

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F311100

DAVID BROOM	CLAIMANT
GERBER PRODUCTS COMPANY	NO. 1 RESPONDENT
ST. PAUL TRAVELERS INS. CO. INSURANCE CARRIER	NO. 1 RESPONDENT
SECOND INJURY FUND	NO. 2 RESPONDENT
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	NO. 3 RESPONDENT

OPINION FILED JANUARY 19, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Fort Smith, Sebastian County, Arkansas.

Claimant represented by EDDIE H. WALKER, JR., Attorney, Fort Smith, Arkansas.

Respondents No. 1 represented by JAMES ARNOLD, II, Attorney, Fort Smith, Arkansas.

Respondent No. 2 represented by DAVID PAKE, Attorney, Little Rock, Arkansas.

Respondent No. 3 represented by JUDY RUDD, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on October 12, 2006, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on July 18, 2006. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

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

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.

2. On July 9, 2003, the relationship of employee-employer-carrier existed between the parties.

3. Claimant is entitled to the maximum compensation rate for 2003.

By agreement of the parties the issues to litigate are limited to the following:

1. Compensability of the claimant's left shoulder and neck injuries on July 9, 2003.

2. Related medical.

3. Temporary total disability from July 16, 2003, until June 2, 2006.

4. Permanent partial impairment of 9 percent for the neck and 7 percent for the shoulder.

5. Is the claimant permanently and totally disabled or entitled to wage loss over his impairment?

6. Second Injury Fund liability.

7. Attorney's fees.

In regard to the foregoing issues the claimant contends that Dr. Johnson took him off work as of January 24, 2006, and that the claimant is entitled to temporary total disability benefits from that date until a date yet to be determined. The claimant also contends that he is entitled to reasonably necessary medical treatment in regard to his cervical spine. The claimant contends that his attorney is entitled to an attorney's fee regarding any disability benefits relative to the cervical spine that has not already been paid.

In regard to the foregoing issues the respondents contend that the claimant has reached maximum medical improvement for the compensable injury sustained in the accident of July 9, 2003; that the respondents have paid all indemnity benefits to which the claimant is entitled; and that the respondents have provided and paid for all reasonably necessary medical evaluation and treatment for the compensable injury.

In regard to the foregoing issues Respondent No. 2 contends that Respondents No. 1 cannot prove that the fund has liability in this case. Respondents No. 1 have indicated in its joinder notice that the Fund was joined on the basis of several prior conditions. First, it alleges that the claimant had as pre-existing rotator cuff tear. The Fund would respond by stating that there is no medical proof that Mr. Broom had a rotator cuff tear prior to the last work injury of July 9, 2003. It would also state that no physician ever assigned any degree of permanent anatomical impairment or any permanent physical restrictions for any shoulder condition prior to July 9, 2003. The Fund would allege that any rotator cuff tear, if it exists, was latent within the meaning of the Second Injury Fund law prior to July 9, 2003. The same would be true for any degenerative joint disease condition of the left shoulder prior to that date. Additionally, the Fund would allege that any prior left shoulder problem completely resolved prior to the last work injury, and does not combine with it to produce the claimant's current disability status. Respondents No. 1 may also allege that the claimant suffered from prior low back problems and

“panic attacks.” There are no medical documents to date which reflect any prior low back condition. While the claimant stated in his deposition that he suffered a low back strain in 1990, he was off work for only a bout a month, received only chiropractic treatment, and returned to the same job without problems. There are no medical records to reflect the assignment of an anatomical impairment rating, and any testimony from the claimant about the assignment of one would clearly be “hear-say.” The Fund would object to any such testimony. Additionally, it is the Fund’s position that any prior low back problem does not combine with the work injuries received on July 9, 2003, to produce the current disability status. Regarding the “panic attacks,” the Fund would contend that such condition is not sufficient to invoke Second Injury Fund liability. While the claimant continues to make medication for such condition, he testified that the medication controls that condition. Additionally, “panic attacks” are not capable of sustaining a rating of permanent anatomical impairment under the AMA Guides, 4th Edition, and cannot meet the requirement of Ark. Code Ann. §11-9-102 in that they do not manifest “objective and measurable findings of physical injury which would be necessary to prove a permanent condition.” Finally, the Fund would contend that, even if there is some evidence of a combination of disabilities or impairments, it would not be greater than the disability or impairment from the July 9, 2003, work injury, considered alone and of itself. As a result of that last work injury, Mr. Broom has undergone a left shoulder surgery for which

he has been assigned a 7 percent whole body impairment rating, and a neck surgery for which he has received a 9 percent whole body rating. The FCE of May 2, 2006, shows that the physical injuries from the July 9, 2003, work injury alone have caused Mr. Broom's physical capacity to be "...less than sedentary..." which excludes him from any type of employment in the known job market. Alternatively, if Respondents No. 1 are successful in its defense of the compensability of the neck and left shoulder claim, then the claimant would not be entitled to any degree of permanent anatomical impairment. If that is the case, the claimant would not be entitled to any amount of wage loss disability benefits as a matter of law.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted medical records marked Claimant's Exhibit No. 1. Respondents No. 1 submitted the deposition of Dr. Bebout which is marked Respondents No. 1's Exhibit No. 1. Respondent No. 2 submitted the claimant's answers to interrogatories marked Respondent No. 2's Exhibit No. 1. Respondent No. 2 submitted additional documentation marked Respondent No. 2's Exhibit No. 2. The parties submitted a joint exhibit marked Joint Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that he started working for the respondent in 1998 as an instrumentation electrician. The claimant

testified that on July 9, 2003, he was carrying a motor weighing approximately 110 to 120 pounds up and down a stairway over a conveyor when his foot missed a step and he fell. The claimant testified that in the process of falling, he tried to hold onto the motor as well as catch himself and when he did the weight of the motor yanked his arm all the way down. The claimant testified that he was carrying the motor with both hands but when he tried to catch himself it left all the weight of the motor on his left arm. The claimant testified that he had immediate pain from the corner of his neck down his left shoulder and down into his left arm. The claimant testified that he reported this incident and did go to the doctor two days after the incident. The claimant testified that he continued to work for the respondent after he was seen by the doctor and continued working for them up until his surgery. The claimant agreed that he was under active treatment by his doctor from July 11, 2003, up until Dr. Bebout did his surgery.

The claimant testified that after his incident he had pain in his shoulder and arm and could not raise his arm any higher than half way up. The claimant testified that after his surgery his range of motion was better but he still had intermittent pain. The claimant remembered that after his surgery, he continued to have pain in his neck and some numbness and tingling in his arm.

The claimant testified that after his surgery and before Dr. Bebout referred him to a neurosurgeon, he did not have any new injuries to his shoulder but he did have another accident in 2004. The claimant remembered that on October 24, 2004, he fell at work.

The claimant testified that prior to July 2003 he was seen by Dr. Asbury about a month earlier complaining of shoulder pain. The claimant testified that the doctor administered a shot in his shoulder and he did not receive any other treatment until after he fell carrying the motor. The claimant testified that he continued to work for the respondent throughout June and July 2003 doing his regular duties. The claimant testified that he did not recall his visit to Dr. Asbury in June 2003 at the time of his deposition since it was three years earlier and he had undergone both shoulder surgery and neck surgery. The claimant testified that the type of work he was doing for the respondent in June and July 2003 as an electrician involved carrying motors which would weigh up to or over one hundred pounds, climbing ladders, lots of lifting, working above his head and doing the work required of an electrician. The claimant testified that after Dr. Asbury gave him that one shot he did not have any further concerns about his shoulder until he got hurt in July 2003.

The claimant testified that Dr. Bebout advised him to be seen by a neurosurgeon and that the workers' compensation case manager set an appointment for him with Dr. Johnson. The claimant testified that he underwent neck surgery in May 2005 and when he was released to return to work by Dr. Johnson, he did in fact return to work for the respondent. The claimant testified that he worked for the respondent about five or six months but due to the intensity of his pain as well as muscle spasms he no longer could work. The claimant testified that when Dr. Johnson released him to

return to work he had a fifteen-pound weight lifting restriction. The claimant agreed that after his surgery and he was returned to work on restricted duty. The claimant testified that he continued to get pain pills from Dr. Johnson as well as his family physician and due to his worsening condition Dr. Johnson, on January 24, 2006, took him off work and has not released him to return to work since that date. The claimant testified that since Dr. Johnson took him off work he has also been seen by Dr. Asbury, Dr. Landherr, Dr. Bigger and Dr. Sullivan as well as the respondents sent him back to be seen by Dr. Holder. The claimant testified that he has not done any work for money since January 24, 2006.

The claimant testified that he was 55 years old, had fourteen years of school indicating that he had an associate's degree in computer electronics and only has used this degree for about six to eight months after he got out of school in 1981. The claimant testified that other than the short period of time he worked in the computer field most of his work has been physically demanding. The claimant testified that he has worked primarily as an electrician in an industrial setting and has worked for several different manufacturing companies, all in a position as an electrician. The claimant testified that he could not return to the type of physically demanding work he had done for the respondent as well as the other manufacturers he has worked for due to the pain and muscle spasm which that type of activity generated. The claimant testified that he has pain in the back of his neck on both sides of his neck and down his left arm through his shoulder and into his

hand. The claimant testified that he has numbness in his left hand and that he also has pain half way down his back. The claimant testified that his left hand and arm are limited in that he does not have as much strength as he once did and he experiences pain as well as numbness. The claimant agreed that Dr. Johnson and Dr. Holder have both written reports indicating that he is unable to return to work and neither one of them has released him to return to work to date. The claimant testified that Dr. Sullivan has written a report dated September 29, 2006, indicating that he is totally disabled and that this doctor has never released him to return to work either.

On cross examination, the claimant was asked extensively about his lack of memory of his treatment by Dr. Asbury on June 10, 2003, when he received an injection in his left shoulder. The claimant agreed that after his July 9, 2003, fall he did not tell any of his treating physicians about receiving an injection in his left shoulder one month earlier. The claimant agreed that after his accident on July 9, 2003, he was initially treated by Dr. Clark who referred him to Dr. Wolfe. The claimant testified that Dr. Wolfe gave him injections in his shoulder. The claimant agreed that Dr. Bebout subsequently did surgery on his shoulder on October 21, 2003. The claimant agreed that he worked up until the date of his surgery and then was off work following his surgery before Dr. Bebout released him with restrictions to return to work. The claimant was asked if he remembered seeing Dr. Larry Armstrong, a neurosurgeon, after he was released by Dr. Bebout in September 2004

and the claimant responded, "I don't remember seeing him." The claimant agreed that if the medical records indicate that he was seen by Dr. Armstrong he would not question it. The claimant agreed that he continued to work until he fell from a platform in October 2004. The claimant agreed that as a result of this fall he was taken to the hospital and subsequently seen by Dr. Johnson. The claimant also agreed that it was after his October 2004 fall that he ultimately had neck surgery performed by Dr. Johnson. The claimant testified that after his neck surgery he worked for several months for the respondent. The claimant testified that Dr. Johnson took him off work in January 2006 and he began receiving short term disability through the respondent in the amount of \$204 a week for a period of six months. The claimant testified that he sat up an appointment with a vocational rehabilitation specialist for an evaluation but since he is still employed by the respondent he did not go to the appointment. The claimant agreed that none of his doctors have released him to return to work for the respondent. The claimant was asked about his prior work experience and the claimant testified that he has worked primarily as an electrician or an instrumentation electrician. The claimant agreed that in 1996 he was self employed doing computer repair and computer sales. The claimant testified that he would build computers for people and sell them. The claimant testified that he also worked on people's personal computers. The claimant testified that he has applied for social security but has not been approved.

On cross examination by Respondent No. 2, the Second Injury Fund, the claimant testified that when he saw Dr. Asbury in June 2003 he went in for the purpose of having his Zanex refilled. The claimant testified that between the time he saw Dr. Asbury in June 2003 and his accident in July 2003 he did not return to see the doctor for his shoulder. The claimant testified that between June 10 and July 9 of 2003 he was fully capable of doing his job duties for the respondent. The claimant testified that he did receive an impairment rating for his low back during the period of time he was working for Cryovac. The claimant testified that he did not have any surgery on his low back and that he regained his ability to do anything he wanted to do. The claimant testified that his fall off of a platform at work in October 2004 was reported to the respondent and he assumed that it was going to be turned into workers' comp. The claimant agreed that he has had medical treatment as well as neck surgery since this October 2004 fall. The claimant testified that to his knowledge Respondents No. 1 have paid for both his shoulder surgery as well as his neck surgery. The claimant testified that he has received ratings for both his shoulder and his neck and has been paid a part of these permanent partial disability benefits. The claimant testified that his wife is on disability and that their son has taken a second job in order to help pay their bills. The claimant testified that he drove himself to the hearing today from Barling, Arkansas, which is approximately a fifteen-mile drive. The claimant testified that he currently has been treated by a chiropractor and had in fact an

appointment that morning. The claimant was asked where he thinks his pain is coming from and he responded that he honestly could not tell, all he knows is that the pain is there. The claimant testified that he spends his day on the computer or helping his wife. The claimant testified that he does what he can to help before he starts hurting too bad. The claimant testified that he received FMLA benefits for a period of twelve weeks. The claimant testified that the last contact he has had with the respondent was when he turned in his off work slip from Dr. Johnson in January 2006.

On redirect examination, the claimant agreed that his claims for his shoulder and his neck were initially accepted and benefits were paid up through January 2006 by the respondent. The claimant testified that he takes medications every day for his pain. The claimant testified that this medication does not completely take his discomfort away but it does dull it enough so he can get some rest.

The medical records indicate that the claimant began treating with Dr. Asbury in 2001 for anxiety and a variety of physical problems. This treatment primarily consisted of prescription drugs to address the claimant's various symptoms. On June 10, 2003, the claimant was seen by Dr. Asbury for what the doctor opines is rotator cuff syndrome on the left as well as for a refill of his Zanex for his anxiety. The doctor notes that the claimant is able to abduct his arm to 180 degrees with a great deal of pain and exertion. Dr. Asbury administered a steroid shot, noting that the

first injection had 100 percent resolution of symptoms and advised him to take no more than three steroid injections in his shoulder in a lifetime. Dr. Terry Clark writes on July 11, 2003, that the claimant injured his left shoulder while carrying a motor up some stairs and felt a pop and pain. Dr. Clark notes that the claimant has tenderness to palpitation of the left AC joint and the proximal third of the deltoid. Dr. Clark writes that the claimant is able to abduct only to 70 degrees and that increases his discomfort. The claimant was diagnosed with left AC joint strain, medications were prescribed and it was recommended that he do no lifting over twenty pounds and to limit the use of his left shoulder. A radiology report dated July 11, 2003, indicates that the claimant had no fractures, dislocation or significant change in his left shoulder. On follow up treatment by Dr. Clark on July 18 it is noted that he is no worse but actually no better. Dr. Clark recommended physical therapy as well as additional medications and continued him on his work restrictions. When the claimant was seen by Dr. Clark on August 1, 2003, after examination and MRI of the claimant's left shoulder was ordered and again he was restricted to lifting no more than twenty pounds, no pushing or pulling over twenty pounds and to limit the use of his shoulder. An MRI of the claimant's left shoulder made on August 5, 2004, revealed a tiny focal area of increased signal within the supraspinatus tendon, which could represent a tiny partial tear or tiny focal perforation. The doctor reports that the claimant has no tendinous retraction and noted mild hypertrophy and downward sloping of the

acromion process. Dr. Keith Holder writes on August 8, 2003, that the claimant has been in physical therapy for two weeks and that his MRI shows a small defect in the supraspinatus tendon and a down sloping acromion process and mild hypertrophy. Dr. Holder returned the claimant to work with no lifting more than twenty pounds, no lifting overhead, limit use of left shoulder and no repetitive motion of the left shoulder. Dr. Holder also referred the claimant to Dr. Michael Wolfe. Dr. Michael Wolfe writes on August 18, 2003, that he has seen the claimant for left shoulder pain which he has had for one month. After examination and review of the claimant's x-rays and MRI, Dr. Wolfe assessed the claimant with having subacromial impingement syndrome with possible minor rotator cuff pathology. Dr. Wolfe administered a steroid injection and prescribed medications as well as physical therapy. On September 4, 2003, Dr. Wolfe writes that the claimant's injection did not improve his pain and he is able to only abduct about 90 degrees. Dr. Wolfe notes that the claimant is having some numbness and tingling in his left hand which has been bothering him since his injury and he wakes at night with numbness and tingling. After examination, Dr. Wolfe notes that the claimant has left shoulder problems as well as carpal tunnel syndrome for which he recommended a cockup splint for the claimant to wear at night and ordered EMG and NCV studies. The claimant underwent a nerve conduction study on September 8, 2003, which was found to be normal for both upper extremities. After reviewing the claimant's NCV reports as well as talking with the claimant's therapist, Dr. Wolfe writes on

September 11, 2003, that he thinks that the claimant is a candidate for surgical intervention and referred him to Dr. Bebout. Dr. Robert Bebout writes on October 9, 2003, that the claimant reports that he injured his left shoulder while carrying a motor which slipped out of his right hand and all the load was on his left arm which jerked, pulled and hurt his shoulder. Dr. Bebout writes that the claimant has had some steroid injections and some therapy as well as an MRI which showed positive tenopathy and increased signal in the supraspinatus tendon. Dr. Bebout notes that the claimant's pain is located in the upper arm and does not radiate below his elbow. X-rays taken reveal degenerative changes in the AC joint with spurring on both distal clavicle and the acromion process. After physical examination, Dr. Bebout recommended a Munford anterior acromioplasty of the claimant's left shoulder. The claimant underwent surgery on his left shoulder by Dr. Bebout on October 21, 2003. Dr. Bebout writes on November 4, 2003, that the claimant is two weeks after his Munford anterior acromioplasty of the left shoulder. Dr. Bebout writes that the claimant had a thickened, inflamed large chronic subdeltoid bursitis but the rotator cuff was in tact. Home exercises were demonstrated to the claimant and he was also instructed to apply heat to his shoulder prior to exercising and to ice it down afterwards. Dr. Bebout released the claimant to return to work on November 17, 2003, for one handed duty with no use of his left arm. When the claimant was seen by Dr. Bebout on November 19, 2003, it was noted that he had reports of some paresthesia type symptoms in his left upper

extremity which sounds more like radicular symptoms from his neck. Dr. Bebout notes that the claimant has pain in the upper trapezius and base of his neck. Dr. Bebout prescribed medications as well as added some light free weights for his shoulder routine exercises. Dr. Bebout notes that if the claimant continues to have radicular type symptoms they might want to get an MRI of his neck. On December 5, 2003, due to the claimant's continued complains of numbness in his hand up into his upper back and the base of his neck area. Dr. Bebout recommended an MRI of the claimant's neck and took him off work as well as prescribed medication for pain. An MRI of the claimant's cervical spine on December 15, 2003, revealed spondylitic ridging and disc protrusion and moderate channel stenosis at C3-4. This test also revealed disc bulging versus very mild protrusion at C6-7. Dr. Bebout writes on December 18 that the claimant's shoulder has healed well from surgery and that the claimant's MRI shows evidence of C3-4 stenosis which he thinks is causing the trouble with the claimant's shoulder. Dr. Bebout kept the claimant off work until he was seen by a neurosurgeon. A radiology report dated December 22, 2003, sets forth that the claimant has multilevel degenerative change, greatest at C3-4, without definite instability present. The claimant was seen by Dr. Larry Armstrong on December 22, 2003, for an evaluation of his neck problems. After examination of the claimant as well as a review of the claimant's MRI and x-rays, Dr. Armstrong reviewed the claimant's MRI scan with him in detail. Dr. Armstrong did not recommend surgery but did recommend physical

therapy on a formal basis as well as perhaps the use of a TENS unit and the trial of muscle relaxers. Dr. Armstrong noted that the claimant's anxiety and panic attacks will tend to exacerbate his condition. The claimant was followed by Dr. Terry Clark in January and February 2004 for his continuing complaints of neck pain. Medications were prescribed as well as the use of a TENS unit and physical therapy was continued. It was also recommended that the claimant restrict his work to no overhead work.

The claimant underwent a functional capacity evaluation on March 2, 2004. As a result of this extensive functional capacity evaluation, it was determined that the claimant gave full physical effort. Chris Honaker, the therapist giving the test, writes that the test lasted approximately three and a half hours and the deficits noted for the claimant were lifting and usage of his left upper extremity. Mr. Honaker writes that the lifting profile identified the claimant at the light level of function with exception to overhead lifting. It was recommended that he do no crawling unless absolutely necessary, to use two hands while climbing a ladder and to do no weight bearing or repetitive motion of the left arm above his shoulder height. Dr. Bebout continued to follow the claimant for his continued complaints of neck and left upper extremity problems throughout April and into May 2004 with treatment being recommended in the form of medications as well as physical therapy and strengthening programs. Dr. Michael Standefer evaluated the claimant on June 24, 2004, for his continuing complaints of muscle spasms in his neck and left shoulder area and

in the back around his shoulder blade. After a review of the claimant's medical history as well as a review of his MRI and other test findings as well as physical examination it was noted that the claimant does have a focal disc bulging/protrusion/osteophyte formation at C3-4 with moderately severe channel stenosis. Dr. Standefer recommended a myelogram and CT scan to more fully and completely evaluate the claimant's problem. On July 22, 2004, the claimant was treated by Dr. John Swicegood for pain in his cervical spine and left shoulder as well as upper left arm. Dr. Robert Bebout writes on September 29, 2004, that the claimant continues to have problems with his neck and left shoulder. Based on the A.M.A Guide, Forth Edition, Dr. Bebout assesses the claimant with a combined 21 percent whole body disability rating for his current problems.

The claimant was seen at St. Edward's emergency room on October 22, 2004, following a fall from a platform at work and has complaints of left shoulder pain as well as neck and back pain. X-rays taken of the claimant's cervical spine on October 28, 2004, showed mild degenerative disc space narrowing, marginal spondylosis at C3-4 and there is mild degenerative facet joint disease on the right C4-5. X-rays of the claimant's left shoulder showed no bony abnormality. The claimant was seen by Dr. Bebout on October 28, 2004, as a result of his October 21, 2004 fall. After examination, Dr. Bebout opined that the claimant's major symptoms are coming from his neck and orders an MRI. The claimant underwent an MRI on November 19, 2004, which revealed moderate dorsal spondylotic

ridging and disc protrusion at C3-4 resulting to mild to moderate spinal channel stenosis and moderate bilateral foraminal stenosis. Dr. Bebout writes on December 1, 2004, that he has reviewed the claimant's MRI and the findings set forth on that test convince him that this is the reason for the claimant's ongoing shoulder and arm pain. After examination, Dr. Bebout writes that he thinks that the claimant's neck disease has progressed since his last evaluation and he believes this is an ongoing problem from his original workers' comp injury. Dr. Bebout recommended a neurosurgical evaluation and prescribed medications. Dr. Arthur Johnson writes on February 8, 2005, that he has seen the claimant who has problems with neck and shoulder pain and pain into his left arm associated with some spasms. Dr. Johnson notes that the claimant has had these problems since his job related injury in 2003, noting that the claimant's pain continued to be progressively worse. Dr. Johnson notes that the claimant has undergone physical therapy and cervical epidural steroid injections which have not helped. After examination and review of the claimant's MRI, Dr. Johnson assesses the claimant with having osteophyte, C3-4 with neuroforaminal narrowing bilaterally. Dr. Johnson recommended that the claimant be scheduled for an anterior cervical discectomy and fusion at C6-4 due to his failure to respond to conservative intervention. There is a return to work slip signed by Dr. Johnson taking the claimant off work from March 23, 2005, to May 23, 2005, due to his cervical surgery. The claimant underwent cervical surgery performed by Dr. Johnson on May 11, 2005. On May 24, 2005, Dr. Johnson writes that

he has seen the claimant which is now two weeks past his cervical diskectomy and fusion at C3-4. Dr. Johnson notes that the claimant still has some complaints of neck and arm pain but not as much as it was right before his surgery. The doctor notes that the claimant's x-rays show that he has good cervical plate and bone plug placement and that they are to keep the claimant off work for an additional month. Dr. Johnson writes that the claimant can start doing some range of motion with his neck. The claimant was seen by Dr. Johnson on July 5, 2005, for his continued complaints of pain in his neck. Dr. Johnson writes that the claimant reports that his pain is in the back of his neck and runs up and down the spine with no significant radiation to his extremities. The doctor notes that the claimant has returned to work on restricted duty. Dr. Johnson writes that the claimant is status post anterior cervical diskectomy fusion at C3-4 with some residual muscle spasm pain in his neck area. Medications were prescribed and he was to continue with his work restrictions of no lifting greater than fifteen pounds and no work with his hands above his head or looking up on a continual basis. When the claimant was seen by Dr. Johnson on October 6, 2005, he notes that the claimant continues to work and still is having pain in his neck which now is going across both shoulders instead of just in the left side. After examination, the claimant was diagnosed with progressive neck pain that might be secondary to adjacent disc syndrome. Dr. Johnson ordered an MRI of the claimant's cervical spine as well as sent him for cervical physical therapy and prescribed medications. An MRI of the

claimant's cervical spine was done on October 11, 2005, which revealed artifact compatible with hardware from an anterior interbody fusion at C3-4 with no spinal or foraminal stenosis and no disc herniation seen. The claimant began cervical physical therapy on or about October 12, 2005, and was treated at least a couple of times a week up through November 14, 2005. Dr. Johnson writes on January 24, 2006, that he has seen the claimant who still has left arm and shoulder pain since his surgery. The doctor notes that his pain did get better for a while but now has begun to get progressively worse and continues to cause significant problems radiating down his arm. Dr. Johnson prescribed medications and recommended that he follow up with his primary care provider in addition to neurosurgical treatment. Dr. Johnson writes that the claimant will not be able to return to work due to his persistent problems with pain and it is unlikely that this pain will get any better and, therefore, his work status would be off work indefinitely. The claimant continued to be seen by Dr. Asbury for monitoring and prescribing his pain medications. Dr. Asbury filled out a attending physician's statement on behalf of the claimant indicating that he is not able to work due to severe limitations and incapable of minimal activity on March 24, 2006. The claimant underwent a second functional capacity evaluation administered by Chris Honaker on May 2, 2006. The results of this test set forth that the claimant gave full effort during the testing period and that his functioning was less than secondary level according to the lifting profile. Mr. Honaker writes that in general no level or

overhead work is recommended, prolonged positions should be avoided, and that there is a strong concern for safety with low level attempts at lifting. Mr. Honaker also recommended based on the tests that the claimant be allowed to alternate between sitting and standing as needed. Dr. Arthur Johnson writes on June 2, 2006, that the claimant has reached his maximum medical improvement and assessed the claimant with a permanent impairment disability according to the AMA Guides of 9 percent to the body as a whole.

Dr. Bebout in his deposition taken on October 25, 2006, testified that he first saw the claimant on October 9, 2003, on a referral from Dr. Wolfe. Dr. Bebout testified that the claimant presented to him that he had injured his left shoulder at work on July 9, 2003. Dr. Bebout testified that the form that the claimant filled out before he was seen by the doctor indicated that he had never had any other injuries to his left shoulder. Dr. Bebout indicated that his notes set forth that Dr. Wolfe had administered the claimant a steroid injection and recommended physical therapy. Dr. Bebout testified that it is not unusual for a steroid injection to provide relief for a period of three to four weeks and then the underlying inflammation and symptoms associated with the inflammation to return if the underlying cause is still there. Dr. Bebout testified that it is very common that where the first injection was effective symptomatically and then the second injection would not have as favorable a result. Dr. Bebout testified that he gave the claimant a physical examination as well as reviewed his x-rays and MRI. Dr. Bebout testified that the spurs in the claimant's

shoulder area as well as the arthritis noted were there by the time of his accident. Dr. Bebout indicated that following the claimant's shoulder surgery he continued to have complaints of pain in his shoulder area which the doctor agreed was more consistent with a cervical condition. Dr. Bebout stated that there is a diagnostic dilemma with shoulder and extremity pain whether the source is from the shoulder or from the neck stating further that you have to be wary of neck trouble masquerading as shoulder trouble.

On cross examination, Dr. Bebout testified in his deposition that the claimant's rating for his shoulder was based upon passive range of motion. Dr. Bebout explained that he would ask the claimant to move his arm in a certain direction and when the claimant would indicate that he had moved it as far as he could, he then would move the claimant's arm further if possible. Dr. Bebout testified that besides the rating based on loss of passive range of motion, the claimant would also be entitled to a 4 percent rating based upon the AMA Guides, Table 27, due to the type of surgery performed on his shoulder. Dr. Bebout agreed that the mechanism of the type of injury which the claimant experienced on July 9, 2003, would translate into trauma to his left arm, as well as to his cervical spine. Dr. Bebout was asked if it was likely that the claimant's physical event, his accident on July 9, 2003, probably caused the symptoms he had when he first saw the claimant. Dr. Bebout responded, "I think it would cause a shoulder to stiffen up like that, yes, sir." Dr. Bebout agreed that if the claimant had

a pre-existing condition and there was an event that triggered his symptomology and those symptoms never abated, he might agreed that the major cause for the claimant's need for treatment would be that triggering event. Dr. Bebout was asked, "Is it likely that the claimant had some neck involvement all along and it simply was not focused upon because of the immediacy of his shoulder problems?" and Dr. Bebout responded, "You know, one symptom masks or over lies another one because it just is more prominent, and once you get one under control, then the one that wasn't so symptomatic becomes apparent." Dr. Bebout testified that based on information acquired during the taking of this deposition, it appeared to him now that the treatment the claimant required for his shoulder was due to the incident in July of 2003, and not from any pre-existing condition. Dr. Bebout testified that he was acquainted with Dr. Arthur Johnson and considered him to be a good neurosurgeon. Dr. Bebout indicated that he was comfortable relying on Dr. Johnson's opinion that what he treated the claimant for was likely due to the July 2003 accident. On cross examination by the Second Injury Fund, Dr. Bebout was asked if the claimant's neck problems and symptoms increased after his fall on October 21, 2004. Dr. Bebout responded, "No. I thought, like he said, this was an ongoing problem that we had been dealing with from a year ago, I guess—from October of 2003. It seemed to have the same type of problems that he had been having for the last year."

After a complete review of this entire record, I find that the claimant has proven by a preponderance of the evidence that he

sustained a compensable injury to his left shoulder as well as to his neck on July 9, 2003, while working for the respondent. The claimant has testified and even respondent #1 accepted for a long period of time that the claimant had an accident while carrying a hundred pound motor which resulted in his left arm being pulled from the full weight of this motor while it was being carried by the claimant. Dr. Bebout has testified that the claimant had pre-existing problems with his left shoulder which his operation corrected. However, since the claimant was not symptomatic prior to his July 9, 2003, injury, Dr. Bebout agreed that the treatment which the claimant required for his left shoulder was the result of his symptoms which developed after the accident on July 9, 2003. Both Dr. Johnson and Dr. Bebout have agreed that the claimant's neck problems were a continuation of his July 9, 2003, injury. Although the claimant was initially treated and diagnosed with left shoulder problems after his shoulder surgery, he immediately began to complain about pain in his neck and left shoulder area and back area. An MRI revealed problems which Dr. Johnson addressed surgically, but unfortunately, the claimant has continued to have pain and limited use of his left shoulder and arm which seriously affects his ability to work. Respondent #1 should pay for all the costs of this claimant's medical treatment for his left shoulder as well as neck problems. Respondent #1 should also pay temporary total disability to this claimant from July 16, 2003, for the periods of time that the claimant was off work as the result of his compensable injuries. The claimant is entitled to TTD from January

24, 2006, to July 2, 2006, continually. Dr. Arthur Johnson took the claimant off work indefinitely on January 24, 2006, and did not end his healing period until June 2, 2006, when he assessed the claimant with a 9 percent whole body impairment rating for his neck. The claimant is also entitled to a permanent partial disability rating of 9 percent to the neck as assessed by Dr. Johnson and a 7 percent to the body as a whole for his left shoulder as assessed by Dr. Bebout to be paid by respondent #1. I do not find that this claimant is permanently and totally disabled. I do find that he is entitled to wage loss over and above his impairment rating in the amount of 16 percent, which would give him a total disability rating of 32 percent to the body as a whole. This finding of 16 percent above the claimant's impairment rating is based on the claimant's age, education, job experience, his physical limitations, his functional capacity evaluation, and his need for ongoing medical treatment. I do not find any Second Injury Fund liability in this matter.

FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.
2. On July 9, 2003, the relationship of employee-employer existed between the parties.
3. Claimant is entitled to the maximum compensation rate for 2003.
4. The claimant has proven by a preponderance of the evidence

that he sustained a compensable injury to his left shoulder and to his neck on July 9, 2003. See Discussion above.

5. Respondent #1 should pay for the cost of all reasonable and necessary medical treatment for the claimant's left shoulder and neck problems.

6. Claimant is entitled to temporary total disability from July 16, 2003, for the periods of time he was off work as a result of his compensable injuries to January 24, 2006. The claimant then is entitled to temporary total disability from January 24, 2006, to June 2, 2006, continually, which is the period of time Dr. Johnson took the claimant off work indefinitely until he indicated the claimant had reached maximum medical improvement on June 2, 2006.

7. Respondent #1 should pay permanent partial disability to this claimant in the amount of 9 percent to his neck and 7 percent for his left shoulder problems as assessed by Dr. Johnson and Dr. Bebout.

8. The claimant has failed to prove by a preponderance of the evidence that he is permanently and totally disabled. See Discussion above.

9. The claimant has proven by a preponderance of the evidence that he is entitled to wage loss in the amount of 16 percent over and above his permanent partial ratings of 9 percent for his neck and 7 percent for his shoulder. See Discussion above.

10. There is no Second Injury Fund liability found in this matter.

11. Respondent #1 has controverted this claim in its entirety.

12. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that he sustained a compensable injury to his left shoulder and neck while working for the respondent on July 9, 2003.

The respondent #1 shall pay for all reasonable and necessary medical treatment for this claimant's two compensable injuries.

Respondent #1 shall pay temporary total disability to the claimant for the periods of time he was off work as a result of his compensable injuries from July 16, 2003, to January 24, 2006. Respondent #1 shall pay temporary total disability to the claimant from January 24, 2006, to June 2, 2006, which was the period time after Dr. Johnson had taken the claimant off work indefinitely until he stated that the claimant had reached maximum medical improvement.

The claimant has failed to prove he was permanently and totally disabled.

The claimant has proven by the preponderance of the evidence that he is entitled to wage loss in the amount of 16 percent over and above his permanent impairment ratings of 7 percent for his shoulder and 9 percent for his neck. This would give the claimant a total disability rating of 32 percent to the body as a whole. This wage loss should be paid by respondent #1, since I find no Second Injury Fund liability in this matter.

The respondents shall pay to the claimant's attorney, the maximum statutory attorney's fee on the additional benefits awarded herein, with one-half of said attorney's fee to be paid by the respondents in addition to such benefits and one-half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE