

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F406796

PHILLIS MOFFITT, EMPLOYEE

CLAIMANT

DICKERSON LAW FIRM, P.A., EMPLOYER

RESPONDENT

OHIO CASUALTY GROUP, CARRIER

RESPONDENT

OPINION FILED DECEMBER 22, 2006

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on September 29, 2006, at Osceola, Mississippi County, Arkansas.

Claimant represented by the HONORABLE KRISTOFER RICHARDSON, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by the HONORABLE JEREMY SWEARINGEN, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-style claim to determine the claimant's entitlement to additional workers' compensation benefits.

On May 9, 2006, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order of the same date was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' contentions relative to the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Ms. Phyllis Moffitt, the claimant, Ms. Beverly Pharr, and Ms. Gail

Ashmore, coupled with the deposition testimony of Mr. Gregory Wallace and Dr. Jeffrey M. Sorenson, medical reports and other documents, along with video surveillance disc comprise the record in this claim.

DISCUSSION

Phyllis Joyce Moffitt, the claimant with a date of birth of January 17, 1956, commenced her employment with respondent as a legal assistant on March 24, 2003. While the claimant completed the 12th grade she did not go to graduation to obtain a diploma. Claimant concedes that she testified during her deposition that she had graduated from high school.

After high school claimant took some college courses in algebra, sociology and English. Claimant has worked for several different optometry places over the years and has knowledge and experience as an optometric technician. Claimant has also worked as an office manager with responsibilities over payroll, managed employees' time and withholdings, accounts receivable, accounts payable, and did any correspondence the office need.

Claimant's prior employment history reflects that she has worked on manufacturing jobs at Hayworth, Parker Automotive, and Hyttrol. In the manufacturing jobs claimant has both operated machinery and performed assembly type work. Claimant also has experience in retail sales, having sold jewelry at Macy's Department Store in New York. Claimant has also done over-the-road trucking and at one point held a CDL. During her employment with respondent-employer claimant underwent training on electronic court filing, bankruptcy filings, modifications, objections, and other legal filings.

The present claim grows out of injuries the claimant sustained a June 23, 2004, motor vehicle accident. In describing the mechanics of her injury, claimant testified:

I was getting court data coming from Circuit Court and I was parked across the parking lot for the building. There is also a crosswalk that goes in between them. I started crossing the crosswalk, and I saw the truck was going to hit me, but there was nothing I could do because , his statement was - -

* * *

The truck hit me, and he was trying to go around traffic, and (inaudible) He hit me. I went under the truck, and I screamed because I thought the wheel was going to run over my head. He stopped. (T. 9-11).

The claimant's recollection was that the truck struck the left side of her body between her arm and knee, and that she fell to the surface on her right side. Claimant testified that she had pain in her hip as well as scrapes all along her arm and on her hip where she hit the pavement. Claimant was transported from the accident scene by ambulance to St. Bernards Medical Center for emergency medical treatment.

The testimony of the claimant reflects that x-rays were obtained during her emergency room medical treatment and that she was discharged home with instructions to followup with her family doctor, Dr Hurst. While the claimant was at the hospital she notified Ms. Wanda Jones with respondent-employer of her injury. Ms. Jones came to the hospital to see the claimant.

Claimant testified that she did not recall being directed to a specific physician by supervisory personnel of respondent-employer, however she did inform them that she was being seen by Dr. Hurst for her injuries growing out of the accident. Claimant's testimony reflects that while under the care of Dr. Hurst she was provided medication and a referred to an orthopedist and other specialists. Claimant testified that she was also seen by other physicians at the behest of the workers' compensation carrier, to include Dr. Sorenson, a neurologist, and Dr. Jim Moore, a neurosurgeon.

Claimant testified that the first problem she suffered from the accident involved her hip for which she underwent epidural injections, physical therapy, traction, and lots of medications.

Regarding the progression of her symptoms, claimant testified:

My symptoms seemed to have just gotten worse. It gets real weak, I fall a lot. It hurts a lot. It's just very painful.

Everything. With treatments and no treatments. The injections were very painful. I think I had maybe one or two that gave me a couple of week's relief.

It hurts. It hurts to sit any length of time. It's just a very dull, like toothache all the time.

There was a few times like, he did a couple of shots, and then for a couple of weeks there, there was some relief. But they only lasted a couple of weeks. They never lasted very long. There are, I guess there are, like good days and bad days, you know. There are days it does not hurt as bad. But it never stops. (T. 17).

The testimony of the claimant reflects that Dr. Hurst referred her to Dr. Savu, a pain management specialist, who performed the epidural injections. Claimant is seeking additional medical treatment regarding her hip. The testimony of the claimant reflects that the traction that she has undergone, which was supposed to help her hip and neck, was pursuant to the direction of Dr. Moore.

Claimant maintains that her neck problems are also a product to the June 23, 2004, accident. Claimant acknowledged that she did not have any problems with her neck when the accident first occurred. Claimant's testimony reflects regarding the onset of neck symptoms:

I started having the symptoms in my neck well before I went to see the doctor. I can't tell you exactly because I don't remember. But I had been to the doctor so much at that point in time, that I didn't want to deal with anything else right then. When I got to the point where it was bothering me very badly - - I can't remember the exact day.

No. When it started, it didn't hurt as badly. It was something you could kind of ignore for awhile. And then I started getting extreme headaches. And that's originally what I went to the doctor for. (T. 18-19).

Claimant acknowledged that she has fallen since the June 23, 2004, accident:

Well, I, to be honest with you, I've fallen at different times. The doctor first had recommended, you know, let's try walking without the cane. And I just lose my balance. Now if you're asking did I fall before I had that accident, I don't remember. I fall quite a bit I couldn't tell you. (T. 19).

Claimant testified that for her neck problems she has seen Dr. Hurst, Dr. Sorenson and Dr. Moore.

Regarding neck problems prior to June 23, 2004, claimant's testimony reflects:

Well, we went over that, and apparently I was in an accident before. I had had an accident. I didn't remember it at the time. I wasn't even thinking about it at the time but about a year and half before that, a year before that, we were coming back from lunch and a vehicle hit the car. I was in the back seat. The seatbelt had worked and it bruised my collarbone and down through here. And I had a stiff neck. I think I saw Dr. Hurst maybe a couple of times, and then I - - it just went away. (T. 20).

Claimant testified that she did not recall the above at the time of her deposition. Regarding her failure to disclose the afore during the deposition, claimant explained:

I didn't remember. It was a year and a half before. It wasn't a big deal at the time. Basically what I remembered about the most was my collarbone being bruised. It was just - - I didn't remember it. (T. 21).

In distinguishing the symptoms in her neck between the two incidents, claimant testified:

They weren't the same. Like I said, I really did not remember it at the time when he asked me about that. What I remember about the accident was my collarbone. So apparently, it didn't bother me that much. And like I said, I think I went to Dr. Hurst a couple of times.(T. 21).

In describing the problems with her neck which she attributes as residuals of the June 23,

2004, accident, claimant's testimony reflects:

My neck feels like it swells right here at the base of my skull.
And I get a very, very bad headache.

I have had pain in my arms. It just kind of radiates a little bit.
But what bothers me the most is the headaches. (T. 21-22).

The testimony of the claimant reflects that Dr. Hurst referred her to Dr. Routsong for her neck complaints and that the workers' compensation carrier scheduled the appointment with Dr. Soreson for her neck complaint.

The testimony of the claimant reflects that her present activities on an average day consist of trying to clean her house, fixing her meals, reading and working on a quilt top. Claimant noted that she alternates positions when she begin to experience pain. Claimant explained the residuals of her injury which prevents her from working:

Basically, it's two things. I can't sit or stand for any length of time. The medication that I take, I'm not supposed to drive. And it, my attention span I don't think is very good. You know, I take a lot of medication to get through the day. (T. 23).

Claimant, who last worked on June 24, 2003, does continue to drive.

The testimony of the claimant reflects that she is aware that Dr. Moore, who performed an independent evaluation, was of the opinion that she would be eligible for sedentary work. Claimant asserts that her personal doctor, Dr. Hurst, has not released her and that at the time of Dr. Moore's report she did not feel that she could do sedentary work. (T. 23). Claimant's testimony reflects regarding the afore:

Why? For the reasons I said. I can't sit and do what I did before. There's a lot of, you know you would sit for several hours at a time doing that. We were inputting information. And that takes a lot of concentration. And I don't think I could do that anymore. (T. 23).

Claimant asserts that her condition has worsen since the recommendation of sedentary work by Dr. Moore in that she takes more medication than she did earlier.

Claimant testified that she takes Celebrex, Neurotin, Amitriptyline and Flexeril as well as blood pressure medicine. Regarding the effects of the medication on her ability to function, claimant's testimony reflects:

Well when you take Neurotin you're not suppose to drive. The Neurontin helps with the leg cramps. I get leg cramps. It helps with it, but, you know, with some of those you're not suppose to drive. If I'm going to have to go anywhere, I'll skip one of the pills. (T. 24).

Regarding the video CDs of her activity, claimant testified that she has seen them and does not dispute that she retrieved her mail, is able to bend over at the waist and walk down steps, and that she drives her truck. Claimant denies that she goes and work at All About Kitchen and Baths, a business owned by her brother, Greg Wallace. The testimony of the claimant reflects that does go to her brother's business on occasions:

Well sometimes I go just to visit him. Sometimes I will leave my car there so I can go shopping with someone else or my vehicle whatever that I'm driving at the time. At one point in time, my car was tore up, and he loaned me his company truck. So I used that. At one point in time, my ex-husband worked for him, so I went up there to talk to him. And I had some paperwork that I had to do on various things. I was going through a bankruptcy at divorce. I don't have a printer on my computer, so I was using my brother's computer. (T. 26).

Regarding her inability to perform a sedentary job in light of the afore activities, claimant testified:

Because I did those at my pace. If I needed to get up and go do something, I could. I didn't have to spend all day at it. It was something that I didn't spend a great deal of time at one time doing it. (T. 26).

Claimant also testified about services she provided for All About Kitchens and Baths:

I don't know exactly what you mean by that question. I have several times tried to help my brother. He indicated - - Articles of Incorporation would be several thousand dollars. And I found a place on the internet where I could do it at my speed, if I wanted to get up, I could get up. If I wanted to get up and if I wanted to sit down. I tried to help him with those Articles of Incorporation. If I happen to be there working on the computer, when nobody was around, yeah I did because I didn't want to be rushed. But I did not work for my brother and do not work for my brother. At any point in time when there was something that I could do to help him out, I would. (T. 27).

Claimant testified that she can carry bags if they are not too heavy. Claimant asserts that she can carry an empty box. Claimant maintains that there was nothing in the videos that was inconsistent with her contentions for workers' compensation benefits.

Claimant asserts that Dr. Sorenson recommended surgery in the treatment of her neck injury. Thereafter she was referred by respondents to Dr. Moore who also recommended additional treatment, physical therapy and traction.

Regarding the physical problems for which claimant is seeking workers' compensation benefits as a result of the June 23, 2004, accident, claimant asserts that she now takes medication on a regular basis for high blood pressure. Claimant concedes that her primary care physician, Dr. Hurst, had relayed that her blood pressure was "a little bite on the high side" and had counseled her about caffeine and salt in her diet as well as about her smoking prior to the June 2004 accident. (T. 34). During her November 2005, deposition the claimant testified that the reason she was claiming that her that her high blood pressure was caused by the June 2004 accident was because she had never been diagnosed with it before. At the time of the hearing claimant testified regarding the afore:

I don't, what you're asking me is, now as far as diagnosing and telling me it was actually time I was going to have to take medication for it, no. What he counseled me for was to reduce my caffeine, reduce my smoking and my salt, so that it wouldn't get so high that I would have to take medication. After the accident what he had told me was that it would peak when I would be excited, when I would be excited. And that's when I started having to take the medication. (T. 36).

The medical record of the claimant reflects that when she was seen by Dr. Hurst on June 5, 2003, her blood pressure reading was high, 142/100, and the claimant 's hypertension was discussed.

While the claimant testified that she does not know if her problems with urinary tract infections are related to the June 2004, accident, she noted that she has had a kidney infection every since the accident. Claimant concedes that she did have problems for which she received treatment under the care of Dr. Hurst prior to the June 2004, accident. (T. 37).

Regarding her use of a cane on the date of the hearing claimant testified:

At one point in time, we were trying to not walk without the cane if I could keep my balance. I tried to - - I use it whenever there's going to be steps around. I use it quite a bit. I use it more now. But we're trying not to use the cane. I started from a walker. I had a walker right at first. (T. 37-38).

Claimant asserts that she went from a walker to a quad cane to a regular cane to assist her in walking.

Claimant acknowledged that she has had a diagnosis of bilateral carpal tunnel and that she has undergone surgery on the right hand for same. Claimant settled her workers' compensation claim for bilateral carpal tunnel for \$15,000.00.

While the claimant's medical record recite complaints of chest pain, shortness of breath, and gastrointestinal problems, claimant testified that she does not know if the complaints are related to the June 23,2004, accident. Claimant testified that she told the medical provider for

treatment related to her gastrointestinal problems, to include a diagnosis of a hiatal hernia, that she “did not know if it was workers’ comp or not”. (T. 39). Nevertheless, the claimant is claiming the diagnosed August 2005, hiatal hernia as compensable. (T. 41).

The testimony in the record reflects that the claimant underwent a period of hospitalization for approximately a week while diagnostic testing was pursued regarding her chest pain and pulmonary complaints. Claimant denies that she was informed during the hospitalization for the gastrointestinal and lung problems in August 2005, that she had ruptured breast implants.

While the claimant testified that she was in and out of consciousness following the accident, the emergency room report reflects that she denied loss of consciousness. Claimant denies that she informed Dr. Braden when she was seen by him two months following the accident, that she lost consciousness in the accident. Claimant testified that she would defer to the contents of the medical records regarding the afore.

The testimony of the claimant reflects that at the time of the emergency room visit following the June 23, 2004, accident her chief complaint was right hip pain. Claimant received medical treatment for her right hip and sacroiliac area following the accident over the next ten (10) months. The claimant underwent a MRI scan of her pelvis on June 25, 2004, which was normal with the exception of an ovarian cyst. Claimant testified that the reason she declined hospitalization on June 26, 2004, was because she does not like going to the hospital, and not because she would not be able to smoke.

Claimant testified that she had no recollection of going on a business trip during a weekend in August 2004, and needed some medicine, as reflected in an August 4, 2004, report of

Dr. Hurst. Claimant offered that the only thing that she could think of regarding the afore is that she went to one of the doctors.

The testimony of the claimant reflects that following her July 2004, physical therapy for her hip complaints, she was seen by Dr. James Schrantz, an orthopedist, for treatment of both her hip and leg problems. Claimant testified that Dr. Schrantz gave her some injections, however they were only beneficial in relieving her hip pain for a few minutes.

While uncertain how she came under the care of Dr. Braden, claimant acknowledged that while under the care of same she underwent another round of physical therapy as well as an MRI scan of her lumbar spine. Claimant was referred by Dr. Braden to a pain specialist, Dr. Savu, who administered a round of injections.

Regarding a January 2005 medical report reflecting a ruptured blood vessel in her right eye and the nexus of same to the June 23, 2004, accident, claimant testified:

I believe what I said or what the doctor told me was my blood pressure had probably spiked and caused it to rupture. I don't what caused it to rupture, to be honest with you. (T.48).

In February 2005, Dr. Hurst referred the claimant over to Dr. Jeffrey Sorenson for treatment of the claimant's hip related complaints. Claimant concedes that if the medical records reflect that she saw Dr. Sorenson in February 2005, for left hip complaints she is unable to dispute them. During the February 2005, visit to Dr. Sorenson claimant did not relay complaints relative to her neck. Claimant acknowledged that Dr. Sorenson did not recommend any kind of surgical procedure regarding her pelvic problem.

The medical records reflect that he claimant has physical therapy, pursuant to the directions of Dr. Braden, from February 2005 through April 2005. Claimant testified that she did

not recall the physical therapist telling her that she was not focused enough, not trying hard enough, or not being compliant with the therapy. Claimant's testimony reflects that the afore physical therapy did not help at all.

In May 2005, claimant return to Dr. Braden and again underwent nerve conduction studies. Claimant testified that she does not recall the results of the studies. Claimant was seen by Dr. Sorenson on May 4, 2005, and complained of neck problems. Claimant noted that she had registered similar complaints to Dr. Hurst prior to May 4, 2005. Claimant's testimony reflects that she cannot recall when her neck problems began. During her deposition claimant acknowledged that she probably did not mention her neck complaints to either of her treating physicians or medical providers between June 2004 and May 2005.

Claimant maintains that she was focused on the severe pain in her hip following the June 23, 2004, accident, and as a consequence, did not pay attention to her neck problems. The evidence in the record reflects that the claimant did discuss other ailments with her providers and physicians during the June 23, 2004/May 4, 2005, time period. Regarding the absence of any mention of her neck complaints, claimant testified:

Again, as I said, sir, I had been seeing the doctors so much I didn't want to deal with anything else at that point in time. The blood pressure was something that he brought up. (T. 53).

The testimony in the record reflects that while the claimant did recall the May 2003, motor vehicle accident in which she injury her shoulder during her deposition, she denied ever having neck pain prior to the June 23, 2004, accident. As a consequence of the afore, claimant testified during the deposition that her present neck complaints were the product of the June 23, 2004, accident. Claimant attributed her vomiting during the May 2003, accident to the restraint

of her seatbelt choking her and not as a result of any neck pain. (T. 55). A May 13, 2003, medical record reflects that the claimant has severe neck pain, however claimant's testimony reflects that she only recalls having a stiff neck and being bruised across the sternum.

Claimant testified that she does not remember if she told Dr. Sorenson of any prior neck problems when she was seen by him in May 2005. The medical records reflect that the claimant sought treatment on November 20, 1998, at St. Bernards' Regional Medical Center for neck trauma growing out of an automobile accident. The medical records of the visit reflect that the claimant had cervical spine x-rays, was provided a cervical collar, which she kept pulling off her neck, and refused the blood alcohol test.

The claimant was referred to Dr. Routsong by Dr. Sorenson in May 2005, relative to her neck complaint. Claimant did not disclose any history of prior neck problems or complaints at the time of the May 2005, visit to Dr. Routsong.

On September 7, 2005, claimant was seen by Dr. Jim J. Moore, a Little Rock neurosurgeon, who prescribed traction and some therapy. Claimant asserts that she followed the recommendations of each of her examining and/or treating physicians. Claimant acknowledged that she did not return to sedentary work as recommended by Dr. Moore.

Claimant concedes that she had a telephone conversation with Ms. Beverly Pharr of the Dickerson Law Firm on October 6, 2005, following the sedentary work restriction of Dr. Moore. Claimant acknowledged that she was informed that respondent-employer wanted her to come back to work in a sedentary work capacity and would make reasonable accommodations for her if needed. There is no testimony in the record to reflect that the claimant relayed concerns about having to go to doctor's appointments or physical therapy and how the same would impact on the

sedentary job to supervisory personnel of respondent-employer. Claimant acknowledged that she followed up with Ms. Pharr and left a message on her answering machine stating that she was not coming back to work and refusing the position on October 11, 2005.

Claimant acknowledged that she was subsequently contacted by the insurance adjustor, Mr. Dave Long, by e-mail regarding the sedentary work recommendation of Dr. Moore.

Claimant does not dispute that Mr. Long offered to make up the difference in temporary disability payments of what she might miss from work doing sedentary work if she had to go to the doctor or physical therapy and was unable to go into work.

At the time of the claimant's refusal of the sedentary work offer from respondent-employer she was bankrupt and also had a third party claim pending against the driver of the automobile in the June 23, 2004, accident. Claimant asserts that she is uncertain what impact her returning to work would have had on her third party claim. Claimant continues to maintain that the reason she did not return to work was because she was in too much pain and was unable to concentrate. The afore was relayed by the claimant in her November 7, 2005, deposition. The testimony reflects that on November 8, 2005, claimant did the Articles of Incorporation for her brother's business, All About Kitchens and Baths, and filed them with the Secretary of State's Office.

Regarding her reasons for declining the sedentary work offered by respondent-employer, claimant testified:

No, sir. Again, I do not feel like that - - that particular job does require a lot of concentration. It takes a lot of data. Much more data than anything else I've got to input. (T. 66).

Other than preparing the Articles of Incorporations for her brother's business, claimant denies

that did any work for her brother. Claimant concedes that she filed loan applications for her brother and processed them using his financial data and paid utility bills. (T. 67-69). During her November 7, 2005, deposition claimant testified that her pain was not controlled sufficiently so that she could maintain her concentration and that she did not anticipate returning to the work force in the future.

Claimant's testimony reflects that she has seen the video surveillance, which covers the dates January 11, 19-20, and February 13-16, 2006, and that she is the blond female depicted in them. Claimant concedes that on one of the videos she is seen walking up and down steps of her house to check the mail and is not using a cane or holding onto the handrail. Claimant asserts that she was "trying not to use the cane" at the time. (T. 71). Claimant also acknowledged that at the time of the surveillance she drove a Jaguar. Claimant testified that the bags that she was seen carrying in the surveillance contained paper and that the boxes were empty.

Claimant denies that she remained at her brother's business, All About Kitchens and Baths, the entirety of the time that the vehicle that she was driving, as seen in the surveillance was at the business:

I was not there - - I was running errands, I might come back. I did not stay there. The video shows, it shows the vehicle there. It does not show me there. (T. 73).

Claimant asserts that at time she was visiting her ex-husband who happened to work at All About Kitchens and Baths on occasions. Regarding the accuracy of the videos claimant testified:

I saw several of the videos, sir, where I stumbled, started to fall, and they would take the video camera up to the trees.

He moved it up as I started to fall, yeah. (T. 74).

The claimant's testimony reflects that more than five (5) employees worked at All About Kitchens and Baths.

Ms. Beverly Jane Pharr, a three year employee of respondent-employer, testified that she has worked as a HR specialist and as an administrative assistant. On June 23, 2004, Ms. Pharr worked as a part-time administrative assistant for respondent-employer. In September 2005, Ms. Pharr worked in the capacity of a HR specialist for respondent-employer, with job duties and responsibilities of administering the insurance program, taking care of all the workers' compensation issues, payroll and evaluations.

With respect to her familiarity with the claimant, Ms. Pharr testified:

Well, I have never met her until today. I had talked to her on the phone back in September of 2005. And I think maybe we had exchanged emails over work issues when she was working for us. (T. 81).

In September 2005, Ms. Pharr became aware that the claimant had been released to sedentary work duties. Ms. Pharr testified regarding a conversation she had with the claimant about the claimant returning to work for respondent in sedentary job on October 6, 2005. Ms. Pharr's testimony reflects that she informed the claimant that the job she was being offered was within the sedentary work restrictions. Regarding the claimant's response to the job offer, Ms. Pharr testified:

She said something about she would have to go to the doctor several times a week, and that she would need to meet every day with the physical therapist.

I told her that would not be a problem, that we would accommodate her in any way we needed to, you know, that would help her.(T. 83).

Ms. Pharr maintains that at the time the position was offered to the claimant it was a formal

position with respondent-employer. Ms. Pharr's testimony further reflects that the offered position was one that respondent-employer was agreeable to modify in whatever way necessary to accommodate the claimant's work restrictions. Claimant did not accept the position. Ms. Pharr testified:

When I returned to my office, and I was working at several offices during that time, when I returned to my office on the 11th of October, I had a voice mail that she had left the day before stating that she would not take the position. (T. 84).

The Jonesboro office of respondent-employer closed on October 28, 2006, the day prior to the hearing in this claim. At the time of the closing there was only one position filled at the office, which was the receptionist. Ms. Pharr testified that the other employee, a legal assistant, of the Jonesboro office of respondent-employer were let go at the end of June 2006. Prior to June 2006, respondent-employer had five or six employees in the Jonesboro office. The testimony of Ms. Pharr reflects that in November or December 2005, respondent-employer began the process of laying off employees in preparation of closing the Jonesboro office.

Ms. Pharr acknowledged that she did not furnish to Dr. Moore or Dr. Hurst a written a job description of the position offered to the claimant. Ms. Pharr explained:

No. I didn't. When she did not accept the job, it wasn't necessary to make any contact with her doctors to see exactly what they mean about, you know, what she could do and couldn't do. We felt that was something we would have to have in writing from Lynn, who would have asked for something in writing from her doctors to find out exactly what the restrictions were. (T. 88).

Regarding the availability of a sedentary position at respondent-employer, Ms. Pharr testified:

Well, we would have created whatever she needed to get her back to work.

Well, as I said, we were actually creating a job for her to accommodate her. So we would have checked with her doctor if she accepted the position and see what her restrictions would have been. (T. 88-89).

The testimony of Ms. Pharr reflects that the claimant did not seem motivated to return to work.

Ms. Gail Ashmore testified that she is currently employed by respondent-employer as Director of Administration, as official title that she has held for three (3) years. Regarding her job responsibilities Ms. Ashmore's testimony reflects:

All administrative duties, the human resources, the accounts payable, advertising, marketing, anything that is of a non-legal basis.(T. 91).

Ms. Ashmore testified that she is generally familiar with the various types of positions that are available with respondent-employer. Ms. Ashmore noted with respect to the classification of "sedentary":

No, sir. But I know the word sedentary, and I can tell you that it would involve some of - - the job would be, where they would be able to sit for short periods of time, would need to stand when necessary, the individual in the sedentary position would need to have some flexibility in being able to get up and move around and not stand or sit too long. (T. 92).

One of the exhibits in the record is a job description of a position that the claimant previously worked:

This is the position that she had worked at before, when she came, when she worked as part time. She did this on a part time basis. She would have worked in this position with accommodations for her limitations upon her return. (T. 93).

Regarding the modifications to the position that would have been put in place had the claimant accepted the position, Ms. Ashmore testified:

If she, cone of the work that we do, like if she would be e-filing something she might have to sit for a long period of time. We would

have looked at the task that were involved in that particular job description. We would have talked with her doctor to say, this is what's required, how long should she sit? How long should she stand? And then we would have allowed her to work within those ranges. If there was anything in there, we probably would not have let her lift ten pounds. We would have worked with her and her limitations because we wanted to get back to her level of health. (T. 93-94).

Ms. Ashmore testified that had the claimant accepted the sedentary position additional inquiries would have been made of her treating physicians.

The testimony of Ms. Ashmore reflects that prior to October 2005, claimant had worked in a modified position due to physical problems:

Yes, sir. As a matter of fact, she started to work for us March 24th of 2003. In November, November 19th, 2003, we received a resignation by email saying that she could not, she could no longer work full time due to what she called physical limitations I believe is the term that she used. She said that she would, if we ever had anything part time that she would be, she would really love to come back to work with us part time if we had anything of that capacity. But that she just could not work full time. She said that she would work with us through the end of the holidays so that we could, so she could help out. (T. 95).

Ms. Ashmore's testimony reflects that a position was made for the claimant in response to the November 19, 2003, email of the claimant. (T. 97).

The testimony of Mr. Gregory Wallace, the claimant's brother and owner of All About Kitchens and Baths was obtained by deposition on June 23, 2006, and designated a part of the record in this claim as Joint Exhibit #1. Mr. Wallace testified that All About Kitchens and Baths is a business which builds and installs kitchens and bathrooms and has twelve (12) subcontractors. Mr. Wallace owned and operated another business, All About Kitchens and Baths, Too, for approximately three (3) months before it ceased. Mr. Wallace's testimony reflects that he has two full time employees, John Bishop and Betty Bishop, that work in the

main office of All About Kitchens and Baths. Mr. Bishop has work for Mr. Wallace for approximately 1 ½ years, and his daughter, Ms. Betty Bishop, has been so employed approximately six (6) months. The business was started approximately one and one-half (1 ½) years prior to the June 23, 2006, deposition of Mr. Wallace. The business is located at 5510 Stadium Boulevard in Jonesboro, Arkansas.

Mr. Wallace testified during the June 23, 2006, deposition that he is responsible for deciding works for All About Kitchens and Baths, and has responsibility for payroll and bookkeeping, as well as keeping track of his own books. Mr. Wallace maintains that he is responsible for writing the checks of his employees. Further, the testimony of Mr. Wallace reflects that the claimant has never worked for him or All About Kitchens and Baths, nor has she ever performed any kind of services or assistance for him or for All About Kitchens and Baths in a business capacity.

The testimony of Mr. Wallace reflects that he has very little understanding of the claimant's workers' compensation claim, only that he was aware of the June 23, 2004, accident, in that the claimant was run over by a vehicle. Mr. Wallace testified:

And she's - - from what I understand, she's seen a lot of doctors and has had a lot of pain. That's basically, you know, all I know. (JX #1, p.10).

Mr. Wallace's testimony reflects that he talks with the claimant every day and sees her every other day. The claimant divorced Don Moffitt in February 2006. Mr. Wallace's testimony reflects that Mr. Moffitt is a part-time employee of All About Kitchens and Baths, with duties that include putting out fliers for the business and running errands out of town, an dis paid a salary and commission. Mr. Wallace testified that the claimant has access to and use of the

computers of All About Kitchens and Baths, for personal use.

Mr. Wallace's testimony reflects that in the past six (6) months the claimant has assisted him in helping to get several loans by completing the paperwork. Mr. Wallace maintains that the claimant completed the paperwork at her house. Mr. Wallace denied that the claimant prepared the application or completed paperwork on the premises of All About Kitchens and Baths.

Regarding the various tasks performed for him by his sister, the claimant, Mr. Wallace note that his parents died when he was young and that his sister does a lot for him personally.

Regarding his observations of the claimant since the accident, Mr. Wallace testified that she walks with a limp. Mr. Wallace testified that the claimant has walked using a quad cane since the first of the year 2006, although he is uncertain if she has used it every time that he has seen her. The office of All About Kitchens and Baths is approximately twelve (12) miles from Bay.

The claimant is listed as the registered agent of service for All About Kitchens and Baths. The records of the Arkansas Secretary of State reflects that the claimant is listed as an office, incorporator and an organizer of All About Kitchens and Baths. Mr. Wallace denies that the claimant keeps any financial information regarding All About Kitchens and Baths. The testimony of Mr. Wallace reflects that the ownership of All About Kitchens and Baths breakdown as 50% each between himself and Mr. Keith McElyea, who is his brother-in-law.

The deposition testimony of Dr. Jeffrey M. Sorenson, a Memphis neurosurgeon with Semmes-Murphey Neurologic & Spine Institute, was obtained on September 6, 2006, and is herein designated a part of the record as Joint Exhibit #2. The testimony of Dr. Sorenson reflects that he first saw the claimant on February 9, 2005, at which time the claimant relayed that

her chief complaint was pain in her left hip and leg and swelling in the right leg. The claimant also relayed at the time of the initial visit to Dr. Sorenson that her left leg would go numb at times. The claimant did not relay to Dr. Sorenson any problems with her neck during the initial February 9, 2005, visit.

The testimony of Dr. Sorenson reflects that during the February 9, 2005, visit the claimant's most painful area was the sacroiliac joint rather than the lumbar spine or lumbar disc area. Dr. Sorenson testified that while the claimant did complain of some intermittent numbness in her leg there was not a clear cut case of radicular pain, which is nerve root pain. Further the MRI did not show clear cut nerve root compressions. When questioned regarding his diagnosis of sacroiliitis or sacroiliatic pain and his expectation of maximum medical improvement relative to the claimant, Dr. Sorenson testified:

That's a - - that's a difficult question to answer. Sacroiliitis can be a chronic difficult problem to treat. I couldn't tell you an exact figure of how long it would take for her to maximally improve. Some people are better in a few weeks, and some people, it's many months of therapy.

* * *

You know, there are some people who would have a single injection and the pain is gone and they feel great. There are other people that have injections and physical therapy and never really improve. So there are cases that just don't improve despite therapy. (JX. #2. p. 16).

Surgery is not typically recommended for sacroiliac pain.

Regarding any casual nexus between the claimant's complaint of neck pain and the June 23, 2004, accident, Dr. Sorenson's testimony reflects:

. . . We just know that she showed up with an MRI and that she had cervical disc herniations. And of course, she had not complained to me of pain in that area during earlier visits. And so it apparently became

symptomatic later.

Whether the accident contributed to it or not, I mean, who knows. Your guess is as good as mine. (JX. #2, p. 19-20).

Dr. Sorenson further testified:

Yeah. Again, causation is a complicated issue because basically everything that happens to you in your life can contribute to the degeneration of the discs in your neck or back. You know, anything that happens to you can contribute. So how much did that event contribute versus other events in her life, who knows? (JX. #2, p. 22).

Dr. Sorenson noted in reviewing the June 23, 2004, emergency room report relative to the claimant's accident and notation of "multiple trauma diagnosis, cervical sprain" under the differential diagnosis. Dr. Sorenson added that it was not clear what the diagnosis was based on. The report reflects an entry usually indicating negative or no complaint of neck pain. Dr. Sorenson testified that had the claimant injured her neck in the June 23, 2004, accident he would have expected her to have experienced some symptoms within a couple of days after the accident.

Following the February 9, 2005, visit of the claimant, Dr. Sorenson testified that he did not see her again until May 11, 2005. Regarding the May 11, 2005, visit, Dr. Sorenson testified that the claimant was there for a follow-up of sacroiliitis. At the time the claimant complained about neck pain which radiated up into her left upper extremity. The afore symptoms were of recent onset. Claimant was next seen by Dr. Sorenson on June 29, 2005, at which time he had an opportunity to view the claimant's cervical MRI scans. The reports recites that the MRI of the cervical spine shows a C5-6 and C6-7 HNP. Regarding the radiologist's finding relative to the claimant's cervical spine MRI, Dr. Sorenson testified:

Stenosis simply means narrowing. So he saw narrowing or the

central canal, which is where the spinal cord passes, narrowing on either side of the spine where the nerve roots exit and then going to travel into your arm. And the narrowing was felt to be the reason for her arm pain, nerves being pinched.

Osteophytosis at C6-7 is a reaction to a disc bulging. Bone spurs - - form along with a bulging disc, and that's referred to as an osteophyte. (JX. #2, p. 32).

Dr. Sorenson commented on the conclusions of the radiologist,[moderately severe central spinal stenosis and moderately severe neuroforaminal stenosis] relative to the claimant's cervical MRI scan:

Well, the underlying cause of the stenosis is the disc bulging out. As the disc bulges out, it narrows the opening that the nerve root exits from. And as that disc continues to bulge, the bone spurs form.

But they're a secondary process.

Sure. They can tell you - - for example, C6-7, there being an osteophyte there can tell you that the disc herniation is not acute at that level, but you can't really say much beyond that. You can't say that, you know, that it's been bulging for a year or two years or three years. But it will tell you that something that just - - it's not something that happened yesterday. (JX. #2, p. 33-34).

The findings on the claimant's cervical MRI scan are consistent with disc degeneration. The testimony of Dr. Sorenson reflects that at the time the claimant complained of neck pain to him during the May 11, 2005, visit, she did not disclose a history of a prior neck injury. Regarding the value of the afore, Dr. Sorenson testified:

It would be helpful to answer that question. Of course, the most recent MRI is what everything hinges upon in terms of treatment. The MRIs from the past become more important when you want to try to explain exactly when things developed. And you know, I guess they're more important in the legal realm.

You know, from a medical standpoint, if I have the most recent MRI, you know, I can go on that and not see the previous MRIs, because that's the current state of her neck. And however it got that way and

however long it took to get that way, it's still that way, and that's what I'm treating.

So I didn't necessarily have to see her previous films in order to treat her. (JX. #2, p. 37-38).

In a May 15, 2003, medical report, the claimant complained of severe neck pain as her chief complaint. An x-ray report of May 13, 2003, relative to the claimant reflects the presence of degenerative disc disease at C5-6 and C6-7 levels, the same levels identified on the May 2005 cervical MRI scan. The May 13, 2003, x-ray report relative to the claimant also reflects the presence of osteophytosis at the afore levels, as well as bilateral neuroforaminal narrowing at the same levels. Regarding the impingement of the nerve roots at the C5-6 and C6-7 levels, Dr.

Sorenson testified:

Well, that's a - - that's a little bit of a different question. Because the nerve root - - the foramen will narrow to a certain extent before the nerve roots are impinged. So as the narrowing begins, the nerve roots are not impinged. And as it continues over time, it reaches a point at which the nerve roots do become impinged. So you can have the stenosis before you have the impingement. (JX. #2, p. 44).

The claimant was involved in an automobile accident on or about November 20, 1998, and received medical treatment. During the afore, the cervical x-rays were obtained. The radiologist report regarding the afore reflects chronic degenerative changes at C5-6 and C6-7 levels. Regarding the nexus between the claimant's June 23, 2004, accident and May 2005, complaints of neck pain, Dr. Sorenson's testimony reflects:

You wouldn't be able to say with certainty, you know, what. It appears that she's had a long standing chronic disease of those two discs, and it would be difficult to point your finger to any one particular event and say this caused her disc degeneration. (JX. #2, p. 49).

Regarding his surgical recommendation relative to the claimant, Dr. Sorenson testified:

You know, all I can say is that the need for or the recommendation of surgery was related to the current state of her neck. And how her neck got that way is a much more complicated question, which there's no easy answer for. (JX. #2, p. 50-51).

In considering recommending surgical intervention Dr. Sorenson testified regarding the kind of physical complaints he typically considers:

Usually a pain that radiates from the neck into the shoulder and arm with or without tingling, numbness or weakness. For many people, it's simply pain. (JX. #2, p. 52-53).

Regarding causation of the June 23, 2004, accident to the claimant's May 2005, neck complaints, Dr. Sorenson's testimony reflects:

Yeah. It's usually a gray area. But again, the tighter the interval between the accident and the symptoms are, the, you know, better we can establish causation. And the longer the interval, the more ambiguous the link is.

Certainly, we've had people hit by a car, been in a car wreck and they come in with a big disc herniation and neck and arm pain and diagnosed that very same day and had no history of neck pain. And there, the cause is pretty clear cut. And then we have cases like this one where in my mind it's much more of a gray area.

Sounds like there's evidence of some previous degeneration. And how much did each event contribute to the overall time line of degeneration, you know, that's the part that's speculative. (JX. #2, p. 62-63).

The medical in the record reflects that the claimant was seen at the emergency room of St. Bernards Medical Center on June 23, 2004, following her accident. The history recited in the emergency room records relative to the claimant's injury reflects:

HPI: This 48 y o w f was walking across the street when she was struck by a pick up truck which was just starting up. She denies any loss of consciousness. She has pain about the left hip and left elbow. moving the left lower extremity worsens Sx. (RX. #1, p. 50).

On June 25, 2004, claimant was seen by her primary care physician, Dr. William Hurst, D.O., for

complaints growing out of the June 23, 2004, accident pursuant to the discharge directions of the attending emergency room physician of St. Bernards Regional Medical Center. The June 25, 2004, Chart Document of Dr. Hurst relative to the claimant reflects, in pertinent part:

HPI: patient here for follow up from accident as above. She recalls the event well, and it happened wed pm at 1:30 as she was walking in crosswalk. The truck did not see her and hit her and knocked her down, and was very sore on her L side. Td IM was given in ER and she is now here for follow up from that, still very sore in her L hip. (RX. #1, p. 54).

Claimant was prescribed medication for her hip pain and arrangements were made to obtain a pelvic MRI. The MRI scan disclosed a normal pelvic with no hip fracture seen. (RX. #1, p. 57).

A June 26, 2004, chart note of Dr. Hurst relative to the claimant reflects that the claimant was still very sore and was ambulating with her cane in her left hand. The chart note further reflects:

no fever, no other problems, and BP is still up today despite PO norvasc added yesterday. We discussed smoking cessation and caffeine with her BP and will add medicine for her mm spasms she is having. She states no gastrointestinal or genitourinary problems, and other that her L hip is doing OK. (RX. #1, p. 59).

Flexeril was added to the claimant's medical regime during the June 26, 2004, visit. The diagnosis reflected in the June 26, 2004, chart note was that of sprain/strain, hip/thigh nec. The chart note reflects that hospitalization was offered to the claimant, however she declined because she could not smoke in the hospital. The claimant was referred to physical therapy and discharged home. (RX. #1, p. 60).

On July 21, 2004, the claimant was seen by Dr. James L. Schrantz, a Jonesboro orthopedic surgeon, pursuant to a referral of Dr. Hurst. The July 21, 2004, office note relative to

the visit reflects, in pertinent part:

Today then with the tenderness being over the greater trochanteric an injection is carried out with the patient recumbent attempting to hit the bursa. This makes very little difference in her pain. A second injection is given more anterior at the trigger point that is giving her the most trouble when she is standing and this appears to be successful in relieving her pain. We will plan on rechecking here in three weeks if she is having continuing difficulty. (RX.#1, p. 75).

The claimant was again seen by Dr. Schrantz on August 11, 2004. The chart note relative to the visit reflects, in pertinent part:

Ms Moffitt is back today again with severe recurrence of the left greater tochanteric bursitis.

Clinically I can't find anything else as the cause of her pain. She has already undergone a pelvic MRI and a bone scan.

Today an injection is carried out with her standing. The first injection does not relieve her pain and is moved distally an inch and half to get good relief with the injection. We would like to recheck her when her pain starts to come back. If she is still pain free at three weeks, she is to contact us about returning to work. (RX. #1, p. 83).

In a September 1, 2004, letter to Dr. William Hurst, Dr. Schrantz relayed:

Phyllis was seen back in our clinic 9-1-04 again in significant pain. The pain has been a strange greater trochanteric bursitis from the beginning. The pain seems t have moved from that area at this time and is now her greatest area of tenderness is her left SI joint and posterior superior iliac spine. She has been on Vioxx since the initial episode. She doesn't feel that that is doing much. We will stop that and start Celebrex. She has been off of her pain medicine and Flexeril for the last two weeks and feels tht she is much worse from that and unable to sleep. I feel that Flexeril is quite safe for her to take. We will use Darvocet which has been effective for her in the past for pain. An x-ray is obtained of her upper pelvis today. Looking at her sacroiliac joints no bony abnormality is appreciated there. She does not have pain that would be obvious for disc disease. We will set her up for evaluation and care under Dr. Braden for what appears now to be a left SI strain and use physical therapy at HealthSouth in the interval. (RX. #1, p. 84).

On September 15, 2004, the claimant was evaluated by Dr. Terence P. Braden III, D.O., pursuant to the referral of Dr. Schrantz. The September 15, 2004, report relative to the evaluation reflects, in pertinent part:

Summary: Ms. Phyllis Moffitt is a 48-year-old, white female who reports left leg and back discomfort since being struck by a vehicle on 06/23/04. She has had a pelvis MRI scan done, which is normal, and a whole body Bone scan, which is normal. Renal ultrasounds were done, which were normal.

She still reports significant pain and discomfort in the left-back area as well as leg and utilizes a straight cane for her ambulation. (RX. #1, p. 87).

The claimant was subsequently referred by Dr. Braden to Dr. Calin A. Savu, a pain management specialist, for evaluation and treatment. The October 12, 2004, History and Physical of the claimant provided to Dr. Savu reflects, in pertinent part:

HISTORY OF PRESENT ILLNESS: Ms. Moffitt is a very pleasant 48-year-old woman who was injured in a car accident in June of this year. While being in a crosswalk, she was hit on the right side by a truck; she fell on the left side and was dragged for about 10' underneath it. She felt immediate and excruciating pain involving the left hip but the subsequent workup failed to detect any significant abnormality. She went through a physical therapy program, which consisted mostly of modalities. She didn't follow up with a home exercise plan. She also underwent an SI joint injection without much relief. The pain involves the lower back, left more than right, the left buttock, the left thigh and hip. It is worse with lifting, walking and standing but also with sitting. It is described as a deep-seated ache, which occasionally has sharp exacerbations. It is accompanied by weakness described as easy tiredness involving the left lower extremity but only by fleeting numbness involving the left thigh. The pain is constant, seems to have gotten worse despite progressive decrease in the range of her activities and it is partially responsive to pain medication as well as Rest. The pain scores range between a best of 4 and a worst of 8 and there is associated difficulty sleeping. Past medications include nonsteroidals, muscle relaxants, short-acting opioids, ultracet, antidepressants and benzodiazepines. The above-mentioned physical therapy failed to offer significant relief. (RX. #1, p. 91).

The medical in the record reflects that the claimant was seen on several occasions by Dr. Savu and received injection in an effort to treat her complaints. Claimant was seen by Dr. Savu on January 13, 2005. (RX. #1, p. 108).

On January 14, 2005, claimant was seen by her primary care physician, Dr. Hurst, with a chief complaint of swelling in her right leg. The January 14, 2005, Chart note reflects, in pertinent part:

HPI: patient presents back today for chronic leg, back and hip pain. Patient states she has chronic left lumbar and hip pain and now has had some right side pain as well. She states that her right leg is in swelling at times, in addition, and states it's very frustrating. Patient states he been Dr. Savu at the pain center. She is currently taking methadone from him. (RX. #1, p. 109).

On February 9, 2005, the claimant was initially seen by Dr. Jeffrey M. Sorenson, a Memphis neurosurgeon, pursuant to a referral of Dr. Hurst, relative to complaints with pain in her left hip growing out of June 23, 2004, accident. Dr. Sorenson did not provide a surgical option relative to the claimant. (RX. #1, p. 114).

Claimant was seen by Dr. Savu on April 11, 2005, after having undergone a period of physical therapy. The April 11, 2005, report of Dr. Savu relative to the claimant reflects, in pertinent part:

DIAGNOSIS: This is a patient with a relatively trivial injury whose imaging studies are not suggestive of any significant injury. On the other hand, there is some discrepancy between the level of activities that the patient reports an din her presentation in my clinic this is not a patient who underwent aggressive rehabilitation in any fashion. (RX. #2, p. 149).

On April 20, 2005, the claimant underwent a lumbar epidurogram under the directions of Dr. Savu, which yield a normal result. (RX. #2, p. 153-154).

During a April 20, 2005, visit to Dr. Hurst claimant relayed complaint of left hand numbness and concerns that might have carpal tunnel syndrome in her left hand. (RX. #2, p. 150). Claimant underwent electrodiagnostic studies under the directions of Dr. Braden relative to the afore on May 4, 2005. (RX. #2, p. 155-156).

On May 5, 2005, claimant was again seen by Dr. Hurst. The May 5, 2005, office note relative to the visit reflect, in pertinent part:

HPI: patient back with husband, multiple concerns. States in addition to her chronic lumbar pain that requires her to take the methadone, she now has L arm and L neck pains that have been bothering her for a while. States Dr. Braden had done NCV and found no CTS, but she is concerned, and we will image her cervical spine. States she got nerve block from Dr. Savu, pain doctor, and is some better. States her UTI is better too. (RX. #2, p. 158).

After obtaining the results of the claimant's May 7, 2005, cervical MRI scan, claimant was again referred to Dr. Sorenson by Dr. Hurst. (RX. #2, p. 158-167).

On September 7, 2005, the claimant was evaluated by Dr. Jim J. Moore, a Little Rock neurosurgeon. The report reflects that Dr. Moore had access to the claimant medical records regarding treatment for the June 23, 2004, accident. Following his examination of the claimant, Dr. Moore recommended a return to work on a trial basis as long as sedentary could be considered. The September 7, 2005, report of Dr. Moore reflects diagnoses of the claimant of cervical degenerative disc disease, cervical radiculitis, lumbar radiculitis, and sacroiliac sprain/strain. (RX. #1, p. 200-202).

On October 6, 2005, the claimant was seen by Dr. Hurst in a follow up visit. The chart note relative to the visit reflects, in pertinent part:

HPI: Patient back today with multiple medical concerns. She has seen

the WCC doctor in LR and was told that she was going to have to try to return to work. She is frustrated about this and wants to know if she can get physical therapy with some traction on her neck. We discussed traction as an entity and I told her that I be glad to schedule her for some physical therapy but that I was not convinced the traction alone was going to be appropriate or make that much of a difference in her overall condition.

In addition, the patient wants to get some more x-rays of her hip and pelvic area, as she is concerned, if persistent problems are not yet been diagnosed. She is seen multiple different specialists in multiple different procedures performed, but at her request, we will go ahead and get some more x-rays performed to make sure there is nothing else ongoing from a medical standpoint, that has been missed.

The patient states she hurts on daily basis and she states that she is not to the point she can continue to work. (RX. #2, p. 207).

The record reflects the presence of documentation from respondents offering the claimant employment in a sedentary position, basis on the IME report of Dr. Moore, as well as the claimant's response to the offer. (RX. #2, p. 231-234).

After a through consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, viewing the video surveillance, application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On June 23, 2004, the relationship of employee-employer-carrier existed among the parties.
3. On June 23, 2004, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$204.00/\$154.00, for temporary total/permanent partial disability.

4. On June 23, 2004, the claimant sustained injuries to her low back and left side arising out of and in the course of her employment, for which she was temporarily totally disabled and receive appropriate indemnity and medical benefits through October 11, 2005, when she unreasonably refused employment within her restriction.

5. The claimant did not sustain an injury to her cervical spine as a result of the June 23, 2004, compensable accident.

6. The claimant's healing period ended on or about December 7, 2005.

7. The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of June 23, 2004.

CONCLUSIONS

It is undisputed that the claimant sustained injuries within the course and scope of her employment on June 23, 2004, to her low back and left side in a motor vehicle accident. Respondents paid indemnity benefits to the claimant through October 11, 2005, and medical benefits on her behalf through February 1, 2006. Claimant maintains that she sustained an injury to her cervical spine in the June 23, 2004, accident and is entitled to corresponding medical and indemnity benefits as a result of same. Further, claimant asserts entitlement to continuing medical benefits subsequent to February 1, 2006, when respondents ceased payment of same. Respondents deny that the claimant's neck injury/complaint is causally related to the June 23, 2004, accident. Respondents maintain that additional medical benefits are not reasonably necessary in connection with any aspect of the claimant's compensable injury from June 23, 2004. The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having

been sustained subsequent to the effective date of the afore provision.

The claimant received extensive medical treatment following the June 23, 2004, accident for complaints relative to her lower back and hip areas. A thorough review of the medical records generated from the date of the accident through April 2005, failed to disclose complaints relative to her cervical spine. The claimant's cervical spine complaints did not surface in the medical records in connection the June 23, 2004, accident until April 20, 2005, when she complained of symptoms of numbness in her left hand and a suspicion of carpal tunnel syndrome.

To prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, the claimant must establish by a preponderance of the evidence: an injury arising out of and in the course of employment; that the injury caused internal or external harm to the body which required medical services or resulted in disability or death; medical evidence supported by objective findings, as defined in Ark. Code Ann. §11-9-102 (16), establishing the injury; and that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. §11-9-102 (4)(A) (i).

While the claimant denied that she had previously experience cervical/neck complaints prior to the June 23, 2004, accident, the medical evidence in the record is to the contrary. Indeed, the objective findings on which both Dr. Sorenson and Dr. Moore recommended further treatment were in place as early as 1998. Claimant received medical treatment from various physicians and medical providers from June 23, 2004, until April 2005, before registering complaints relative to her neck. The claimant has failed to establish as causal nexus between her diagnosed cervical complaint and the June 23, 2004, accident by a preponderance of the credible

evidence. The claimant's claim for medical and indemnity benefits relative to her cervical spine complaints is respectfully denied and dismissed as not being causally related to the June 23, 2004, compensable accident.

Following her September 7, 2005, independent medical examination/evaluation by Dr. Jim J. Moore, claimant was offered sedentary work by respondents in accordance with the recommendation of Dr. Moore. The credible evidence in the record reflects that respondents made a good faith offer to the claimant to return her to work in a sedentary job position with reasonable accommodations. The claimant's refusal of the sedentary job offer was unreasonable. In his September 7, 2005, IME report, Dr. Moore concluded that the claimant was not at maximum medical improvement, however that the same would occur within three or so months.

An injured worker is entitled to temporary total disability benefits so long as the employee is within the healing period and suffers a total incapacity to earn wages. *Arkansas State Highway and Transportation Department v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). In the instance claim, the evidence reflects that as of October 10, 2005, the claimant no longer suffered a total incapacity to earn wages, having been offered sedentary work. As noted above, the claimant's refusal of the offered sedentary job in the employment of respondent was unreasonable. Accordingly, the claimant's claim for temporary total disability benefits subsequent to October 10, 2005, is respectfully denied and dismissed.

The healing period is that period for healing of an injury which continues until the claimant is as far restored as the permanent character of the injury will permit. *Georgia-Pacific Corporation v. Carter*, 62 Ark. App. 162, 969 S.W.2d 677 (1998). If the underlying condition causing the disability has become more stable and if nothing further in the way of treatment will

improve that condition, the healing period has ended. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S.W.2d 457 (1994). Whether an employee's healing period has ended is a factual determination. *Ketcher Roofing Co. v. Johnson*, 50 Ark. App. 63, 901 S.W.2d 25 (1995).

In the instant claim, Dr. Moore, who had access to the claimant's pertinent medical records growing out of treatment received subsequent to the June 23, 2004, accident concluded, following his review of the records and examination of the claimant that she should reach maximum medical improvement with three months or so of the September 7, 2005, examination. Excluding the claimant's cervical complaints, which did not grow out of the June 23, 2004, accident, the evidence preponderates that the claimant reached the end of her healing period relative to the injuries suffered in the June 23, 2004, accident on or about December 7, 2005.

Ark. Code Ann. §11-9-508 mandates that the employer provide all medical treatment that is reasonably necessary for the treatment of a compensable injury. What constitutes reasonable and necessary medical treatment under the statute is a question of fact. *Gansky v. Hi-tech Eng'g*, 325 Ark. 163, 924 S.W.2d (1996); *Geo Specialty Chem., Inc. v. Clingan*, 69 Ark. App. 369, 13 S.W.3d 218 (2000); *Air Compressor Equipment v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000). The claimant has failed to sustain her burden of proof that additional medical treatment is reasonably necessary in connection with her compensable injury of June 23, 2004. This claim for additional medical benefits subsequent to February 1, 2006, is respectfully denied and dismissed.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE

