

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F214090**

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| <b>ELLIS SUTTON, EMPLOYEE</b>                       | <b>CLAIMANT</b>   |
| <b>MASSMAN TRAYLOR JOINT VENTURE, EMPLOYER</b>      | <b>RESPONDENT</b> |
| <b>ST. PAUL GUARDIAN INSURANCE COMPANY, CARRIER</b> | <b>RESPONDENT</b> |

**OPINION FILED JANUARY 14, 2005**

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH W. HOGAN on October 19, 2004 at Monticello, Drew County, Arkansas.

Claimant represented by the HONORABLE KENNETH A. HARPER, Attorney at Law, Monticello, Arkansas.

Respondents represented by the HONORABLE GENE A. WILLIAMS, Attorney at Law, Little Rock, Arkansas.

**ISSUES**

A hearing was conducted to determine the claimant's entitlement to payment of additional medical treatment and attorney's fees.

At issue is whether or not additional medical treatment is reasonable and necessary as defined by Ark. Code Ann. §11-9-508.

After reviewing the evidence impartially without giving the benefit of the doubt to either party, Ark. Code Ann. §11-9-704, I find the evidence does not preponderate in favor of the claimant.

**STATEMENT OF THE CASE**

The parties stipulated to an employer-employee-carrier relationship on July 22, 2002, at which time the claimant sustained a compensable back injury at a compensation rate of \$425.00/\$319.00. Medical expenses, temporary total disability benefits and an 8% rating to the body as a whole have been accepted.

The claimant obtained a change of physician to Dr. Dorsay Bryant, but the respondents refused to pay for his recommended treatment. The claimant seeks payment of medical expenses and attorney's fees.

The respondents contend Dr. Bryant's treatment is based on the claimant's subjective complaints of pain which are exaggerated based on the surveillance videotape. Additionally, Dr. Bryant has never provided narrative reports nor follow-up reports as requested by Commission Rule 30(N)(3). The claimant was rated and released on December 28, 2003 after receiving treatment from Drs. Kenneth Rosenzweig and James Adametz. Respondents contend additional medical treatment is unreasonable and unnecessary.

The following were submitted without objection and comprise the evidence of record: the parties' prehearing questionnaires and exhibits contained in the transcript along with Dr. Bryant's deposition (taken September 14, 2004), two depositions of the claimant (taken June 20, 2003 and September 17, 2004) and three surveillance videotapes (taken May 16, 2003, September 4, 2003, September 5, 2003 and June 20, 2003).

The following witnesses testified at the hearing: the claimant; and investigators, Chad Gray and Linda Childs. Both investigators observed the claimant walk with a limp, however, Ms. Childs noticed the claimant did not always use his cane on the same side.

The claimant, age 46 (D.O.B. September 11, 1959), has a seventh grade education and sporadic work history mowing lawns and working in construction (carpentry, building forms, pouring concrete, bricklayer's assistant). The claimant lives in Greenville, Mississippi, and has support obligations for two children. He has a history of arrests for fighting. The claimant earned \$14.00 to \$15.00 per hour for the respondent-employer building bridges and had worked for them two and one-half years prior to the accident.

On July 22, 2002 the claimant injured his back trying to climb from a boat to a barge with an injured finger. He immediately experienced back and leg pain and notified his supervisor. Out of fear of being terminated, the claimant continued working for a couple of weeks until the pain became so intense he asked his employer to send him to the doctor.

The claimant came under the care of Dr. Adametz in Little Rock who performed surgery on

July 10, 2003 for a disc herniation at L3-4/L4-5 with nerve root compression. On March 25, 2004, the claimant obtained a change of physician to Dr. Bryant in El Dorado. The claimant reported to Dr. Bryant that he remained symptomatic with back pain and a burning sensation in his legs. Dr. Bryant prescribed medication for back spasms and excused him from work. The respondents paid Dr. Bryant's first office visit, but did not pay mileage or the recommended treatment. Even though the respondents controverted the claim, Dr. Bryant has continued to treat the claimant. The claimant wishes to continue under the care of Dr. Bryant at the respondents' expense.

The claimant explained that because his left leg is weak, he began falling. At one point, he fell and cut his thumb, requiring fifteen stitches. A friend offered him the use of a wheelchair and he appeared at the June, 2003 deposition using the chair. At times, he also uses a crutch and a cane. The claimant acknowledged that no physician prescribed the wheelchair, crutches or cane. He testified he used the wheelchair to avoid walking long distances, (Tr. p. 28-29). However, he used the wheelchair at his attorney's office where the parking lot is adjacent to the office. This distance easily compares to the distance the claimant walked from the truck to the gas station/convenience store without the wheelchair.

On cross-examination, Attorney Williams pointed out that the claimant testified in his first deposition that he quit school in the tenth grade as opposed to the seventh grade. He also emphasized that the claimant used his wheelchair entering his lawyer's or doctor's office but did not use the chair as shown in the surveillance videotape at a convenience store and gas station or when he arrived home. In the first deposition, the claimant denied any motor vehicle accidents, a statement that conflicts with the medical records. He also denied problems with his legs and back prior to the incident at work. This statement also conflicts with the medical records.

In the second deposition, the claimant stated he quit using the wheelchair in June, 2003 but medical records indicate he used the chair attending physical therapy in November, 2003, visiting Dr. Adametz on December 8, 2003, and seeing Dr. Bryant in 2004. None of his physicians cautioned him against the use of the wheelchair, crutches or cane.

## MEDICAL EVIDENCE

Medical records from a 1997 motor vehicle accident (MVA) were provided, however they are handwritten and difficult to read. It appears the claimant was treated for a contusion and strain of the right shoulder and thigh and laceration to the left hand. The claimant was treated for another MVA in 1999 complaining of neck and back pain, right shoulder pain and injury to both knees.

Medical records indicate the claimant complained of left leg weakness with numbness and difficulty walking in a report dated July 7, 2002. The report indicates the claimant had trouble with his left leg after a motor vehicle accident in 1982. He also complained of left arm and shoulder pain and pain in his right index finger attributed to arthritis. Due to his claim of parathesia, a CT scan of the brain was conducted n July 7, 2002 and interpreted as normal. These bills were submitted to the group carrier, United Healthcare and these physical complaints pre-date the accident at work on July 22, 2002.

The claimant returned to the emergency room (ER) with complaints of pain in both shoulders, elbows, wrists and hands and was prescribed medication.

On August 13, 2002 he reported to the ER with complaints of left thigh pain after injuring himself at work. An lumbar x-ray taken August 27, 2002 was interpreted as normal.

The claimant began treatment with Dr. Rosenzweig in September 2002 with medication and physical therapy. Dr. Rosenzweig released him to return to work with no permanent impairment rating or work restrictions based on negative diagnostic testing (x-ray, MRI, bone scan, EMG/NCV study of the lower extremityies).

In a report dated May 16, 2003, Dr. Adametz reviewed the claimant's July 2002 MRI scan and opined the claimant needed surgery for a herniation at L3-4, L4-5.

The claimant visited Dr. Adametz using a wheelchair. In a report dated December 8, 2003, Dr. Adametz questioned the claimant's abilities and requested an Functional Capacity Evaluation (FCE) to evaluate the claimant's sincerity. "I asked him again specifically what he did at home when he didn't have a wheelchair handy and he says that he was able to walk, but had to hang onto the wall

or something.” The surveillance videotapes show the claimant was capable of walking without the assistance of a cane, crutches or a wheelchair and without holding on to anything for support.

The claimant told Dr. Adametz that he had applied for Social Security Disability in December, 2003. Dr. Adametz opined the claimant was capable of sedentary work or light lifting (10 to 15 lbs.), but doubted the claimant had the necessary training or education to do that type of job.

In a subsequent report dated December 29, 2003, Dr. Adametz commented that the FCE was not determinative of the claimant’s physical capabilities because “he either self-limited or refused most things. There is also information from an investigation that says that he is clearly able to walk and not use a wheelchair all the time, although he does sometimes use a cane.” Dr. Adametz released the claimant with an 8% rating.

Dr. Bryant assumed the claimant’s care and prescribed medication (anti-inflammatories, Lorcet, Vioxx, Skelaxin and Bextra). Dr. Bryant summarizes the claimant’s medical history in a report dated April 12, 2004. In his deposition, Dr. Bryant testified his treatment was based on the claimant’s reported symptoms (Depo. p. 7, 9, 11). Dr. Bryant also testified the claimant had not reached maximum medical improvement and was unable to work. Evidently, Dr. Bryant is unaware of the claimant’s deposition testimony indicating he tried to go back to work for the respondent-employer and had made job applications elsewhere (June 20, 2003, Depo. p. 28-30/39-40).

Dr. Bryant’s deposition also contains irrelevant and duplicative medical records with Administrative forms, lab results, unrelated health problems, correspondence, and receipts. There is even a medical record on another patient, Mary Strickland. Counsel is once again reminded to include only relevant documents. Filling the depositions and hearing transcripts with irrelevant reports slows down the Commission’s review of the file and contributes to unnecessary court reporting expenses.

### **SURVEILLANCE VIDEOTAPES**

The surveillance videotapes show the claimant being driven to his doctor's and lawyer's offices by a companion. The companion then pushes the claimant in a wheelchair.

In contrast to this image, the claimant is able to drive his truck and walk into a gas station/convenience store and his home without the assistance of a cane, crutch or wheelchair. He does not use the walls of the store or the truck to steady his gait. The claimant does appear to walk with a slight limp.

The claimant's behavior on the videotape combined with his lack of effort on the FCE reflect poorly on his credibility.

The September, 2003 videotape shows two females who look directly at the surveillance camera and one appears to wave.

### **CHANGE OF PHYSICIAN**

The claimant testified he changed doctors because Dr. Bryant in El Dorado was closer to the claimant's home in Greenville, Mississippi than Dr. Adametz's office in Little Rock. I note the change of physician was requested after Dr. Adametz released the claimant to return to work.

When a physician assumes the case, the Commission would find it helpful to know if the new doctor has a different strategy for treating the claimant.

According to the claimant, he has not responded to steroid dose-packs, trigger point injections, surgery, physical therapy, Neurotin, Amitriptyline, Ultram and muscle relaxers. If Dr. Bryant has a course of treatment that has not been tried before then he should explain his plan so that may be taken into consideration when weighing the evidence.

I note that the claimant has not requested temporary total disability benefits, however, I would point out that Dr. Bryant's treatment seems to be aimed at pain management. There is no evidence that the claimant has re-entered a healing period.

## FINDINGS AND CONCLUSIONS

As this claim arose after July 1, 1993, this case is governed by Act 796 of 1993 which must be strictly construed. Ark. Code Ann. §11-9-704, §11-9-717.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. §11-9-508(a). However, injured employees have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary for treatment of the compensable injury. Norma Beatty v. Ben Pearson, Inc., Full Workers' Compensation Commission, February 17, 1989 (Claim No. D612291). What constitutes reasonable and necessary medical treatment is a fact question for the Commission, and the resolution of this issue depends upon the sufficiency of the evidence. Gansky v. Hi-Tech Engineering, 325 Ark. 163, 924 S.W.2d 790 (1996). In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, it is necessary to analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Workers' Compensation Commission, December 13, 1989 (Claim No. D511255).

The evidence in this case shows the claimant has given inconsistent statements in his deposition and hearing testimony and exaggerated the extent of his injuries. While he does walk with a limp, there is some medical evidence showing his leg problems predated his injury at work. There is also no evidence that treatment provided by his physicians to date has been helpful.

Accordingly, I find continued medical treatment to be unreasonable and unnecessary.

1. The Workers' Compensation Commission has jurisdiction of this claim in which the relationship of employer-employee-carrier existed among the parties on July 20, 2002 at which time the claimant sustained a compensable back injury at a compensation rate of \$425.00/\$319.00. Medical expenses, temporary total disability benefits and an 8% rating to the body as a whole have been accepted.
2. I find the claimant is not a credible witness.
3. Additional medical treatment with Dr. Bryant is

unreasonable and unnecessary.

This case is respectfully denied and dismissed.

IT IS SO ORDERED.

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ELIZABETH W. HOGAN  
Administrative Law Judge