

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F603488**

<b>EDDIE HERRON, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>AMERICAN GREETING CORPORATION, EMPLOYER</b>	<b>RESPONDENT #1</b>
<b>ZURICH AMERICAN INSURANCE CO., CARRIER</b>	<b>RESPONDENT #1</b>
<b>SECOND INJURY FUND</b>	<b>RESPONDENT #2</b>
<b>DEATH &amp; PERMANENT DISABILITY TRUST FUND</b>	<b>RESPONDENT #3</b>

**OPINION FILED JULY 25, 2007**

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on April 27, 2007, at Blytheville, Mississippi County, Arkansas.

Claimant represented by the HONORABLE MIKE J. ETOCH, JR., Attorney at Law, Helena West Helena, Arkansas.

Respondents #1 represented by the HONORABLE DAVID C. JONES, Attorney at Law, Little Rock, Arkansas.

Respondent #2 represented by the HONORABLE TERRY PENCE, Attorney at Law, Little Rock, Arkansas.

Respondent #3 represented by the HONORABLE JUDY W. RUDD, 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 workers' compensation benefits. On January 30, 2007, 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 among the parties, the issues to be addressed during the course of the hearing, and the parties' contentions relative to the afore issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

With respect to any additions or modifications to the previously filed pre-hearing questionnaires, claimant contends that the actual date of the injury, which servers as the basis for the present claim was May 17, 2006. Respondents #1, has submitted an Amended Prehearing Questionnaire which set forth their contention relative to permanent disability benefits as well as major cause. Respondent #2 noted that at the time it submitted the responsive filing to the Pre-hearing Questionnaire a position was not taken relative to the extent of disability and Second Injury Fund liability. After having obtain additional medical evidence, Respondent #2 takes the position that there was no new injury that caused objective findings in May 2006, and that all claims of disability pre-existed the episode in question.

The testimony of Eddie Herron, the claimant; Phyllis Herron, Seteria Lenzy, Shirley Smith, Gordon Clay, and Jeremy Couch, coupled with medical reports and other documents comprise the record in this claim.

### **DISCUSSION**

Eddie Herron, the claimant, with a date of birth of September 30, 1956, who has been married for thirty (30)years, testified that while he has had hearing difficulty since before he was married, to his knowledge the same had never prevented him from getting employment. Claimant denies that his hearing difficulty has impacted on his selection of employment. Claimant completed the 8<sup>th</sup> grade and later obtained a GED. Claimant underwent training in police work, which was obtained at Mississippi County Community College. Claimant utilized

his law enforcement training as an auxiliary police officer for approximately four (4) years. The claimant has undergone two eye surgeries and two laser eye surgical procedures, in addition to four (4) hernia repair surgeries.

The claimant's employment history reflects that he was employed at Aurora Steel in 1971-72, in the shipping and receiving department. The work entailed heavy manual labor of loading and unloading truck. The testimony of the claimant reflects that between 1972 and 1975, he did not work but instead traveled with his uncle to Oklahoma before return to Aurora. In 1976, claimant worked in a shoe factory in Osceola. Claimant's first period of employment by respondent #1 was from 1977 to 1979, as a forklift operator. Thereafter, claimant was employed at Arco, Inc., in west Chicago. Claimant then returned to respondent #1 for year or two in the packing department. Claimant was then employed at EckAdams where he performed several different jobs to include spot weld, work on a bender machine, and work in the wood shop. Claimant was then employed by the Osceola School District for ten (10) years as a custodian and bus driver. Claimant then returned to the employment of respondent #1 in 1995, in the packing. (JX #1).

The testimony of the claimant reflects that the first time he hurt his back was during his employment with American Greeting in 1979, which entailed approximately three (3) weeks of treatment at the hospital in Osceola. Following the three (3) weeks of treatment claimant returned to work and did not have further difficulties with his back until 1991.

By the time of the 1991, back injury claimant was employed by Osceola School District as a custodian and school bus driver. The claimant underwent back surgery under the care of Dr. Allen Boyd, was off work for a period of six (6) months, and received an eight (8 %) percent

permanent partial disability rating. Claimant returned to his job with the school district where he suffered a second injury to his back on or about February 1, 1995. Claimant received medical treatment and was off work for approximately one (1) month as a result of the February 1995, back injury at the school district. Claimant returned to the employment of the school district for a short period following the second back injury, however submitted his two weeks notice after tentatively securing new employment. When the new job did not come through claimant returned to the school district only to learn that his position had been filled.

At the time of his employment with respondent #1 in 1995, claimant worked in the packing department and performed janitorial work. Claimant ultimately became a leader in maintenance over the clean-up crew. After respondent #1 hired a outside company to perform the maintenance job claimant was offered and accepted a machine specialist position after taking the test for it.

Claimant's testimony reflects that he was employed in the position of a machine specialist at the time of injuries to his back in 2001 and in 2005. In describing his job duties as a machine specialist in the employment of respondent #1, the claimant testified:

Oh, you had to set up a machine and make sure it was running right and you had to keep it running right.

Probably about ten pounds, until we had to catch the cards on the end of the machine. And, you know, when we had to, they started switching that over. The last, the last year I worked there the machine specialist was going to have to do the work of the one that used to catch the cards, they were going to do all that stuff and put them over in a bin and stuff like that. (JX. #1, p. 40-41).

The testimony of the claimant reflects that before he left respondent #1 he had begun the task of catching the cards, noting that the weight of the stacks was between 20 to 25 pounds.

The testimony of the claimant reflects that in 2001 he sustained an accidental injury to his back while employed by respondent #1. Claimant testified:

Well, I was a machine specialist, and I was running a machine and having to take the boxes off this conveyor and put on the skid and someone put some skids behind me and I didn't know they were there, and the machine was messing up, and I ran over to cut my machine off, and when I turned around to go over there, I tripped over the skids and fell and hurt my back. (T. 48).

Claimant maintains that he reported the injury to his supervisor. As to whether he filed a workers' compensation claim as a result of the incident claimant responded:

I thought I did, but we went in and she went to the office and when we got in there, she started asking me all kinds of questions about it. She was filling this paperwork out and I had to sign it. (T. 49).

Claimant asserts that he was told that he needed to sign the documents and he did so.

The claimant testified that he next suffered an injury to his back when he fell off a platform at work. In describing the incident, claimant testified:

I was working on the machines, and then I went down to the end of the platform that I was on, and I slipped and fell and hit a bolt - and it caught me on my hip, and I scratched my chest up. I went and told Shirley Smith about it - it scratched my chest and my shoulder. (T. 50).

Claimant explained the Shirley Smith was the lead person who had taken Jeremy Couch's place that particular night. Claimant testified that he did not know whether a workers' compensation claim was filed in connection with the incident. The testimony of the claimant reflects that the afore incident occurred in March 2005.

The testimony of the claimant reflects that approximately two (2) months following the March 2005, incident he suffered another accident in the employment of respondent #1. The claimant characterized the May 17, 2005, incident, as "the one that put me where I can't do

anything”. (T. 51). In describing the mechanics of the May 17, 2005, accident, claimant testified:

Well, I went - we had to clean the machines up. It was on Sunday night, and I went and unplugged the air hose and when I started walking back toward the end of the machine, something just hit me in the back and I just went down. And it hit me a second time, and I had to go down to the floor - down on my knees. I couldn't move or anything. (T. 51).

Claimant testified that he had never experienced a similar episode prior to the incident. Claimant testified regarding the individuals that were present at the time of the accident:

Seteria - I don't remember her last name. And Shirley Smith came over, and they called for my supervisor, Jeremy Couch. He came over, they tried to help me up, and it was hurting pretty bad when they were trying to help me up, and they finally got me up on my feet. They had to wheel me out of there, you know, on a cart they had, and got me out of there. They called me wife to come and get me. (T. 51-52).

The testimony of the claimant reflects that he was transported home from the plant by his wife and that he went to Dr. Cullom, his family physician, the next day. Claimant testified that his medical treatment by Dr. Cullom consisted of injections in his back, pain pills and muscle relaxers. Claimant's testimony reflects that he did not attempt to return to work because he could not physically. Claimant asserts that in late June 2005, about a month following the incident, respondent #1 terminated his employment.

Claimant asserts that during the period subsequent to the May 2005, incident he was under the active medical treatment of Dr. Collum and taking pain pills and muscle relaxers for his back complaint. Claimant testified that he was ultimately referred by Dr. Collum to Dr. Richard Jordan, a North Little Rock neurosurgeon, following a Blytheville MRI scan. Claimant noted that Dr. Jordan was unable to read the Blytheville MRI, and, as a consequence, he had another MRI scan performed in Little Rock.

The testimony of the claimant reflects that he underwent back surgery in the form of a fusion under care of Dr. Jordan. Claimant testified that he did not return to work following the surgical procedure of Dr. Jordan.

While the claimant testified that he did not remember being seen by Dr. Jordan prior to the 2005 referral by Dr. Collum, he does not dispute the accuracy of medical records of Baptist Health Medical Center-North Little Rock reflecting a February 11, 2004, examination of him by Dr. Jordan. (RX #1, p. 88). Claimant concedes that he continued to have back problems and treatment for several years following his 1991 back injury and surgery. Claimant does not dispute the February 3, 1995, subsequent back injury sustained during his employment with the school district, although he credibly testified that he did not recall the specifics of it.

Claimant acknowledged receiving the American Greetings Employee Handbook at the time he commenced his employment with respondent #1 in 1995. Claimant does not dispute the presence of postings throughout the facility of respondent #1 regarding the filing of workers' compensation claims.

The evidence reflects that the claimant filed a disability income claim form in February 2001, which reflected that the medical condition which served as the basis for the filing was not caused by his work with respondent #1. The claimant was ultimately admitted to St. Bernards Medical Center in July 27, 2001, for testing and treatment. The claimant filed his claim for the medical treatment with his health insurance carrier. (T. 62).

While the claimant testified that the pain that he experience in the May 2005, incident was more severe than any he had previously experienced he does not dispute that he had seen a doctor days prior to the incident for back pain. A review of the medical reports in the record

reflects that the claimant was seen by Dr. S.R. Cullom pm February 25, 28, March 10, 21, and May 9, 2005. (RX #1, p. 93-96) (CX. #1, p. 5). Claimant also acknowledge that he was seen by his doctor due to back pain in late April 2005. The claimant's work attendance records reflect substantial periods of absence from work. Claimant concedes that he was off work for more than six (6) months from October 2002 through April 2003. Claimant noted that the afore entailed surgery for his bladder. Claimant acknowledged being off work for several weeks from May 2001 through September 11, 2001, with treatment for his back which include a hospital admission and blocks relative to his back pain.

Claimant acknowledged experiencing and reporting episodes of 30 to 45 minutes of low back pain several times throughout the day in November 2002. Claimant described the pain during the afore period as "cracking, snapping feeling". Claimant was kept off work by his doctor at the time he sought medical treatment on November 2, 2004. The afore was not filed as a workers' compensation claim. Claimant also concedes that he was never told by personnel of respondent #1 not to file a workers' compensation claim or that he could not filed such a claim.

Claimant also acknowledged that he has constantly taken pain medication for his low back pain since 1992. The testimony further reflects that when the would leave his prescription pain medication at home his wife would bring it to him at his job. The evidence reflects that on April 1, 2005, claimant had a MRI scan performed relative to his lumbar spine, prior to the May 2005 incident which serves as the basis for the present claim. Claimant concedes that he has had MRI's performed over the years because of back pain and problems.

Claimant acknowledged that he had physically had problems walking for a number of years prior to May 2005. The afore entailed moving slow as he walked and having to stop and

take breaks while walking because of back pain and problems. (T. 70-71).

During cross-examination, claimant testified that in March 2005, when he slipped off the end of the platform hitting a bolt that was hanging out of a machine which scratched his chest did not cause any appreciable back pain. Further, claimant acknowledged that following the May 2005, incident he did not inform anyone at work that he was claiming the incident as a workers' compensation injury. Claimant denies that on May 17, 2005, he specifically told his supervisors that the incident was not work-related:

No, he went and asked me - well, he said, you've had this pain before, haven't you? I said, yeah, I've had it before. But, he wasn't there the night that I hit my - hip on that there screw and bolts. (T. 72).

Claimant added, that he did not remember his supervisors asking him if he had hurt himself at work on May 17, 2005. Claimant acknowledged that an AR-C was not filed regarding the May 17, 2005, incident until April 2006.

It is undisputed that the claimant's attorney filed the AR-C with the Arkansas Workers' Compensation Commission via cover letter of March 31, 2006, which was stamped marked on April 3, 2006. The date of injury reflected on the AR-C is March 22, 2005.

Claimant denies that he returned to the employment of respondent #1 and discharged employment duties subsequent to his last injury, which he has identified as May 17, 2005.

Claimant testified regarding the afore:

No, I don't think I could have did anything. I might have been, I don't really remember. I don't think I could have made it. (T. 76).

Claimant later conceded that he "think" he returned and worked several weeks. (T. 77). The documentary exhibits of respondent #1 reflect that the claimant worked through June 2006, and

into July 2006. (RX #2, p. 73).

Claimant acknowledged that he filed for unemployment benefits following the termination of his employment by respondent #1. (RX. #2, p. 77-83). The records of the Department of Workforce Services reflect that the claimant last worked on July 15, 2005, and that he was discharged from his employment on July 18, 2005. (RX. #2, p.80- 83).

When questioned regarding the air hose incident of May 17, 2005, which serves as the principle basis for the present claim, claimant testified that the hose has a “lot of power”and “jerks” when released. Claimant acknowledged that he did not have to bend over to reach the hose. The testimony of the claimant reflects that he did not feel any pain while releasing the hose. Claimant maintains that as he was walking away toward the front of the machine after having released the hose the pain started in his back. The claimant testified that he was just walking when he experienced the sudden excruciating back pain. Claimant concedes that during the time period of the incident he was having problems with his legs which resulted in him having a tendency to fall. (T. 80-81).

The testimony of the claimant reflects that he is aware that his 1991 back surgery was at the L4-L5 level. Claimant’s testimony reflect that his December 2005 fusion surgery under the care of Dr. Jordan was at the L4-L5 level due to lumbar instability.

Claimant’s testimony reflects that medical treatment rendered by Dr. Cullom following the “hose incident” included injections in his back and the use of a sonolator. Claimant concedes that he had been seeing Dr. Cullom on a regular basis since February 2005 because of back pain. The medical evidence in the record reflects that medical treatment rendered by Dr. Cullom throughout the period had consisted of injection, sonolator, and pain medication.

During re-direct questioning, claimant testified that he has difficulty remembering dates. Further, claimant maintains that at the time of the March 2005, incident, in addition to scraping his chest, he fell on his hip on the concrete surface suffering a “real bad” jar. While responding that he did not try to file a claim for the incident testified that he went to the office and reported it to Shirley Smith. Claimant later testified regarding his reasoning for not filing a claim:

Shirley Smith said it’s close to home time and she wasn’t gonna do no paperwork on it. She said I’m glad you came in and showed me that on your chest. She said, if anything comes up, we’ll know about it - what happened.

I though she would go ahead and file one, but she said she wasn’t gonna do the paperwork on it. (T. 87).

Claimant’s testimony reflects that subsequent to the March 2005 incident he did not “have real bad problems” with his back until the hose incident in May 2005.

The testimony of Mrs. Phyllis Herron, the claimant’s wife, reflects that she and the claimant have been married since 1976. At the time of their marriage in 1976 the claimant worked at a shoe factory. Mrs. Herron confirmed that the claimant worked for respondent #1 before his employment with the Osceola School District. Further, Mrs. Herron acknowledged that the claimant underwent surgery on his back in 1991, under the care of Dr. Boyd, a Memphis physician, relative to a 1989 back injury that he sustained in his employment with the school district. Mrs. Herron noted that following his recovery the claimant returned to his work with at the school district until 1995, when he was again employed by respondent #1.

Mrs. Herron testified that the claimant left the employment of the school district because of the heavy physical labor tasks that were imposed on him by supervisory personnel in the discharge of his job duties - specifically heavy lifting. Mrs. Herron maintains that the general

factory work at respondent #1 was lighter than the claimant's job duties at the school district. Mrs. Herron testified that while the claimant started out performing general factory duties he eventually discharged the duties of a machine specialist for respondent #1.

Mrs. Herron is employed at respondent #1 and works the first shift. Claimant worked the third shift at respondent #1. Additionally, the testimony in the record reflects that two (2) of the claimant's daughters and a nephew are employed by respondent #1. Mrs. Herron asserts that respondent #1 discourage employees from filing a workers' compensation claim. Mrs. Herron testified that while she has both short term and long term disability through her employment with respondent #1, the claimant only had short term disability. Mrs. Herron testified that in her opinion respondent #1 wanted injured employees to file claims on short term disability and medical rather than file workers' compensation claims. (T. 24).

Mrs. Herron's testimony reflects that the claimant's work record consistent without missed time from 1995 until 2001. Mrs. Herron testified:

I believe it was - there for a while, he worked real good, and he didn't miss from when he started, you know, he had a good record and stuff, and then that happened - that happened again - I can't remember. I can't remember. (T. 17).

The testimony of Mrs. Herron reflects that during the time of the claimant's employment at respondent #1 he underwent two (2) eye surgeries, bladder surgery, and three (3) hernia repair surgeries. Mrs. Herron also acknowledged that the claimant has severe hearing difficulty, and that in 1996, a hearing aid was recommended. (T. 36).

Mrs. Herron testified regarding a specific at respondent #1 involving the claimant:

Yes, sir. I remember coming out there , picking him up. I don't know exactly what date it was or anything like that, but I remember

picking him up. The supervisors came out there and brought him out there on the truck, and I got - picked him up. He couldn't walk - barely, he - I mean - he would walk - they was helping him to the truck.

This was the last one [incident]. (T. 18).

Mrs. Herron acknowledged that she was not present at the time of a 2001 incident at work involving the claimant when he fell over some skids. The testimony of Mrs. Herron reflects that she was called to pick up the claimant following the incident; that she did so; and that she took him home. Mrs. Herron offered that in her opinion the claimant's condition regarding his back gradually got worse following the 2001 incident. (T. 24-25).

Regarding the claimant's last incident at work in 2005, Mrs. Herron testified:

I remember Gordon Clay, Glen, and it might have been Jerry Couch, came out - brought him out there. I'm not sure - I think it was about three or four of them brought him out there to the truck, and I - they helped him - they put him in there, you know, helped him get in the truck, and I came and got him and took him home, or took - I don't remember if I took him to the emergency room or what. (T. 20).

Mrs. Herron's testimony reflects that while she believed that claimant missed some work following the incident, she does not remember if he returned to respondent #1 and attempted to work.

During cross-examination, Mrs. Herron acknowledged that she does not hold a management position in her employment with respondent #1, but rather is a material handler, and as such her assessment of the handling of workers' compensation claims by respondent #1 is her personal opinion. Mrs. Herron concedes that respondent #1 furnishes American Greetings' Handbook to its employees. Having not read the Handbook Mrs. Herron's testimony reflects that she was not aware that the handbook reflects how and when to report claims. Further, Mrs.

Herron acknowledged that she was not aware of respondent #1's actual employment policy regarding reporting claims. (T. 34).

Mrs. Herron testified that she did not remember if the claimant went to the doctor on a frequent basis for back problems between 1995 and 2000. Likewise Mrs. Herron testified that she did not remember if the claimant had filed for disability because of his back problems in 2001. Mrs. Herron concedes that the disability application form dated February 20, 2001, bears the signature of her husband, the claimant. (T. 41).

Mrs. Herron testified that she did not recall if the claimant was being actively treated by his back problems prior to May 2005. Mrs. Herron concedes that the claimant may have been treated by Dr. Cullom with a Sonolator and Decadrin injections regarding his back a few weeks prior to the May 2005, incident.

Ms. Seteria Lenzy, a seven year employee of respondent #1, is a machine specialist who worked in close proximity to the claimant. Regarding her observations of the claimant prior to May 2005, Ms. Lenzy testified:

He would walk slow, sometimes staggering, like he was tired or drunk, and he was on his pain medicine. (T. 91).

Ms. Lenzy's testimony reflects that the claimant has complained of back problems for the two (2) years that she worked with him. With respect to the May 2005, incident at work involving the claimant, Ms. Lenzy testified:

I was working at the machine next to his, and I heard him say, oh, and I said, Ed, are you okay? And he didn't say anything and he was standing there holding on to the side of the conveyor belt, and I saw him lowering himself down, so I got off my machine and went to sit next to him and asked him if he was all right, and he said, it's my back, and he lowered himself to the floor, on his - to his knees, and then he was down. And I

called Phyllis and had her page Jeremy, and told her to page him three times so he would know something was wrong. (T. 92).

Ms. Lenzy testified that the claimant was several feet from the air hose when she arrived at his side. The testimony of Ms. Lenzy reflects that the claimant's response was his "back" to her inquiry of what was wrong. Further, Ms. Lenzy testified that the claimant never indicated to her that his problem was the result of his work.

Ms. Lenzy denied that employees of respondent #1 are discouraged from filing workers' compensation claims. In terms of reporting work-related injuries, Ms. Lenzy testified that anytime an employee is injured the employee is supposed to tell the supervisor or leader.

The testimony of Ms. Lenzy reflects that after lowering himself to the floor the claimant was unable to get up by himself. Ms. Lenzy's testimony reflects that an ambulance was called and the claimant was taken out on a stretcher.

Ms. Shirley A. Smith, a 28-year employee of respondent #1, is a senior machine specialist. Ms. Smith testified regarding her observations of the claimant prior to May 2005:

That he was having problems and he was having to take a lot of pain pills and muscle relaxers, slow getting to work, moving slowly.(T. 98).

Ms. Smith also testified that every since she has known the claimant, which covers the span of time that he has worked in the machine department, he would have to stop and rest when walking. Regarding her knowledge of the claimant taking medication at work, Ms. Smith's testimony reflects:

Because he would be - like, one time out there he was throwing up. I took him crackers and Sprite. He had took some pain pills and didn't eat nothing, is what caused him to throw up, because I've asked him. And then he'd also ask me to get his wife to bring him his medicine. I would go to the guard shack and get it cause he was not allowed to go get it. (T. 100).

Ms. Smith testified that the claimant's physical complaints "most of the time was just that his back was bothering him". (T. 100).

Ms. Smith also provided testimony regarding an event involving the claimant which occurred in March 2005:

Yeah, there was one event where the shift had just begun. He had told me he had fell, and showed me the scratches on his back, and said he fell over the skids.

I told him - at that time, I would say, I told him now, if it bothers you, let me know. Come back to me, and we'll take care of it. (T. 100).

Ms. Smith maintains that the claimant never returned to her with complaints growing out of the incident. Ms. Smith acknowledged that an incident report was not completed the night of the reporting. While asserting that the claimant was not having any physical problem, Ms. Smith conceded, regarding the lack of a completed accident/incident report, "and we didn't follow the rules just right". (T. 101).

Ms. Smith's testimony reflects that subsequent to May 2005 the claimant never came to her and relayed that he wanted to file a workers' compensation claim. Ms. Smith testified that respondent #1 has "several posters" around the plant regarding the filing of workers' compensation claims.

Ms. Smith was not present when the claimant unplug the hose on May 2005, however arrived as the claimant was being assisted down the aisle from the machine. Ms. Smith testified that she did not ask anyone present at the time what had happened, responding, "I just figured it wasn't none of my business and we just stood there". The testimony of Ms. Smith reflects that while she did not inquire what had happened several people present volunteered and told her

what had happened when she walked up to the claimant's location. Ms. Smith's testimony reflects regarding her job as a senior machine specialist:

My job is to place people where they belong, make sure they're in their work areas and doing their job. (T. 103).

Ms. Smith maintains that her employment position is not that of a lead person or supervisor.

On cross-examination, Ms. Smith acknowledged with respect to the March 2005, incident, that Mr. Couch had gone and she was taking his place at the time. Regarding her failure to complete/file an accident report relative to the claimant's reporting, Ms. Smith testified:

Well, the reason - okay, I was busy at that time. I told him if it bothered him - which I didn't follow through on - I know the rules, which, that was my fault. I told him if it bothered him, to come back to me. (T. 104).

Ms. Smith testified that the claimant did report the March 2005 incident to her and, "he showed me his back". (T. 104). The testimony of Ms. Smith reflects that at the time of the March 2005, reporting, claimant relayed that he had fallen over a skid.

Mr. Gordon Clay, now retired, was formerly employed by respondent #1 for 43 years.

Mr. Clay was a supervisor on the third shift. Mr. Clay testified regarding his observation of the claimant prior to May 2005:

Well, just when he was coming in, you know, and everything. He'd just crawl, nearly, to get in and everything. He'd go - walk down the aisle going through the line, he worked on floor line down there, he'd have to stop. (T. 106).

Mr. Clay maintains that while he never discussed the claimant's back problems with him directly, he knew that the claimant experienced same.

The testimony of Mr. Clay reflects that in May 2005, he held the position of coordinator

in general 40, which was a different department then where the claimant worked, and that at that particular time he was the senior supervisor. With respect to the May 2005, incident involving the claimant, Mr. Clay testified:

Well, Jeremy Cough and myself were walking the area. I was supposed to have been there, and he got a page. We got three fast pages and we know there's a problem in the area, to a certain number and everything, and we went to area 22, and everything, and noticed he was on the floor, and asked him what happened and everything, and he said his back give away on him. Jeremy asked him, he said did you get hurt? He said, no, I didn't get hurt, my back just give away on me. (T. 107).

\* \* \*

Oh, we asked him - we told him we needed to take him to the emergency room, you know, and he said, no. He said I didn't get hurt or anything. He said my back just give way on me. He said I can't afford to leave. (T. 107).

Mr. Clay's assessment of the claimant's remarks was that the claimant did not get hurt at the time of the May 2005, incident, but rather his back had "just give way". (T. 108). Mr. Clay explained that "you don't normally" file workers' compensation form if the person is not hurt at work.

Regarding the routine reporting procedures Mr. Clay testified:

If someone gets hurt at work or anything, we have a form to fill out and turn in to our safety administrator, as well as our nurse. (T. 108).

Mr. Clay explained his understanding of the claimant's comment that he could not afford to leave work following the May 2005, incident:

I figured that his attendance was so bad that he'd probably lose his job if he left, is what I figured he meant. (T. 111).

Mr. Clay testified that he has had previous back problems, to the point that he has been down in the floor and unable to get up without assistance, and that his back has gone out on him. Mr.

Clay's testimony reflects that the claimant's responses with such clarity that he felt that he was capable of answering questions.

Mr. Jeremy DeWayne Couch, an 11 ½ years employee of respondent #1, testified that he is employed as a coordinator. Mr. Couch's testimony reflects, regarding the policies and procedures of respondent #1, with respect to workers' compensation claims:

Workman's comp - if there is an accident that happened at work, we do fill out an accident investigation and send them to - we either - this happened on third shift - we take them to the emergency room on third shift.

There's posters on - worker's compensation posters on every bulletin board in the plant. (T. 114).

Mr. Couch testified that he first learned that the claimant was claiming the May 2005, incident as a workers' compensation claim one and one-half (1 ½) years following the incident.

Mr. Couch was the claimant's immediate supervisor. The testimony of Mr. Couch reflects, regarding his observation of the claimant prior to May 2005:

Eddie was very slow moving. I knew that he was taking prescription medications. Me and Eddie had had conversations about his back injuries, previous back injuries, and everything, and i was very aware that he had back problems. (T. 115).

Mr. Couch noted that the claimant had been off work for a significant period because of the back problems prior to May 2005:

Yes, he just returned from a previous back problem before this May 17<sup>th</sup> date, where he - I mean, he was going to Little Rock to have exploratory service . . . and medical attention. (T. 115).

Mr. Couch's testimony reflects, based on the attendance records, that the claimant was off work starting in December 2004 for several weeks at a time. (RX #2, p. 72). The attendance records

also reflect that the claimant was off work beginning March 1, 2005, through March 21, 2005. (RX. #2, p. 73).

Mr. Couch provided information regarding the hose that the claimant unplugged on May 17, 2005, which serves as a basis of the present claim:

This hose is a non-pressurized hose. It does have a quick release on the disconnect, where, if you disconnect it, it just unplugs. It's non- I don't see how it would fly up and hit you or anything like that. There is an air nozzle on the very end of it to blow off a machine or - it's a flock material to blow all the flock off of the machines during changeover or cleaning. (T. 116-117).

Mr. Couch testified that the psi is very low when the hose is released. The release is 2 ½ to 3 feet up from the floor, or approximately waist high, which not require bending down to un-do. Mr. Couch is 6'1" in height.

Mr. Couch's testimony reflects that during this period [May 2005] the claimant was having quality and production problems which had resulted in the issuance of one warning for quality by him in addition to earlier ones.

Regarding his recollection of the May 2005, incident which now serves as the basis for the present claim, Mr. Couch testified:

In May of 2005, I was paged three times, which means it's an emergency. I rushed to the area where the emergency page came from and I saw Mr. Herron kneeled down on the floor.

I asked Mr. Herron, at that point in time, I said, are you okay? I was looking out for his well-being, and he said my back gave out on me. I said, is this work related, Eddie, or not? And he said, no, it's not work related, it just gave out on me. I said, well, we need to take you to the emergency room anyway, just to get you some medical attention. And he said, no, I can't afford to miss cause my days are too close - I'm too close on my attendance. (T. 118-119).

The testimony of Mr. Couch reflects that the claimant was located between 6 to 7 feet from the hose at the time he arrived at the site of the emergency pursuant to the page. Mr. Couch testified that he would not allow the claimant to resume work because he could tell that he was in a lot of pain and that he was not physically able to work. Mr. Couch added that respondent #1 does not allow employees to work under those conditions. The claimant was sent home by Mr. Couch.

Mr. Couch testified that an accident report was not completed at the time of the May 2005 incident because the claimant reported that it was not work related.

There is not a dispute regarding the claimant's medical history prior to his employment by respondent #1 in 1995. On August 20, 1991, while employed by the Osceola School District, claimant sustained an injury to his low back, and underwent diagnostic studies and treatment by a number of physicians. A December 1, 1991, MRI scan disclosed the presence of a L4-5 small disc herniation centrally and paramedian to the left and at L5-S1 a small Schmorl's node involving the inferior L5 end plate, with no disc bulging or disc herniation being observed. On December 13, 1991, claimant underwent a partial hemilaminectomy at the left L4-5 with removal of extruded disk, discectomy and decompression of the L5 nerve root, under the care of Dr. Allen S. Boyd, Jr., a Memphis neurosurgeon. On February 13, 1992, claimant was released to return to work with a 25 pound one month weight lifting restriction, with an estimated permanent physical impairment of 8% to the body as a whole.

A February 1, 1995, office note of Dr. S. R. Cullom, relative to the claimant, reflects a 24-hour period of back pain radiating into both legs. X-rays of the lumbar spine disclosed the presence of muscle spasm. The February 1, 1995, office note also reflected that the claimant has had back pain for two (2) years relative to a work-related injury.

The claimant was again seen at Semmes-Murphey Clinic by Dr. Boyd on February 9, 1995. The office note relative to the visit reflects that the claimant was doing well until the first of the month, when he bent over at work to pull some legs on a table, and had been incapacitated with back pain since. The office note reflects that the CT scan performed the preceding date reported a mild bulge at L3-4 and L4-5, but no evidence of disc herniation. At the time of the afore claimant remained in the employment of the Osceola Public School District.

Claimant commenced his employment with respondent #1 in mid-1995. In October 1996, the claimant was seen and examined by Dr. James L. Canale, a Blytheville otolaryngologist. The examination disclosed severe sensorineural hearing loss bilaterally and a recommendation that he wear a hearing aid. (RX. #1, p. 15-16).

The earliest medical report relative to the claimant's back subsequent to his 1995, employment by respondent #1 contained in the record is a September 19, 2000, chart note of Dr. Cullom, regarding a three day period of back pain on the part of the claimant. The chart note recites the absence of known trauma in connection with the back pain. Muscle spasm was documented during the examination. (RX. #1, p. 17).

Following a November 30, 2000, visit to Dr. Collum, which was the product of two (2) period of sever back pain with marked muscle spasm, and a December 4, 2000, follow-up visit, arrangements were made for the claimant to undergo a MRI scan of the lumbar spine on December 6, 2000, at Baptist Memorial Hospital. The impression of the radiologist relative to the MRI scan was that of degenerative changes of the lumbar disc without stenosis or herniation. (RX. #1, p. 19-23).

On February 15, 2001, the claimant was seen by Dr. Cullom. The chart note relative to

the visit reflects “Thoracic & Lumbar Strain-recurrent”. Claimant’s examination during the afore visit reflects the presence of “marked spasm” for which he was prescribed Flexeril, Medrol pack, and Lorcet Plus. It is pertinent to note that the claimant filed his claim for treatment by his family physician, Dr. S. R. Cullom, with his group health insurance carrier. Further, the Associate Disability Statement, which was filed in furtherance of a group claim for benefits, reflects that the claimant last worked on February 13, 2001, that the first date of treatment of his condition was February 15, 2001, and that the condition was not caused by his work. (RX.#2, p.60-61). The medical in the record reflects that the claimant treated with Dr. Cullom through February 19, 2001, in conjunction with the afore group health insurance filing. (RX. #1, p. 24-26).

The medical in the record reflects that the claimant returned to Dr. Cullom on April 12, 2001, with a history of back pain on three days duration. Thereafter, the medical reflects that the claimant was seen multiple times monthly through August 2001, relative to back and neck complaints. (RX. #1, p. 27-42). Claimant also underwent further diagnostic studies during the afore time frame. On May 24, 2001, claimant underwent a MRI scan Baptist Memorial Hospital-Blytheville relative to his lumbar spine. The radiologist report regarding the MRI scan reflect the following impression: Loss of signal with degenerative changes L4-5 and L5-S1 with slight central bulging but without nerve root impression. Reference to previous study 12/06/00. (RX. #1, p. 32). On June 8, 2001, claimant returned to Dr. Cullom with complaints of neck and back pain which was assessed as cervical and lumbar strain. The office note reflects that Dr. Cullom referred the claimant to Dr. South. The medical records reflects that the claimant was subsequently admitted to St. Bernards Medical Center on July 27, 2001, pursuant to the

directions of Dr. Demetrius S. Spanos, a Jonesboro neurologist, where he underwent a post-myelogram CT of the lumbar spine. The afore study revealed mild annular disc bulging at the L4-L5 level, minimal posterior disc bulging at the L5-S1 level, and no signs of focal disc herniation, focal neural compromise, or stenosis. There is no medical in the record to reflect that the claimant was seen by a medical provider in 2001, subsequent to August 13, 2001.

The claimant was seen by Dr. Cullom on February 20, 2002, regarding low back pain which was radiating to the left leg, which was of 12 hours duration. After a February 21, 2002, follow-up visit, there are no medical records of the claimant receiving treatment relative to his low back pain until May 9, 2002. Claimant was next seen by Dr. Collum for complaints relative to his low back on October 3, 2002, October 7, 2002, October 28, 2002, and October 31, 2002.

On November 4, 2002, the claimant was evaluated at the NEA Clinic by Dr. Robert Abraham, a Jonesboro neurosurgeon, pursuant to a referral of Dr. Cullom. The initial evaluation report of Dr. Abraham reflects, in pertinent part:

**HISTORY OF PRESENT ILLNESS:** Mr. Herron is a 46-year-old white male who has left lumbar pain with left lower extremity pain on occasion. He recalls no major accidents or initiating event. Patient has seen Dr. Cullom. He had a CT scan, physical therapy and meds with only temporary relief. (RX. #1, p.50).

Following his examination Dr. Abraham assessed the claimant's complaint as "left lumbar radiculopathy". Pursuant to the directions of Dr. Abraham the claimant underwent an MRI scan of the lumbar spine. In his November 14, 2002, Progress Note, Dr. Abraham outlined the results of his examination of the claimant, as well as the results of the MRI scan and his assessment of the claimant's complaint:

**RADIOGRAPHIC STUDIES:** MRI of the lumbar spine revealed L5/S1

bulging disk, degenerative joint disease at L2/3, L4/5, L5/S1. L5/S1 is central and left paracentral.

**ASSESSMENT:**

- 1) Left lumbar radiculopathy.
- 2) Left L5/S1 herniated nucleus pulposus. (RX #1, p. 55).

Dr. Abraham recommended pelvic traction in the treatment of the claimant's complaint along with counseling. In accordance with the afore, the claimant was referred to Dr. Sunil Gera, a Jonesboro pain management specialist, by Dr. Abraham.

A December 26, 2002, report of Dr. Gera relative to his evaluation of the claimant, pursuant to the above, reflects, in pertinent part:

**HPI:** This is a 46-year-old white male who was seen in consultation on December 26<sup>th</sup> at the request of Dr. Abraham. He had a back surgery about 10 years ago. He has been having pain for two years. From September 30 it has been flared up and he has been in real distress. . . . He describes this pain as sharp and aching in character. It goes all the way from the back to the left hip to the left leg and he is noticing some numbness in both upper extremities. He denies any weakness associated with this. Bending head forward, backward, bending body forward, bending body backward, walking, sitting, lifting heavy objects, **sneezing and coughing increase the intensity of the pain.** Medicine is not giving him any relief. Lying down and standing gives him some relief. **He had physical therapy without any relief** and had some epidural injection two years ago in Memphis, which gave him some relief. He also had some kind of nerve block. He denies any litigation, bowel or bladder incontinence because of pain. (RX. #1, p. 57).

Dr. Gera assessed the claimant's complaints as low back syndrome, lumbar radiculopathy, facet syndrome, and post laminectomy-lumbar. Treatment measures initiated by Dr. Gera included hot water treatment with a hot water bottle, medication (Hydrocodone/Elavil/Skelaxin), and scheduling of LESI as well as keeping the claimant off work for four weeks. (RX. #1, p. 59).

The medical in the record reflects that the claimant underwent the treatment measures as

recommended by Dr. Gera, having obtained a good relief as of the February 7, 2003, visit after the steroid injection. Claimant returned to Dr. Gera on March 6, 2003, and relayed that when he returned to work he started hurting again. A review of the medical records reflect that the claimant underwent a trasforaminal epidural steroid injection at L5-S1 under flourscopy under the direction of Dr. Gera on March 10, 2003. (RX #1, p. 66).

The medical records reflects that claimant was seen by his primary care physician, Dr. Cullom for complaints of back pain in July and August 2003. The claimant's return visit to Dr. Cullom on October 13, 2003, relative to back pain resulted in the subsequent February 11, 2004, initial visit to Dr. F. Richard Jordan, a North Little neurosurgeon. (RX. #1, p. 70-76).

The February 11, 2004, Baptist Health Medical Center-North Little Rock report relative to the claimant's evaluation by Dr. Jordan reflects, in pertinent part:

The patient is a 47-year-old male with complaints of back and left hip pain. The pain seems to be described as being more n the left buttock and it hurts more to extend than it does to flex. He injure his back four years ago at work. He has a past history of back problems with a lumbar surgery in 1990. He did well following that surgery until the work incident in 2000. He has been treated with physical therapy and dedication and was sent for pain management where he had a series of epidural sterioid injections with minimal benefits. He is continuing to work. An MRI was done which showed degenerative changes mostly at L4-L5 and L5-S1 with the most significant finding being facet arthropathy again at the lower two lumbar segments. He did not have any disk protrusion, canal or foraminal compromise. Having failed at all other measures we have decided to bring him now for bilateral radiofrequency lumbar facet neurotomies with eqidural steroid injection to try to help with his ongoing back pain. (RX. #1, p. 76).

The February 11, 2004, hospital report of Dr. Jordan reflects his impression of he claimant's complaint as lumbar spondylosis. (RX. #1, p. 77). Claimant underwent the bilateral radiofrequency lumbar facet neurotomy L1 to S1 with an epidural steroid injection under the care

of Dr. Jordan. (RX. #1, p. 90).

The medical records reflects that the claimant was seen by his primary care physician, Dr. Cullom, on two (2) occasions in May 2004 and once in September 2004, relative to recurrent low back pain. (RX. #1, p. 79-80). The medical reflects that the claimant underwent hernia repair surgery on December 7, 2004. (RX. #1, p. 82-84).

Following the December 2004, hernia repair surgery, the medical reflects that the next time claimant was seen for medical treatment was February 18, 2005, relative to complaints of pain in his low back and left foot. The February 2005, chart notes of Dr. Cullom do not reflect that the claimant's complaints were the product of a work-related accident. (RX. #1, p. 85-87, 93-94).

The claimant was again seen by Dr. Cullom on March 10, 2005, and March 21, 2005, regarding complaints of back pain. (RX. #1, p. 95-96). Claimant underwent an MRI of his lumbar spine on April 1, 2005, at Great River Medical Center, in Blytheville, Ar., pursuant to the direction of Dr. Cullom. The April 1, 2005, MRI report reflects degenerative changes of the spine, central disc protrusion with signs of perineural enhancement noted at the L4-L5 level, and signs of previous laminectomy noted at the L4-L5 level. (RX. #1, p. 97). Claimant was seen by Dr. Cullom on April 29, 2005, and May 9, 2005, relative to back pain. A May 10, 2005, chart note reflects that the claimant should return if his symptoms regard his back pain worsened or did not improve. (CX. 1, p. 6).

A June 12, 2005, report of Dr. Jordan to Dr. Cullom reflects that the claimant was seen by him on May 20, 2005. The report further reflects:

I saw Mr. Herron back in the office on May 20, 2005 for the first time

since January 2004. He still has some back and left leg pain, although now he has a new pain in the upper middle part of the back. He has also described a new tendency to fall.

We had treat him previously with a facet neurotomy. He has a new MRI of the lumbar spine from April 1, 2005 showing degenerative changes of the spine, with a mild central disc protrusion at L4/5 paracentral to the right with mild spinal stenosis. However, the other pain of which he complains is unrelated to that. He also has some weakness of his triceps bilaterally, and he id most tender in the right medial scapular area in the lower third. His deep tendon reflexes are normal.

I asked for him to arrange a cervico-thoracic MRI in his local are(a) and have them sent to me. I gave him a prescription for Lorcet 5, #30 with 3 refills. (RX. #1, p. 100).

On May 31, 2005, the claimant underwent MRIs regarding his cervical and thoracic spine at Great River Medical Center pursuant to the direction of Dr. Cullom. (RX. #1, p. 99). The claimant was seen by Dr. Cullom on several occasions in July 2005, with assessments of leg cramps, thoracic strains, and lumbar strains. (CX. #1, p. 9-13).

Corroborative of the claimant's testimony that Dr. Jordan was not pleased with the quality of the Blytheville diagnostic study the record reflects that on July 28, 2005, Dr. Jordan scheduled an August 2, 2005, lumbar MRI with contrast for the claimant at St. Vincent Health System-North. (CX. #1, p. 15). The radiologist report regarding the August 2, 2005, diagnostic study reflects, in pertinent part:

Impression-

Disc desiccation at all lumbar disc levels with the exception of L1/2 and L3.4.

Small central and left-sided disc protrusion at L2/3 with no compression of adjacent neural structures.

Mild posterior bulges at L4/5, L5/S1 and T11/12 again with no compression of adjacent neural structures. (CX. #1, p. 16).

In an August 13, 2005, report to Dr. Cullom Dr. Jordan relayed that the claimant had been seen on July 26, 2005, with complaints of back and leg pain. The report further noted that the claimant “does not work at this time due to the pain in his back and legs”. After detailing the results of the claimant’s physical examination, the report reflects plans to obtain an MRI of the lumbar spine before deciding which course of action to take with respect to treatment measures. (CX. #1, p. 18).

The record reflects the presence of a August 24, 2005, radiology report regarding a study of the same date. The report reflects, in pertinent part:

LUMBAR SPINE:

Lateral flexion-extension views of the lumbar spine are supplied only for review. There is limited flexion, but reasonably good extension of the lumbar spine seen in lateral projection only.

Anterior lipping is seen at L3 on the superior-anterior aspect and in the lower dorsal/upper lumbar spine.

A review of the CT evaluation of 2002 of the lumbar spine indicated at that time normal CT of the lumbar spine was reported. (CX. #1, p.20).

The claimant was again seen by Dr. Jordan on November 21, 2005. In a November 21, 2005, report to Dr. Cullom regarding the visit Dr. Jordan relayed:

We saw Eddie in the office today with complaints of low back that radiates down into the left leg. He stated that this pain is severe all the time.

He is a 47 year old white male who injured his back the first time in 1988 or 1989. The second injury was in 2002 and a third injury in April of 2005.

His MRI of the lumbar spine shows that he has an HNP of L5-S1 and spinal stenosis at L2-S1. On physical exam, he is very protective of his left leg and cannot sit or stand without hurting. He cannot walk any distance without causing severe pain.

After discussing the options for treatment we have decided to proceed with a discectomy with a possible fusion from L4-5 and L5-S1 which will be done at St. Vincent's North. He was given a prescription today of Lorcet #50 with one refill and Soma #50 with one refill. (CX. #1, p. 25).

On December 22, 2005, the claimant was admitted to St. Vincent Health System-North pursuant to the direction of Dr. Jordan with a preoperative diagnosis of lumbar instability, and underwent a surgical procedure in the form of a posterior lumbar interbody fusion at L4-L5, posterior lumbar interbody fusion at L5-S1 with posterior Alphatec instrumentation and fusion L4 to S1 and PEEK intervertebral spacers. (CX. #1, p. 27-109).

The claimant was seen in followup by Dr. Jordan on January 20, 2006. In his February 4, 2006, correspondence to Dr. Cullom regarding the follow-up visit, Dr. Jordan noted of the claimant:

. . . . He presented with complaints of fatiguing easily while walking and muscle spasms in his lower back and legs when standing. He is very satisfied with the results of his surgery, stating that he is doing much better and that the leg pain he was experiencing prior to his surgery is now resolved. X-rays fo the lumbar spine shows that the grafts and instrumentation are in good alignment. (CX. #1, p. 113).

A November 22, 2006, report of Dr. Jordan to Dr. Cullom regarding the claimant reflects, in pertinent part:

I wanted to update you regarding your patient, Eddie B. Herron, who was in our office on 11/10/06 for a postoperative follow up visit regarding his posterior lumbar interbody fusion with instrumentation of L4-L5 and L5-S1. He presented with complaints of low back pain that radiates down the left leg, with tingling and numbness in the left foot. In the last two months he has fallen several times as his left leg will buckle beneath him. He is unable to lift over 20 pounds without an increase in pain. His past surgical history includes a recent hernia surgery.

He would like to file for disability and is requesting an impairment rating today, stating he has no money and no job. An impairment rating was

given of 16% because of his lumbar fusion. His current medications include Hydrocodone and Flexeril. He declines to proceed with further surgical intervention at this time. We will not schedule a follow up visit at this time but he is to call our office and follow up with us as needed. We will continue to keep you apprised of his progress. (CX. #1, p. 120).

In a March 21, 2007, response to a February 23, 2007, from claimant's attorney, Dr. Jordan relayed that the claimant "has a permanent disability rating of 16% according to the AMA 4<sup>th</sup> edition and reached maximum medical improvement on 11-06-06". The letter further reflects that the claimant was "permanently disabled due to his work related injury", and that it was doubtful that he would "ever be able to attain gainful employment". (CX. #1, p. 121).

In addition to the claimant's attendance records during his employment with respondent #1 reflecting substantial and prolonged periods off work prior to February and May 2005, the hearing record also reflects the presence of a print-out of the claimant's prescription medication covering the period November 14, 1991 through May 9, 2005, from Star Pharmacy.

Additionally, the parties, the claimant and respondent #1, have submitted post-hearing brief, which are herein designated a part of the record.

After a thorough review of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, 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. At all times pertinent, to include May 17, 2005, the relationship of employee-employer-carrier existed among the claimant and respondents #1.
3. At all times pertinent, to include May 17, 2005, the claimant earned wages

sufficient to entitle him to weekly compensation benefits of \$466.00/\$350.00, for total/permanent partial disability.

4. The claimant has failed to sustain his burden of proof by a preponderance of the credible evidence that he suffered an injury on May 17, 2005, within the course and scope of his employment which caused internal or external harm to the body requiring medical services or resulting in disability, with medical evidence supported by objective findings establishing the injury.

### **CONCLUSIONS**

There is not a dispute regarding the employment relationship between the claimant and respondent-employer #1. Further, the evidence preponderates that prior to his employment by respondent #1 the claimant sustained a work-related low back injury while employed by the Osceola Public School District which required surgery and resulted in an 8% permanent physical impairment to the body as a whole. Claimant maintains that in 2005, he sustained an injury within the course and scope of his employment with respondent #1 which required medical treatment and has resulted in anatomical impairment and rendered him permanently totally disabled. Claimant seeks corresponding workers' compensation benefits as well as controverted attorney fees.

In addition to asserting that the claimant did not sustain a compensable injury in May 2005, as a result of a specific incident, respondent #1 also that notice of the claim was not provide until the April 3, 2006, filing of the Form AR-C by the claimant. As a consequence of the afore, respondents #1 maintain that if the claim is found compensable they would not be responsible for the payment of benefits to and/or on behalf of the claimant until such notice was

received. Further, respondents #1 content that if the claim is found compensable and the claimant found to have sustained additional anatomical impairment as a result of same, any wage loss or permanent partial disability benefits, to include permanent total disability, incurred by the claimant would be the responsibility of the Second Injury Fund, respondent #2.

Respondent #2 denies that the claimant sustained a compensable injury in his employment with respondent #1 in May 2005. Further, respondent #2 asserts that even if determined that the claimant sustained a compensable injury in the employment of respondent #1 in May 2005, the claimant did not incur any additional anatomical impairment as a result of same. Additionally, respondent #2 denies that any anatomical impairment that the claimant may have sustained in the most recent injury has combined with the prior impairment to produce the claimant's current disability.

The present claimant 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 credible evidence in the record reflects that at the time of his 1995 employment by respondent #1 claimant experienced residuals relative to compensable injuries sustained in the employment of his previous employer, the Osceola Public School District. Further, the claimant sought a change of employment as a direct result of the physical demands of his employment with the Osceola School District.

While the claimant rendered testimony regarding at least three (3) separate work-related incidents sustained in the employment of respondent #1 since he commenced his employment with same in 1995, the core of the present claim centers on an incident/episode which occurred in

May 2005. Although the claimant initially identified the incident which serves as the basis of the present claim as having occurred on a different date, the evidence preponderates that the date of the occurrence was May 17, 2005. *See Edens v. Superior Marble & Glass*, 346 Ark. 487, 58 S.W.3d 369 (2001).

The credible evidence in the record reflects that the claimant required and obtained periodic medical treatment relative to his low back complaints, residuals of his prior work-related injury with the Osceola Public School District, throughout his employment with respondent #1. Claimant demonstrated physical limitations and restrictions, residuals of the prior work-related injury, and required medications consistently during his employment with respondent #1 prior to 2001 and thereafter.

In addition to the May 17, 2005, incident involving the air hose, which serves as the basis for the present claim, claimant presented testimony regarding an incident where he fell of a platform and another one of falling over some pallets. Nonetheless, the claimant filed claims with his group health care provider for medical treatment associated with his back complaint and not with the workers' compensation provider.

In order 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 the employment; that the injury caused internal or external harm to the body which required medical services or resulted in objective finding, as defined by 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) (Repl. 2002). Should the claimant fail to establish by a preponderance

of the evidence any of the requirements for establishing the compensability of the claim, compensation must be denied. *Mikel v. Engineered Specialty Plastics*, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

The credible evidence in the record reflects that at the time of the May 17, 2005, incident the claimant had completed his job task of releasing a air hose and was simply walking back to the end of his machine when he experienced a severe onset of pain in his back. Claimant has not engaged in any strenuous physical activity nor did he trip or fall as a result of an uneven surface. Claimant acknowledged to co-workers and supervisory personnel that he had not suffered an accidental injury. Indeed, the claimant was desirous of resuming his employment duties following the episode, however was not permitted to do so by his supervisor. While the claimant required assistance out of the plant to get to his vehicle, where his wife had been summoned, there are no medical reports in the record reflecting that the claimant sought or obtained medical treatment on May 17, 2005, or May 18, 2005, following the episode.

The claimant's first medical treatment following the May 17, 2005, episode was a May 20, 2005, visit to Dr. F. Richard Jordan, a North Little Rock neurosurgeon. The June 12, 2005, medical report regarding the visit did not identify the May 17, 2005, episode or any work-related incident as the basis for the visit, however it does describe a "new" tendency of the claimant to fall.

A review of the claimant's medical records reflects the presence of objective finding of muscle spasms, bulging discs and degenerative disc disease dating back to his earlier work related injury in the employment of the Osceola Public School District. Further, the medical records reflects that the claimant was prescribed pain medication and Flexeril consistently prior

to his employment with respondent #1. Diagnostic studies generated prior to either of the claimant's asserted work-related incidents in the employment of respondent #1 when compared to those subsequent to the asserted incidents do not reflect appreciable objective evidence of new findings. Indeed, the December 22, 2005, surgery performed by Dr. Jordan was for instability in the claimant's lumbar spine. The claimant has failed to sustain his burden of proof by a preponderance of the credible evidence that he sustained an injury arising out of and in the course of his employment with respondent #1 on May 17, 2005. This claim is respectfully denied and dismissed.

**IT IS SO ORDERED.**

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**Andrew L. Blood, ADMINISTRATIVE LAW JUDGE**