability, if any.

In regard to the foregoing issues Respondent No. 2 contends that the claimant cannot prove that she suffered a compensable injury on February 20, 2002, and the Fund adopts as its own all the defenses that Respondents No. 1 are exerting in their claim.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted two packets of documentary evidence marked Claimant's Exhibit No. 1 and Claimant's Exhibit No. 2. Respondents No. 1 and Respondent No. 2 submitted medical

information marked Their Exhibit No. 1 and Exhibit No. 2 and Respondents No. 1 and Respondent No. 2 submitted non-medical information marked Respondents No. 1 and Respondent No. 2's Exhibit No. 3. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that while working for the respondent on February 20, 2002, she and another CNA had taken a three hundred-pound lady into the rest room and, in the process, the patient decided that she was going to lie in the floor. The claimant testified that she did everything she could to keep the patient up out of the floor. The claimant testified that she did not know that she was hurt immediately but within an hour she had leaned over to pick up a piece of paper off the floor and felt her back grab and she could not stand up. The claimant testified that she did not report the incident at the time the woman got in the floor but she did report the incident about 10:00 that night. The claimant testified that the respondent sent her to Occupational Medicine where she was seen by Dr. Holder. The claimant testified that her back hurt and was real stiff and that the doctor recommended physical therapy. The claimant testified that besides the back pain and stiffness she also had muscle spasms as well as pain radiating down her left leg.

The claimant testified that she has had back problems before February 20, 2002, for which she has received treatment. The claimant testified that she did not have any restrictions at the time that she went to work for the respondent and prior to working

for the respondent she had worked at another nursing home as well as worked for the Orange Blossom Dairy. The claimant testified that working as a CNA she is required to give patients showers, transfer and feed patients as well as keep the room straight. The claimant testified that she had been doing this type of work approximately one year prior to working for the respondent. The claimant testified that while working as a CNA she is required to lift anywhere from one hundred pounds up although with a higher weight she would have assistance. The claimant testified that when she worked for the Orange Blossom Dairy she milked cows, loaded trailers with square bails of hay, raked and cut hay, feed cows and often times was on a tractor up to eight hours a day. The claimant testified that she worked at the dairy for approximately eleven years.

The claimant testified that in 1980 to 1981 after she had her daughter she had an epidural and afterwards her back kept bothering her. The claimant testified that she was eventually diagnosed with scoliosis and put in a back brace after which she did not have any problems. The claimant testified that she also has been involved in a motorcycle accident and a car accident. The claimant testified that within one year of when she first went to work for the respondent she was not having problems with her back.

The claimant testified that following her February 20, 2002, accident the respondent provided medical care for her up until April or May 2003. The claimant testified that she was released at that time by her doctor. The claimant testified that she was not

working for the respondent at the time she was released by her doctor because she had been fired due to her not being qualified to do the job that she was transferred into. The claimant testified that following her back injury she worked light duty as a CNA then the respondent transferred her to an admitting clerk job. When asked if she had any clerical experience, the claimant testified that she did not and does not know how to type. The claimant testified that she worked as an admitting clerk for approximately six months and that she was learning to type but that when she would be doing filing one of the other girls would help out with the typing. The claimant testified that after she was terminated, she went back to school and after she finished school, she put her applications in at businesses around Ozark but was unable to find a job. The claimant testified that she is still hurting and she stumbles and falls, explaining that she basically lays around a lot during the day. The claimant testified that she currently is not looking for employment, stating that she has been approved for social security disability.

The claimant testified that she was forty-three years old, had gone through tenth grade in high school and had gotten her GED. The claimant testified that she has also worked as a waitress but no longer can do that because of the lifting requirements. The claimant testified that she has severe headaches and constant severe back pain with pain going down her left leg which causes her to fall if she gets up too fast. The claimant testified that she had lifting limitations of not over twenty to twenty-five pounds

given to her by Dr. Holder. The claimant testified that she cannot do bending, stooping or twisting noting that even trying to do the laundry and picking up the laundry basket causes her pain as does loading the dishwasher. The claimant testified that her husband and her daughter-in-law help clean her house.

The claimant testified that after her injury she went to school to learn to be a medical transcriptionist because it was her understanding that she could do this work at home. The claimant testified that she has completed her schooling but has not been able to find work. The claimant testified that she currently has quit looking for work because all of the jobs she applied for wanted her to have three to five years of experience as well as experience in a hospital or doctor's office which she did not have. The claimant agreed that she just gave up.

On cross examination by Respondents No. 1, the claimant agreed that she was an admitting clerk for the respondent from July 4, 2002, until she was terminated on March 28, 2003. The claimant also agreed that she was able to do that job although she could not type very good. The claimant was asked about her typing and the claimant testified that she still cannot type very fast even though she has successfully completed the medical transcriptionist college curriculum indicating that she barely got by. The claimant agreed that in her deposition she had testified that she was terminated by the respondents because of her attendance as well as not being an asset to their company. The claimant testified that in the application that she filled out when she initially went to work for

the respondent she was not truthful with several of her answers, particularly dealing with her past medical history. The claimant admitted that in March 1981 she was hospitalized due to a motorcycle accident where she was treated for a concussion. The claimant agreed also that in 1981 in July or August she was also hospitalized for two weeks for chronic low back pain and muscle spasm. The claimant agreed that she was hospitalized a couple of other times in 1981 for chronic low back pain and personality disorder. The claimant agreed that in 1983 Dr. Bailey noted that she had scoliosis of the thoracic spine which was slowly progressing and she was limited in walking and pushing. The claimant agreed that in August 1984 she was hospitalized with chest pain and that these records also indicate that she had frequent headaches as well as chronic low back pain. The claimant testified that in October 1998 she was involved in a motor vehicle accident where she injured her cervical spine, right knee and right wrist and that three days later she was thrown from a horse and had a concussion. The claimant agreed that she has been treated by Dr. Buie throughout the 1980s and has gone through numerous examinations and tests for her back. The claimant also agreed that she remembers being told that she needed to lose weight and to exercise.

Beginning in the 1990s the claimant began being treated by Dr. Helen McClard. The claimant acknowledged that Dr. McClard's notes will indicate that she was treated for upper back, chest and migraine problems. The claimant remembered that she underwent knee

surgery by Dr. Long for problems she had been having since an automobile accident in 1998. The claimant agreed that during her treatment by Dr. Long, he also diagnosed her with right carpal tunnel syndrome.

The claimant agreed that when she injured her back while working for the respondent she did not feel any pain initially but approximately one hour later, when she leaned over, she started having pain for the first time. The claimant was shown a series of questions in her deposition concerning her past medical history and her answers to these various questions were less than forthright in many areas. In the claimant's deposition, she was asked if prior to her February 20, 2002, incident had she ever had an injury to her back she responded "no" and again in her deposition she had testified that when she was seen by Dr. Buie for a diagnosis of scoliosis in 1981 and 1982 and he had put her in a back brace for a year that she had not had any trouble with her back since then. The claimant agreed that this was not a true statement. The claimant testified that she had been off work for the entire week prior to February 20, 2002, due to pneumonia. The claimant agreed that she has long standing asthma which makes her prone to having pneumonia. The claimant testified that she went on her own to see Dr. Capocelli in order to obtain a second opinion. The claimant remembers that Dr. Holder had her undergo an MRI after her February 2002 incident and that test reflected a disc herniation at L2-3. The claimant agreed that Dr. Capocelli had her undergo another MRI and that test showed that the L2-3 disc was smaller than it had

been the year before. The claimant agreed that neither Dr. Capocelli or his nursing assistant has recommended surgery. The claimant agreed that she had submitted her resignation to the respondent before February 20, 2002, because she was moving to Ozark and did not want to drive back and forth to work. The claimant further agreed that after she left the respondent's employment she began drawing unemployment benefits within two to three weeks of her last day of work for the respondent and she drew these benefits until January 2004. The claimant acknowledged that she enrolled at the Ozark Campus of Arkansas Tech in August 2003 and that Arkansas Rehabilitation paid her tuition for the year that she went to school. The claimant agreed that she did not look for work after she started to school and further agreed that she went to school five days a week and that it was a year-long program. The claimant testified that she graduated in June 2004 and looked for jobs until sometime in August 2004 but has not looked for work since then. The claimant testified that she applied for and has just been approved for social security disability benefits agreeing that in her social security hearing she told her hearing officer about her chronic headaches, her chronic back pain, her knee surgery and her depression and psychological problems. The claimant indicated that she was aware that Dr. Holder had given her a 5 percent impairment rating for her L2-3 herniated disc. The claimant did agree that she had another MRI in April of this year but was not aware of the results.

On cross examination by Respondent No. 2, the claimant testified that back in 1991 it was Dr. McClard that had recommended that she lose weight. The claimant testified that at that time she weighed 169 pounds and that the doctor had indicated to her that it would be easier on her whole body, her legs, her back, just her general health to lose weight. The claimant indicated that she had tried to lose weight by cutting back on eating and taking diet pills but the few pounds she lost she has gained back. The claimant testified that currently she weighs about 175 to 180 pounds and she cannot tell any difference with this weight gain as to her physical being. The claimant testified that she did not talk to anyone in an interview when she was applying for a medical transcriptionist job nor did she fill out any applications. The claimant explained that she went through Arkansas Hot Jobs or Monster Jobs and would look at these sites and if a job was open she would attach her resume'. The claimant testified that most of the job openings that she found were in a doctor's office or at a hospital and she was wanting to work from her home. The claimant testified that ever since her February 2002 injury she has had a headache twenty-four hours a day seven days a week. The claimant explained that she had had a MRI and a CT scan run and when she came out of the hospital she blacked out and when she came to she was in the ER and has had a headache ever since. The claimant was asked if she considered her headaches being caused by her lifting a three-hundred pound patient in February 2002 and the claimant responded, "Yes." The claimant was then asked if any doctor had

causally connected these headaches with her February 2002 injury and the claimant responded, "None that I know of, or I'm not sure." The claimant testified that her right knee is not bothering her even though she did have surgery on it some years ago. The claimant testified that it was her left leg that is bothering her. The claimant testified that she stays depressed all the time due to her pain and not being able to do what she used to be able to do and that this has contributed to her inability to work. The claimant testified that she took a cut in pay when she was moved to the admitting clerk job while working for the respondent. The claimant was asked if she had received a twenty-five-cent raise when she was moved to the admitting clerk job and the claimant responded, "Not that I can recall."

On redirect examination, the claimant testified that her doctor's visits and back problems caused her to miss work, therefore, her attendance problems are related to her back injury. The claimant agreed that her back condition since February 20, 2002, is different from the back problems she had before that date. The claimant explained that the pain is different, she has stronger muscle spasms, pain goes down her leg and she falls. The claimant testified that at the time that she filled out a work application for the respondent she was not having any kind of problems with her back nor was she under any kind of medical treatment for her back. The claimant agreed that once her attorney mentioned various events which had been brought up in her deposition, she recalled the events and testified correctly about them. The claimant testified

that in order to draw unemployment benefits she had to be actively seeking employment. The claimant testified that after a period of time when she could not find a job that was when she began her schooling. The claimant indicated that she did not think helping the patient in February 2002 caused her to have a constant headache but it was the diagnostic testing which was recommended by her treating physician following this event that has caused her headaches.

On recross examination by Respondent No. 1, the claimant agreed that one of the big differences with her back problems before and after 2002 is that she was hospitalized numerous times for her back before 2002 and she has not been hospitalized at all for her back since 2002. The claimant also agreed that the only employers that she made contact with in order to meet her requirements to draw unemployment benefits were located in Ozark.

On recross examination by Respondent No. 2 the claimant testified that she probably missed once or twice a week after her February 20, 2002, accident until she was terminated. The claimant explained that not all of these were for her back problems but at least one day a week she would miss work due to her back problems.

Gary Smith testified on behalf of his wife saying that they had been married since February 2003. Mr. Smith testified that he knew the claimant approximately one month before February 20, 2002. Mr. Smith testified that for this period of time he would see the claimant typically on weekends and had the opportunity to observe her activities. Mr. Smith was asked if there was anything in her

activities that would cause him to conclude that she appeared to be limited in any way and Mr. Smith responded, "No." Mr. Smith testified that subsequent to February 20, 2002, the claimant appears to be physically different than before and that he has observed her stumbling, falling and just being in general pain.

On cross examination by Respondent No. 1, Mr. Smith testified that he was unaware that the claimant had been off work for an entire week prior to February 20, 2002.

After the claimant rested, Respondents No. 1 called Donna England who testified that she was employed by the respondent in June 2001 as the employee health nurse. Ms. England testified that part of her duties involved interviewing perspective employees and that she interviewed the claimant. Ms. England was asked to review the claimant's employment application and she acknowledged that she had heard the claimant testify that several of her responses to the questionnaire were not true. This witness agreed that the claimant was applying for a CNA position and Ms. England testified that if the claimant had answered honestly to the questions asked of her on the questionnaire, she would not have been put to work as a CNA on July 16, 2001. Ms. England testified that after February 20, 2002, the claimant continued to work as a CNA but on special light duty until July 2002 when she was placed as an admission's clerk. This witness testified that she believes the claimant was given a twenty five cents per hour raise when she was transferred to the clerk's position. Ms. England testified that the claimant was terminated at the end of March 2003 due to absenteeism and that none of the

absentees related to her alleged injury of February 20, 2002, were counted against her. Ms. England agreed that during this period of time the respondent was paying workers' compensation benefits to the claimant in the form of medical treatment. Ms. England testified that she was unaware that the claimant had not truthfully filled out her employment questionnaire until the claimant's deposition was taken earlier in the year 2004.

On cross examination by the claimant's attorney, Ms. England agreed that at the time of the claimant's termination she was still receiving workers' compensation benefits. When Ms. England was asked about the claimant's allegation of injury on February 20, 2002, Ms. England responded that there were not witnesses that the respondent had just taken the claimant's word for what had happened. Ms. England testified that on February 20, 2002, there was a patient there that was heavy and that the claimant was working with that patient. Ms. England testified that if the claimant had accurately filled out her employment questionnaire, she would not have been hired that day but would have been examined to see if she was able to perform the functions of a CNA. Ms. England was asked if the claimant did not have any medical restrictions on her activities would the respondent have hired her and Ms. England responded, "If the physician released her to perform the activities of the job, then, yes, we would have."

The medical records set forth that the claimant was seen by Dr. Terry Clark on February 22, 2002, with complaints of low back pain, noting that she caught a patient who was falling. The

doctor's notes indicate that the claimant denies radiation of pain down her legs. The claimant was examined and diagnosed as having lumbar strain for which she was prescribed medications and to return to work with a lifting restriction of nothing over twenty pounds and limited bending, stooping, twisting, squatting and kneeling and to limit repetitive motions of the back. Dr. Keith Holder writes on February 27 that he has seen the claimant for her reports of having more pain now going down the left posterior thigh which she stated started Monday or Tuesday after work and a long period of driving. It is noted that the claimant is going to physical therapy daily and using a TENS unit as well as taking medications. The claimant was continued on medication as well as physical therapy and her limited light duty. On March 15, 2002, Dr. Holder writes that the claimant reports more numbness in both legs with pain radiating to the left leg both anterior and posterior. The claimant was continued on her physical therapy, medications and was referred for an MRI as well as to continue with her work restrictions. The claimant's MRI made on March 22, 2002, sets forth that the claimant has a small to moderate size left L2-3 disc protrusion with slight cephalad extrusion of fragment up behind L2. She also has a small left paracentral disc protrusion at T12-L1 with slight caudal extrusion of fragment behind L1 with minimal compression on the ventral thecal sac. On March 25, 2002, Dr. Holder writes that he has reviewed the claimant's MRI which shows a herniated disc at L2-3 to the left and that the claimant is to continue her physical therapy, medications, work restrictions

and is being referred to Dr. Armstrong, a neurosurgeon, for evaluation. Dr. Clark saw the claimant on March 29, 2002, where the claimant reports that her leg goes numb and she falls. The claimant was recommended for sedentary duty only, noting that she has an appointment with Dr. Armstrong on April 11. The claimant was seen by Dr. Armstrong on April 11, 2002, and after taking an extensive history as well as giving the claimant an examination, Dr. Armstrong diagnosed the claimant with having lumbosacral myofascial dysfunction with associated myofascial neuralgia in the lumbosacral and thoracodorsal region and recommended continued conservative therapy management, physical therapy and did not recommend any surgical intervention. Dr. Clark writes on April 19, 2002, that the claimant still has discomfort especially with prolonged sitting, stating that she is still falling occasionally and states that her leg gets completely numb. It is noted that the claimant's herniated disc is deemed by the neurosurgeon to be non-surgical, at which time Dr. Clark recommended an EMG and nerve conduction velocities of her left lower extremities because of her complaints of paresthesias. The doctor recommends that she continue with limited work. Dr. Holder writes on April 23, 2002, that the claimant has been back to work for one day after being off for two weeks but within five hours she was experiencing significant pain. Dr. Holder notes that she has seen a neurosurgeon who has not recommended surgical intervention but has recommended continued conservative care. The claimant was scheduled for LESIs and her medications were adjusted as well as

she was to continue with physical therapy and a return to work with no lifting over fifteen pounds and no repetitive motion of the back. The claimant, on April 30, 2002, underwent an EMG nerve conduction study to evaluate her low back with radiation of pain to her left leg and this study was normal. The claimant was seen on May 29, 2002, by Dr. Holder where she reports that she was feeling better as to her back but now is complaining of headaches after her lumbar epidural steroid injections. After examination, Dr. Holder continued the claimant on her epidural steroid injections recommending medications and her same work restrictions.

The claimant began seeing Dr. John Kareus for her complaints of persistent headaches since undergoing a lumbar epidural steroid injection. Dr. Kareus took an extensive history of the claimant's complaints as well as her medical history. After examination, the doctor recommended that the claimant proceed with an EEG. Various options were discussed but the doctor preferred to proceed with bed rest for a few days to see if her headaches would respond as well as to see the results of the EEG. Dr. Kareus writes on June 10, 2002, that the claimant was in for a lumbar puncture to evaluate her headaches. After this test was conducted, it was recommended that the claimant remain restful for the remainder of the day and the possibility of a blood patch was indicated. The claimant was taken off work until her headaches were under control. On June 17, 2002, Dr. Kareus writes that the claimant has continued to have consistent headaches and they have sent her for a blood patch which has eased her headaches considerably. The doctor notes that the

claimant continues to have back problems and complains of intermittent double vision, noting that how this is related to her back problem is unclear.

The claimant was seen on July 3, 2002, by Dr. Holder, noting that she has done well since last Friday following her steroid injections and she is to continue her medications as well as return to work with no lifting over twenty-five pounds and no repetitive back motions. Dr. Holder notes on August 2, 2002, that the claimant reports that she is better, except for a headache, and Dr. Holder released the claimant at that time to work with no lifting over thirty-five pounds and no repetitive back motions but to return to work with no restrictions on August 9, 2002. The claimant on November 19, 2002, was assessed with a 5 percent whole person impairment rating of 5 percent to the whole body for her lumbar problems, noting that she has reached maximum medical improvement and may return to work without restrictions as a meeting clerk. The claimant continued to be seen at the Cooper Clinic Occupational Medicine Clinic in February and March 2003 for her complaints of back pain for which she was prescribed medications and work restrictions. Dr. Holder writes on April 7, 2003, that the claimant still reports low back pain although she has been going to physical therapy with aquatherapy over the last week. Upon physical examination, the claimant reports tenderness and she is diagnosed with lumbar strain with a herniated disc not pressing on the nerve roots. Dr. Holder recommended that she continue on her medications and that she may return to work with

her previous restrictions. Dr. Holder notes on May 8, 2003, that the claimant's functional capacity evaluation showed that she can return to her previous level of activity as an admitting clerk for the respondent and that she has requested a refill of her Neurotin. The claimant's medication was refilled and it was recommended she return to work with her previous restrictions and she was released from the clinic at this time.

The claimant underwent a functional capacity evaluation on May 1, 2003, and after extensive testing the examiner set forth the claimant's physical abilities in a two-page chart. The examiner noted that due to clinical inconsistencies and questionable client reports, this evaluation may not reflect the true capabilities of the patient, however, it does reflect her minimum physical abilities.

Dr. Capocelli writes on July 3, 2003, that based on the claimant's MRI of March 2002, there is a slight left lateralizing disc protrusion at T12-L1 which does not appear to compress the cord nor did it narrow the neuroforamina and that at L2-3 there was a left paracentral disc protrusion with slight cephalad extension with no nerve root compression. Dr. Capocelli writes that the claimant has these noted disc protrusions as well as degenerative disc disease. The doctor writes that the degenerative disc disease could well explain her chronic back pain but there is nothing from this test to explain her radicular pain since there is no evidence of cord compression or narrowing of the neuroforamina. The doctor

recommended undergoing an additional MRI to see if there has been any changes since 2002 and adjusted her medications.

The claimant was seen by Dr. John Kareus on July 14, 2003, for her headache disorder and after much discussion of her various medications, her prescriptions were modified. Dr. Kareus writes on September 16, 2003, that in addition to the claimant's headache problems she is also complaining of numbness in her left hand. The doctor performed Phalen's and Tendal's tests which were positive and the doctor opined that the claimant has developed left wrist carpal tunnel syndrome for which he gave her bilateral wrist splints. Dr. Kareus continued to see the claimant for her complaints of headaches throughout the remainder of 2003 and on February 9, 2004, Dr. Kareus recommended that the claimant undergo an EEG and an MRI scan to determine if she has any evidence of epilepsy and on February 12, 2004, these tests were conducted. The EEG was normal during wakefulness and the claimant's MRI revealed a stable small portable venous angiomas in the left cerebellar vermis and right frontoparietal lobes with left maxillary sinus mucous retention cyst.

The claimant underwent an MRI of her lumbar spine on April 14, 2004, which revealed a small left paracentral disc herniation with slight caudal extrusion at the T12-L1 level. The radiologist notes that this is very small and does not actually abut the spinal column. Dr. Nelson, who read the MRI, further writes that the lumbar spine is otherwise normal.

The respondent's medical exhibits set forth that the claimant was seen by Dr. Mumme on March 5, 1981, with complaints of low back pain. After examination and a variety of tests, no specific etiology of the claimant's problems were discovered. On April 2, 1981, the claimant was seen for follow up by Dr. Mumme where he notes that she currently is under the care of Dr. Buie following a motorcycle accident. The claimant was involved in a motorcycle accident in March 1981 and after being hospitalized overnight, Dr. James Buie released the claimant noting that her x-rays showed no remarkable findings other than a slight lumbar dextroscoliosis as well as a diagnosis of abrasions to her left hand, injury to her left elbow and a cerebral concussion. On July 25, 1981, Dr. Douglas Parker treated the claimant for her complaints of chronic low back pain which began approximately one year ago, noting that she had been in an automobile accident. These notes do indicate that the claimant was involved in a motorcycle accident in March 1981 and was diagnosed with chronic back pain. The radiologist's report of July 25, 1981, indicates that the claimant has mild degenerative changes at the S1 joints on both sides but no other abnormalities are apparent. In August 1981 the claimant was seen at the Sparks Regional Medical Center for mental problems and after evaluation and observation, she was diagnosed with personality disorder. The claimant continued to be seen by Dr. Buie for her complaints of low back pain and a mylogram performed on August 26, 1981, set forth questionable abnormality at the L4-5 level. In a history given to Dr. McKinney on August 18, 1984, the claimant

reports that she has had scoliosis and is suppose to wear a back brace, noting that she had been in the hospital twice with back pain in the last few years. The claimant had extensive psychological evaluation and observation in August 1984 where she was again diagnosed with an adjustment disorder. The claimant was treated at the St. Edwards Mercy Medical Center Emergency Room on August 15, 1988, following a motor vehicle accident where she was admitted with complaints of right wrist, right knee and cervical spine pain. Just four days later, the claimant was again seen at St. Edwards after being thrown from a horse. A radiology report dated October 19, 1988, shows that the claimant has reversal of the normal cervical lordosis at C5-6 with minimal offset of C5 and C6. It is also noted that the claimant has disc space narrowing at C5-6 and C6-7. The claimant underwent multiple treatments for a wide variety of medical complaints from reoccurring low back pain to a spider bit to bronchitis/asthma to a brick falling on her left leg, treatment for poison ivy, migraine headaches, pain in her chest and treatment when she got hit on the top of the head. The claimant underwent a scope of her right knee on November 29, 1991. In April 1992, the claimant was diagnosed with right carpal tunnel syndrome and Dr. James Long placed her in a cockup splint.

After a review of this entire record, I find that the claimant has proven by a preponderance of the evidence that she suffered a temporary aggravation to a pre-existing condition when she was lifting or working with a three-hundred pound patient on February 20, 2002. The respondents have testified as has the claimant that

the claimant did work with a large patient on February 20, 2002, and the respondent did not question that the claimant, in fact, did injure herself on that date for which they provided medical treatment and accommodated her work restrictions. The claimant, however, has an extensive and long varied medical history, most of it pertaining to low back problems with an undetermined etiology, this extensive medical history also includes reports of headache, vision problems as well as emotional or mental problems. The claimant's medical past involves several traumatic events such as a motorcycle accident, motor vehicle accident as well as being thrown from a horse, all of which resulted in her having multiple complains always including back pain. The medical records seem to be void of information concerning treatment for this claimant between 1991 and the claimant's February 2002 event. Although the claimant was not truthful in her application at the time she applied for work with the respondent, nor in her deposition, she had had a little over a ten-year period of time when she had not had active treatment for her back and if she had reported her previous problems and been examined by a physician, possibly would not have been assessed any restrictions or found to be in need of restrictions at that time. Respondents' No. 1 raised the Shipper's Defense based on the claimant's false representation at the time of her hiring by the respondent. In Shipper's Transport v. Stepp, 265 Ark. 365, 578 S.W. 2d 232 (1979) it was found that the following factors must be present before a false statement in an employment application will barr benefits;

(1) The employee must have knowingly and willfully made a false representation as to his physical condition.

(2) The employer must have relied upon the false representation and this reliance must have been a substantial factor in the hiring.

(3) There must have been a causal connection between the false representation and the injury.

Although this claimant's credibility is seriously questioned, at the time she filled out the application for the respondent it is understandable that she did not note her prior back complaints. As stated earlier, the claimant had had about a ten to eleven year hiatus from her back problems and had been engaged in very heavy physical work, at the dairy as well as a CNA without problems. Therefore, I find that the first prong of the Shipper's three prong test is not met in order to barr this claimant from seeking benefits.

I find that the claimant's back problems resulting from her February 20, 2002, event resolved as of July 3, 2003, when she was seen by Dr. Capocelli. Dr. Capocelli notes that although the claimant does have noted disc protrusion as well as degenerative disc disease, he notes that, in his opinion, it is the degenerative disc disease that should explain her chronic back pain because there is nothing on the test to reveal evidence of cord compression or narrowing of the neuroforamina to explain her radicular pain. Dr. Capocelli had the claimant undergo a second MRI which indicates that the previous study of March 22, 2002, showed a small to

moderate size left sided disc protrusion at L2-3 and that this is now noted as a bit smaller in size suggesting that this has retracted. Therefore, medical treatment for the claimant's compensable injury and TTD are awarded to this claimant up to July 3, 2003. It is noted that the claimant terminated her employment with the respondent in March 2003 and immediately began drawing unemployment benefits up until January 2004. Therefore, temporary total disability would not be allowable from March 2003 up through January 2004.

On November 19, 2002, the claimant was assessed a 5 percent impairment rating by Dr. Holder for what then was considered her compensable injury of a herniated disc at the L2-L3. When Dr. Capocelli had the claimant undergo a second MRI in July 2003, it is noted that the claimant's herniated disc at L2-3 is retracting and was noticeable smaller. The claimant underwent a third MRI on April 14, 2004, and there is no mention of a herniated disc at the L2-3 level, only that she has a T12-L1 slight herniation and that her lumbar spine is otherwise normal. I find, therefore, that the claimant is not entitled to a 5 percent permanent impairment rating since it is obvious that she had no permanent injury resulting from her February 20, 2002, event. Based on the previous discussion and my finding that there was no permanent impairment resulting from the claimant's February 20, 2002, event, wage loss over the 5 percent impairment rating is not found nor is there any Second Injury Fund liability in this matter.

FINDINGS & CONCLUSIONS

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

2. On February 20, 2002, the relationship of employee-employer-carrier existed between the parties.

3. The claimant's injury was initially accepted as compensable and all benefits are paid to date.

4. The claimant has proven by a preponderance of the evidence that she sustained a temporary low back problem while working for the respondent on February 20, 2002. See discussion above.

5. The respondents should pay for all reasonable and related medical treatment for this claimant's temporary aggravation from February 20, 2002, through July 3, 2003. See discussion above.

6. The claimant is entitled to temporary total disability from the date of her injury to July 3, 2003, excluding the periods of time which this claimant was working for the respondent and when she was drawing unemployment benefits. See discussion above.

7. The claimant is not entitled to a 5 percent impairment rating. See discussion above.

8. The claimant is not entitled to wage loss over an impairment rating. See discussion above.

9. There is no Second Injury fund liability in this matter.

10. The respondents have controverted this claim in its entirety.

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

ORDER

The claimant has proven by a preponderance of the evidence that she sustained a temporary aggravation to her back on February 20, 2002, which had resolved by July 3, 2003.

The respondents should pay for all medical costs from February 20, 2002, through July 3, 2003.

The respondents should pay temporary total disability to this claimant from February 20, 2002, through July 3, 2003, excluding the periods of time when she was working for the respondent as well as the periods of time she was drawing unemployment benefits.

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.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE