

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F606927

CYNTHIA JOHNSON, EMPLOYEE

CLAIMANT

GINO MORENA ENTERPRISES, EMPLOYER

RESPONDENT

WAUSAU INSURANCE COMPANY, CARRIER

RESPONDENT

OPINION FILE SEPTEMBER 17, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on August 6, 2007, at Little Rock, Pulaski County, Arkansas.

Claimant appeared pro se.

Respondents represented by the HONORABLE MICHAEL E. RYBURN, 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 July 10, 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 by the parties, the issues to be addressed during the course of the hearing and the parties' contentions relative to the same. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Cynthia Johnson, the claimant, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Cynthia Johnson, the claimant, with a date of birth of May 1, 1956, is a high school graduate who has also completed beauty school. Claimant is right hand dominate. Claimant was employed by respondent-employer for approximately five (5) years and last discharged employment duties in June 2005.

The testimony of the claimant reflects that respondent-employer is a cosmetology and barbering business which is located on the Little Rock Air Force Base in Jacksonville, Ar.

Regarding her employment and duties with respondent-employer, claimant testified:

At first, I just worked part time and then I went full time, and then they made me manager of the shop, and I did the books, payroll, hiring, firing, supplies, just everything. (T. 6).

Claimant notes that because she was working full time and as a manger at the time of the March 24, 2004, accident her net earnings as reflected in her bi-weekly check were \$640.00.

Claimant maintains that she suffered an injury to her right hand and wrist while moving chairs within the course and scope of her employment with respondent-employer on March 24, 2004. In describing the mechanics of her injury, claimant testified:

And all I did was like we - they told us to do, we was trained to do. We don't lift the chairs. We just take them and - they're on rollers - and we just push them like this and then roll them off the mats and or however were gonna clean the mats that day, and I just had the back of the chair and I just - all I did was roll it like this. That's all I did, and my hand just swelled up and - it hurt when I did it, but we were trying to get done, and then we went to another chair and I did the same thing. But with this hand, all I did was take the chair and kind of turn it like that and my hand hurt really bad, and it swelled up immediately. I mean, it just like, poof, before my eyes. (T. 8).

Claimant explained that she had swelling in the right hand as well as a large knot, which she assessed as a sprain. Claimant telephoned her boss and reported the injury on the date of the

accident.

Claimant asserts that after moving the second chair and at the recommendation of her co-worker, Rita, she telephoned the home office, which is located in San Francisco, Ca., and reported the injury. Claimant was directed by supervisory personnel of the home office to obtain medical treatment at the Concentra facility in North Little Rock. Claimant obtained medical treatment at the North Little Rock Concentra Health Center as directed. The testimony of the claimant reflects regarding the medical treatment she received at the Concentra Health Center at her initial visit following the accident:

Oh, yeah, I went over there, and as soon as I went in, they gave me an x-ray. But the doctor looked at me and said, oh, just sprained. And I went, yeah, that's what everybody says, but it's hurting. And he said, well, we're gonna look a little more at it, but I think it's just a sprain. And then he played with my hand and moved it and he said, well, you didn't break nothing. You know, it will probably swell a little bit and he gave me something like - something they took off the market, you know, I can't remember, for inflammation. (T. 9-10).

Claimant was released to return to restricted duties with no lifting greater than five pounds.

Claimant was also provided a hand brace. Claimant denied ever having any problems with either of her wrists prior to the March 24, 2004, accident. Claimant asserts that she was directed to return in follow up for treatment within a week of the initial visit.

The testimony of the claimant reflects that she was able to work within the medical restrictions imposed on her in connection with her injury. The testimony of the claimant reflects that there were some improvements in her symptoms following the initial medical treatment in that the swelling went down some, however the "bump" on her wrist remained. Claimant was later referred by the physician at Concentra Health Center to physical therapy for one to two

weeks. The physical therapy was discontinued by the physician when the claimant failed to realize any improvement in her hand/wrist.

The testimony of the claimant reflects that during the period of physical therapy and medical treatment she continued to work, however she cut back on doing hair. Claimant observed that she was mostly doing books, setting appointment, and trying to rest her hand. The testimony of the claimant reflects that the more she used her hands the more pain she had. The cost of the claimant's medical treatment was paid by respondents.

Claimant's testimony reflects that after undergoing conservative treatment measures to include medication, physical therapy, and injections she was referred by the Concentra treating physician to a specialist, Dr. Michael Moore, a Little Rock orthopedic surgeon and hand specialist. Claimant estimates that she was seen on five (5) occasions by Dr. Moore. Claimant noted that by the time of her treatment under the care of Dr. Moore she had already gone down to part-time status at her request relative to her work.

The testimony of the claimant reflects regarding her continuing work activity following the March 24, 2004, accident and medical treatment:

We have a lady come in and she used to be manager at another store, and I complained about my hand so much, he said I need to take it easy. You just do the books and this and that, and at first I was okay. (T. 15).

Claimant's testimony reflects that once she went to part-time status her net earnings were reduced to \$400.00, biweekly.

Claimant testified that her initial treatment under the care of Dr. Moore consisted of injections. Claimant later underwent additional diagnostic studies, to include a bone scan and a CT scan. Claimant maintains that Dr. Moore recommended an additional diagnostic procedure

which was performed at St. Vincent Medical Center. Respondents refused to pay the afore procedure, which claimant estimates costed in excess of \$4,000.00, and is on her credit report.

Claimant testified, regarding her continuing course of treatment at the directions of Dr. Moore:

. And then Dr. Moore - he said well, let me get this report back and we'll figure out a call to action to get that hand working. And then aft all that, I think it was like a week, I called him and I said to his nurse, I'm hurt really bad from what they did to me up at the hospital cause they gave me some kind of injection in there. And he was on vacation and I guess his person that takes over when you're on vacation or something - they told me to come in and they gave me some numbing shots in my hand, which was supposed to last like two weeks, but it only lasted like a couple of days. On my next appointment, he said, he goes, we're gonna fix that hand, don't worry about it. You know, we'll probably need a little surgery, whatever. He was talking to me, and I said, whatever it takes, or just cut it off right about here cause I can't handle it no more. And then he said he was gonna schedule an appointment and get all the stuff together and then - that was the appointment that I went to and there was a workman's comp nurse there, and she said, before we do anything, I need you to go to St. Vincent's and take a blood test, and I said, yeah, I'll take it - for what? I don't do drugs or anything. And she said, no, we went to test your rheumatoid arthritis, and I said, okay. So, I went over there and took a test and when I came back, they had me go in the office, and she said that there was rheumatoid arthritis in my blood test and that workman's comp didn't have to cover me no more. (T. 16-17).

The testimony of the claimant reflects that she did not again see Dr. Moore following the above visit due to a lack of a source of payment or insurance. Claimant testified:

And because I didn't have any insurance, and my hand was hurting like hell, and I just wanted to take an axe and cut it off up her is how I feel. I got on the books at UAMS for an appointment in the rheumatoid clinic there, and they - when I went in, they gave me a blood test, and Dr. Lipsmyer said that my rheumatoid arthritis was slight to none, and that she would get to the bottom of it, but she wanted me to take some kind of cancer drug to help bring the swelling down or something. It had all these side effects. It was like \$50.00, and I told her I can't pay for it. I wasn't working by that time, because I wasn't working. Things just got really bad for me. And, eventually, then I lost my home and then I had a lot of more problems going on and my daughter let me move in with her. (T. 17-18).

The claimant testified that she has not seen Dr. Lipsmeyer since the one occasion in June 2006.

Regarding the time frame that the respondents refused to pay further workers' compensation on her behalf in the claim, claimant noted that the same occurred when she was released by Dr. Moore to return to work, however prohibited from using her right hand.

Claimant's testimony reflects:

Zero use of the right hand - and I called, who is now my manager, Betty, and I said, Betty, and she said, did they fix it? And I said, no, now they won't even take care of me cause they said that they think I have rheumatoid arthritis and they're dropping me. And she goes, well, you know that we - you know, her, now, she's taken over the manager job - she said, Cynthia, you know we don't have anything for you to do. You can't just come up her and sit. You know, there's no point even trying to do - if you're doing hair or you're not being manager, there's no job for you. (T. 19-20).

With respect to her ability to work since being released by Dr. Moore with directions not to use her right hand, the claimant testified:

I am unable to work because there's no way. I'm right-handed, and I've tried it, you know, just kind of hanging onto the blow dryer - I can't do it. I don't have the strength in there. One hand has like 70 pounds of strength, and the other hand is like 15. I just can't do it, and I can't roll the brush around and I can't cut with scissors cause it makes my hand swell up. And on there, on one of those tests, which Dr. Moore never said anything to me. Of course, he said they were gonna do this plan of attack to fix my hand, that day that the workman's comp nurse said, we don't have to cover you no more. Nobody ever told me that, and it hasn't been fixed. (T. 20-21).

Claimant disputes that rheumatoid arthritis is the basis for her current complaints and difficulties with her right hand rather than a work-related injury.

On cross-examination while acknowledging four (4) prior bladder surgeries, two back surgeries, an appendectomy, a caesarean, and a surgery to remove a cancerous thing off of her leg, claimant denied any prior problems with her hand. Claimant acknowledged a prior

workers' compensation claim regarding a back injury, which resulted in her first back surgery in 1991. Claimant testified that at the time of the second back surgery was she was not working.

Claimant explained:

I wasn't working at all. What happened was a bone chip broke off from the previous surgery or something and it caused me to have bad sciatica and I couldn't go to the bathroom, so I had to have a second surgery. But that had nothing to do with workman's comp or anything. It wasn't paid out of it. (T. 23).

Claimant denied that she had ever had any other workers' compensation claim or other insurance claim for any reason like a motor vehicle accident. Claimant acknowledged residing at the 6513 Tom Box Road address when she was working. Claimant noted that her house did catch fire and burn while she was away, also that her car had caught fire. Also the claimant recalled being injured when she was struck by a vehicle in September 2001, sustaining left knee ligament injury. Regarding an insurance claim growing out of a slip and fall at Days Inn, claimant testified:

I remember that.

When? I wasn't working and a little bit after that, I lost where I was working and I had a little money and I went and I was staying at a motel. And when - as soon as I got in the bathtub and I turned around to wash my hair, I went sailing in the bathtub. And what that was, is the people hadn't been cleaning under the mat, which I thought the bathroom looked just fine. And I stepped in there and when it broke, underneath was completely black with mold.

And I fell and cracked my head and went to the emergency room and they told me to go. (T. 26-27).

The motel accident occurred on July 13, 2005. Claimant asserts that her injury growing out of the motel accident included a cracked elbow. Questioned whether it was her right elbow,

claimant testified:

I can't remember. I just fell back like that and slid and I called the - it took me a while cause it knocked the breath out of me, but I thought I was going to die, it hurt so bad when I cracked my head open. And I went to the bed and I called the front desk and I said, I need some help in here because I just fell and I want you to look at this bathroom. And they came in and they had no idea that it wasn't being cleaned underneath there. And the mat in the bathtub was fine, so I didn't know there was black underneath there, and that black slipped and made me crack my head, and they said we're going to send you in an ambulance to the hospital, and we're so sorry, and I said, I don't really want to go in an ambulance. And I called my daughter, and she came and got me and took me to the emergency room. (T. 27-28).

Claimant testified that she was uncertain if she injured her right wrist in the July 13, 2005, motel room accident. Respect to any claim growing out of the motel accident, claimant testified:

The manager of the motel told me to bring him the bill whenever it came due, and he would pay for my medicine - just bring him everything. And I was staying there. I stayed there for about two or three weeks.

He asked me if he paid the - I settled it with him. He asked me if he paid the hospital bill and all my medicine and I think it was \$500.00 pain and suffering cause I hurt for a couple of days since that knot was so big on my head. (T. 28-29).

Claimant acknowledged that she was treated for depression prior to the March 24, 2004, accident. Claimant explained:

I started getting treated for that when my husband ran off with his girlfriend that he was working with and that caused a lot of depression. (T. 29).

The afore occurred in 1999. Claimant continued to receive treatment at UAMS for the depression.

Regarding the March 24, 2004, incident moving the chair at work, claimant acknowledged that the chair rolled "just find". Claimant asserts that she tore something in her right wrist in the incident and that she was not informed of it. Claimant concedes that Dr. Moore

diagnosed her condition as rheumatoid arthritis. Claimant added:

Well, he - that's kind of the way it sounds in the report cause I read it, too, but that's not what he told me. (T. 30).

Claimant concedes that she went to UAMS and obtained treatment for rheumatoid arthritis following her treatment with Dr. Moore. Claimant maintains that she did not tell the physicians at UAMS about the March 24, 2004, chair incident because she was unaware of the contents of the medical records of Dr. Moore. Claimant maintains that Dr. Moore told her that there was a connection between the March 24, 2004, accident and her rheumatoid arthritis:

Yes, he told me that - oh, no, he didn't tell me about the arthritis. It was the workman's comp. He never said nothing about arthritis to me. (T. 31-32).

Claimant acknowledged that she continued to work for approximately 15 months following the March 24, 2004, accident, limited her work activities. After the fifteen month period, claimant's testimony reflects:

I continued trying to work, but my hand hadn't gotten any better and the pain was so much at night that I just wanted to get drunk or chop it off, because it hurt so bad. And I've had, like, falls in the bathtub - you know, fallen and cracking my knee, and I couldn't use it. I'm okay. This is something I did at work. (T. 32).

The testimony of the claimant reflects that she has an appointment to be seen by a physician to discuss the finding of a tear in her wrist as reflected in the medical records of Dr. Moore. (T. 33).

Claimant noted that she had not had a source of income since her employment with respondent ceased in June 2005. Regarding the basis for her inability to work, the March 24, 2004, right wrist injury, claimant testified:

Because I can't use this hand and so much pain with it. My depression is pretty bad, because I don't have an income. My daughter

just lets me stay with her. (T. 34).

A prior hearing in this claim was rescheduled because the claimant was receiving treatment for depression and had to go for an appointment at UAMS for the problem. Claimant's testimony reflects that she has used measures learned during physical therapy to help with the stiffness in her wrist that she experiences in the mornings. Claimant acknowledged that experiencing pain in her right ankle and low back and requesting the examining physician at UAMS to look at it. Claimant continued to receive treatment at UAMS, however not for arthritis. Claimant is pursuing a claim for Social Security disability benefits. (T. 35).

The testimony of the claimant reflects that she occasionally wears a splint on her right hand. While she can move her finger and hand claimant maintains that the hand is "useless", testifying:

Even Dr. Moore - on the last appointment, he said, I don't know how you ever use this hand, and he said, zero use of the hand, cause it's very painful to - I don't have any bend in it and I don't have any strength in it. (T. 36).

Claimant acknowledge that she has not been provided an off-work excuse by any of the physicians at UAMS, noting that at the time of her treatment she informed her medical providers that she was not working.

Claimant's testimony reflects that respondent-employer is operation at the site on the Little Rock Air Force Base in Jacksonville:

Yes, it is, and the same manager that - on the day - that last appointment when workman's comp dropped me, Dr. Moore wrote out that thing, zero use of wrist, can return to work - I gave it to - I went out there and I gave it to the new manager and she told me, she said, you already know how the company goes - there's no work for you if you can't do hair, and so, I didn't have no work. (T. 38).

Claimant explained why she has not sought work elsewhere which would not involve use of her right hand:

I don't really have any training for anything else, and at that time, knowing my depression was so bad, that I just really wanted to jump off a bridge because I couldn't handle the pain in my hand and how things have gone. (T. 38).

The medical in the record reflects that the claimant was seen at Concentra Health Center on March 25, 2004, by Dr. John H. Adametz, Jr., relative to her arm, "which was injured on 3/24/2004 5:00 PM". The report noted mild swelling of ulnar styloid, the distal ulna and dorsal along with tenderness during the physical examination. The claimant's injury was assessed as wrist sprain, wrist pain, and forearm strain. The claimant was provide Bextra, a wrist splint, and modified activity release. (CX #1, p. 3-4).

The claimant was seen in follow-up by Dr. Adametz at Concentra Health Center on March 30, 2004. The clinic note relative to the visit reflects, in pertinent part:

She feels the pattern of symptoms is improving and feels better. Patient has been working within the duty restrictions. Patient has been taking medications and had noted improvement. The pain is located on palmar aspect of the distal forearm and ulnar aspect of the right wrist. Pain Intensity Level: 2/10. The pain is described as aching. (CX. #1, p. 5).

Following her examination during the March 30, 2004, visit, the claimant was released to regular activity with directions to use the splint prn.

The claimant return to Concentra Health Centers on April 14, 2004, for complaints relative to her right wrist at which time she was seen by Dr. Michelle Ibsen. The clinic note relative to the April 14, 2004, visit reflects:

She feels the pattern of symptoms is worsening. Pt was released to regular duty but now c/o pain in the right wrist with minor swelling

after diagnosis of wrist sprain. Patient has been working their regular duty. The pain is located on the thenar eminence. (CX. #1, p. 6).

The physical examination noted swelling with decreased grip and pain in the thenar eminence. Claimant was provided medication, Bextra, wrist splint carpal tunnel, and daily physical therapy, along with a return appointment on April 19, 2004. (CX. #1, p. 6).

The April 19, 2004, clinic note relative to the claimant's return visit to the Concentra Health Center, reflects that she was seen by Dr. Adametz and reported improvement in her symptoms. The physical examination disclosed mild swelling of dorsal. Claimant was scheduled for daily physical therapy for one week as well as provided instructions in a home exercise program. (CX. #1, p. 7-8). When seen by Dr. Ibsen at Concentra Health Center on April 23, 2004, claimant reported improvement in her symptoms and was released to regular activity. (CX. #1, p. 16).

Following the April 23, 2004, release from care the next medical in the record evidencing receipt of medical treatment by the claimant is a December 30, 2004, clinic note of Concentra Health Center relative to a visit by the claimant of the same date. The clinic note reflects that the claimant had been working her regular duty. Dr. Adametz's physical examination of the claimant right wrist disclosed the presence of moderate swelling of dorsal and ulnar, pain with grasping, grip strength on the right at 15, and 60 on the left. Claimant was provided ibuprofen and a modified duty release which included no lifting over 5 pounds, no pushing/pulling over 5 pounds of force, prohibited from using power tool with her right hand, directions to wear the brace and apply ice. The December 30, 2004, clinic note also reflects that the claimant was to see a hand surgeon at the earliest convenient time. (CX. #1, p. 17).

In accordance with the above, on January 27, 2005, the claimant was initially seen by Dr. Michael M. Moore, a Little Rock orthopedic surgeon. The January 27, 2005, report of Dr. Moore reflects, in pertinent part:

. . . She was seen at the *Arkansas Hand Center* on 01/27/05 for evaluation of her right wrist. As you may remember, she is a pleasant, 48-year-old, right-hand dominant hairdresser who was at work 8 months ago when she injured her right wrist. The injury occurred while she was moving chairs. She noted the onset of pain and swelling over the dorsoulnar aspect of the right wrist. Ms. Johnson reports the swelling in her right wrist has improved. Unfortunately, she has noted persistent pain over the aspect of the right wrist and stiffness in the fingers. She denies numbness in the fingers of her right hand. Ms. Johnson has been treated with conservative measures, including splinting and therapy; unfortunately, her symptoms have persisted.

* * *

Dr. Adametz, I agree with your opinion regarding Ms. Johnson. Her clinical history and physical examination are consistent with chronic right wrist pain.

Due to the fact that her symptoms have persisted, it was my opinion further evaluation was indicated. Her right wrist and hand will be evaluated with a triphasic bone scan. She will return to the office following the study at which time I will determine her final treatment plan. (CX. #1, p.19- 20).

The claimant was seen in follow-up by Dr. Moore on March 1, 2005. The March 1, 2005, report reflects, in pertinent part:

. . . A triphasic bon scan of the right wrist revealed focal, increased activity in the wrist. The findings were consistent with trauma or inflammatory arthritis. Ms. Johnson's wrist pain symptoms are located over the dorsal and ulnar aspect of the right wrist. The pisotriquetral shear test is positive. She denies numbness in the fingers of her right hand.

* * *

In my opinion Ms. Johnson should continue conservative treatment. She underwent an injection into the right wrist pisotriquetral joint, which included 1 cc of 1% lidocaine, 1 cc of 0.5% Marcaine, and 1 cc of betamethasone. Blood studies will be obtained to rule out inflammatory arthritis. Ms. Johnson will continue to wear a splint for protection. Sherri, my assistant, will contact her in the next 2 or 3 weeks to assess her response to the injection. If her right wrist pain symptoms do not improve, she will be scheduled to undergo an MRI scan of the right wrist. Ms. Johnson will return to the office in 1 month for follow-up evaluation at which time I will determine her final treatment plan. . . . (CX. #1, p. 22).

The March 1, 2005, report relative to the Triple-Phase scan of the bilateral hands and wrist, reflects in pertinent part:

Opinion:

Intense right wrist uptake in all 3 phases is nonspecific possibly from trauma, surgery or inflammatory arthropathy. There is some surrounding soft tissue uptake possibly from reflex sympathetic dystrophy.

Recommend clinical correlation and plain film correlation if not yet obtained. (CX. #1, p. 23).

Claimant was again seen by Dr. Moore on May 12, 2005. The May 12, 2005, report noted the results of the triphasic bone scan and the claimant's continued symptoms. The report recites the need for further evaluation of the claimant to include an MRI arthrogram.(CX. #1, p. 24-25).

The June 24, 2005, radiology report relative to the fluoroscopic-guided right wrist arthrogram and MRI of the right wrist reflects, in pertinent part:

Findings: The synovium is markedly irregular. On the initial injection, no contrast extended into the more radial aspect of mid carpal row; however, contrast extended to the carpal/metacarpal joints and lateral along the mid carpal row. There is no evidence for triangular fibrocartilage complex tear, as seen on the second injection.

Impression:

Findings suspicious for rheumatoid arthritis with marked synovial irregularity and intercarpal ligamentous disruption distal to the mid carpal row as described above. (CX. #1, p. 26).

The June 24, 2005, radiology report regarding the MRI of the claimant's right wrist with contrast reflects, in pertinent part:

IMPRESSION:

1. Findings consistent with probable rheumatoid arthritis. I suspect there is a tear along the ulnar aspect of the triangular fibrocartilage complex, as well as involving the scapholunate and lunotriquetral ligaments. This may be seen in association with rheumatoid arthritis.
2. Small ganglion as described above. (CX. #1, p. 28).

The claimant returned to Dr. Moore on June 30, 2005. After noting the results of the various diagnostic studies, the June 30, 2005, report reflects, in pertinent part:

Ms. Johnson will complete her evaluation after blood studies are obtained. She understands if the studies are consistent with an inflammatory arthritis, she will require evaluation by a rheumatologist. In addition, it is my opinion the inflammatory arthritis would not be directly related to her work activities. This statement is made within a reasonable degree of medical certainty. Ms. Johnson was fitted for a splint to wear for protection. She was given a prescription for Mobic to take on a daily basis. Ms. Johnson cannot use her right hand or arm for work activities. She understands and agrees with the treatment plan as outlined and all questions were answered. (CX. #1, p. 30).

After having obtained the results of the June 30, 2005, blood studies, Dr. Moore authored a final report regarding the claimant on July 15, 2005. The report reflects, in pertinent part:

. . . . The radiologist felt these findings were suspicious for rheumatoid arthritis. Blood studies were performed that revealed an elevated rheumatoid factor.

Based on these studies, it was my opinion Ms. Johnson's right wrist pain symptoms were most likely related to rheumatoid arthritis.

I have recommended that she be evaluated by a rheumatologist who could determine if she has rheumatoid arthritis. In addition, they could provide treatment recommendations for this problem. At this time, I cannot definitely state that Ms. Johnson's right wrist injury, which occurred several months ago, would be the primary cause of the rheumatoid arthritis. I would certainly defer to the rheumatologist's opinion regarding this matter.

At this time Ms. Johnson does not have an impairment to her right wrist or hand related to the injury that occurred 8 months ago. This statement is made within a reasonable degree of medical certainty. (CX. #1, p. 36).

The medical in the record reflects that the claimant was seen at UAMS on May 9, 2006.

The Outpatient clinic record reflects that the claimant relayed a history of her right wrist complaint as well as the identity of her medical provider relative to same. Claimant underwent additional diagnostic studies at UAMS. (CX. #1, p. 38-42).

The claimant was seen by Dr. Eleanor Lipsmeyer, a rheumatologist, at UAMS. A June 6, 2006, outpatient note relative to the claimant authored by Dr. Lipsmeyer reflects, in pertinent part:

I have seen and examined Cynthia A. Johnson with Dr. Walton Troy. She is a 50-year-old white woman who developed right wrist pain and was found to have rheumatoid arthritis. She was previously working as a hairdresser. She is now on the MAPS program here at UAMS and we can obtain medication. She continues to have right wrist pain and swelling despite Ibuprofen. She has a positive rheumatoid factor and anti-CCP. We were considering starting her on DMARDS, but she was not able to afford them. Her right wrist x-ray show changes consistent with rheumatoid arthritis.

* * *

Physical examination The joints are all normal except for the right wrist, which shows synovitis and severe limitations, flexion, and extension. Remainder of the joints is normal. No active synovitis or synovial proliferation.

IMPRESSION: 1) Rheumatoid arthritis with monoarthritis of the right wrist. (CX. #1, p. 43).

After a thorough consideration of all of the evidence in this record, to include the testimony of the claimant, 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. On March 24, 2004, the relationship of employee-employer-carrier existed among the parties.
3. On March 24, 2004, the claimant sustained an injury to her right wrist arising out of and in the course of her employment with respondent.
4. The claimant has failed to sustain her burden of proof by a preponderance of the evidence that she remained within her healing period and total incapacitated from engaging in gainful employment as a result of the March 24, 2004, compensable right injury subsequent to June 30, 2005.
5. Medical treatment received by the claimant relative to her March 24, 2004, right wrist complaint was had pursuant to the directions of respondents and under the care of respondent sanctioned physicians from March 25, 2004, through June 30, 2005. Respondents are liable for the cost of said treatment, to include the right wrist MRI scan had at the directions of Dr. Michael M. Moore, pursuant to *Southern Hospitalities v. Britain*, 54 Ark. App. 318, 925 S.W.2d 81 (1996).

CONCLUSIONS

The claimant suffered an injury to her right wrist on March 24, 2004, while moving a chair within course and scope of her employment. The injury was reported to appropriate supervisory personnel and some corresponding medical benefits were paid on behalf of the claimant by respondent in connection with the reported March 24, 2004, accident. Claimant

asserts entitlement to temporary total disability benefits and additional medical benefits relative to the injury. Respondents take the position that the claimant's initial injury was a sprain to her right wrist which has resolved, however her present complaint for which she seeks additional workers' compensation benefits is not work-related but rather rheumatoid arthritis, which is not compensable.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision. To be entitled to workers's compensation benefits for a specific incident injury the claimant has the burden of proving by a preponderance of the evidence that she suffered an accidental injury, identifiable by time and place, that arose out of and in the course of her employment, caused internal or external physical harm to her body and required medical services supported by objective findings. Ark. Code Ann. §11-9-102 (4)(A)(i); *Kimbrell v. Arkansas Department of Health*, 66 Ark. App. 245, 989 S.W.2d 570 (1999).

The claimant, who is right-hand dominant, was employed by respondent for approximately five (5) years. Claimant performed duties both as a hairdresser and manager for respondent. There is no evidence in the record to reflect that claimant experienced difficulties or limitations relative to her right wrist/hand prior to March 24, 2004. On March 24, 2004, while performing employment duties, moving a chair, claimant experienced pain in her right wrist. The incident was reported to appropriate supervisory personnel of respondent, and the claimant was directed to obtain medical treatment relative to same at the Concentra Health Centers.

At the time of her initial visit of March 25, 2004, to the Concentra Health Center in North

Little Rock, claimant relayed a history of the March 24, 2004, injury. Objective finding recorded by Dr. John H. Adametz, Jr., relative to his physical examination of the claimant during the March 25, 2004, visit included “mild swelling of ulnar styloid, the distal ulna and dorsal”. The claimant’s injury was diagnosed as a wrist strain/forearm strain, for which she was provided a wrist splint and medication in the form of Bextra. The claimant was also provided a limited/modified duty release.

The claimant discharged employment duties within the medical restrictions imposed by her treating physicians as she continued to receive medical treatment relative to her right wrist complaints growing out of the March 24, 2004, accident. On April 23, 2004, the claimant was released to from medical care to return to her regular employment duties following an examination by Dr. Michelle Ibsen.

Following the April 23, 2004, visit to the Concentra Health Center, the claimant was next seen for medical treatment relative to her right wrist complaint on December 30, 2004. While the claimant attributed her wrist complaints during the afore visit to the March 24, 2004, accident, the clinic note of the visit reflects she had been working her regular duty. The claimant was referred to Dr. Michael M. Moore, a Little Rock orthopedic surgeon and hand specialist, by Dr. Adametz. Claimant remained under the care and treatment of Dr. Moore through June 30, 2005.

While under the care and treatment of Dr. Moore claimant underwent additional diagnostic studies to include an MRI scan, triphasic bone scan, and blood study work-up. The medical treatment had by the claimant relative to her right wrist following the March 24, 2004, reporting of the accident was had at the direction of respondents designated physicians or

referrals therefrom. Accordingly, expenses incurred in the afore treatment are the responsibilities of respondents. The credible testimony of the claimant reflects that respondents failed to pay the cost of a diagnostic study ordered by Dr. Moore which was obtained at St. Vincent Medical Center. Pursuant to Ark. Code Ann. §11-9-508 and the court ruling in *Southern Hospitalities v. Britain*, 54 Ark. App. 318, 925 S.W.2d 81 (1996), respondents are liable for the payment of the afore bill.

Based on the results of the diagnostic studies generated pursuant to his directions, on June 30, 2005, Dr. Moore released the claimant to restricted duties prohibiting the use of her right hand. Dr. Moore noted that the diagnostic studies to date were suggestive of and consistent with an inflammatory arthritis. Subsequent blood work studies performed at the directions of Dr. Moore and later at UAMS disclosed a positive rheumatoid factor and anti-CCP.

Dr. Moore recommended, based on the results of the diagnostics studies, that the claimant be evaluated by a rheumatologist. Dr. Moore attributed the claimant's continuing complaints relative to her right wrist to inflammatory arthritis. The triphasic bone scan of the claimant right wrist revealed intense uptake in the wrist consistent with trauma or inflammatory arthropathy.

On June 30, 2005, Dr. Moore released the claimant to return to work. In his June 30, 2005, report, Dr. Moore expressed the opinion that inflammatory arthritis would not be directly related to the claimant's work activities. In a July 15, 2005, correspondence Dr. Moore concluded based on the blood studies that the claimant's right wrist pain symptoms were most likely related to rheumatoid arthritis. Dr. Moore also conceded that he could not definitely state that the claimant's March 24, 2004, right wrist injury would be the primary cause of the rheumatoid arthritis.

When released by Dr. Moore on June 30, 2005, claimant was informed that she could use her right hand or arm for work activities. Respondents take the position that the claimant's inability to discharge employment duties subsequent to June 30, 2005, is the product of rheumatoid arthritis and not the March 24, 2004, work-related injury. Likewise respondents maintain that the claimant's need for medical treatment subsequent to June 30, 2005, is due to the diagnosed rheumatoid arthritis and not the work-related March 24, 2004, accident.

Claimant disputes the assessment/diagnosis of rheumatoid arthritis and points to the presence of a tear identified in the June 24, 2005, radiology report, as the basis for her inability to work and need for continued medical treatment. Claimant asserts that she was unaware of the presence of the tear until she obtained and reviewed her medical records.

Dr. Moore had access to the results of the diagnostic studies at the time he rendered his opinion regarding the assessment of the claimant's right wrist complaint and any nexus to her work activities. Dr. Moore deferred to the rheumatologist regarding whether the claimant's March 24, 2004, right wrist injury would be the primary cause of the rheumatoid arthritis.

Medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. Ark. Code Ann. §11-9-102 (16)(B); *Crudup v. Regal Ware, Inc.*, 341 Ark. 804, 20 S.W.3d 900 (2000). A medical opinion must be more than speculation in order to be within a degree of medical certainty. *Freeman v. Con-Agra Frozen Foods*, 344 Ark. 296, 40 S.W.3d 760 (2001).

In the instant claim, claimant sustained a compensable injury to her right wrist on March 24, 2004. Claimant received active medical treatment for the March 24, 2004, injury from March 25, 2004, through April 23, 2004, at which time she was released from medical care to return to

her regular job duties. There is no evidence in the record to reflect that the claimant received medical treatment for the right wrist complaint between April 24, 2004, and December 30, 2004. When the claimant returned for medical treatment on December 30, 2004, she had mild swelling in the wrist which she attributed to the March 24, 2004, accident. Claimant received sanctioned medical treatment until June 30, 2005, when it was determined that her continuing symptoms were the product of inflammatory arthritis - specifically, rheumatoid arthritis. The claimant has failed to sustain her burden of proof by a preponderance of the evidence that there is a causal connection between the March 24, 2004, compensable right wrist sprain and the subsequent diagnosed rheumatoid arthritis which resulted in her incapacitation as of June 30, 2005. The claimant's claim for workers' compensation benefits subsequent to June 30, 2005, is respectfully denied and dismissed.

AWARD

Respondents are herein ordered and directed to pay all reasonably necessary and related medical expenses growing out of the claimant's March 24, 2004, compensable right wrist injury, to include diagnostic studies and procedures had at the directions of sanctioned treating physicians, to include Dr. Michael M. Moore, as well as referrals therefrom.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809, until paid.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE