

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F311958**

<b>JOAN S. STUARD, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>HOPE SCHOOL DISTRICT, EMPLOYER</b>	<b>RESPONDENT</b>
<b>RISK MANAGEMENT RESOURCES, TPA</b>	<b>RESPONDENT</b>

**OPINION FILED JUNE 6, 2006**

Hearing before Administrative Law Judge J. Mark White on March 9, 2006, in Hope, Hempstead County, Arkansas.

Claimant represented by Mr. Howard Goode, Attorney at Law, Texarkana, Arkansas.

Respondents represented by Ms. Betty Demory, Attorney at Law, Little Rock, Arkansas.

**STATEMENT OF THE CASE**

On March 9, 2006, the above-captioned claim came on for a hearing in Hope, Arkansas. A pre-hearing conference was conducted on July 18, 2005, and a Prehearing Order was entered that same day. A copy of the July 18, 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-carrier

relationship existed at all relevant times, including May 16, 2003; that on May 16, 2003, the claimant sustained a compensable injury; that respondents accepted the May 16, 2003, injury as compensable and paid some benefits; and that the claimant was granted her one-time change of physician by the Commission on March 19, 2004, to Dr. Charles Vermont.

The parties agreed that the issues to be presented were whether the claimant is entitled to permanent partial disability benefits; whether additional medical treatment is reasonably necessary in connection with the compensable injury; and controversion and attorney's fees. At the hearing, the parties agreed to waive the issue of the claimant's entitlement to temporary total disability benefits. The issue of permanent total disability was expressly reserved by the claimant.

The claimant contends that she is entitled to permanent partial disability benefits; that she is entitled to payment of her medical expenses; and that she is entitled to attorney's fees.

The respondents contend that the claimant has been provided all appropriate benefits to which she is entitled; that they have paid the claimant's authorized medical expenses; that they have denied treatment the claimant has received from unauthorized providers; and that they have not received any medical bills since March 2004.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record as a whole, to include medical reports 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 A.C.A. § 11-9-704:

1. The 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 has proven by a preponderance of the evidence that the medical treatment rendered by and at the referral of Dr. Vermont, Dr. Schlesinger, Dr. Boop, and Dr. Tobey, for the claimant's neck, back, concussion, depression, and mental status changes, has been reasonably necessary in connection with the compensable injury.
4. The claimant has proven by a preponderance of the evidence that additional medical treatment remains reasonably necessary in connection with the compensable injury.
5. The claimant has failed to prove by a preponderance of the evidence that she is entitled to permanent partial disability benefits.
6. The respondents have controverted all benefits sought herein.

## DISCUSSION

### I. History

The claimant works for the respondent-employer as an English teacher for Hope High School. On May 16, 2003, the school was holding its graduation ceremonies outdoors at the football field. A thunderstorm was approaching as the festivities began, but the principal refused to move the event indoors into the adjacent gymnasium, even though it had already been prepared as an alternate site in case of inclement weather. The claimant testified that as the storm moved closer to the stadium, she and other teachers began to move students from the football field into the gym. Before long a heavy rain began, causing the crowd to scramble towards the gym. To exit from the field to the gym the crowd had to pass through a narrow gate. Just outside this gate, the claimant testified, she was knocked into a red metal pole. She recovered, but she was then knocked down again, this time to the ground. She fell onto a metal storm drain grate and was trampled by the crowd.

Lacy Hale, a student who was graduating that evening, testified she realized the claimant had been knocked down when she tripped on the claimant's foot. She testified that she saw others step on the claimant, and she helped the claimant up. Doss Walker, a fellow teacher at the high school, testified he too helped the claimant off the ground. He said, "she was definitely hurt. Of course, it was raining and she

was wet and muddy." The claimant testified that she reported the injury promptly to her principal, Tommy Morrison, and that she showed him her bloody elbow and other injuries.

Morrison, in contrast, denied that the claimant reported any injuries, though he could not recall whether he knew of the claimant falling that night. As will be discussed below, the initial medical reports noted "significant" abrasions to the claimant's body, injuries which would have been observable to Morrison. The parties have stipulated that the claimant was actually injured. Hale and Walker agreed that the claimant had fallen to the ground, and the picture of the area demonstrates it would have been muddy with rain. Undoubtedly, the claimant's graduation gown would have been muddy and probably torn, not to mention the other visible signs of an injury. Yet despite all this, Morrison claimed that the claimant appeared "regular" after the graduation ceremony. This testimony is implausible and unreasonable in light of the other evidence of record. A person who had experienced the injury described by the other witnesses and the medical records would in no conceivable way appear "regular" to a reasonable observer. Moreover, Morrison's demeanor betrayed some animosity towards the claimant. Given his demeanor, given the utter implausibility of his testimony, and given the conflicts between his testimony and that of the other witnesses, I find the testimony of

Morrison to be entirely lacking in credibility, and I therefore accord his testimony no weight.

In part because of the severe weather, the claimant chose not to seek medical treatment that evening, a Friday. The following Monday, when she went to school, she had difficulty turning her body. She went to Morrison's secretary, who provided her the appropriate paperwork and instructed her to call the company doctor, Dr. Garrett. The claimant called Dr. Garrett's office and made an appointment, and she was instructed by Dr. Garrett's staff to first go to the hospital for a CT scan. Before she left the school to go to the doctor, she encountered Maurice Henry, a school custodian who according to his own testimony also serves as a co-safety coordinator, authorized to handle workers' compensation issues for the district. Henry testified he told the claimant to fill out paperwork and report the injury to Morrison, which the claimant had already done. He provided no other instructions to the claimant.

The claimant went to the hospital to have the CT scan, but the school refused to authorize the procedure. The claimant was instructed to return to the school to see Lou Katherine Montgomery, the superintendent's secretary who served as the other safety coordinator authorized to handle the district's workers' compensation issues. Montgomery asked to see the paperwork the claimant had already

completed for Morrison, and Montgomery scheduled a doctor's appointment and CT scan for the following day.

Dr. Garrett saw the claimant the following day and recorded her history as follows:

Ms. Stuard was walking out of the graduation ceremonies Friday night during the storm. There was a stampede of people and she was knocked down and actually kicked in the head. She had several other injuries. She has quite a bit of pain on her right temple area. Also a pretty significant abrasion of her right elbow. She has multiple aches and pains from where she fell and was hit. She has had a headache since Saturday morning. She has had some nausea but this is better. It sounds like she was somewhat disoriented at times, although this is improving as well.

Dr. Garrett gave his assessment as, "Fall with probably concussion and numerous other injuries, including abrasions, particularly to her right elbow." A CT scan was finally performed the day after the visit with Dr. Garrett, revealing nothing abnormal. The claimant saw a chiropractor, C.A. Primeaux, on May 22. His notes reflected that the claimant's headaches were getting worse, and that her neck and shoulders were stiff and sore. On May 23, Dr. Garrett recorded that the headaches were improving. As of May 29 Dr. Garrett recorded that the continued chiropractic treatment was beneficial, but that the claimant continued to complain of headaches. The claimant continued to treat with the chiropractor through June 13; his notes

reflect some improvement, but with continued neck and shoulder problems.

On July 1, the claimant returned to Dr. Garrett. His note reads:

Ms. Stuard comes in today complaining of increased confusion, difficulty making words, writing words, visual disturbances, blurred vision, and having a lot of pain in her neck and down into her lower back. I am going to ask Dr. Soeller to evaluate her, but I also think she needs an MRI scheduled. She did have a concussion. CT scan was negative. With increasing symptoms, I think this needs to be done.

He added later in the note, "She is well oriented and no obvious confusion on interview today."

That same day, family practice physician Dr. Charles Vermont called the claimant to check on her mother. He knew the claimant well through his treatment of both her and her mother. He testified that when he spoke to the claimant on the phone that day, "she just sounded like she was not herself." He described "a definite change in her demeanor and her sense of well-being" after her injury. Because of these observable mental status changes, changes he thought unprecedented in her prior medical history, he asked the claimant to come see him. She saw him on July 3. He recorded her as reporting stiffness in the neck and parasthesias in the upper extremities. He observed "significant paravertebral muscle spasm and ... limited ROM of the neck." Dr. Vermont contacted Dr. Garrett to discuss her case and concurred with Dr. Garrett's recommendation of an MRI. X-rays of the cervical

spine taken by Dr. Vermont showed “spasm, no fracture or dislocation.” An MRI of the brain was performed July 9, with normal results.

On July 11 the claimant saw Dr. C.E. Soeller, the orthopedic specialist originally recommended by Dr. Garrett. Dr. Soeller wrote in his treatment note:

She has also seen Dr. Vermont who obtained spine films, which I have obtained the reports as well as the x-rays and reviewed them myself. These do not show any abnormalities of her cervical, thoracic, or lumbar spine. This was also affirmed by the radiologist who read the films.

This statement by Dr. Soeller is odd, in that it completely misconstrues the x-rays reports. The radiologist *did*, in fact, observe abnormalities of the cervical and lumbar spine – degenerative changes and lordosis of the lumbar spine, and a straightening of the lordotic curve of the cervical spine indicating the presence of muscle spasms, which was corroborated by Dr. Vermont’s direct observation of “significant” spasm. Yet Dr. Soeller says nothing of these abnormalities, nor of the spasms observed by Dr. Vermont and by the physical therapist to which Dr. Soeller referred the claimant. That physical therapist, in fact, described the lumbar spasms as “massive” in a July 24 progress note. Dr. Soeller’s false/mistaken representation of the radiologist’s findings, and the unanswered question of whether he was aware of the presence of muscle spasms, renders the credibility of the remainder of his opinions suspect, at best.

Dr. Soeller recommended a soft cervical collar and physical therapy. When the claimant returned to Dr. Soeller on July 25, he noted that the physical therapy had improved the claimant's neck stiffness, and he released her from his care. Notably, Dr. Soeller never made any effort to treat or consider the claimant's non-orthopedic complaints – in particular, her headaches and mental status changes.

Though Dr. Soeller had released her, the claimant continued with the physical therapy he had prescribed. The claimant began treating with Dr. Vermont at some point in this time, and he was eventually designated as her treating physician. He recorded in his notes of September 8:

The main reason she came in today is that she is changing workman's comp doctors to me. There is a long note back in June. She apparently got trampled at a High School graduation. I received a call from Jeff Haynes, her physical therapist and she is having a tremendous amount of muscle spasm. She complains of incapacitating pain. Some of this radiates around to the chest.

Dr. Vermont recommended continued physical therapy and testing. He noted he was "concerned about some underlying structural injury, given the persistence and the severity of the discomfort. Also, she has some concussive symptoms. We did work her up mental status change."

The claimant continued to treat with Dr. Vermont, and he recommended that she see a neurosurgeon. His notes quote the carrier as saying they would provide

an independent evaluation by a neurosurgeon, but instead they sent the claimant back to Dr. Soeller. Dr. Soeller performed a perfunctory exam and gave his assessment as, "multiple complaints without evidence of medical findings to support them." This statement by Dr. Soeller is simply astonishing, in that it makes no account for the massive documentation of continuing muscle spasms in the claimant's back. Why Dr. Soeller ignored these findings, or was unaware of them, is unexplained in the record. This uncertainty underscores why, as explained above, I assign little weight to Dr. Soeller's opinions in this matter.

MRI scans performed at Dr. Vermont's orders revealed a "moderate disk bulge/osteophyte complex at C5-6 causing mild canal stenosis," and a "small" bulge at C3-4. On January 12, 2004, the claimant finally saw a neurosurgeon, Dr. Scott Schlesinger. Dr. Schlesinger read the MRI films as showing no significant herniation and no stenosis. Yet Dr. Schlesinger falsely asserted that the radiologist agreed with his interpretation – as noted above, the radiologist explicitly opined that the disc bulge at C5-6 was causing "mild canal stenosis." Nonetheless, Dr. Schlesinger recommended a chronic pain management program, as well as evaluations by a neurologist and psychiatrist.

Dr. Vermont testified at the hearing that he became the claimant's authorized treating physician on March 19, 2004. Whether the treatment by Dr. Schlesinger

prior to this date was authorized is unclear from the record.

By April 2, Dr. Vermont noted, the continuing physical therapy had finally begun to relieve the claimant's chronic muscle spasms. On June 1, she saw a neurologist, Dr. Bradley Boop. He noted as follows:

Her complaints are primarily cognitive today, though she has had neck pain and headaches. She is describing difficulty learning new things and says there is random loss of long-term memory, with islands of preservation. She is describing inability to concentrate or to perform serial tasks, and she has to use cues to remember her lessons she is teaching. She describes combining the wrong words when writing on the board. She feels her speech is garbled at times. She feels that she has lost track of time. She feels her ability to spell has deteriorated. She does describe her headache as being severe and being associated with neck pain and occipital burning. Her headache then becomes more right-sided than left and is associated with nausea and sweating.

Dr. Boop gave his impression as follows:

Historically, she may have had a closed head injury. She now has significant cognitive complaints. She has a normal neurological examination and little objectively abnormal on assessment of cognition with brief bedside tests. I remain concerned that there has been some ongoing stress and depression. She does have ongoing pain.

Dr. Boop recommended medication and neuropsychiatric testing. The testing revealed that her cognitive functioning was "minimally to mildly impaired."

Dr. Boop read the test results as showing the claimant to be “suffering from some degree of posttraumatic stress disorder. There were some cognitive abnormalities on testing and so we will have to follow her for change over time, but overall *I think that most of this is a reaction to concussion* and the stress that she went through” (emphasis added). He recommended referral to a psychiatrist.

Psychiatrist Dr. Edward Tobey saw the claimant on February 2, 2005. He diagnosed her in accordance with the DSM-IV as having “major depressive illness.” He recommended only medication changes. As of March 22, Dr. Vermont reported the claimant as “doing reasonably well” with the medication prescribed by Dr. Tobey. The claimant returned to Dr. Tobey on July 22, “feeling better and noticing less depression.”

At the hearing, Dr. Vermont testified that the claimant’s mental status changes and depression were due at least in part to the accident:

I think it was triggered by this accident and the fact that her situation was not acknowledged by her treating physicians or employer or the workman’s comp system and she was ignored and treated like a malingerer. If you take someone who has been married and is in her fifties, who has children, who is a school teacher and not some trash, but you treat them like trash, they might get depressed.

Q Dr. Vermont, do you have any other opinions regarding this case?

A No, that is my opinion. I do think Ms. Demory has certain points but I don't think that any of them compare to the larger picture.

Q The larger picture being?

A That she had an accident that was damaging, a concussion, a significant injury to her neck and back, and some acute pain which then became chronic, and she was simply ignored and put between a rock and a hard place because workman's comp would not acknowledge the need for her treatment.

## **II. Adjudication**

### **A. Additional Medical Treatment**

An employer must promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). What constitutes reasonably necessary medical treatment is a question of fact. *Ark. Dept. of Correction v. Holybee*, 46 Ark. App. 232, 878 S.W.2d 420 (1994).

In considering this matter, it should be noted that the parties have already stipulated to the compensability of the claimant's injuries. Therefore, the presence or absence of objective findings of injury are not dispositive, for the law does not require a claimant to establish her entitlement to additional medical treatment with objective medical findings. *Williams v. Prostaff Temporaries*, 64 Ark. App. 128, 979

S.W.2d 911 (1998). It should also be noted that the presence of other causal factors or pre-existing conditions is not dispositive as to the claimant's entitlement to additional treatment. The claimant need show only that the compensable injuries were an aggravating causal factor in her need for treatment. *General Elec. Railcar Repair Servs. V. Hardin*, 62 Ark. App. 120, 969 S.W.2d 667 (1998).

After reviewing the voluminous medical record, together with the deposition and hearing testimony of Dr. Vermont, I am persuaded that Dr. Vermont's treatment recommendations have been reasonably necessary. Though Dr. Soeller dismissed the claimant's complaints, as discussed above I give his opinion little weight. On balance, I find the opinion of Dr. Vermont, as supported by the opinions of Drs. Schlesinger, Boop and Tobey, to be more persuasive. I recognize that other conditions, including pre-existing conditions, and thyroid problems discovered after the accident, may also play a causative role in the claimant's present condition. But I am persuaded that her compensable injuries are an aggravating casual factor.

Therefore, I find that the claimant has proven by a preponderance of the evidence that the medical treatment rendered by and at the referral of Dr. Vermont, Dr. Schlesinger, Dr. Boop, and Dr. Tobey, for the claimant's neck, back, concussion, depression, and mental status changes, has been reasonably necessary in connection with the compensable injury. I further find that the claimant has proven by a

preponderance of the evidence that additional medical treatment remains reasonably necessary in connection with the compensable injury. In making these findings, I recognize that while reasonably necessary, some or all of the treatment rendered prior to March 19, 2004, may have been unauthorized treatment. I make no finding as to whether that prior treatment was in fact authorized or otherwise exempt from the rule that unauthorized treatment is not the liability of the respondents.

### **B. Permanent Partial Disability Benefits**

The claimant contends she is entitled to an award of permanent partial disability benefits. However, after reviewing the record I am unable to identify any anatomical impairment rating assigned by any of the claimant's physicians. Without submitting into evidence a physician's report assigning a permanent impairment rating, a claimant is not entitled to permanent disability benefits. *Wren v. Sanders Plumbing Supply*, 83 Ark. App. 111, 116 S.W.3d 461 (2003); *but see Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994). I therefore conclude that the claimant has failed to prove by a preponderance of the evidence that she is entitled to permanent partial disability benefits.

## AWARD

The claimant has proven by a preponderance of the evidence that the medical treatment rendered by and at the referral of Dr. Vermont, Dr. Schlesinger, Dr. Boop, and Dr. Tobey, for the claimant's neck, back, concussion, depression, and mental status changes, has been reasonably necessary in connection with the compensable injury; and that additional medical treatment remains reasonably necessary in connection with the compensable injury. The respondents are hereby directed and ordered to pay benefits in accordance with the findings of fact and conclusions of law set forth herein.

No indemnity benefits have been awarded herein. An attorney's fee may be awarded only on indemnity benefits owed and controverted. Ark. Code Ann. § 11-9-715. Therefore, no attorney's fees are awarded herein.

All accrued sums shall be paid in a lump sum without discount, and this award shall earn interest at the legal rate until paid pursuant to Ark. Code Ann. § 11-9-809.

**IT IS SO ORDERED.**

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**HON. J. MARK WHITE**  
Administrative Law Judge