

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F500138 (08/01/04)

WANDA MORRISON, EMPLOYEE	CLAIMANT
EGAN MANUFACTURING CO., EMPLOYER	RESPONDENT
WESTPORT INSURANCE CO., CARRIER	RESPONDENT

OPINION FILED APRIL 2, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on January 5, 2007, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE M. SCOTT WILLHITE, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by the HONORABLE MICHAEL R. MAYTON, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above style claim to the claimant's entitlement to additional workers' compensation benefits.

On November 14, 2006, 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 contentions of the parties relative to the afore issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Wanda Morrison, the claimant, coupled with medical reports, and other

documents comprise the record in this claim.

DISCUSSION

Wanda Morrison, the claimant, with a date of birth of March 11, 1962, obtained her GED in either 1990 or 1991. The claimant is originally from Phoenix, Arizona, where she was born and resided until she was 34 years of age. The claimant's work history during the time she resided in Phoenix, Arizona was that of a caregiver, which entailed caring for elderly people as well as her daughter. Claimant received payment by a state agency to perform the afore services. The claimant is right hand dominate.

The testimony of the claimant also reflects, relative to her work history, that her family had a coil winding shop where she worked during the summers from the age of 13 to the age of 17. The claimant was in the 12th grade at the time she dropped out of school. The claimant's testimony reflects that she moved to Missouri after leaving Arizona. The claimant denied that she performed work outside the house while in Missouri. Claimant noted that she was a housewife.

The testimony of the claimant reflects that her daughter has been chronically ill pretty much most of her life, which has resulted in the claimant being a stay-at-home mom most of her daughter's life. The claimant's daughter has chronic asthma and a skin disease.

After four to five years in Missouri the claimant moved to Ravenden, Arkansas. Once in the Ravenden area claimant secured employment at McCloud's Grocery store for approximately nine (9) months where she worked as a cashier and ran the deli department. Claimant commenced her employment with respondents on May 18, 2004. Claimant's testimony reflects regarding her employment with respondent:

I believe it was in May 2004 because I was excited that my daughter had finally graduated high school and I was going to have a life of my own. She had finally - - shw was going to try taking care of herself and things on her own and I was going to start my own life. (T. 17-18).

The testimony of the claimant reflects that respondent-employer makes aluminum outbuilding. Regarding her job duties, claimant testified that she operated the chop saw cutting the window frames down for the outbuildings and that in the afternoons she operated the punch press. Claimant performed the afore duties from May 2004 until August 2004 at which time she began to experience problems with her upper extremities.

The testimony of the claimant reflects that Dr. Traci Buxton has been her family physician since 2000. Claimant denies that she any kind of physical problems with herself, her hands, or arms prior to her employment with respondents in 2004.

The claimant testified that she had informed her supervisor that she was experiencing problems with her upper extremities, and that a during a slow period she was encouraged to go have it taken care of. Claimant denies that she was directed to a specific medical provider by her supervisor to address her upper extremity complaints.

Claimant explained that after the pain became unbearable she preceded to the emergency room of St. Barnards Medical Center one day after work to obtain treatment for her complaint. Claimant's testimony reflects that she was referred by the emergency room physician to Dr. Spanos for follow-up treatment. The testimony of the claimant reflects that she did indeed followup her treatment with Dr. Spanos and that she informed supervisory personnel of respondent of that treatment. The testimony of the claimant reflects that she worked light duty for a period until the symptoms in her hands would not allow her to continue.

Claimant testified that she treated with Dr. Spanos for a period of time until she was referred by same to Dr. Michael Moore for surgery. In early 2005, claimant underwent surgery on her right upper extremity under the care of Dr. Moore. Claimant denies that she obtained any relief from the pain and symptoms she was experiencing in her right upper extremity following the surgery. Claimant asserts that following the surgery on her right upper extremity her symptoms “gradually started getting worse.” (T. 21). The claimant testified regarding the symptoms she experienced from the point that her surgical scar was healed:

I was still having numbness and pain shooting up my thumb, and it had gotten to where it was shooting to my elbow and underneath my arm. (T. 21).

The testimony of the claimant reflects that prior to her surgery on her right upper extremity her symptoms had remained consistent relative to her hand and wrist. Specifically, claimant testified that her arms were “real weak” and that she had trouble hanging onto things. Claimant also noted that she did not experience the shooting pains up her arm like she did subsequent to the surgery.

Claimant explained that prior to the right upper extremity surgery she symptoms in her right arm were such that she was unable to grip an object. Claimant noted that following the surgery she was still dropping things and having problems with her hand coordinating and working.

Claimant’s testimony reflects that prior to the surgery on her right upper extremity she was having symptoms in her left upper extremity:

I was having a lot of weakness. I was getting to the point where it was just a chore for me to drive home from work. My arm lost, what would you call it, they just los strength. I couldn’t grip a

steering wheel. I would have to stop on the way home from work. I had no strength in my hands and my arms. (T. 22-23).

Claimant note that she had pain associated with the strength loss, mainly in the right arm. On a scale of 1-10, claimant described the pain in the right arm at "10" and that in the left arm at "8".

Claimant testified that when she was seen by Dr. Moore there was discussion regarding surgery on her left upper extremity and that the same was approved:

. . . I was approved to have both of them worked on, and Michael Moore gave me the option of having them done at the same time or one right after the other. And I still had a daughter in school, and I still had to tend to the home life, and so I hand nobody to help me if I was to do both of them at the same time, so I chose to do one and then do the other. (T. 23-24).

The testimony of the claimant reflects that since there were no benefits gained from the right wrist surgery Dr. Moore declined to perform surgery on the left upper extremity. Claimant's testimony reflects that she did not get any more treatment from Dr. Moore after the failure of the right wrist surgery. Claimant acknowledged that she was referred by Dr. Moore to Dr. Rutherford after the right wrist surgery. Claimant met with Dr. Moore after the tests were performed by Dr. Rutherford, at which time she was released from the care of same.

Claimant maintains that at the time of her release by Dr. Moore she was unable to function normally. The testimony of the claimant reflects that she was unable to grip an object with her right hand or to close her grip as a result of the pain and strength loss. Claimant explained:

It was both. My hands lock up sometimes and the pain shoots through them and I have numbness. I can't feel what I'm touching. (T. 26).

The testimony of the claimant reflects that at the point that Dr. Moore discharged her she

returned to her family physician, Dr. Buxton, for medical treatment. Claimant maintains that while Dr. Buxton attempted to refer to different physician for further treatment she was unable to see anyone because she had no income.

As a result of a change of physician request the claimant was allowed to see Dr. Simard in Memphis. Claimant testified that she has not had a followup EMG, as recommended by Dr. Simard, since October 2005. Claimant also returned to Dr. Spanos seeking further medical treatment following her release by Dr. Moore. The claimant pay for the afore treatment herself, however there is an outstanding balance. Claimant testified that she was not aware that Dr. Spanos had recommended follow-up care including chronic pain management.

The testimony of the claimant reflects that she was seen by Dr. Spanos once or twice following her release by Dr. Moore. Claimant is now receiving treatment under the care of Dr. Buxton relative to her upper extremities. The testimony of the claimant reflects that Dr. Buxton has made a referral to another physician, Dr. Barrons.

Claimant acknowledged that prior to her release by Dr. Moore she was referred by same to Paul Cooper, a hand therapist. Claimant maintains that in going through the therapy she did her "absolute best". (T. 28). Claimant disputes any suggestion in the records of Mr. Cooper that she did not do her best during the therapy, and maintains that she was limited only by her pain physical limitations in her hands.

Regarding her present symptoms in her right upper extremity, the testimony of the claimant reflects:

My hand feels like - - it feels like it's just shriveling up inside.
I have pain going through my thumb and my wrist. (T. 29).

With respect to her left upper extremity, claimant noted that her left thumb feels numb, and that she is having numbness and pain further up in the left arm. As a consequence of the symptoms in both upper extremities claimant maintains that she is very limited in her house chores.

Claimant explained:

I can't use either hand for a very long period of time without dropping things or losing my grip, or shooting pains through my hands. (T. 29).

Claimant estimates that after performing an activity with her right upper extremity for twenty (20) minutes her symptoms reach the point that she has to cease using it.

The testimony of the claimant reflects that bills generated relative to the medical treatment of her hand complaints under the care of Dr. Buxton since being released by Dr. Moore remain unpaid. Claimant was unaware, pursuant to the records, that treatment relative to her hand complaints under the care of Dr. Buxton were paid by respondent prior to her release by Dr. Moore.

Claimant denies that she ever had any problems performing lifting, or anything requiring her to grip things prior to her employment with respondents in 2004. Additionally, claimant denies that she had any problems doing housework prior to 2004. Claimant note that a major part of duties as a caregiver for the elderly involved doing housework, housecleaning, grocery shopping, paying bills, and bathing.

Regarding her effort to return to work for respondents since being released by Dr. Moore on May 16, 2005, the testimony of the claimant reflects:

I've been in contact with them and I told them that I still hadn't had my left hand taken care of. I was still having problems with the right hand. And they suggested that I just don't come back until I am able to

absolutely go back to work. (T. 34).

The testimony of the claimant reflects that in her present physical condition regarding her right and left upper extremities, “there is no way I could perform my duties”. (T. 34). Claimant maintains that she is physically unable to work due to her upper extremity problems. The claimant’s testimony reflects that she is unable to do detail work or even write a letter given the present status of her hands. Claimant has not sought any jobs since May 2005, explaining that it is her understanding that she remains employed by respondent-employer until “we resolve this matter”. (T. 35).

The testimony of the claimant reflects that while she was referred to Dr. Barron and Dr. Eickert by Dr. Buxton she has never either. Claimant testified that Dr. Buxton has referred her to Dr. Gillian. Claimant’s testimony reflects that she is unaware of Dr. Gillian’s medical specialty, however she is being set up to have another EMG and is being sent to an arthritis specialist by same. Claimant is requesting Commission approval for authorization of the afore at the expense of respondents.

Claimant acknowledged that respondents have never denied her surgery relative to her left hand. Claimant also concedes that the May 16, 2005, EMG study by Dr. Rutherford did not disclose the presence of the previously diagnosed mild carpal tunnel syndrome on the left, and as a consequence of the afore further surgery was not recommended. Further, claimant acknowledged that she is aware the both Dr. Harriman and Dr. Spanos have agreed with Dr. Moore and Dr. Rutherford that she does not have CTS in the left upper extremity.

Claimant asserts that while there may not be a positive finding on the EMG relative to her left upper extremity, she continues to have pain in both arms. Claimant denies that she has been

involved in any activity which would cause her situation with her left upper extremity to get worse since May 16, 2005. In denying any activity to cause the symptoms in her left upper extremity to worsen since May 16, 2005, claimant testified:

I've not done any activity. I've had an awful lot of stress in my life. My finance recently - - I've been helping him through cancer treatments. He just passed away. And my daughter has just miscarried, dealing with that and knowing that I can't work, my stress level has just been skyrocketed this last year. (T. 40).

The testimony of the claimant reflects that while she contacted respondent-employer in accordance with the directions of her doctor in May 2005, she relayed nevertheless that she had not had surgery on her left wrist and she was continuing to have difficulties with the right wrist. Regarding the nature of her release by Dr. Moore on May 16, 2005, claimant testified:

Well, from what I understand the release was just saying that he had done all that he could possibly do for me at that particular time. (T. 41-42).

Claimant maintains that while she knew that she could not return to full duty work, she had no problem going back to work.

Claimant testified that it is her understanding, regarding the release by Dr. Spanos, that he had done all he could do treatment-wise. Claimant asserts that she was unaware that in his August 15, 2005, report Dr. Spanos indicated that she was not disabled and put no restrictions on her work activities. Claimant added:

Well, no, but I mean, I'm not disabled. I have all my limbs, and legs. I don't consider myself a disabled person. I'm just having problems getting my arms and hands to work properly again. (T. 42).

The testimony of the claimant reflects that she was unaware that Dr. Mark Harriman in his March 30, 2006, report released her to full duty with no restrictions. Claimant explained

regarding Dr. Harriman:

. . . Our conversation lasted about twenty minutes. I was in and out of there and he really just did x-rays and told me he found nothing wrong and he couldn't see where there had ever even been carpal tunnel syndrome in my hand, and the was the extent of our visit. (T. 42-43).

Claimant disagrees with the physicians that have released her to full duty without restrictions.

The testimony of the claimant reflects that while in Arizona, with the exception of the work performed part-time between the ages of 13 and 17, at the family owned rewinding company, the only work she performed was taking care of her grandparents for about five or six years. Claimant was paid by the state of Arizona for taking care of her grandparents and her daughter.

In 1994 or 1995, claimant moved from Arizona to Dexter, Missouri where she remained for 5 to 7 years, during which time she did not work outside of the home. Thereafter the claimant moved to the Ravenden, Arkansas area, where she has lived for seven to eight years. As noted previously claimant worked at McCloud's Grocery for several months before obtaining employment with respondent in May 2004. Claimant last discharged employment duties for respondent in August 2004.

Claimant denies that the onset of her symptoms occurred shortly after she begin her employment with respondent in May 2004. The testimony of the claimant reflects that while her symptoms being in August 2004, she had discussed them with her family physician, Dr. Buxton before going to the emergency room.

The evidence in the record that on November 1, 2004, pursuant to the direction of Dr. Spanos she underwent EMG in Jonesboro. On May 16, 2005, claimant underwent another EMG

in Little Rock, under the direction of Dr. Rutherford pursuant to the referral of Dr. Moore. On October 7, 2005, claimant was seen by Dr. Simard, who requested a second EMG, however the same was not authorized by respondents.

Claimant offered that even the results of the right hand surgery and the opinions expressed by Dr. Moore, Mr. Harriman, and Dr. Spanos, she still desires to have surgery performed on her left upper extremity.

One of the earliest medical reports contained in the record is the December 14, 2004, report of Dr. Michael M. Moore, a Little Rock orthopedic surgeon. The report reflects, in pertinent part:

Wanda Morrison was seen at the **Arkansas Hand Center** on 12/14/04 for evaluation of her hands. She is a pleasant, 42-year-old, right-hand dominant female who has worked at Egan Manufacturing for approximately 7 months. Shortly after beginning her employment, she noted the onset of pain and numbness in both hands. She reports her job requires her to perform repetitive pushing and gripping using both hands. She holds aluminum bundles as they are cut with a chisaw. She describes significant gripping and pulling using both hands when she uses punch presses, electrical caulk gun, and when she sets glass into window frames. She denies a recent history of trauma. She reports the pain and numbness in her hands awakens her at night.

A nerve conduction and EMG study performed on 11/14/04 was consistent with severe right carpal tunnel syndrome and mild left carpal tunnel syndrome.

* * *

In my opinion Ms. Morrison's clinical history, physical examination, and recent nerve conduction and EMG study are consistent with bilateral carpal tunnel syndrome.

I discussed treatment options at length with Ms. Morrison, which included splinting, injections and splinting, or carpal tunnel surgery. She reported that she has worn splints with minimal relief. She felt her right hand symptoms were significant; she elected to proceed with right carpal tunnel release.

Based on the results of the nerve conduction and EMG study, which suggested a severe right carpal tunnel syndrome, I felt this was a reasonable decision. I reviewed the indications, risks, and potential complications of surgical treatment and all questions were answered.

Ms. Morrison can resume light duty work. She should not perform pushing, pulling, or lifting greater than 10 pounds using her hands. She should not use her hands to perform repetitive activity or significant gripping. In addition, Ms. Morrison will wear carpal tunnel splints as needed.

In my opinion the work activities as described by Ms. Morrison could aggravate or precipitate symptoms associated with carpal tunnel syndrome. Specifically, she did not describe any hand or arm pain symptoms prior to her appointment at Egan Manufacturing. In addition, she described job as requiring significant gripping, pushing, and pulling using both hands. Ms. Morrison did not describe hobbies or other activities that required strenuous use of her hands. (RX. #1, p. 1-3).

On February 2, 2005, the claimant underwent carpal tunnel release surgery on the right under the care of Dr. Moore. (RX. #1, p.6-7).

On March 22, 2005, the claimant was seen in follow-up by Dr. Moore. The report reflects that the claimant relayed that the numbness in her right had improved, although she still had pain in the palm of the right hand which radiated into the fingers. The report also reflects that surgery was scheduled for release of the left carpal tunnel on May 2, 2005. The report concluded by noting that the claimant would continue light duty work. (RX. #1, p. 8).

The claimant was again seen by Dr. Moore in follow-up on April 28, 2005. After recording the claimant's continuing complaints relative to her right carpal tunnel release, the report reflects, in pertinent part:

At this time, I cannot explain Ms. Morrison's persistent right hand pain complaints. It should be noted that her physical examination does not reveal swelling, inflammation, erythema, or edema in the right hand or arm. Ms. Morrison was scheduled to proceed with left carpal tunnel surgery on 05/02/05. At this time, I do not feel left carpal tunnel surgery is indicated

until we can determine the etiology of her persistent right hand pain complaints. Furthermore, the nerve conduction and EMG study performed on 11/01/04 suggested a mild left carpal tunnel syndrome.

Due to the fact that Ms. Morrison has persistent right hand complaints, it was my opinion further evaluation was indicated. She will be seen in the Therapy Unit to undergo a BTE validity test. Following the study, she will be evaluated by Dr. Reginald Rutherford. I would appreciate his opinion regarding Ms. Morrison's persistent pain complaints. The evaluation will include a repeat nerve conduction study and EMG study of both hands. If the nerve study of the left hand is normal, Ms. Morrison will not require left carpal tunnel surgery. In regards to the right hand, if there appears to be improvement in the median nerve function, it is unlikely her clinical history and physical examination will be consistent with recurrent or persistent right carpal tunnel syndrome. I informed her that I would see her in the future if Dr. Rutherford felt my participation in her care was indicated. At this time, I do not feel Ms. Morrison is a candidate for any further surgical treatment. (RX. #1, p. 9-10).

On May 16, 2005, claimant underwent the diagnostic studies as recommend by Dr. Moore under the direction of Dr. Rutherford. The report regarding the study reflects, in pertinent part:

The nerve conduction study demonstrates improvement in right median nerve function. Current abnormalities are mild in degree. Study of the left median nerve is normal. Based upon present clinical examination and electrodiagnostic testing there is no role for consideration of further peripheral nerve surgery in Ms. Morrison's case. Ms. Morrison's problem was personally discussed with Dr. Michael Moore. (RX. #1, p. 13).

Dr. Moore authored a May 26, 2005, report relative to the claimant reflecting the results of diagnostic study by Dr. Rutherford, which included a BTE validity test that suggested a submaximal effort. The report further reflects, in pertinent part:

At this time, it is my opinion Ms. Morrison is not a candidate for left carpal tunnel surgery.

Dr. Rutherford's evaluation did not reveal any evidence of reflex sympathetic dystrophy. In addition, her physical examination revealed giveaway pattern weakness of both upper extremities with symmetrical reflexes. Dr. Rutherford agrees with my opinion that Ms. Morrison is not a candidate for any further

peripheral nerve surgery. I cannot explain her persistent right hand pain symptoms; however, her physical examination is unremarkable. The post-operative nerve conduction and EMG study suggested improvement in the median nerve function. Ms. Morrison's clinical history and physical examination do not reveal any evidence of reflex sympathetic dystrophy. (RX. #1, p. 14).

Thereafter, Dr. Moore opined that the claimant did not require any further evaluation or treatment, and assessed the extent of her anatomical impairment as a result of the surgical procedural at 5% to the right hand. (RX. #1, p. 14).

On July 13, 2005, claimant was again seen by Dr. Demetrius S. Spanos, a Jonesboro neurologist, at the request of Dr. Traci Buxton. The claimant has previously been seen by Dr. Spanos who performed the November 1, 2004, nerve conduction and EMG study. The July 13, 2005, report of Dr. Spanos noted that the claimant did not present on that occasion as a part of a workers' compensation evaluation. The report concludes:

From a neurologic standpoint, given the response that she has had to carpal tunnel release of the right upper extremity, I would agree with Dr. Moore that having the patient undergo left carpal tunnel would not be advisable. I would advise having her evaluated at the NEA Sports Therapy Center by Paul Cooper, who specializes in hand therapy, and if is not successful proceed to evaluation for chronic pain management. (RX. #1, p. 16).

The claimant was again seen by Dr. Spanos on August 15, 2005. The report relative to the afore visit reflects that Dr. Spanos reiterated that she should not proceed with carpal tunnel release surgery on her left wrist. The report further reflects the opinion of Dr. Spanos that the claimant was not disabled and that she should resume her previous work duties. (RX. #1, p. 19).

Pursuant to the change of physician request, which was granted, on October 7, 2005, claimant was seen by Dr. Jean Simard. The report reflects, in pertinent part:

She is still having some weakness in both of her hands. The previous right carpal tunnel surgery scar looks good. There is no swelling or synovitis. Her grip strength is weak. The Tinel sign is positive, mainly over the right. The reflexes are normal and symmetric. She has no significant pain.

TREATMENT

We elected to repeat the EMG and nerve conduction study and we will most likely have to complete the investigation also with a cervical spine MRI. She understands and consents with treatment plan. She will follow-up after the EMG and nerve conduction study of her upper extremities. We also reviewed and signed the patient's medical record history sheet dated October 7th, 2005. (CX. #1, p. 2).

On March 20, 2006, the claimant was evaluated by Dr. Mark Harriman, a Memphis orthopedic surgeon, at the request of respondents. The report of Dr. Harriman reflects that he had access to the claimant's prior medical records relative to the diagnosed bilateral carpal tunnel syndrome as well as her surgical and postoperative medical records. The March 20, 2006, report reflects, in pertinent part:

She is here today stating that she can only use her hands for about two hours. She describes bilateral pain, but did not mention numbness to me at all until I mentioned and she says, "Oh yes, my hands are numb all the time." The pain that she has is on the thumb side and ulnar side of each hand, worse on the right than on the left. She says that the symptoms on the right are similar to what she had before her surgery. She also describes a "knot" in the palm of the right hand and wants to know why it's there. It should be noted that she has not worked at all since December 2004.

PE: She presents today a pleasant, cooperative white female 5'2", 115 pounds, BP 96/61. The exam shows no swelling in either hand. She is very jumpy on exam and almost any effort on my part to touch her around her wrists or hands causes her to withdraw as if in pain. She has good pulses. She has good light touch sensation and describes no numbness during today's examination. She describes marked pain in each wrist as I try to range them, but once I distract her, she has perfectly normal range of motion in the wrist, again, with no swelling or crepitation. Intrinsic muscle testing was normal. She gave a non-physiologic effort at grip testing and basically the "open palm" type of grip maneuver on each hand. Phalen's test was positive immediately

on both hands, again, signifying a non-physiologic finding. I palpated her incision in her palm on the right side where she states there is a know and I can see a well healed small incision form previous carpal tunnel surgery, but I do not either see nor palpate any type of know. I also do not see any evidence of dystrophic changes in either hand.

* * *

The questions on Ms. Morrison will now be addressed. First of all, I do not think that the patient needs another EMG nerve conduction velocity testing as suggested by her most recent physician her in Memphis, Dr. Simard. I simply don't think it's a reasonable medical necessity and her last nerve conduction study of May 2005 was normal. She is also very non-physiologic on her findings.

Second, the patient does not need carpal tunnel surgery on her left upper extremity.

Next, I do believe that the patient has reached maximum medical improvement from her carpal tunnel problem and I agree with the 5% upper extremity rating on the right upper extremity and 0 rating on the left upper extremity. I agree that there are no restrictions. She can resume full duty employment. (RX. #1, p.24-25).

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 provision and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On August 1, 2004, the relationship of employee-employer-carrier existed among the parties.
3. On August 1, 2004, the claimant earned wages sufficient to entitle her to weekly compensation benefits at the rate of \$155.00/\$154.00, for temporary total/permanent partial disability.

4. On August 1, 2004, the claimant sustained an injury in the form of bilateral carpal tunnel syndrome arising out of and in the course of her employment, and for which she has been paid appropriate medical and indemnity benefits.

5. The claimant reached the end of her healing period as of May 16, 2005.

6. Medical treatment rendered to the claimant subsequent to May 26, 2005, by physicians other than Dr. Jean Simard, was not reasonably necessary relative to the compensable injury of August 1, 2004.

7. Further diagnostic studies, to include a repeat EMG and nerve conduction study as recommended by Dr. Jean Simard, are not reasonably necessary in connection with the claimant's compensable injury of August 1, 2004.

CONCLUSIONS

The compensability of the claimant's diagnosed bilateral carpal tunnel syndrome is not disputed. Claimant maintains that she continues to experience symptoms in both upper extremities which renders her totally incapacitated from engaging in gainful employment and in need of further medical treatment. Claimant seeks the afore corresponding workers' compensation benefits as well as controverted attorney fees. Respondents take the position that the claimant has been paid all appropriate workers' compensation growing out of the compensable injury.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to additional workers' compensation as a result of an injury having been sustained subsequent to the effective date of the afore provision. As note above, the compensability of the claimant's bilateral carpal tunnel syndrome is not disputed.

The evidence preponderates that the claimant received medical treatment under the care of Dr. Traci Buxton and Dr. Demetrius S. Spanos prior to coming under the care of Dr. Michael M. Moore. The cost of the claimant's medical treatment relative to the compensable diagnosed bilateral carpal tunnel syndrome was paid for by respondent through the point in time that she came under the care of Dr. Michael Moore on December 14, 2004.

The claimant underwent surgery in the form of carpal tunnel release on the right under the care of Dr. Moore on February 2, 2005. Dr. Moore released the claimant as having reached maximum medical improvement in a May 26, 2005, correspondence. The last received medical treatment pursuant to the directions of Dr. Moore on May 16, 2005, when she underwent diagnostic studies under the care of Dr. Rutherford. Dr. Moore's last direct personal contact with the claimant was had during a April 28, 2005, visit.

While the claimant returned to both Dr. Buxton and Dr. Spanos subsequent to her May 2005, discharge from the care of Dr. Moore, the evidence preponderates that the treatment rendered by same was not reasonably necessary in connection with the claimant compensable injury. Further, Dr. Spanos authored reports corroborative of those of Dr. Rutherford, Dr. Moore and Dr. Mark Harriman, regarding further surgery and the claimant's ability to return to unrestricted job duties.

The respondent-employer owes only those benefits that are reasonably necessary in connection with the compensable injury sustained by the claimant. *GEO Specialty Chemical v. Clingan*, 69 Ark. App. 369, 13 S.W.3d 218 (2000). While the claimant does not have to support a continuing need for medical treatment with objective findings, she nevertheless bears the burden of proving, by a preponderance of the evidence, that additional medical treatment is

reasonably necessary in connection with her compensable injury. Ark. Code Ann. §11-9-508 (a).

The claimant has failed to sustain her burden of proof by a preponderance of the credible evidence that further medical treatment, to include a repeat EMG/NCV study is reasonably necessary in connection with her August 1, 2004, compensable injury.

The evidence preponderates that the claimant reached the end of her healing period in May 2005, when she was assessed with a 5% permanent physical impairment to the right upper extremity. Claimant was also released to return to work without restriction as of May 26, 2005. Once the claimant reached the end of her healing period and was released to return to work her entitlement to temporary total disability benefits growing out of the compensable injury also came to an end. Drs. Moore, Rutherford, Spanos, and Harriman have all opined that the claimant has reached maximum medical improvement and is capable of return to her regular employment duties without restriction. The claimant has failed to sustain her burden of proof by a preponderance of the evidence that she remained within her healing period subsequent to May 2005, such that she would be entitled to temporary total disability benefits.

This claim for additional medical and temporary total disability benefits is respectfully denied and dismissed.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE