

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E903970

DAVID LANNING

CLAIMANT

TRANS STATE LINES

RESPONDENT

GALLAGHER BASSETT,
INSURANCE CARRIER

RESPONDENT

OPINION FILED JUNE 30, 2005

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Fort Smith, Sebastian County, Arkansas.

Claimant represented by DAVID HARP, Attorney, Fort Smith, Arkansas.

Respondents represented by MELISSA CRINER, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held in the above styled claim on April 5, 2005, in Fort Smith, Arkansas. A pre-hearing order was entered in this case on February 8, 2005 . This pre-hearing order set out the stipulations offered by the parties and outlined the issues to be litigated and resolved at the present time. During the hearing, the stipulations and the issues were amended to reflect that the claimant was actually paid all appropriate temporary total disability benefits through June 17, 2002. A copy of the pre-hearing order with that amendment noted thereon, was made Commission's Exhibit No. 1 to the hearing.

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

1. On March 29, 1999, the relationship of employee-employer-carrier existed between the parties.
2. The appropriate weekly compensation rates are \$375.00 for total disability and \$281.00 for permanent partial disability.
3. On March 29, 1999, the claimant sustained compensable injuries to his head, neck, shoulder, and right leg.

4. There is no dispute over the payment of medical expenses, prior to July of 2003.
5. There is no dispute over the payment of temporary total disability benefits accruing through June 18, 2002 (T. 16-17).

By agreement of the parties, the issues to be litigated and resolved at the present time were limited to the following:

1. The claimant's entitlement to additional medical services during and after July of 2003.
2. The claimant's entitlement to additional temporary total disability benefits from June 18, 2002 through a date yet to be determined.

In regard to these issues, the claimant contends:

"Claimant contends that he has been temporarily and totally disabled since May 1, 2000 and that the respondents have refused to pay temporary total disability benefits and medical treatment since that time. The claimant is entitled to a controverted attorney's fee."

In regard to these issues, the respondents contend:

"Respondents contend that continued medical treatment is not reasonable and necessary in this matter. Respondents contend that all appropriate benefits have been paid with regard to this matter."

DISCUSSION

I. ADDITIONAL TEMPORARY TOTAL DISABILITY

The first issue to be addressed concerns the claimant's entitlement to additional temporary total disability benefits from June 18, 2002, through a date yet to be determined. In the prior Opinion, which became final on February 20, 2002, the claimant was found entitled to "an open ended award of temporary total disability benefits commencing on September 15, 1999". However, this does not relieve the claimant from again proving his entitlement to additional temporary total disability

benefits, beginning on June 18, 2002. In order to meet this burden, the claimant must again prove that he continued within his healing period from the effects of his compensable injuries and that his compensable injuries have rendered him totally disabled from performing all forms of regular gainful employment for which he would otherwise be qualified (not just the type of position he held at the time of his injury), from June 18, 2002 through a date yet to be determined.

The record reveals that the claimant is 49 years old and is a high school graduate. He still maintains his commercial driving license (CDL). At the hearing, the claimant was personable and appeared of at least average intelligence.

At the hearing, the claimant testified that he had not worked, had not been physically able to work, and had not made any attempt to work, since the prior hearing on May 23, 2000. He stated that he has continued to have problems with his right shoulder. These problems include a sharp pain upon any activity, and inability to reach overhead. He described his right arm as "not working properly" and on occasions caused him "unbearable" pain. It was his testimony that he could not get his arm comfortable enough to sleep and that his arm would wake him up after approximately three hours. He described difficulties with walking "very far" and sitting "for very long," including severe headaches. He further described his right hip as "not 100%" and that this was part of his "walking problem." However, he repeatedly gives, as his reason for his inability to work, only his right shoulder complaints (T9 and T16). The claimant concedes that he was and is able to assist his wife by doing some of the housework, but not anything heavy such as running the sweeper.

In his testimony, the claimant acknowledged that one of the reports of Dr. Bradley Wilson indicated that he was working in a hardware store. However, he denied that he had actually worked at that time. Instead, it was his testimony that a long time friend owned the hardware store. Although he frequently went to the store to

see and visit with his friend, he did not work, but just sat around visiting and drinking coffee. The claimant also acknowledged that his wife did, for at least a period of time after June 19, 2002, own and operate a ceramic shop. Although he denied actually working in this business, he conceded that he was either convicted or plead guilty to receiving stolen property that he had obtained for use in this business and had spent a period of time in jail.

On direct examination, the claimant testified that he had never previously experienced any problems with his right shoulder (T.10). However, on cross examination the following exchange took place:

"Q. Mr. Lanning, you have had several past -a broken neck and shoulder over the years, have you not?

A. Yes, ma'am."

The medical evidence shows that Dr. Bradley Wilson released the claimant to return to limited duty employment on June 18, 2002. He restricted the claimant from frequent lifting of more than 10 pounds, occasional lifting of more than 20 pounds, sitting or standing for more than one hour at a time, and cumulative sitting or standing for more than four hours per day.

On August 19, 2002, the claimant was seen at Dr. Wilson's request by Dr. Brian Oricoli. At that time, the claimant voiced complaints with his neck, his right upper extremity, and headaches. Dr. Oricoli diagnosed the claimant's difficulties as :

"1. Chronic cervical/trapezius myofascial pain.

2. Probable post-concussive syndrome."

Dr. Oricoli recommended a change in the claimant's medication and a trial use of a TENS unit. However, he undertook no further treatment of the claimant at that time and imposed no restrictions on the claimant's activities.

On October 4, 2002, the claimant was evaluated by Dr. John Brophy, apparently

at the respondent's request. Following his evaluation, Dr. Brophy diagnosed the claimant's difficulties as being attributable to:

- "1. Cervical/trapezius myofascial pain syndrome without clinical evidence of radiculopathy or myelopathy.
2. Tension headaches associated with normal neurological examination.
3. Right shoulder joint pain.
4. Right hip pain."

Based upon his review of the prior medical records and testing and his own examination, Dr. Brophy makes the following statement:

"Recommendations: I would recommend initiation of a detoxification program for his chronic narcotic use. I have suggested initiation of a true endurance exercise program such as progressing a two mile walk with an exaggerated arm swing in an effort to tone his trapezius and cervical paraspinal muscles. If he has not undergone a formal orthopaedic evaluation for his right shoulder and hip, this should be accomplished. From a neurologic standpoint, there is no objective reason why he could not return to work at full duty without restrictions should he have a desire to do so. It is my sense that he fixated on this injury and his impending potential settlement and nothing is likely to improve until the closure of the legal matter occurs. From the standpoint of his work injury in relationship to his headache, trapezius and neck pain, I would consider him at maximum medical improvement at this time with a PPI rating (according to the AMA Guides, Fifth Edition) of zero (0%). In my opinion, closure could be obtained after clearance by orthopaedics of his right shoulder and right hip with regard to his work injury.

With regard to Dr. Oricoli's opinion from 19 August, 2002, I would agree with the diagnosis of cervical/trapezius myofascial pain syndrome; however, I would be consider this problem at maximum medical improvement within six months of the time of injury. I would disagree with the diagnosis of post traumatic headaches as these tend to resolve spontaneously in the vast majority of patients within six months of the time of injury and are not considered at all likely 1 year after the injury. If Dr. Oricoli believes Mr. Lanning can benefit from Zoloft, Depakote, and Ritalin for mood alteration, he should

consider a psychiatric diagnosis which would be unrelated to the work injury in March 1999."

The claimant was ultimately seen by Dr. Keith Hollingsworth, an orthopaedic surgeon, on May 5, 2003. Curiously, when Dr. Hollingsworth evaluated the claimant on that date, he recorded complaints involving the claimant's neck, headaches, and radicular pain into the claimant's right arm and shoulder. No complaints were noted with his physical examination of the claimant's right shoulder would appear to have been entirely normal. Dr. Hollingsworth noted the following:

"Right shoulder: No muscle atrophy is noted. Forward flexion is to 180 degrees. External rotation is to 75 degrees. Internal rotation is to T10. Rotator cuff testing reveals a supraspinatus strength of 5/5. External rotation strength is 5/5. Subscapularis lift-off test and Napoleon test is negative. Negative provocative testing for SLAP lesion. Negative O'Brien's maneuver. Negative impingement testing of Neer and Hawkins. No pain with acromioclavicular palpation or cross body abduction. No atrophy of the supraspinatus or infraspinatus fossa. The patient denies any numbness or tingling."

He diagnosed no particular injury or defect directly involving the claimant's right shoulder. At that point, Dr. Hollingsworth directed his attention to the evaluation and treatment of the claimant's neck. Based upon the fact that the claimant and his wife advised Dr. Hollingsworth that an MRI of the cervical spine had never been performed (which was inaccurate), Dr. Hollingsworth recommended a cervical MRI.

On May 7, 2003, the recommended cervical MRI was performed. This study revealed only mild degenerative changes of an arthritic nature that involved three levels of the claimant's cervical spine. Curiously, these arthritic changes were not expressly noted on the cervical MRI study that was performed on July 21, 1999.

The claimant was seen, for follow up by Dr. Hollingsworth on May 12, 2003. At that time, Dr. Hollingsworth noted that the claimant's complaints continued to focus on his neck or cervical spine and that the physical examination performed on that date

was unchanged from the previous examination on May 5, 2003. Dr. Hollingsworth diagnosed the claimant's difficulties as being attributable to cervical degenerative disc disease. He also noted that the claimant voiced the desire to try a course of cervical epidural injections. This would seem somewhat curious, since the claimant had reportedly previously experienced a reaction to this type of injection (a fact which he does not appear to have related to Dr. Hollingsworth). Dr. Hollingsworth released the claimant back to the care of Dr. Pearlman for the purpose of administering these injections.

The claimant returned to Dr. Pearlman on July 2, 2003. At that time, Dr. Pearlman noted complaints of constant aching pain throughout the claimant's lower neck and pain throughout his right shoulder. He also noted complaints of numbness in both of the claimant's arms and hands, which awaken the claimant at night. On physical examination, Dr. Pearlman noted that the claimant was in no acute discomfort, that he had mild tenderness at the cervical thoracic junction, that cervical motion was hesitant in extension (due to reported neck pain), that there was moderate tenderness at the right AC joint, that the claimant's range of motion of his right shoulder was full, that some type of "impingement sign" was moderately positive, that the claimant's distal upper extremities were without edema, that the claimant exhibited full strength in his upper extremities, and that the claimant exhibited a positive Tinel's sign over the median nerves of his wrists, bilaterally. Dr. Pearlman diagnosed the claimant's difficulties as being attributable to cervical spondylosis, right shoulder AC tendinitis, and bilateral carpal tunnel neuropathies. He recommended injections to the claimant's cervical spine and to the right shoulder subdeltoid bursal area. He also recommended electrodiagnostic studies of the claimant's upper extremities. He continued the claimant on his same medications.

On July 24, 2003, the claimant was seen (also apparently at the respondent's

request) by Dr. John Wilson, an orthopaedic surgeon in Little Rock, Arkansas. In his report of that date, Dr. Wilson stated that it is his understanding he was to evaluate the claimant for his right shoulder and right hip complaints. Dr. Wilson noted that the claimant complained of pain in his right shoulder after attempting to use the shoulder for any period of time. He noted that the area complained of involved both the anterior and superior areas of the shoulder. However, Dr. Wilson observed that the claimant did not report any "clicking or popping" in the shoulder. Dr. Wilson's physical examination of the claimant's shoulder was reported as follows:

"Examination reveals a normal range of motion of his right shoulder with the scapula stabilized. There is no crepitation palpated when movement is asked. There is good strength, both anteriorly and laterally."

Dr. Wilson observed that x-rays which were performed on the claimant's right shoulder were normal. Curiously, Dr. Wilson also stated that the claimant has given a history of a "strain" of his right shoulder. However, the claimant's description of the March 29, 1999 incident, shows only a possible blow to his right shoulder from allegedly striking it on something inside the motor compartment of his truck, rather than a pull or strain.

In regard to the claimant's right hip complaints, Dr. Wilson recorded symptoms that were in the form of pain over the lateral aspect of the right hip on weight bearing, but with no "clicking or popping" of the hip joint. Dr. Wilson's physical examination of the claimant's right hip revealed only "exquisite tenderness" over the greater trochanter muscle. X-rays performed by Dr. Wilson reveal no abnormality involving the claimant's right hip.

The only additional treatment recommended by Dr. Wilson was one or more steroid injections into the bursa of the claimant's right hip. He further opined that the claimant would not have any permanent impairment as a result of either his right shoulder or right hip complaints.

The claimant returned to Dr. Pearlman on August 5, 2003. At that time, he received his first series of cervical facet steroid injections for his diagnosed cervical spondylosis/facet arthropathy. He returned to Dr. Pearlman on September 4, 2003, and reported that the injections had no effect on his symptoms. On that date, Dr. Pearlman further indicated that the claimant had received an injection of anesthesia into his right shoulder on July 2, 2003. This injection is not reflected in Dr. Pearlman's report of July 2, 2003. Apparently, this injection was unsuccessful in relieving the claimant's shoulder complaints. On August 5, 2003, Dr. Pearlman recommended a different form of injection for the claimant's cervical complaints which he indicated would be both therapeutic and diagnostic. He also recommended electrodiagnostic studies of the claimant's right upper extremity.

On September 11, 2003, the claimant apparently received the diagnostic and therapeutic injections to the cervical spine from Dr. Pearlman. On September 18, 2003, the claimant underwent a third cervical MRI, apparently at the direction of Dr. Pearlman. The reason for this MRI study was given as pain in the neck with pain going down both arms and numbness of the left hand. This MRI study revealed degenerative changes in the lower cervical spine without any significant compromise of the canal or neural foramina and was essentially the same as the prior study in May of 2003.

On September 22, 2003, the claimant was again seen by Dr. Brian Oricoli, an associate of Dr. Pearlman. Dr. Oricoli states that the purpose of this visit was to perform the nerve conduction studies of the claimant's upper extremities, as requested by Dr. Pearlman. Dr. Oricoli noted in his report that the claimant related a history that he had received various cervical injections with little benefit and had, in fact, an onset of significant left upper extremity numbness following the last series of injections. In his physical examination, Dr. Oricoli observed that the claimant was in no acute distress (an observation contained in most of the claimant's

physical examinations over his lengthy course of treatment), that motion of the claimant's cervical spine revealed only a slight limitation in lateral rotation. He further observed that the claimant exhibited 5/5 strength throughout his upper extremities, with the only exception being a mild weakness of the intrinsic muscles of his left hand and a more noted weakness of these muscles in the right hand. Except for subjective diminished sensation, the remainder of the examination appeared negative. Dr. Oricoli reported that his nerve conduction studies revealed only the presence of a bilateral median neuropathy that was indicative of bilateral carpal tunnel syndrome, more severe on the right than the left. His testing revealed no evidence of any radiculopathy or peripheral neuropathy which would explain the claimant's other associated upper extremity symptoms. Dr. Oricoli returned the claimant to Dr. Pearlman's care.

On November 5, 2003, the claimant was seen by Dr. Pearlman for continuing complaints of neck and shoulder pain with severe headaches. Curiously, Dr. Pearlman noted that the claimant reported reduction in his pain for approximately one week following the previous episode of cervical epidural steroid injections. Dr. Pearlman records no mention of the previously reported episode of left upper extremity numbness following these injections. He records that the claimant did report an episode of headaches and numbness in his right hand and had received an evaluation at an emergency room, which included a CT scan of his head or brain (apparently this CT scan was interpreted as normal). Dr. Pearlman did not record any activity or event as to precipitating these difficulties. On physical examination, Dr. Pearlman noted only subjective complaints of moderate to mild tenderness in the trapezius and right AC joint areas. He observed that range of motion of the claimant's right shoulder was full, even though it produced "reported" discomfort. Impingement signs were found to be negative and the claimant's upper extremity strength was normal. Dr. Pearlman

diagnosed cervical spondylosis and right shoulder tendinitis. He recommended an MRI study of the claimant's right shoulder and prescribed certain medications for symptomatic relief.

The recommended MRI study was performed on the claimant's right shoulder on November 10, 2003. This study was interpreted as showing degenerative spurs about the acromioclavicular joint which "just impinged" upon the underlying rotator cuff, signs of chronic tendinitis of the right rotator cuff, and fluid around the biceps tendon which could be indicative of tenosynovitis.

The claimant was next seen by Dr. Pearlman on January 20, 2004. At the time of this visit, the claimant purportedly reported that his narcotic and other medications were "helpful." However, he still complained of significant shoulder pain and headaches. However, at this time, the claimant further stated that these headaches were also caused by his long-standing uncontrolled diabetes and that he and his family physician were working on this problem. The claimant also complained of occasional numbness and tingling in his hand, which generally occurred in the evenings. His final complaint was a poor range of motion in his right arm. The claimant's physical examination on this visit also showed that a "poor" range of motion of his right arm, that he was unable to abduct the right arm against resistance, that he had positive impingement signs, and a positive "dropped arm test." The claimant's various pain medications were continued and the claimant was referred for an orthopaedic evaluation of his right shoulder.

On February 2, 2004, the claimant was again seen by Dr. Hollingsworth of the Ohio Orthopaedic Center. Dr. Hollingsworth notes that the recent MRI study of the claimant's right shoulder showed mild arthrosis and a grade III acromion with some evidence of rotator cuff tendinitis. On this visit, the physical examination now showed positive impingement testing on Neer and Hawkins tests. This is clearly a

significant change from his evaluation in May of 2003. The claimant's rotator cuff strength continued to appear normal with only minimal acroclavicular pain. Testing for a SAP lesion also continued to be negative as were the subscapularis lift-off test and cervical loading and rotation test. Dr. Hollingsworth did not indicate whether x-rays studies that performed on this visit differed from the previous studies in May of 2003. At this point, Dr. Hollingsworth diagnosed the claimant's right shoulder difficulties as being attributable to a subacromial impingement of a chronic nature and recommended an arthroscopic decompression.

On April 21, 2004, Dr. Pearlman authored a report to the claimant's attorney, which stated as follows:

"I believe within a reasonable medical probability that Mr. Lanning suffered aggravation of cervical spondylosis and right shoulder AC tendinitis/arthropathy as a result of his initial injury, 3/99. These conditions have been gradually progressive and have required continued treatment."

The medical record is then silent, until July 22, 2004. On that date, the claimant underwent an MRI study of his lumbar spine. This study was requested by a Dr. Katherine Humes. The reason for this study was given as low back pain, and a history was noted that the claimant had experienced an injury at work five years ago. This MRI was interpreted as revealing:

"At L2-3, no disc herniation or protrusion is identified. No central canal stenosis is seen. Lateral recesses appear patent bilaterally. Moderate hypertrophic change and facet joints is noted.

At L3-4, no disc herniation or protrusion is identified. No central canal stenosis is seen. Moderate hypertrophic change in facet joints is noted. Lateral recesses appear patent bilaterally.

At L4-5, there is a moderate broad based circumferential disc bulge. There is marked hypertrophic change in the facet joints, greater on the right than the left, causing moderate to marked stenosis of the right lateral recess. No central canal stenosis is seen.

At L5-S1, no disc herniation or protrusion is identified. No central canal stenosis is seen. Moderate hypertrophic change in the facet joints is noted. Lateral recesses appear patent bilaterally.

IMPRESSION:

Broad based circumferential disc bulge that is moderate in degree with moderate to marked hypertrophic change in facet joints, greater on the right than the left, causing moderate to marked narrowing of the right lateral recess. No central canal stenosis is seen. No disc herniation or protrusion is identified."

Finally, this record further relates that plain x-rays which were performed at the same time as the MRI, showed "mild degenerative retrolisthesis of L5 on S1."

The next medical record is the August 24, 2004, "operative report" of Dr. Pearlman. This report indicates that on that date, Dr. Pearlman performed facet injections at L4-5 and L5-S1 for lumbar spondylosis/facet arthropathy.

On December 30, 2004, a fourth cervical MRI was performed. The report of this study does not show at whose request it was conducted. However, the purpose for this study is given as neck pain and numbness with right arm weakness. This study was interpreted as showing:

"Findings: There is straightening of the normal lordic curvature. There is decreased signal in the disc spaces relating to degeneration. There is mild disc space narrowing at C4-5 and C5-6. The signals in the vertebral bodies are normal.

C2-C3 and C3-4: Canal and foramina are normal.

C4-C5 disc bulge and mild distortion of the sac. The foramina are unremarkable. C5-C6 there is a mild disc bulge. There is mild foraminal narrowing related to osteophytes at the uncovertebral joints. C6-7 and C7-T1, the canal and foramina are normal.

Signal and contour of the cord is normal.

IMPRESSION:

Mild degenerative changes most prominent at C5-6 where there is mild foraminal narrowing. I do not see any canal

stenosis. As compared to the previous MRI report of 05/07/03, I do not note an obvious change."

On February 22, 2005, Dr. Pearlman again saw the claimant for what he described as "follow up" of the claimant's lower back pain. Dr. Pearlman recorded the claimant's complaints as a dull aching pain throughout his lower back, which is worse with activities, standing, walking, and bending. He noted that the claimant experienced no radiation of the pain into his lower extremities, but that the claimant did complain of a sense of generalized weakness in his anterior legs when "transferring sit to stand." He stated that the claimant was to follow up with a Dr. Uselman for his back complaints and with Dr. Hollingsworth for his right shoulder complaints. He noted that the claimant reported that his continuing pain medication "continued to be helpful." On physical examination he observed a mild tenderness in the claimant's lumbosacral junction with increased pain on lumbar extension. Strength was observed as "full." Dr. Pearlman also recited a summation of some of the numerous prior tests performed on the claimant which included repeat electrodiagnostic studies of the claimant's upper extremities on January 26, 2005. Although this second EMG/NCV record has not been introduced, Dr. Pearlman observed that these repeat studies apparently revealed only the same abnormalities that had previously been seen in the electrodiagnostic studies of Dr. Oricoli on September 22, 2003 (i.e. bilateral carpal tunnel syndrome). The other studies mentioned by Dr. Pearlman were the MRI of the cervical spine that was performed on December 30, 2004, and the MRI of the claimant's lumbar spine that was performed on July 22, 2004. Dr. Pearlman diagnosed the various conditions being experienced by the claimant as lumbar spondylosis, cervical spondylosis, bilateral carpal tunnel neuropathies, and right shoulder impingement.

Finally, in a note which is dated April 5, 2005, Dr. Pearlman stated that, in his expert opinion, the claimant was currently unable to return to work due to his shoulder complaints, which Dr. Pearlman attributed to his BWC(?) shoulder injury. Dr. Pearlman further stated the claimant would continue to be so disabled until he receives the recommended arthroscopic surgical procedure.

The surveillance tape, which has been introduced by the respondents (Respondents' Exhibit No. 3), shows the claimant attaching a car hauler to a van, securing a vehicle onto the car hauler, driving off in the van with the car attached and sometime later unattaching the car hauler from the van. This surveillance tape also shows the claimant engaging on other occasions in the routine day to day activities of normal life. However, in the car hauling episode, the claimant is shown to repeatedly bend and twist at the waist, and to repeatedly squat or stoop for periods of time. He also is shown to engage in reaching, pushing, pulling, and carrying with both of his arms. Finally, he is shown to bend and twist his neck. Although the claimant testified that he subsequently experienced increased difficulties with his right arm after engaging in these activities, such discomfort is clearly not apparent on the surveillance video. The private investigator's report (Respondents' Exhibit No. 2) further reflects that the car hauling incident required the claimant to make a two hour round trip to deliver the vehicle and return. During the tape, the claimant did not appear to be experiencing any ill effects from this two hour drive.

After consideration of all the evidence presented, it is my opinion that the claimant has failed to prove by the greater weight of the credible evidence that he is entitled to continuing temporary total disability benefits from June 18, 2002 through a date yet to be determined. Specifically, I find that he has failed to prove by the greater weight of the credible evidence, that his compensable injuries continued to render him totally disabled from performing all forms of regular gainful

employment for which he would otherwise be qualified after June 18, 2002.

The medical evidence shows that the claimant's primary complaints have, from time to time, focused on one portion of his anatomy and then another. Some of these complaints appear to have resolved following his compensable injury and then reappeared at a later time. The medical evidence also shows that the claimant is experiencing difficulties, including difficulties with his right upper extremity, from non employment related conditions of diabetes and carpal tunnel syndrome. Some of the disabling symptoms which the claimant describes in his testimony, are clearly attributable to these non compensable conditions. Any restrictions or limitations resulting from these non compensable conditions cannot be considered in determining the claimant's entitlement to additional temporary total disability benefits.

It is also important to note that almost all of the objectively documented defects that involve the claimant's cervical spine, right shoulder, and low back are essentially degenerative arthritic changes, which occur over time, as the natural result of the aging process rather than as the result of any specific acute injury. Although Dr. Pearlman has opined that the claimant's cervical and right shoulder symptoms were caused by an aggravation of these degenerative arthritic abnormalities, involving his cervical spine and right shoulder, no such opinion is expressed by any physician in regard to the claimant's lumbar difficulties. I would also note that fundamental changes have occurred in the claimant's right shoulder symptoms and findings long after his compensable injury.

Most importantly, the nature and magnitude of the claimant's symptoms appear to far outweigh his objective findings. The objectively documented physical damage or defects, shown by the medical evidence would reasonably be expected to produce symptoms of the described severity after two years of rest and conservative medical care. However, according to the claimant's testimony, his symptoms have never

improved, but have continued to worsen, even after six years of rest and conservative treatment.

The claimant's own testimony is the primary evidence that has presented to prove that his physical limitations and restrictions have remained sufficiently severe to prevent him from performing any form of regular gainful employment and have been since June 19, 2002. I simply find that his testimony in this regard is not entitled to any weight and credit. Clearly, the physical activities he was shown to be capable of on the surveillance video tape without any apparent difficulty far exceeds the limitations he describes in his testimony.

In reaching my decision, I am aware that Dr. Pearlman has stated that, in his expert opinion, the claimant has continued to be totally disabled as the result of the effects of his right shoulder difficulties and will remain so until after the recommended diagnostic and possibly corrective arthroscopic procedure. I also recognize that Dr. Pearlman attributes all of the claimant's right shoulder difficulties to his initial compensable injury in March of 1999. However, it is apparent that Dr. Pearlman's conclusion that these right shoulder defects prevent the claimant from performing any employment is based in great part on the claimant's subjective right shoulder complaints. Clearly, these subjective complaints were not sufficient to prevent the claimant from performing, without apparent difficulty, the rather strenuous activities with his right arm and shoulder that are demonstrated on the surveillance tape. It is highly doubtful that these complaints have been any more disabling since that time. However, if these symptoms have subsequently become more disabling, it is highly unlikely that this increase had any connection with his compensable injury. As previously noted, the medical evidence shows no evidence of impingement syndrome during the claimant's orthopaedic evaluations by Dr. Hollingsworth, in May of 2003 and Dr. Wilson in July of 2003. Curiously, the first

real indications of tendinitis, bursitis, or impingement syndrome (all conditions generally associated with cumulative stress on a joint) seem to have first manifested themselves in November of 2003, which would be some four and a half years after the claimant's compensable injury. It is also interesting to note that after evidence of impingement syndrome appeared, Dr. Pearlman begins to describe the March 29, 1999 compensable injury to the claimant's right shoulder as a "strain," which would be generally associated with a pull or twisting type injury, rather than merely a direct blow (as previously described).

II. LIABILITY FOR ADDITIONAL MEDICAL EXPENSES INCURRED AND RECOMMENDED DURING AND AFTER JULY OF 2003

The next issue concerns the claimant's entitlement to the payment of additional medical expenses incurred and recommended during and after July of 2003. Again, the burden rests upon the claimant to prove his entitlement to such benefits. In order to meet this burden, the claimant must prove that these medical services represent "reasonably necessary medical services" for his compensable injuries.

Medical services are "reasonably necessary" when they are necessitated by or connected with a compensable injury. Reasonably necessary medical services must further have a reasonable expectation of accomplishing the purpose or goal for which they are intended. However, reasonably necessary medical services are not limited solely to those services intended to actually improve or resolve the physical damage caused by the compensable injury, but also extend to those services reasonably necessary to determine the nature and extent of the physical injury, to maintain the level of healing achieved, and to simply reduce or resolve the symptomatic complaints produced by the compensable injury.

The medical evidence shows that the claimant has received a variety of medical services on and after July of 2003, for a multitude of complaints. The record further

reveals that even more medical services have been recommended. For the sake of simplicity and clarity, it would be best to deal with each of the services indicated by the medical record, individually.

The first of the medical services that is indicated by the medical record is the evaluation by Dr. John Wilson on July 24, 2003. As it appears that this evaluation was performed at the respondents request, the respondents are under a contractual obligation to Dr. Wilson to pay this expense. Clearly, the services rendered the claimant by and at the direction of Dr. Wilson were connected with his compensable injuries and the respondents request for this evaluation alleviates the necessity of determining whether or not it was actually "reasonable." Thus, the respondents are liable for this expense.

Next, are the medical services provided to the claimant by Dr. Pearlman on August 5, 2003, September 4, 2003, and September 11, 2003. These services consist primarily of steroid and anesthetic injections to the claimant's neck or cervical spine for his cervical complaints, and a reasonable follow up or monitoring of the effects of these injections. I find this treatment to be necessitated by or connected with the claimant's compensable cervical injury and to be of a type and nature commonly employed in the treatment of such injuries. Therefore, these medical services represent reasonably necessary medical services under Ark. Code Ann. §11-9-508, and are the liability of the respondents herein, subject to the medical fee schedule established by this Commission.

Next, is the MRI of the claimant's cervical spine that was performed on September 18, 2003. While this testing may have been related to the claimant's compensable cervical injury and resulting complaints, I do not find it to be "reasonably necessary," as that term is defined by the Act. The claimant had undergone two prior MRI studies of his cervical spine, the last of which was performed only four months

prior, on May 7, 2003. It would appear that both of these prior studies were of satisfactory quality and there is simply no justification shown as to why a third study would be appropriate to accurately diagnose the nature and extent of the claimant's compensable cervical injury.

Next, is the evaluation of the claimant and the performance of electrodiagnostic studies, in the form of an NCV/EMG, by Dr. Brian Oricoli on September 22, 2003. The evidence shows that this study was performed at the request of Dr. Pearlman, in order to assure an accurate determination of the etiology of the claimant's upper extremity complaints and to either confirm or rule out a cervical radiculopathy. Under the circumstances at the time, such a test would appear reasonable and appropriate medical practice for the evaluation of cervical injuries and symptoms such as that exhibited by the claimant. The evidence further reveals that this testing did, in fact, accomplish its purpose and ruled out the presence of a cervical radiculopathy as the cause of the claimant's upper extremity complaints. Therefore, I find that this evaluation and testing represents reasonably necessary medical services, within the meaning of Ark. Code Ann. §11-9-508, and the expense of such services should be the liability of the respondents herein (again, subject to the medical fee schedule established by this Commission).

The medical report of Dr. Pearlman dated November 5, 2003, indicates that the claimant experienced an episode of headache and numbness in his right hand for which he was evaluated at the FMC emergency room, and that a CT scan was performed at that time. The claimant has failed to prove that any such services he received at the emergency room of FMC were related to or necessitated by any of his compensable injuries. I would note that Dr. Pearlman expresses no opinion as to what necessitated these services, but would further note that other reports of Dr. Pearlman indicate that the claimant's headaches have been attributed to his

uncontrolled diabetes (report of January 20, 2004-Claimant's Exhibit No. 1, page 21). Therefore, the respondents would not be liable for any expenses incurred as the result of services rendered to the claimant during his emergency room visit at FMC.

On November 4, 2003, the claimant was seen and evaluated by Dr. Pearlman for complaints involving his cervical spine and right shoulder. These were essentially the same complaints which the claimant had been voicing since his compensable injuries. This report indicates that Dr. Pearlman examined the claimant, renewed his long-term medication for symptomatic relief, made some modification in this medication, and recommended an MRI of the claimant's shoulder. The services provided the claimant by Dr. Pearlman would appear to be reasonable and medically appropriate for the monitoring and managing of the claimant's chronic complaints. I find these medical services to be reasonably necessary within the meaning of Ark. Code Ann. §11-9-508. Thus, the expense of these services subject to the medical fee schedule established by this Commission, is the liability of the respondents herein.

Next, is the MRI study performed on the claimant's right shoulder on November 10, 2003. This study was requested by Dr. Pearlman in order to accurately ascertain the nature and extent of the claimant's continuing right shoulder complaints. This form of test is commonly recognized by the general medical community as being an appropriate diagnostic tool to accurately determine the etiology of chronic shoulder complaints. In fact, this study appears to have accomplished that purpose. Therefore, the right MRI performed on the claimant's left shoulder on November 10, 2003, also represents reasonably necessary medical services under Ark. Code Ann. §11-9-508. Again, the respondents are liable for the expense of this service, subject to the medical fee schedule established by this Commission.

The evidence next shows that the claimant was seen for a routine visit for his continuing chronic cervical complaints and for a review of his right shoulder MRI

study by Dr. Pearlman on January 20, 2004. At that time, and on the basis of the MRI findings, Dr. Pearlman recommended an orthopaedic consultation or evaluation by Dr. Hollingsworth. The services provided to the claimant by Dr. Pearlman, on January 20, 2004, appear to be routine follow up and management for the claimant's chronic difficulties that are attributable to his compensable cervical injury. Thus, these services would also constitute reasonably necessary medical services. Again, the respondents are liable for the expense of these services, subject to the medical fee schedule established by this Commission.

Next, the record shows that the claimant was evaluated by Dr. Hollingsworth on February 2, 2004. This evaluation was necessitated by the claimant's chronic right shoulder complaints and the findings noted on the right shoulder MRI. At that time, Dr. Hollingsworth diagnosed chronic right shoulder subacromial impingement and recommended a right arthroscopic decompression, which has not been performed. As previously noted, the claimant's right shoulder impingement syndrome, which necessitated this evaluation and the recommended arthroscopic procedure, has not been shown to be causally related to the claimant's compensable injury of March 29, 1999. Such a condition is inconsistent with the trauma the claimant describes as occurring in the accident on March 29, 1999. Clearly, the claimant had continuously complained of difficulties with his right shoulder, since the accident. However, the claimant's testimony indicates that he had, in fact, experienced significant prior injuries to his right shoulder joint. The objective medical evidence indicates that the claimant's right shoulder difficulties on and after February 2, 2004, were in the form of degenerative arthritic changes and spurring of the shoulder joint and resulting tendinitis and bursitis. Such conditions are not generally associated with the trauma described by the claimant as occurring in the accident of March 29, 1999. More importantly, no actual signs of impingement of the claimant's right shoulder joint had

been noted prior in November of 2003, and repeated previous orthopaedic evaluations of the claimant's right shoulder had expressly recorded no signs or symptoms of shoulder joint impingement. Therefore, I find that the evaluation of the claimant's right shoulder by Dr. Hollingsworth, on February 2, 2004, and his recommended arthroscopic decompression of the claimant's right shoulder joint would not represent medical services necessitated by or connected with the injury to the claimant's right shoulder that occurred in the employment related incident of March 29, 1999. The respondents would not be liable for the expense of these services.

The medical evidence indicates that Dr. Pearlman authored a report to claimant's counsel on April 21, 2004. However, there is no indication that he actually saw or treated the claimant on that date. Clearly, the mere obtaining of a medical report by claimant's counsel does not represent a reasonably necessary medical service for the claimant's compensable injury. Thus, the respondents are not liable for any expense incurred as the result of the obtaining of this report.

The next medical services that are indicated by the medical record consists of a lumbar spine MRI that was performed on July 22, 2004. The actual study shows that it was requested by a Dr. Katherine A. Humes. The study further indicates that it was performed as a result of complaints of low back pain which the patient attributed to an injury at work five years prior. Curiously, the initial medical records from 1999, show any complaints of right hip pain and record no complaints of pain actually involving the claimant's lower back. The first complaint of back pains appear to involve the claimant's thoracic spine. Finally, the first mention of lower back pain is not found until Dr. Pearlman's report of October 4, 1999. However, shortly thereafter, the claimant's lower back symptoms appear to entirely resolve and there is no mention of any further symptoms specifically involving his lower back until the MRI study on July 20, 2004. A review of this study shows that it only revealed the

presence of degenerative arthritic changes and expressly excluded the presence of any disc herniations, protrusions, or vertebral fractures that would be indicative of an acute trauma injury. Therefore, I find that the claimant has failed to prove that the lumbar MRI that was performed on July 22, 2004, was not necessitated by or connected with any compensable injury the claimant sustained to this portion of his body on March 29, 1999. Thus, the respondents would have no liability for the expense of this testing.

The next medical services that are indicated by the medical record consists of treatment rendered to the claimant by Dr. Pearlman on August 24, 2004. This treatment was directed solely toward the claimant's lumbar complaints. As the claimant has failed to prove that these complaints are related to the employment incident and injury on March 29, 1999, and the medical services provided by Dr. Pearlman for these complaints would not represent reasonably necessary medical services under Ark. Code Ann. §11-9-508. Therefore, the respondents would not have any liability for the expenses incurred for these services.

The next medical services indicated by the record is a fourth cervical MRI that was performed on December 30, 2004. Although the claimant's medical index indicates that this study was performed at the request of Dr. Pearlman, the study, itself, reveals that it was performed at the request of Dr. James Uselman. Although Dr. Pearlman subsequently indicated that Dr. Uselman would follow the claimant for his lumbar difficulties, Dr. Uselman apparently involved himself in the claimant's continuing cervical difficulties. However, there is no indication that this involvement was at the request of Dr. Pearlman. In light of the fact that three prior MRI studies had already been performed (all of which were apparently of adequate diagnostic reliability) and that the symptoms recorded at the time of this study were identical with those recorded at the time of the prior studies, there is simply no logical reason

or necessity for this fourth MRI. Not surprisingly, this fourth study noted no obvious change from the prior study on May 7, 2003. In fact, the abnormalities noted in this study were essentially identical with those noted in the prior studies of May 7, 2003, and September 18, 2003. This cervical MRI clearly does not represent reasonably necessary medical services for the claimant's compensable cervical injury and the respondents would not be liable for the expense of this study.

Dr. Pearlman's records show that a second EMG/NCV was performed on the claimant's upper extremities on January 26, 2005. He does not indicate the person requesting this study on the exact reason it was requested. However, all of the claimant's prior MRI's had failed to show any spinal cord or nerve root impingement, so as to raise the possibility of a radiculopathy as the cause of the claimant's upper extremity complaints. The claimant had previously undergone an EMG/NCV that ruled out any radiculopathy as the source of these complaints, but identified their source as bilateral carpal tunnel syndrome, which apparently has never received any treatment. Again, not surprisingly, this second EMG/NCV also showed only bilateral carpal tunnel syndrome. Clearly, this testing was not necessary or reasonable to accurately ascertain the nature and extent of any of the claimant's compensable injuries. Thus, the respondents are not liable for the expense of this testing.

Finally, the medical record shows that the claimant was seen by Dr. Pearlman on February 22, 2005. Dr. Pearlman indicates that the purpose of this visit is for follow up of the claimant's lower back pain. His physical examination also shows that it was apparently limited to his lower back. However, he goes on to summarize some of the various testing that has been performed on the claimant and expresses his diagnosis of the etiology of all of the various complaints exhibited by the claimant. Finally, he states that he has changed some of the claimant's long term medications and that the claimant "will proceed for further evaluation for his cervical pain and

right shoulder impingement." As the services rendered to the claimant by Dr. Pearlman, on this visit, appear to have been necessitated by his lower back complaints and as the claimant has failed to prove that these lower back complaints are related to or connected with any compensable injury he sustained in the employment related accident on March 29, 1999, these services of Dr. Pearlman would not represent reasonably necessary medical services, as that term is defined by the Act. Therefore, the respondents would not be liable for the expense incurred as the result of any services rendered the claimant by Dr. Pearlman on April 5, 2005.

At this point, it is necessary to address the apparent recommendation of Dr. Pearlman for further evaluation of the claimant for his cervical pain (Dr. Pearlman's recommendation of further evaluation of the claimant's right shoulder impingement has already been dealt within this Opinion). The evidence shows that this claimant has been under active medical treatment by Dr. Pearlman for the injuries he allegedly sustained in the employment related incident of March 29, 1999, for approximately six years. During this period of time, the claimant has received by and at the direction of Dr. Pearlman extensive multiple tests and evaluations and extensive conservative treatment. From the medical evidence presented and the claimant's testimony it appears that none of this conservative treatment appears to have provided the claimant with any real or lasting benefit. Clearly, any injuries sustained by the claimant in the employment related accident of March 29, 1999, should by this time have been accurately diagnosed and adequately treated. In fact, it appears that the claimant and possibly even Dr. Pearlman have attributed every possible complaint and difficulty which the claimant reports to have experienced, after March 29, 1999, to the employment related accident on that date. The extensive tests performed on the claimant have only objectively demonstrated essentially degenerative arthritic conditions and systemic conditions such as diabetes and bilateral carpal tunnel

syndrome. Curiously, Dr. Pearlman has shown no desire to become involved in the claimant's care for his systemic conditions, even his bilateral carpal tunnel syndrome. Hopefully, it is because these conditions fall outside his area of expertise, rather than the fact that these conditions would not even arguably be compensable, so as to provide for the payment of medical expenses under the Workers' Compensation Act. I do find it strange that the claimant, at least, is bent upon obtaining a surgical arthroscopy of his right shoulder for his right upper extremity difficulties, but has apparently made no attempt to obtain any surgical relief of his documented severe right carpal tunnel syndrome, which would be far more likely to resolve most of his longstanding complaints with his right upper extremity.

It is simply my opinion that the greater weight of the credible evidence amply demonstrates that the claimant has now received all the evaluations and tests reasonably necessary to accurately determine the nature and extent of any physical injuries he may have sustained in the employment related accident of March 29, 1999. Any further evaluation or testing, as a result of his continued complaints, would not be reasonable or necessary.

FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 29, 1999, the relationship of employee-employer-carrier existed between the parties.
3. On March 29, 1999, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$375.00 for total disability and \$281.00 for permanent partial disability.
4. On March 29, 1999, the claimant sustained compensable injuries to his head, neck (cervical spine), right shoulder, and right leg.

5. There is no dispute over the payment of temporary total disability benefits accruing through June 17, 2002 (apparently, there is no dispute over temporary total disability benefits accruing through June 19, 2002).
6. The claimant has failed to prove by the greater weight of the credible evidence that he continued within his healing period from the effects of his compensable injury, after June 19, 2002. Specifically, he has failed to prove that his compensable injuries rendered him totally disabled from performing all forms of regular gainful employment, for which he would otherwise be qualified, on and after that date.
7. There is no dispute over the payment of medical expenses that were incurred prior to July of 2003, and all such expenses have been paid.
8. The respondents are liable for the expenses incurred as a result of the evaluation of the claimant by Dr. John Wilson on July 24, 2003, for the reasons heretofore set forth in this Opinion.
9. The medical services rendered to the claimant by and at the direction of Dr. Jon Pearlman on August 5, 2003, September 4, 2003, September 11, 2003, November 5, 2003, November 10, 2003, and January 20, 2004, represent reasonably necessary medical services for the claimant's compensable injuries. Pursuant to Ark. Code Ann. §11-9-508, the respondents are liable for these expenses, subject to the medical fee schedule established by this Commission.
10. Any medical services rendered to the claimant by and at the direction of Dr. Pearlman on April 21, 2004, August 24, 2004, December 30, 2004, and February 22, 2004, do not represent reasonably necessary medical services for any compensable injuries sustained by the claimant in the

employment related accident of March 29, 1999. Therefore, the respondents would not be liable for the expense incurred as a result of these services.

11. The cervical MRI study performed on the claimant on September 18, 2003, does not represent reasonably necessary medical services for his compensable cervical injury and the expense of this study is not the liability of the respondents herein.
12. The evaluation and testing performed on the claimant by Dr. Brian Oricoli, on September 22, 2003, represents reasonably necessary medical services for the claimant's compensable cervical injury. Pursuant to Ark. Code Ann. §11-9-508, the expense of these services is the liability of the respondents herein, subject to the medical fee schedule established by this Commission.
13. The medical services provided to the claimant by and at the direction of Dr. Keith Hollingsworth, on February 2, 2004, does not represent reasonably necessary medical services for any compensable injury sustained by the claimant in the employment related accident on March 29, 1999. The respondents are not liable for the expense of these services.
14. The MRI study of the claimant's lumbar spine, performed on July 22, 2004, does not represent reasonably necessary medical services for any compensable injury sustained by the claimant in the employment related accident on March 29, 1999. Thus, the respondents are not liable for the expense of this study.
15. The cervical MRI study performed on the claimant, on December 30, 2004, does not represent reasonably necessary medical services for the

claimant's compensable cervical injury. Therefore, the respondents are not liable for the expense of this study.

16. The claimant has failed to prove that the EMG/NCV that was performed on his upper extremities on January 26, 2005, was a reasonably necessary medical service for his compensable injuries. Therefore, the respondents are not liable for the expense of this testing.
17. The claimant has failed to prove that any medical services provided him by and at the direction of the emergency room of the Fairfield Medical Center in October or November of 2003, including a CT scan of his head or brain, represent reasonably necessary medical services for any compensable injury he sustained in the employment related accident of March 29, 1999. Therefore, the respondents are not liable for any expense incurred as the result of these services.
18. The respondents have controverted the claimant's entitlement to any temporary total disability benefits that accrued after June 19, 2002, and his entitlement to the payment of any medical expenses that were incurred during and after July of 2003.
19. A reasonable fee for the claimant's attorney would be the maximum statutory attorney's fee on any controverted medical expenses herein awarded.

ORDER

The respondents shall be liable for the expense of the additional medical services herein found to be reasonably necessary for the claimant's compensable injuries. Such liability is subject to the medical fee schedule established by this Commission.

The respondents shall be liable to the claimant's attorney for one-half of the

maximum statutory attorney's fee on the additional controverted medical expenses herein awarded. The claimant's attorney is herein authorized to receive from any benefits which may hereinafter become due and payable to the claimant the remaining one-half of this maximum statutory attorney's fee.

The respondents shall not be liable for the expense of any medical services where it has been herein found that the claimant has failed to prove that such medical services represent reasonably necessary medical services for his compensable injuries.

The claimant's request for additional temporary total disability benefits should be and hereby is denied and dismissed for the reasons heretofore set forth in this Opinion.

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.

MICHAEL L. ELLIG
Administrative Law Judge