

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F406674

LINDA GULLEY	CLAIMANT
ST. EDWARD MERCY MEDICAL CENTER	No. 1 RESPONDENT
SISTERS OF MERCY HEALTH SYSTEM INSURANCE CARRIER	No. 1 RESPONDENT
SECOND INJURY FUND	NO. 2 RESPONDENT

OPINION FILED JUNE 8, 2005

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 RANDY MURPHY, Attorney, Little Rock, Arkansas.

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

STATEMENT OF THE CASE

A hearing was held on March 17, 2005, 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 January 13, 2005. 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 15, 2002, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her back and right hip on October 15, 2002.

4. Respondents No. 1 have paid all medical expenses.

5. The claimant is entitled to a compensation rate of \$354.00 for temporary total disability and \$265.00 for permanent partial disability.

6. The parties agree that the claimant reached the end of her healing period on or before June 30, 2003.

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

1. Permanent partial impairment of 5 percent to the whole body.

2. Claimant's entitlement to permanent and total disability or wage loss over the 5 percent impairment.

3. Second Injury Fund liability.

4. Attorney's fees.

In regard to the foregoing issues the claimant contends that she was sent to Dr. Luke Knox by Respondent No. 1 and Dr. Knox assessed a 5 percent impairment to the body as a whole yet the respondent has failed and refused to pay benefits in regard to that rating. Thus, the claimant contends that Respondent No. 1 has controverted the claimant's entitlement to permanent disability benefits. The claimant contends that when the effects of her preexisting conditions are considered in combination with the effects of her Job related injury she is permanently and totally disabled. The claimant contends that the Second Injury Fund has

some liability for wage loss disability in this case since the claimant had preexisting conditions, she sustained a compensable injury that resulted in permanent impairment and the combined effects of injury caused her to be more disabled than she would have been based upon the effects of the compensable injury alone. The claimant contends that her attorney is entitled to an appropriate attorney's fee in regard to all permanent disability benefits.

In regard to the foregoing issues Respondents No. 1 contend that the claimant did not sustain any permanent impairment in connection with the October 15, 2002, injury. Respondents No. 1 contend the claimant cannot establish that the major cause of her disability is the October 15, 2002, injury.

In regard to the foregoing issues Respondent No. 2 contends that it was just joined in this case. It can take no position until discovery has been completed.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. Respondents No. 1 submitted medical reports marked Respondents No. 1's Exhibit No. 1, a deposition of the claimant marked Respondents No. 1's Exhibit No. 2 and a benefits calendar marked Respondents No. 1's Exhibit No. 3. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that she was 56 years old, had completed high school as well as an LPN course and taken numerous courses at Westark. The claimant testified that she primarily has been an LPN during her working life but that she has also worked as a nurse's aid, worked in a grocery store, a variety store, has been a factory inspector, and worked as a house keeper in a hospital as well as in the hospital laundry.

The claimant testified and it has been stipulated that she was injured on October 15, 2002, while working for the respondent. The claimant explained that she fell out of a chair injuring her back and right hip. The claimant testified that the respondents sent her to Dr. Holder and that he ordered physical therapy as well as for her to continue taking Celebrex.

The claimant testified that in the early 90s Dr. McDade operated on her to remove a pituitary tumor. The claimant testified that after this tumor was removed she developed adrenal insufficiency and then over time other medical problems began to develop. The claimant testified that she was given steroids after her tumor surgery and that they caused her to develop glaucoma, diabetes, hypoparathyroidism and hypothyroidism. The claimant testified that over these past few years she had been treated by a variety of doctors and that there have been periods of time when she was not able to work as a result of these medical problems. The claimant testified that before her fall in October 2002 she also fractured her hips. The claimant testified that because of

these various medical problems and the fact that she was tired all the time, her job was switched to that of an ACC Clerk. The claimant testified that before the October event she was taking somewhere between twelve and seventeen different medications for her various problems.

The claimant testified that after her compensable fall, Dr. Holder referred her to Dr. Clark who in turn referred her to Dr. Evans who then referred her to Dr. Swicegood. The claimant testified that Dr. Swicegood ordered a CT scan of her lower back and administered injections in her back. The claimant agreed that Dr. Swicegood treated her for SI joint pain and that this is the area where she has continued to have problems since her October 15, 2002, fall plus pain in her hip. The claimant testified that her workers' compensation case worker referred her to Dr. Luke Knox for an independent medical examination. The claimant testified that she did in fact see Dr. Knox and he examined her. The claimant testified that as a result of her examination by Dr. Knox, he assessed her with a 5 percent whole body impairment rating but she has not been paid this rating.

The claimant agreed that Dr. Kocher took her off work in June 2003. The claimant testified that Dr. Kocher treated her prior to her October 2002 job related fall for her other health problems. The claimant testified that at the time Dr. Kocher took her off work she was still having problems with her right hip and that she was still under active treatment for her right hip. The claimant testified that the problems with her right hip limit her ability to

stand for any length of time, noting that all the jobs she has had required her to stand most of her shift. The claimant testified that the fall in October 2002 made her hip much worse than it was before.

On cross examination by Respondents No. 1, the claimant agreed that on her own she went to see Dr. Standefer. The claimant testified that Dr. Standefer did a clinical examination as well as ordered additional MRIs of her back and pelvis area. The claimant testified that Dr. Kocher has treated her for many different things but as to her back and hip problems he has only given her pain medication. The claimant testified that after she fractured her pelvis she continued to work noting that she was off for a period of time while she was in the hospital and shortly after she was released but that she was able to continue to work after that event. The claimant agreed that she does not have any impairment rating for her fractured pelvis. The claimant stated that she is drawing long term disability benefits which are offset by her social security disability benefits. The claimant testified that after her October fall and when she was released by Dr. Holder to return to work she was able to do her work only with the help and cooperation with her co-employees. The claimant testified that she does not remember telling her physical therapist that she was pleased with her progress and that her right hip pain had resolved. The claimant testified that when she saw Dr. Kocher he was not permitted to document or treat her compensable injury. The claimant testified that she was in the hospital in the year 2004

for kidney stones. The claimant testified that she was in the hospital for a number of things particularly severe adrenal crisis in the year 2000. The claimant testified that her condition continued to deteriorate until Dr. Kocher finally recommended that she stop working on June 30, 2003.

On cross examination by Respondent No. 2, the claimant testified that she has had a hearing problem all of her life, however, it has gotten worse over the past four or five years. The claimant agreed that she does wear a hearing aid. The claimant testified that she has never been turned down on a job because of her hearing problems. The claimant testified that she lives alone and takes care of her own house as well as her car. The claimant was asked at length about her educational background and the claimant stated that besides obtaining her LPN certificate she has also taken numerous classes just because she wanted to take them. The claimant testified that she has completed an EMT class as well as a dental assistants class obtaining a certificate of completion. The claimant testified that in Arkansas she has taken classes in hopes of getting her RN degree. The claimant testified that she thinks that she is approximately a year and a half from getting her RN degree. The claimant testified that she stopped taking classes because the work just got too hard on her since she was working so much. The claimant testified that when she was working as an ACC Clerk her duties included giving directions to people in the hospital as to where different departments were, making lists for the doctors of their patients and making new charts for patients

who came in. The claimant agreed that this job required her to verbally give instructions to people when they came into the hospital and also to be proficient with the keyboard and printer. The claimant testified that besides these desk duties she also would deliver the patient charts to the different wings of the hospital explaining that the amounts of paper she would have to carry around the hospital would vary but that this task over a day would take approximately one hour of her time. The claimant testified that she would also answer the telephone and direct calls throughout the hospital as well as field problems which might come up with a patient's family. The claimant testified that she had seen a Dr. Walz in 2003 for a neuropsychological evaluation but this had nothing to do with her October 15, 2002, fall. The claimant testified that between 1986 and 2000 she saw Dr. Kareus for her headaches and seizures. The claimant testified that in the past she has been plagued with blackout spells stating that one time she blacked out in her kitchen. The claimant further explained that her brain surgery resulted in her having a nature steroid deficiency which requires that she take steroids and that she will have to take this drug for the rest of her life. The claimant again testified that the steroid injections have caused her many medical problems including glaucoma, diabetes, hypothyroidism and a vitamin D insufficiency. The claimant was asked if she remembered being in the hospital in the year 2000 with respiratory distress syndrome. The claimant testified that yes she did remember it and she was on a ventilator for five days and

developed pneumonia. The claimant testified that after her hospitalization, she had to return to work because she was not eligible for long term disability benefits. The claimant agreed that if she had been eligible for long term disability at that time she probably would not have returned to work. The claimant testified that also after her hospitalization she began to fall a sleep and have cognitive problems and that these problems have continued to get worse. The claimant agreed that in her deposition she stated that the reason she stopped working in June 2003 was because of her cognitive problems. The claimant also agreed that Dr. Kocher had advised her to stop working in the year 2000 but that she could not due to finances.

On redirect examination, the claimant testified that all the time she was seeing Dr. Kocher she was also being treated by Dr. Clark, Dr. Holder, Dr. Evans and Dr. Swicegood for her hip and back problems.

The medical records set forth that the claimant was seen at Cooper Clinic by Dr. Keith Holder on November 6, 2002, as a result of her compensable injury. After examination, the claimant was diagnosed with having right greater trochanteritis and medications as well as physical therapy were recommended. The medical records set forth that the claimant continued to receive treatment for her right hip pain as well as treatment for numerous other physical problems. On December 20, 2002, Dr. Holder examined the claimant for her complaints of increased right hip pain and recommended that she undergo an MRI, increase her Celebrex and continue her work

restrictions to include alternate sitting, standing and walking as tolerated. The claimant's MRI on December 24, 2002, reveal that the claimant had no acute hip abnormality setting forth that specifically there was no hip fracture demonstrated. On December 27, 2002, Dr. Terry Clark writes that the claimant reports that she is feeling much better saying that increasing her Celebrex has helped tremendously. It is noted that the claimant's MRI was normal. Dr. Clark examined the claimant and recommended that she continue to take Celebrex and to return to work without restrictions. Dr. Clark writes on January 3, 2003, that the claimant reports that she has had a flair up of right hip pain noting that there were no recurrent injuries. After examination the claimant was prescribed Celebrex and to alternate sitting, standing and walking as tolerated at work. On January 8, 2003, the claimant was seen by Dr. James Bradburn for her hearing problems. After examination, Dr. Bradburn recommended that she replace her hearing aids. Dr. Jeffrey Evans writes on January 13, 2003, that he has seen the claimant for her complaints of right hip pain since her October 15, 2002, fall at work. After examination, Dr. Evans diagnosed the claimant with having right sided sciatica and prescribed physical therapy for her low back. The claimant continued to be treated by several doctors for several different medical problems which include but not limited to sleep disorder, restless legs, diabetes, depression, problems with her ankles, seizure disorder and headaches. The medical records set forth that each new doctor which the claimant sees for a particular medical

problem points out that she is on numerous medications often stating as much as twenty-two to twenty-seven different medications for her various medical problems. On March 19, 2003, Dr. Evans referred the claimant to Dr. John Swicegood for pain control and recommended that she undergo an MRI of her lower spine. The claimant's MRI on March 19, 2003, sets forth that she has very mild narrowing at L4-5 further setting forth that she has left abdomen calcification and urethral stone which cannot be excluded. The claimant underwent an MRI of her lower spine on April 7, 2003, which was read to be normal. Dr. David Kocher writes on May 30, 2003, that he has seen the claimant in the clinic after her extended hospital stay noting that she had been in the hospital for a period of seven days for headaches and seizure as well as adrenal insufficiency. The claimant started treatment with Dr. John Swicegood on May 12, 2003, for her right sciatic joint pain resulting from a trauma. The claimant underwent a CT scan of her pelvis on June 13, 2003, which showed that she had mild deformity inferior pubic rami which could be due to a previous trauma but no definite acute fracture line was detected. This test also revealed degenerative changes of the claimant's sacroiliac joints.

Dr. William Knubley writes on June 24, 2003, that the claimant has just recently been in the hospital for presumably topamax induced side effects. Dr. Knubley notes that he has treated the claimant for multiple problems primarily mentioning word finding difficulties, paresthesias and changes in her vision. The doctor writes that the claimant has been seen by Dr. Pat Walz for

neuropsychiatric testing and that she also is being seen by Dr. Kareus for her sleep disorder. Dr. Patricia Walz put the claimant through a neuropsychological evaluation on June 20, June 23, and June 25, 2003. After this extensive evaluation, Dr. Walz assessed the claimant with having cognitive changes secondary to multiple medical conditions and major depression. Dr. Kocher writes on June 30, 2003, that the claimant is just recently out of the hospital due to blackout spells and inability to think. Dr. Kocher notes that the claimant was seen by Dr. Kareus and has been to see Dr. Knubley as well as Dr. Walz. Dr. Kocher notes that the claimant has been diagnosed with major depressive disorder as well as panhypopituitarism reflux esophagitis, Type II diabetes and mellitus, hypocalcemia, orthostatic hypertension, restless leg syndrome and seizures. Dr. Kocher writes that he has given the claimant a slip saying that she was disabled for work, noting that today he is seeing a person who is upset and just does not feel good, noting that a trial of antidepressants is very reasonable and Effexor would be the drug of choice.

The next time the claimant was seen for her back or hip problems were on October 1, 2003, when Dr. Jeffrey Evans writes that the claimant is seen for left sided sciatica. Dr. Evans notes that upon evaluation her exam is unchanged from previous and assesses her with having right sided sciatica. The claimant was seen by Dr. Evans on December 3, 2003, for her right sided sciatica where it is noted that she had a bad fall at home, falling on her right side and right hip about five weeks ago which has given her

some discomfort which persisted to the date of this appointment. Dr. Walz did a follow up psychological evaluation of the claimant on December 2 and December 10, 2003, where it is noted that the claimant's performance has improved in some areas but that she is still depressed. Dr. Kocher writes on January 8, 2004, in response to the insurance company's inquiry concerning the claimant. Dr. Kocher sets forth the claimant's primary disabling conditions as being panhypopituitarism with known adrenal insufficiency, seizure disorder (epilepsy) and sleeping disorder, the doctor notes that the claimant fell in November 2003 and sustained extensive bruising of her abdomen and right hip, skin abrasions of her right hip and also complained of left arm pain, blackout spells, Type II diabetes mellitus and orthostatic hypertension. Dr. Kocher notes that the secondary conditions the claimant experiences which contribute to her disability are: hypothyroidism, hypoparathyroidism, glaucoma, sleep disorder, restless leg syndrome, chronic skin infections, kidney stones, bilateral moderate hearing loss, mental slowing related to numerous medications, moderate to severe depression and hypocalcemia. Dr. Kocher then outlines the various tests which the claimant has undergone, noting that she may have surgery in the near future to repair the fracture of her left wrist. The doctor lists the claimant's restrictions as any strenuous or mentally demanding activities, noting that he does not see any possibility for improvement and none is expected. Dr. Kocher notes that the claimant's date of total disability began on June 9, 2003, and will persist for the rest of her life. The claimant was seen by Dr.

Kocher on March 18, 2004, with complaints of her right ankle swelling. Dr. Evans writes on April 5, 2004, that he has seen the claimant for follow up of her right sided sciatica, noting that she is still hurting quite a bit. The claimant was prescribed medications and encouraged to continue seeing Dr. Swicegood for his treatments. Dr. Stephen Manus writes on April 13, 2004, that he has seen the claimant and after examination diagnoses the claimant with having heart rhythm disorder and hypopituitarism. In Dr. Manus' report he lists the medications being taken by the claimant which at that time were 16.

The claimant was seen by Dr. Luke Knox on May 13, 2004, and after an extensive review of her past medical history as well as an examination and review of the claimant's various tests, Dr. Knox writes that his diagnosis is back and right leg pain with a negative MRI scan of the lumbar spine, however, there were positive findings over the right sacroiliac. Dr. Knox further notes that the claimant's objective clinic findings are nil but writes that in the face of her SI joint findings on the CAT scan, he would determine these to be objective findings to document her work related injury. Dr. Knox ordered a bone scan. On May 20, 2004, Dr. Knox writes that he has reviewed the claimant's bone scan and that it is completely normal. Dr. Knox writes that in the face of her normal bone scan, he would not recommend any further treatment and that the claimant had reached maximum medical improvement. Dr. Knox assesses the claimant with a 5 percent permanent partial disability to the body as a whole based on the A.M.A. Guides, Forth

Edition, setting forth a table at page 113 and section B. Dr. Knox recommended that the claimant not return to her pre-injury work status due to her overwhelming medical condition and recommended that she might consider a functional capacity evaluation to determine her level of ability to work. The claimant underwent an MRI on December 22, 2004, which sets forth that she had no significant abnormalities evident in the lumbar spine. It is noted, however, that there is minimal disc bulging at the T11-12 level. The MRI of the claimant's right hip was normal. Dr. Michael Standefer had previously written on December 22, 2004, that he had reviewed the claimant's medical history as well as her various radiographic tests and bone scan. Dr. Standefer writes that he sees no evidence of any obvious problem but in view of her persistent pain he ordered the MRI which was found to be normal.

After a complete review of all of the evidence, I find that the claimant has failed to prove by a preponderance of the evidence that she is entitled to a permanent impairment rating of 5 percent to the body as a whole. Dr. Knox has assessed the claimant with a 5 percent whole body impairment rating using Table 75 on page 113 of the A.M.A. Guides, Forth Edition. However, the tests which Dr. Knox reviewed as well as the tests which he had made were all within normal range as to this claimant's hip and low back problems. It is not questioned that this claimant is permanently and totally disabled but it is noted that she has a multitude of problems and these medical problems seem to be expanding with time and age. The claimant, for years, has taken numerous medications

for numerous medical problems and the claimant herself testified that prior to her compensable fall on October 15, 2002, she would have quit working due to her medical problems except for her financial problems. The claimant in her deposition also stated that the reason that she stopped working in June 2003 was because of her cognitive problems. This claimant has continued to sporadically have complaints of low back and right hip pain but it is also noted that she has experienced numerous falls due to seizures and blackouts which are unrelated to her compensable injury which could have exacerbated or caused her to have discomfort in her low back and hip. Dr. Kocher, on June 30, 2003, sets forth a number of medical problems including major depression which this claimant is suffering from but the medical problems listed do not include low back or hip pain. Therefore, I find no permanent impairment resulting from this claimant's compensable fall of October 15, 2002. I also find that there is no Second Injury Fund liability in this matter.

FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.
2. On October 15, 2002, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to her back and right hip on October 15, 2002.
4. Respondents No. 1 have paid all medical expenses.

5. The claimant is entitled to a compensation rate of \$354.00 for temporary total disability and \$265.00 for permanent partial disability.

6. The parties agree that the claimant reached the end of her healing period on or before June 30, 2003.

7. The claimant has failed to prove by a preponderance of the evidence that she is entitled to a 5 percent permanent partial impairment rating as assessed by Dr. Knox. The numerous medical examinations and tests run on this claimant's low back and right hip set forth no objective findings of injury on which to assess a permanent impairment rating. Also see discussion above.

8. I find that the claimant has failed to prove that she is permanently and totally disabled or entitled to wage loss as a result of her compensable injury or a combination of her compensable injury and her multitude of other medical problems for which Respondents No. 1 or the Second Injury Fund should be liable.

9. There is no Second Injury Fund liability.

ORDER

The claimant has failed to prove by a preponderance of the evidence that she is entitled to an impairment rating for her compensable fall of October 15, 2002. Therefore, this claim for benefits should be denied in its entirety.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE