

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F307560 & F404799

DAVID RUPP, EMPLOYEE	CLAIMANT
PRESCOLITE, INC., EMPLOYER	RESPONDENT
LIBERTY MUTUAL FIRE INS. CO., CARRIER	RESPONDENT NO. 1
AMERICAN HOME ASSURANCE, CARRIER	RESPONDENT NO. 2
SECOND INJURY FUND	RESPONDENT NO. 3
DEATH & PERM. TOT. DIS. TRUST FUND	RESPONDENT NO. 4

OPINION FILED APRIL 12, 2006

Hearing before Administrative Law Judge J. Mark White on January 26, 2006, in El Dorado, Union County, Arkansas.

Claimant represented by Mr. F. Mattison Thomas, III, Attorney at Law, El Dorado, Arkansas.

Respondents No. 1 represented by Mr. David C. Jones, Attorney at Law, Little Rock, Arkansas.

Respondents No. 2 represented by Ms. Melissa Ross, Attorney at Law, Little Rock, Arkansas.

Respondents No. 3 represented by Mr. David L. Pake, Attorney at Law, Little Rock, Arkansas.

Respondents No. 4, represented by Ms. Judy Rudd, Attorney at Law, Little Rock, Arkansas, and excused from participation in this hearing.

STATEMENT OF THE CASE

On January 26, 2006, the above-captioned claim came on for a hearing in El Dorado, Arkansas. A pre-hearing conference was conducted on October 31, 2005, and a Prehearing Order was entered that same day. A copy of the October 31, 2005, Prehearing Order has been marked as Commission Exhibit No. 1 and made a part of the record herein without objection. At the hearing, the parties confirmed that the stipulations, issues, and respective contentions, as amended, were properly set forth in the Prehearing Order.

The parties stipulated that the Arkansas Workers' Compensation Commission has jurisdiction of this claim; that the employee/employer relationship existed at all relevant times, including October 2000 and June 2003; that respondent no. 1, Liberty Mutual Fire Ins. Co., provided coverage to the respondent-employer and was on the risk in 2003; that respondent no. 2, American Home Assurance, provided coverage to the respondent-employer and was on the risk in 2000; that respondent no. 1 and no. 2 have controverted both claims in their entirety; that as of June 2003, the claimant earned sufficient wages to be entitled to the maximum compensation rates for both 2000 and 2003; and that if the claimant is found to be permanently totally disabled, such disability did not begin until after his last day of work, July 6, 2004.

The parties agreed that the issues to be presented were whether the claimant sustained a compensable injury in 2000; whether the claimant sustained a recurrence or compensable aggravation of a pre-existing injury in June 2003; apportionment of benefits; notice; whether claims on the 2000 injury are barred by the statute of limitations; whether the claimant is permanently totally disabled; in the alternative, whether the claimant has sustained wage loss in excess of his permanent anatomical impairment; whether the claimant is entitled to permanent partial disability benefits; determination of the liability, if any, of the Second Injury Fund; the entitlement of the respondents to offsets; whether the respondent-carrier may credit payment of permanent partial disability benefits towards its \$75,000 statutory maximum; and controversion and attorney's fees. At the hearing, over the objection of the respondents, the claimant was allowed to withdraw all issues of permanent benefits, including permanent total disability, from consideration in this hearing.

The claimant contends that in October 2000 while closing a gate he sustained an injury to his low back which he reported to Russell Deason, his supervisor at the time; that the claimant and his supervisor agreed to allow the claimant's medical insurance provided by his employer to pay for the costs so the employees who worked under the claimant and Mr. Deason would not lose a party which was given routinely when there were no lost work time injuries; that the claimant has been

receiving medical attention constantly since the October 2000 injury; that as a result of the injury, the claimant is entitled to medical benefits, temporary total disability benefits, and permanent partial disability benefits; and that the claimant has now become permanently totally disabled.

Respondent No. 1, Liberty Mutual Fire Insurance Co., contends that the claimant did not sustain a compensable work-related injury in either 1999/2000 or in June 2003; in the alternative, that if the claimant did indeed sustain a compensable injury in 1999 or 2000, that respondent no. 2 should be held liable for said benefits, if the claim is not held barred by the statute of limitations; that the claimant's June 2003 problems were a mere recurrence of the original incident in 1999 or 2000 for which the prior carrier should be held liable; that there are no new objective findings of a new injury or aggravation concerning the June 2003 incident; that the claimant would not be entitled to temporary total disability benefits or wage loss, as he was part of a general lay-off in November 2003 and was also offered other employment at a different facility or location; that they are entitled to an offset for the claimant's salary continuation paid, an offset for any health carrier benefits paid, as well as an offset for any group disability carrier payments made for any periods for which they are held liable for benefits; that they should not be liable for any type of wage loss, as the major cause of any of the claimant's impairment would be his pre-existing

injuries/impairments, and not related to the alleged incident of June 2003; that the Second Injury Fund or Death & Permanent Total Disability Trust Fund would be responsible for any wage-loss benefits; that the claimant underwent an anterior cervical microdiscectomy at C6-7 on February 26, 1987, and would have been entitled to a permanent partial disability rating; that as the claimant was diagnosed with a herniation following the alleged incident of 1999 or 2000, the claimant would be entitled to an impairment rating at that point; that the 1987 and 1999/2000 injuries and disabilities have combined with the current disability for Second Injury Fund liability purposes; that if the claimant is held to be permanently totally disabled; either respondent no. 1 or no. 2 would be entitled to a credit for payments on the claimant's anatomical impairment rating towards the \$75,000 cap on carrier payments for permanent total disability; that the Trust Fund should be responsible to take over payments following \$75,000 in payments after the claimant comes to the end of his healing period, no matter how the payments are characterized; and that since there is no impairment rating, the claimant is not entitled to wage loss or permanent total disability benefits.

Respondent No. 2, American Home Assurance, contends that the statute of limitations has run with regard to this claim; that respondent no. 2 did not receive any notice of injury until the claimant filed his Form C with the Commission on

February 3, 2004; that even if compensability is found and the statute of limitations defense is overcome, respondent no. 2 should not be liable for benefits until they received actual notice of the claimant's injury; that the claimant was a supervisor for the respondent-employer and knew that if he did not report his alleged injury he would not be covered by workers' compensation; that the claimant made the independent decision not to file a claim for his alleged injury until he did so on February 3, 2004; and that the medical evidence does not support a compensable injury with regard to the 2000 incident.

Respondent No. 3, the Second Injury Fund, contends that the alleged 1999/2000/2001 work injury is not compensable; that the claimant cannot prove the elements of a specific-incident injury on whichever of the three (3) dates he decides to designate as his injury date; that a claim for benefits was not made within the two (2) year statute of limitations for bringing a claim; that the claimant cannot prove a specific-incident injury to his neck occurring on June 21, 2003; that the major cause of any permanent anatomical impairment to the claimant's neck is not due to the alleged June 21, 2003, work incident; that the alleged June 21, 2003, neck injury is not the major cause of the claimant's alleged functional disability; that the Second Injury Fund does not have liability in this case; that the claimant is not entitled to an award of attorney's fees from the Fund; that there is no proof of record of any degree of

permanent anatomical impairment in regards to either injury; that in the absence of such proof there can be no wage-loss disability; and that it is entitled to credit per Ark. Code Ann. § 11-9-411 for any other benefits received by the claimant, including short-term disability, long-term disability, or any other benefits with the exception of Social Security disability benefits, for any period of disability that would be the same that would be owed under wage loss.

Respondent No. 4, the Death & Permanent Total Disability Trust Fund, contends that pursuant to Ark. Code Ann. § 11-9-525 (b)(1), Second Injury Fund liability must be determined prior to consideration of the Death & Permanent Total Disability Trust Fund liability; that if the Second Injury Fund is found to not have liability and the claimant is found to be permanently and totally disabled, the Trust Fund stands ready to commence weekly benefits in compliance with Ark. Code Ann. § 11-9-502; that the Trust Fund therefore has not controverted the claimant's entitlement to benefits; that respondent no. 1 must first pay permanent partial disability in the form of the anatomical ratings for the claimant's compensable injury before payment of permanent total disability benefits; and that respondent no. 1 is not entitled to credit against its \$75,000 maximum for payment of the claimant's permanent partial anatomical ratings for the compensable injury.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record as a whole, to include medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witnesses and to observe their demeanor, the following findings of fact and conclusions of law are hereby made in accordance with Ark. Code Ann. § 11-9-704:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. The stipulations agreed to by the parties are reasonable and are hereby accepted as fact.
3. The claimant sustained his initial injury in 2000.
4. The claimant filed a claim for compensation for the 2000 injury in 2004.
5. The claimant has failed to prove by a preponderance of the evidence that the claim for his 2000 injury was timely filed.
6. Any claim for the 2000 injury is therefore barred by the statute of limitations.
7. The claimant has failed to prove by a preponderance of the evidence that the existence and extent of any new 2003 injury is established by medical evidence supported by objective findings.
8. The claimant has therefore failed to prove by a preponderance of the

evidence that he sustained a new compensable injury or a compensable aggravation of a pre-existing injury in 2003.

9. Respondents nos. 1 & 2 have controverted this claim in its entirety.

DISCUSSION

I. History

The claimant worked for the respondent-employer as a die cast supervisor. He testified that in October 2000 he injured his low back while closing a fence gate. He said, "something popped in my back and I had pain." He testified that he reported the incident to his supervisor, Russell Deason, and told him he would see a doctor in a few days if needed, though Deason testified and denied the claimant reported any injury in 2000. The pain did not improve, and the claimant said he told Deason he wanted to go to the doctor. The claimant testified that he and Deason agreed the claimant would not report the injury as work-related but instead he would file it on his group health coverage. He testified that he and Deason made this agreement because if he had reported a lost-time incident, his employees would have lost certain benefits and safety awards. These benefits and awards were granted only when there were no lost-time claims filed. Deason denied entering into any such agreement with the claimant.

The claimant sought treatment from his personal physician, Dr. Clint Netherland, on October 2, 2000. Dr. Netherland noted complaints of low back pain “for the last week” originating at the L4-5 area, along with right leg numbness. Dr. Netherland said nothing of a work accident, and the claimant said he lied to Dr. Netherland in furtherance of his agreement with Deason not to report the injury as work-related. Dr. Netherland diagnosed low back pain and prescribed medication.

The medical records reflect that the claimant’s low back pain became progressively worse over the following months, producing radiating pain into the right leg. An MRI scan performed February 19, 2001, revealed a large herniated disc at L5-S1 and degenerative changes at other levels. Dr. Netherland referred the claimant to a neurosurgeon, Dr. Freddie Contreras. Dr. Contreras recommended surgery as of November 1, 2001, but the claimant declined surgery. The claimant returned to work at some point, though he testified he was not pain free.

The claimant then came under the care of Dr. Robert Watson. Dr. Watson treated him for an apparently unrelated shoulder condition in 2002, and Dr. Watson’s notes reflect continued complaints of back pain. As of June 6, 2003, the claimant was still complaining of back pain, rating his pain as 7 to 8 on a 10-point scale. For some time Dr. Watson had been treating him with a narcotic, Oxycontin.

The claimant testified that he sustained a second work injury in June 2003

when he slipped on some stairs and fell onto his tailbone, causing pain in his low back, neck and arms. He said the accident occurred on a Friday or Saturday, and he sought treatment the following Monday. Dr. Watson's treatment notes of Monday, June 23, record that the claimant "fell 2 days ago, leg numb, arm has shooting pain." The notes record tenderness in the low back but make no mention of neck pain. The claimant testified that he and Deason again agreed not to report the injury, so as not to endanger their employees' safety awards. Deason again denied entering into any such agreement, but he admitted the claimant reported an injury to him in 2003.

The claimant returned to Dr. Watson on July 17, at which point his history was recorded as follows: "same pain as always but bothering him a lot more lately – hasn't hurt it or reinjured himself – just hurting more." Next to this history, under the label "onset/timing," a check is placed next to the phrase "gradual onset." Dr. Watson noted the presence of cervical and lumbar muscle spasms – the only mention of spasms in the medical records. An MRI scan performed September 25, 2003, revealed a large herniated disc at L5-S1, as had the MRI scan performed in 2000. A cervical MRI scan also revealed mild posterior bulging at C3-4, C4-5 and C5-6, and a "solid-appearing fusion" at C6-7. The claimant testified he underwent a cervical fusion surgery in the 1980s.

At some point Dr. Watson took the claimant off of work; the claimant testified that he attempted to work part-time but was unable to do so. He eventually stopped working after a general lay-off and has not returned to work since. The most recent medical notes in the record date from 2003. The claimant testified that he has recently been treating with a Dr. Seale in Oklahoma, but none of this doctor's records were introduced into evidence. The claimant continues to take muscle relaxers and narcotic pain medication, and he continues to file these claims on his personal health insurance.

II. Adjudication

A. Statute of Limitations

Arkansas law limits the time in which a claim for compensation may be filed. It is the burden of the claimant, not respondents, to prove that a claim for additional compensation has been timely filed. *Aluminum Comp. Of America v. Rollon*, 76 Ark. App. 240, 64 S.W.3d 756 (2001). The relevant statute of limitations states in pertinent part:

A claim for compensation for disability on account of an injury, other than an occupational disease and occupational infection, shall be barred unless filed with the Workers' Compensation Commission within two (2) years from the date of the compensable injury. If, during the two-year period following the filing of the

claim, the claimant receives no weekly benefit compensation and receives no medical treatment resulting from the alleged injury, the claim shall be barred thereafter.

Ark. Code Ann. § 11-9-702 (a)(1)(A).

The claimant contends his initial injury occurred in 2000, though he initially contended an injury date of 1999. The record documents that the claimant did not file a claim for compensation for this injury until 2004, far beyond the two-year limit established by statute. The claimant has identified no reason why the statute would have been tolled during this time. I find that the claimant has failed to prove by a preponderance of the evidence that the claim for his 2000 injury was timely filed. Any claim for the 2000 injury is therefore barred by the statute of limitations.

B. Characterization of 2003 Injury

The claimant testified he sustained another injury in 2003. Respondent no. 1 contends this 2003 injury was a recurrence of the 2000 injury, while respondent no. 2 contends the 2003 injury was an aggravation of the 2000 injury.

An aggravation is a new injury resulting from an independent incident; a recurrence is not a new injury but merely another period of incapacitation resulting from a previous injury. *Maverick Transportation v. Buzzard*, 69 Ark. App. 128, 10 S.W.3d 467 (2000). Being a new injury with an independent cause, an aggravation

must meet the requirements for a compensable injury. *Crudup v. Regal Ware, Inc.*, 341 Ark. 804, 20 S.W.3d 900 (2000).

After the 2000 injury, the claimant complained only of low back pain. He testified that his June 2003 fall caused renewed low back pain, but that it also caused neck and arm pain. He testified that he fell on a Friday or Saturday and went to the doctor the following Monday. The record contains a treatment note from Family Care of South Arkansas dated Monday, June 23, 2003. The note states the claimant came in that morning complaining of leg numbness and arm pain after a fall “2 days ago.” The note makes no mention of any objective finding of injury. Though the claimant testified that his neck “was really bad” after the fall, the note says nothing of neck pain.

It was not until some three weeks later, on July 17, when the claimant complained to a doctor of neck pain. The treatment note of July 17 records complaints of both neck and low back pain, yet the note specifically quotes the claimant as saying this new back and neck pain occurred gradually and that he did not re-injure himself. The July 17 note does record observations of cervical and lumbar spasms – the only notation of spasms anywhere in the record. The claimant returned to the doctor on August 4, but no spasms were noted after July 17.

MRI exams were performed after both the 2000 and 2003 alleged injuries. The

lumbar spine findings of the two exams are, for all practical purposes, identical. Other than the one single notation of spasm, there is no new objective finding of injury to the lumbar spine after the 2003 incident. A cervical MRI was performed only after the 2003 injury, revealing mild bulging and degenerative disc disease at three levels, as well as a fusion at C6-7. The claimant acknowledged in his testimony that he underwent a cervical fusion surgery in the 1980s. One can only guess whether the cervical MRI findings are due to the 2003 fall, the prior cervical fusion surgery, or something else. The fact that no spasms were observed two days after the fall raises a question as to whether the spasms observed three weeks later were related to the fall or to something else. The claimant admits he lied to his doctors, and I am thus hard-pressed to find him a credible witness or to rely on his testimony in support of a causal connection.

Given the above, I find that the claimant has failed to prove by a preponderance of the evidence that the existence and extent of any new 2003 injury or aggravation is established by medical evidence supported by objective findings. I therefore conclude that the claimant has failed to prove by a preponderance of the evidence that he sustained an aggravation or new compensable injury in 2003. Because I so find, the remaining issues identified by the parties are moot and need not be addressed.

AWARD

The claimant has failed to prove by a preponderance of the evidence that he sustained a compensable injury or aggravation. Therefore, this claim for benefits must be, and it hereby is, denied and dismissed.

IT IS SO ORDERED.

HON. J. MARK WHITE
Administrative Law Judge