BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F606649

DONIS LONG — CLAIMANT

MCKEE FOODS CORPORATION — RESPONDENT

RISK MANAGEMENT RESOURCES
INSURANCE CARRIER — RESPONDENT

OPINION FILED **FEBRUARY 13, 2007**

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

Respondent represented by CURTIS L. NEBBEN, Attorney, Fayetteville, Arkansas.

STATEMENT OF THE CASE

A hearing was held on December 5, 2007, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on August 22, 2006. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

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

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On June 21, 2005, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to her head on June 21, 2006.

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

1. Compensability of the claimant’s low back injury.
2. Related medical.

In regard to the foregoing issues the claimant contends that she was injured on June 21, 2005. Her head and lower back were injured when she fell while carrying a fifty-pound tub.

In regard to the foregoing issues the respondents contend that all authorized reasonable and necessary medical expenses have been paid to date based on the present medical evidence. Respondents have advised the claimant that she can return to the Arkansas Occupational Health Clinic for additional treatment. The respondent know of no outstanding issues in this claim.

The documentary evidence submitted in this matter consists of the Commission's Prehearing Order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1. The respondent submitted documentary evidence marked Respondent's Exhibit No. 1. All of these exhibits were admitted without objection.

DISCUSSION

______The claimant testified that she was 34 years old and was initially hired by the respondent as a packaging technician. The claimant testified that on June 21, 2005, she was working on a line and had a 50 pound tub in her hands when she tripped over a dolley. The claimant testified that there was just enough room between the manufacturing line for her to fall on the concrete on her buttocks. The claimant testified that she was between two lines which were approximately waist high. The claimant testified that as she fell, she was like a pinball hitting one thing and then another and eventually hit her head which knocked her out. The claimant testified that when she came to, her boss was standing over her. The claimant testified that she hit her head on the end of the line where the motors are located. The claimant testified that her rear end hit the concrete floor, then her legs went up and over the dolley, and

her head was leaning up against the motors. The claimant testified that initially she was knocked out, and when she came to, she was confused and her supervisor wanted to get her to the nurse's station. The claimant testified that when she stood up it was like everything dumped out of her head and she became wobbly so she was taken to the nurse's station in a wheelchair. The claimant testified that she does not have a lot of memory of what was said and done but she does remember talking to the nurse. The claimant testified that she can remember getting in a white van with someone that she thought was the nurse but has no memory of the trip. The claimant testified that she is not sure if the nurse was a man or a woman. The claimant agrees that she was taken to the Lowell Clinic. After she was seen at the clinic, she was told that she could not go to any other doctor. The claimant testified that she has never had a head or back injury in the past. The claimant testified that after her injury, she was told that she could not drive and that she had to come to work. The claimant testified that after her accident she had physical problems from the middle of her right thigh, a bruise on her back, her rear end bothered her where she hit the concrete floor, and the back of her legs hurt from hitting the dolley. The claimant stated that she bruises easily. The claimant testified that she told the doctor about her back hurting. The claimant testified that the doctor at the Lowell Medical Clinic sent her for a CT scan. The claimant testified that she was seen by a doctor at the Mercy Hospital but was unsure if it was the day of the accident or not.

The claimant testified that she was seen by a chiropractor and then she went to the Northwest Medical Hospital where a Dr. Orman referred her to Dr. Cannon for shots in her back. The claimant testified that Dr. Cannon referred her to Dr. Routhsong, a neurosurgeon. The claimant testified that her back has continued to get worse since her

accident in June 2005. The claimant testified that she is still continuing to have problems resulting from her head injury.

On cross examination, the claimant agreed that Dr. Webb is her family physician. The claimant agreed that Dr. Webb had prescribed medication for her for anxiety or bipolar disorder. The claimant states that she was seen at the Lowell Medical Clinic on the day of her accident and reported to them that she was picking up some strawberry shortcake while carrying a basket of rolls and slipped on some strawberry jelly, causing her to fall forward. The claimant testified that whenever she was seen by the doctors, she would tell them the truth about her symptoms. The claimant testified that she does not recall telling Nurse Beasley that most of her symptoms had resolved and now was having complaints of dizziness and vertigo. When asked, the claimant testified that someone at the Occupational Health Center told her that she could not drive. The claimant testified that she was not sure what day she was seen at St. Mary's Hospital but does remember that she was upset because they did not write her a prescription for any medication but what they did was write her a no driving instructions. The claimant agreed that she has, in the past, been cautioned by a physician about being over medicated. The claimant testified that it was very possible that when she saw Dr. Webb on June 15, 2006, that she told him that she had to take more medication than was prescribed for her back pain. The claimant testified that when she was at St. Mary's Hospital, she does not recall whether she told them she was having discomfort in her back. The claimant testified that she has been seen by a chiropractor for her complaints. The claimant testified that she has not worked for anyone since she last worked for the respondent with the exception of working for La-Z-Boy approximately four (4) days before she was terminated because she was not capable of sewing. The claimant testified that she has put her resume out on *Monster.com* but she has not been

out looking for a job because she cannot drive. The claimant explained that when she drives she runs the risk of forgetting where she is.

The claimant, on redirect examination, testified that she had seen a chiropractor once before her accident and that was after the birth of her little girl.

The medical records set forward that the claimant was seen at the Arkansas Occupational Health Clinic by Nurse Max Beasley on June 21, 2005. Nurse Beasley notes that the claimant reports that she sustained several injuries as the result of a fall while at work. The nurse writes that the claimant reports that she was picking up some strawberry shortcake while she was carrying a basket of rolls and she slipped on some strawberry jelly, causing her to fall forward. The nurse reports that the claimant says that she experienced a momentary loss of consciousness and is now complaining of headaches, neck pain, lumbar pain, right hip pain, and that she has contusions on her legs. The claimant also reported that she has significant dizziness. Nurse Beasley writes that the claimant has a history positive for bipolar disorder for which she is taking Zyprexa, Effexor, and Prozac. Nurse Beasley gave the claimant a thorough examination as well as had her undergo a CT scan of her head which was negative. X-rays of the claimant's cervical and lumbar spine and her right hip were also negative for fractures and dislocations, and the x-rays of the claimant's skull were negative for fracture. Nurse Beasley writes that the claimant has multiple fall injuries, mild concussion, cervical and lumbar strain, right hip pain, and contusions on both legs. Nurse Beasley recommended that the claimant take an Alieve twice daily for her headache and discomfort, apply ice to the sore areas for 48 hours, undergo range-of-motion exercises for her neck and lumbar spine, and noted that she could return to work the next day but to avoid lifting more than twenty (20) pounds as well as to avoid bending or twisting at the waist. The claimant was seen at St. Mary's Hospital in Rogers, on June 21, 2005, where she was

treated and released. The doctor's or nurse's instructions are written so small it is difficult to make out what the instructions are, however, it is indicated that the claimant was given three prescriptions. The hospital records indicate that this claimant has pain in her head and has a headache. After examination, the claimant was assessed with having a concussion. Dr. Webb saw the claimant on June 25, 2005, for her complaints of sharp head pain. Dr. Webb assessed the claimant with having a cerebral concussion and prescribed Percocet. The claimant was seen by Nurse Beasley on June 27, 2005, for her multiple complaints. Nurse Beasley notes that the claimant suffered a mild concussion but had a negative CT scan, cervical strain, lumbar strain, right hip pain, and contusions on both legs. The nurse writes that the claimant says that all of these injuries have fairly well resolved, noting that her current complaint is dizziness and vertigo. The claimant reports that she is having problems with her memory since her trauma on June 21, 2005. Nurse Beasley writes that the claimant's personal physician sent her to a place called Mindworks where her diagnosis of having bipolar disorder was changed to traumatic stress disorder, secondary to post-partum depression from four (4) years ago. It is noted that the claimant has been taken off her Zyprexa, Prozac, and diet pills, at which time she was prescribed Flexeril, Percocet, and Lodine. The nurse notes that the claimant stated that she had not returned to work because she feels she is unsafe since she cannot drive. Nurse Beasley writes that the claimant reports that her eyes have been twitching and her thoughts have been racing, not feeling like herself at all. Nurse Beasley writes that, based upon the claimant statements that she is having trouble with dizziness, vertigo, not feeling like herself, and not wishing to go to work, he recommended that the claimant be evaluated by a neurologist. The nurse also recommended that she discontinue all medication except for the Darvocet, Flexeril,

and Lodine. Nurse Beasley returned the claimant to work that day but to avoid performing safety sensitive duties until she is evaluated by the neurologist.

The claimant began being seen by Chiropractor Kent Moore on July 1, 2005. The claimant was evaluated by Dr. David Davis on July 8, 2005, for her complaints of headaches and dizziness. Dr. Davis notes that the claimant reports that her dizziness is vertigo which can occur three or four times a day and is associated with unsteadiness. The claimant reports that motion sickness tablets make her symptoms better. The claimant also reports headaches that begin with mild pain but become severe. The claimant reports that pain medication and motion sickness pills help her headaches and these headaches occur two to three times per week. After a thorough examination, Dr. Davis writes that she is having post concussion symptoms of vascular headaches and vertigo. Dr. Davis opines that both of these symptoms should resolve over time, noting that she had a CT scan of her brain which was unrevealing. Dr. Davis notes that the claimant is going to have a laboratory evaluation and an EEG because of her dizzy spells. The doctor recommended that she take Trazodone and she was given samples of Imitrex. On July 15, 2005, Dr. Davis returned the claimant to regular duty work on July 20, 2005. The claimant underwent an EEG on July 19, 2005, which set forth that focal or epileptiform and abnormalities are not noted. Their absence does not exclude the possibility of seizures syndrome.

The claimant continued to be seen by Dr. Webb for medications for her various problems, beginning on October 12, 2005. On this date, the claimant reports a ten (10) pound weight gain and that she was mis-diagnosed with bipolar disorder, therefore she had stopped taking her medications for this problem. The doctor prescribed medication, one of which is Percocet. On November 23, 2005, the claimant reports hair loss and migraines, and again medications were prescribed. On December 27, 2005, Dr. Webb

notes that the claimant has been in and out of the E. R. with migraines, claiming her face is swollen, and also getting shooting pains. The claimant notes that the medication Panlor has really helped and notes that the E. R. doctor gave her Phenegan, as well as a muscle relaxer. It is noted that she reports daily headaches and was diagnosed with having headaches and anxiety for which medications were prescribed. On January 5, and 6, 2006, the claimant reports that she was seen at the Siloam Springs E. R. for kidney stone problems. Dr. Webb writes on January 17, 2006, that the claimant is wanting stronger Valium and reports that she has used a lot of the Panlor because she is having so many headaches. Again, the claimant was diagnosed with anxiety and prescriptions were recommended. On February 1, 2006, Dr. Webb writes that the claimant reports having a bad cold or flu for over one week and has been taking Thermaflu. The doctor prescribed Thermaflu at that time. On February 2, 2006, it is noted that the claimant called requesting muscle relaxers which Dr. Webb refused. On March 14, 2006, Dr. Webb again prescribed Valium and Panlor for the claimant's anxiety. The subsequent notes indicate that on March 27, 2006, Dr. Webb refused to refill her Valium and that on April 10, 2006, Dr. Webb refused to refill the claimant's Valium and Panlor. Dr. Webb writes on May 10, 2006, that the claimant is in for her mediation refills and a check-up noting that she goes to a chiropractor three times a week. Dr. Webb notes that the claimant returns with multiple anxieties noting that her chiropractor suggested a carotid ultrasound because of periods of confusion. It is noted that the claimant has had periodic periods of confusion for years which has been documented well in his past office records. Dr. Webb notes that the claimant occasionally takes medication to excess and this was discussed with her. After an examination, the claimant was diagnosed with anxiety reaction and the doctor discussed stress with her and she was to continue taking Valium. Dr. Webb writes on May 22, 2006, that the nurse's assessment reports that the

claimant has been going to the E. R. with herniated disc pain and brain swelling. The nurse sets forth that the claimant is on Prednisone and reports getting confused, blurred vision, and that her thought process is not right, as well as her right leg goes numb at times. Dr. Webb writes that the claimant complains of back pain from the low right back over the L3-L4 area. After examination, the claimant was diagnosed with lumbar pain and medications were prescribed. On June 15, 2006, it is noted by Dr. Webb that the claimant completed a PADT, and noting to see form for details, drug contract. It is noted that the claimant's medications were changed and when she was seen at the E. R. she was given Toradol, which really knocks her out for about two days. The nurse reports that the claimant states that the muscle relaxers are what she needs and that she has to take double the medication as prescribed. Dr. Webb notes that the claimant reports that she has continual back pain and has to take more medication than prescribed to control her discomfort. The claimant reports to the doctor that she has a lumbar disc which was ruptured but the doctor notes that they have no medical records to verify that. The claimant also reports tremendous periods of stress, anxiety, even panic associated with muscle spasms. After examination, the claimant was diagnosed with lumbar pain and anxiety for which mediation was prescribed. The claimant was admitted to the Northwest Medical Center on August 15, 2006, with complaints of appendicitis. After examination and a review of her laboratory results, it was noted that her labs were essentially normal and that there was not evidence with problems of her appendix. A CT scan of the claimant's abdomen and pelvis showed Appendicolith but without any evidence of appendicitis. An MRI of the claimant's back was ordered and she was given a dose of steroid which she reported made her feel much better. Dr. Mary Oman, writes that the claimant was released to her family that evening with instructions to take her medications and to return in one week for her MRI results.

The claimant underwent an MRI of her lumbar spine on August 16, 2006, which revealed minimal degenerative disc disease at L5-S1 and an MRI of her pelvis on August 16, 2006, which revealed a normal sacrum. The claimant was seen by Dr. David Cannon on September 19, 2006, for complaints of low back pain with right sided abdominal pain noting that this started when she fell at work on her right side. Dr. Cannon notes that the claimant's MRI of her lumbar spine shows minimal disc changes at L5-S1 and the MRI of her pelvis was normal. Dr. Cannon fitted the claimant with a TENS unit to see if this might help decrease her symptoms and an epidural steroid injection was discussed but refused. Dr. Cannon notes that it may end up that medication management may be her best option and noted that her primary care physician may want to consider a trial of Lyrica to treat her symptoms. The claimant underwent lumbar epidural steroid injections administered by Dr. Cannon on October 20, 2006 and again on November 9, 2006. The claimant reported in the follow-up note dated November 17, 2006, that she feels really good and this has made a remarkable difference in her life. The claimant's past medical records indicate that she was being seen by Dr. Webb as early as November 19, 2002 for problems with anxiety noting that she was seen in the E. R. on Sunday night. Medications were prescribed by Dr. Webb. The claimant continued to be seen by Dr. Webb throughout the years 2003, 2004, and 2005 for her complaints of anxiety, weight gain, and dental problems. Dr. Webb prescribed various medications for her complaints and symptoms and, on occasion, refused to increase or strengthen her dosages as per her request.

After a complete review of this record, I find that the claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury to her low back while working for the respondent on June 21, 2005. It is not questioned, and it has been stipulated, that the claimant sustained a compensable injury to her head on June

21, 2005, for which she has continued to receive treatment. The medical records and the claimant's testimony indicate that after her fall she initially had complaints of back pain as well as neck pain leg pain, and right hip pain. The claimant has continually complained of dizziness, vertigo, and headaches but as early as June 27, 2005, the claimant reported to Nurse Beasley that her cervical, lumbar, and right hip pain as well as contusions to her leg have fairly well resolved. Subsequent to the June 27, 2005 doctor's visit, the claimant's complaints have been primarily due to headaches, anxiety, and dizziness for which she has received a variety of treatments from a variety of physicians. Several tests have been run which have not been revealing as to the claimant's exact problem. On May 22, 2006, the claimant was seen by Dr. Webb who reports that she has been seen at the emergency room for a herniated disc and brain swelling. Dr. Webb notes that the claimant complains of back pain from the low right back area in the L3-L4 area. The claimant did undergo an MRI of her lumbar area on August 16, 2006, which revealed minimal degenerative disc disease at the L5-S1 area. Although the claimant had initial complaints of low back pain subsequent to her June 21, 2005 fall, while working for the respondent, it was some ten (10) to eleven (11) months later that she began to actually have ongoing complaints of low back pain. The MRI results reveal only minimal degenerative disc disease and no impingement is noted. I find that there is insufficient medical evidence to substantiate a compensable injury to the claimant's low back and would seriously question any low back problems resulting from her June 21, 2005 fall since in was nearly a year later that she began to continually began to have complaints of pain in her low back. Therefore, this claim for benefits for this claimant's low back problems should be denied in its entirety.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On June 21, 2005, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to her head on June 21, 2006.
4. The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury to her low back on June 21, 2005. (See Discussion above).

ORDER

______The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury to her low back on June 21, 2005, while working for the respondent. Therefore, benefits for the claimant's low back are denied in its entirety.

IT IS SO ORDERED.

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ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE