

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F409140/F509580/F611070

MELVIN SAMS	CLAIMANT
CRABTREE RV CENTER, INC.	NO. 1 RESPONDENT
AIG CLAIM SERVICES INSURANCE CARRIER	NO. 1 RESPONDENT
SECOND INJURY FUND	NO. 2 RESPONDENT
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	NO. 3 RESPONDENT

OPINION FILED MARCH 12, 2007

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

Claimant represented by MATTHEW KETCHAM, Attorney, Fort Smith, Arkansas.

RespondentS No. 1 represented by CAROL WORLEY, Attorney, Little Rock, Arkansas.

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

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

STATEMENT OF THE CASE

A hearing was held on December 14, 2006, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on October 12, 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 April 1, 2004, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to his back on April 1, 2004.

4. The claimant is entitled to a weekly compensation rate of \$281.00 for temporary total disability and \$211.00 for permanent partial disability.

5. Medical expenses have been paid to May 19, 2005.

6. Temporary total disability was paid to January 7, 2005.

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

1. Additional medical.

2. Additional temporary total disability from January 7, 2005, to a date to be determined.

3. Possible impairment.

4. Permanent and total disability or wage loss over claimant's impairment rating.

5. Second Injury Fund liability.

6. Attorney's fees.

In regard to the foregoing issues the claimant contends that he injured his back when he fell on the property while in the course and scope of his employment on April 4, 2004, on property owned and operated by Crabtree RV Center in Fort Smith, Sebastian County, Arkansas. He subsequently returned to "light duty" at Crabtree's new facility in Alma, Crawford County, Arkansas, and on July 14, 2004, he fell from a piece of equipment while in the

course and scope of his employment for Crabtree TV Center, worsening his already injured back.

In regard to the foregoing issues Respondents No. 1 contend that all appropriate benefits have been paid. The claimant was paid temporary total disability to January 7, 2005, and medical benefits have been paid through May 19, 2005. The claimant was released to return to work in a light duty capacity on or about November 12, 2004. Respondent/employer has made light duty available for the claimant. The claimant self-terminated on January 7, 2005. Therefore, it is respondents' position that TTD benefits are not due and owing with regard to the matter. Respondent/employer further contends that the claimant cannot prove entitlement to wage loss and if he does it will be the liability of the Second Injury Fund. Respondent/employer further contends that there has been no impairment rating given at the time of the hearing and if one is assigned it has not been controverted by the respondents.

In regard to the foregoing issues Respondent No. 2 contends that the claimant cannot prove he is entitled to any permanent benefits. The claimant cannot prove he is entitled to any wage loss disability benefits. The Second Injury Fund has no liability in this case. Respondent No. 2 further explained that the claimant cannot prove that there is any permanent anatomical impairment as a result of any of the 2004 incidences and that without proof of permanent anatomical impairment for whatever the last injury is that two things happen. First of all, there is no Second Injury

Fund liability, and secondly, as a matter of law, it is not appropriate for wage loss to be assessed in the absence of a rating or permanent anatomical impairment.

In regard to the foregoing issues Respondent No. 3 contends that pursuant to Ark. Code Ann. §11-9-525(b)(1), Second Injury Fund liability must be determined prior to consideration of the Death & Permanent Total Disability Trust Fund liability. If the Second Injury Fund is found to not have liability and the claimant is found to be permanently and totally disabled, the Trust Fund stands ready to commence weekly benefits in compliance with Ark. Code Ann. §11-9-502. Therefore, the Trust Fund has not controverted the claimant's entitlement to benefits. The Death & Permanent Total Disability Trust Fund will state its contentions upon completion of discovery.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1 and the deposition of Dr. Gary Moffitt marked Claimant's Exhibit No. 2. Respondents No. 1 submitted documentary evidence marked Respondents No. 1's Exhibit No. 1 and the deposition of Dr. Kelly Kimes marked Respondents No. 1's Exhibit No. 2. Respondent No. 2 submitted documentary evidence marked Respondent No. 2's Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that he was 48 years old and went as far as the eleventh grade in high school. The claimant testified that he did get his GED in 1985. The claimant testified that he worked in the auto body collision repair business for approximately twenty-one years, seventeen of those years being at one business. The claimant explained that his work in the auto body repair business ended when he sustained an on the job injury around 1994 which resulted in him having back surgery. The claimant testified that after his back injury he began drawing social security disability because his physician had indicated that he could not return to the automobile body collision type repair work. The claimant testified that he began to work with the Arkansas Rehabilitation Services to establish his interest and he began a retraining program through them. The claimant testified that his retraining courses included EMS training, fire inspector training, and company officer training. The claimant testified that he completed his arson training in 1999 and then did the requisite training in law enforcement so he could be an arson investigator. The claimant testified that he graduated in January 2000 from the law enforcement training. The claimant testified that near the end of his training he began working as the fire chief for Coal Hill and that after 9-11 he began working for Beverly Enterprises as chief of security. The claimant explained that in his job with Beverly he worked with technology as far as surveillance, assisted when personnel was terminated, and monitored the personnel that

came in and out of the corporate building. The claimant testified that when he left Beverly Enterprises in March or April 2003, he drew unemployment for a period of time.

The claimant testified that he began working for the respondent as a security guard in November 2003. The claimant testified that the respondent's business was not fenced off and they had been and were experiencing problems with theft and vandalism as well as reports of drug dealing on their property. The claimant testified that the respondent's business property was large and they provided an old trailer for him to use as an office. The claimant testified that he could not be there 24/7 and since he was their only security personnel, he would listen to a scanner to try and pick up if there was any type of activity in the respondent's area and he would either go over immediately or if he missed it on the scanner, he might get a call from the Fort Smith Police Department asking him to come to the respondent's business because the alarms were going off. The claimant testified that after a period of time the respondents also had him doing some work for them during the day such as deliver RVs to Tulsa and one time he took a vehicle to Iowa for repairs. The claimant testified that he also has gone out to the owner's home to wait for the utility companies to come check out problems. The claimant testified that he liked his work as well as the extra hours and he thought it was great that he had helped put a stop to a lot of the crime which had been occurring on the respondent's property.

The claimant testified that on April 1, 2004, he was working and had been on patrol of the respondent's property. The claimant testified that at one point he thought he saw someone so he took off out the door and the steps which are suppose to be there had been moved and he went up in the air and landed on his butt on the asphalt. The claimant testified that the next morning he reported to the respondent that some how the steps on his trailer had been moved and it would be nice if someone would either put them back or left him a note that the steps had been moved. The claimant testified that he did report his injury but did not feel that he needed to go to the doctor at that time. The claimant testified that he waited till June to be seen by his own family doctor because he did not want to turn in a workers' comp claim. The claimant testified that as he continued to work for the respondent he continued to get a little stiffer and that is why he went to his own doctor. The claimant testified that on July 14, 2004, he was asked to help at the Alma location because they were building a new shop and needed help. The claimant testified that he was happy to help them out particularly getting hours during the day. The claimant testified that he was working on a motorized lift and when he took a step back the floor had rotted out and he fell through the floor with one of his legs almost up to his waist. The claimant testified that when John Ferguson, one of the supervisors for the respondent, got back from Fort Smith he showed Mr. Ferguson what had happened and Mr. Ferguson indicated that perhaps it was a good idea that he was already taking pain medication. The claimant

testified that when he fell he immediately had a little nausea and dizziness but he suspected it was just from the excitement of such a quick fall. The claimant testified that he took off for the rest of the day but remembers that the respondent called him the next day and asked him to come help with the move from their Fort Smith office out to the Alma office. The claimant testified that following the lift incident, he again felt real stiff and kept thinking that he could work the pain out. The claimant testified that he did not see a doctor immediately after falling through the cherry picker nor did he miss any time from work.

The claimant testified that he was involved in a third incident on July 21, 2004, while working for the respondent. The claimant testified that he was helping with a move from the Fort Smith location. The claimant testified that he was moving a desk out of one of the offices onto a trailer when one of his feet got tangled up in a cable from the trailer and he fell with the weight of the desk on him. The claimant testified that he hit real hard on his left knee, so hard that it felt like it crushed his left knee and tore his jeans. The claimant testified that the man who was helping him move the desk and the people in the office came out and asked if he was all right and he responded that he did not know. The claimant testified that he continued trying to work for the next twenty minutes and finally told his supervisor that he just could not go any more that he was hurting so bad he could not go up and down the stairs. The claimant indicated that his pain was in his hips and down his legs and even felt like it was in his

sides. The claimant described this pain as being a stabbing prodding type pain which would shoot sharply all the way down to his toes. The claimant testified that he had not had this type of pain prior to this incident. The claimant testified that he again went back to his own doctor but once it was discovered that his injury was work related, everything changed. The claimant testified that eventually he went to Crawford Memorial Hospital to get an MRI and then he was sent back to his family doctor, Dr. Norwood, and then was referred to Dr. Standefer. The claimant testified that after being seen by Dr. Standefer and going through a myelogram, he was seen by Dr. Moffitt. The claimant testified that he continued to treat with Dr. Moffitt up until January 2006. The claimant testified that Dr. Moffitt prescribed pain medications for him as well as physical therapy and placed him on light duty. The claimant testified that after he was put on light duty by Dr. Moffitt the respondent had him work during the day and work as a mechanic on the vehicles. The claimant testified that his restrictions were to do no pushing, pulling, or lift anything over seven to ten pounds. The claimant testified that the respondent had him starting up at least 80 to 100 units a day and if a battery had gone bad to change out the battery which he could not do. The claimant testified that Dr. Moffitt recommended that he use a golf cart to get around the respondent's lot because of the uneven surface and because he had a hard time picking up his feet like he needed to without tripping. The claimant testified that he used a golf cart for approximately fifteen minutes one day before it was

taken away from him. The claimant testified that he continued to keep the respondent informed about his doctor's visits as well as Dr. Moffitt's recommendations. The claimant testified that the respondent told him that he would have to do security again and he told the respondent that the security job was not within his restrictions.

The claimant testified that on January 7, 2005, he went to the respondent and reported that he just could not do the work any more that he was hurting too bad. The claimant testified that he told the respondent that the light duty that they were giving him he just could not do. The claimant testified that Kelly, the office manager, discussed this with Burt and she came back and told him that the respondent did not have anything for him and that he needed to turn in his things so that is what he did. The claimant testified that he went home and got all of his uniforms and keys and took them back to the respondent and turned them in. The claimant testified that prior to this January 7, 2005, date when he could not do the light duty which the respondent wanted him to do they seemed to get real agitated and would have almost a tantrum. The claimant testified that he has not worked since January 7, 2005, but he did continue to see Dr. Moffitt for a period of time. The claimant testified that he has began drawing social security disability again.

On cross examination by Respondent No. 1, the claimant testified that in the mid 90s when he had his accident a 700 to 750 pound truck bed fell from a hoist and to keep from being slammed by

the truck bed he tried to push it off of him and was injured. The claimant agreed that he had surgery performed by Dr. Williams in 1998 and was off work as a result of this surgery for several years at which time he drew social security. The claimant also agreed that it was at the recommendation of Dr. Williams that he not return to the auto collision work and instead begin retraining for other jobs. The claimant testified that when he worked as the fire chief he primarily just supervised making sure that people were doing what they needed to do and that the equipment was appropriate. The claimant again testified that it was after this that he began his training and went into security work. When asked the claimant testified that in his opinion it was the cherry picker incident in July that caused him the most problems. The claimant testified that he is receiving \$955 a month social security disability and that he has not applied for any job since leaving the employment of the respondent. The claimant testified that in January it was Kelly Kimes, the office manager, who told him that the respondent did not have any work for him and that he needed to turn his stuff in. The claimant was asked about an office note from Dr. Moffitt's office dated January 7, 2005, that indicated that he had quit his job and the claimant responded, "No, that is not correct." The claimant testified that when he was seen by the doctor at UAMS he told them what had happened to him while working for the respondent. The claimant agreed that UAMS already had the records from his prior back surgery. The claimant testified that he quit seeing Dr. Moffitt because he could not pay the doctor and

that it was such a long drive from Van Buren to Springdale. The claimant testified that it was his understanding from Dr. Moffitt that the doctor wanted him to be seen by a pain manager in Fort Smith. The claimant was asked if he had broken a medication contract with Dr. Moffitt and the claimant responded, "No." The claimant was then asked if his medical records show that he did break a medication contract would he dispute it? The claimant responded, "That is the first time I have heard of any medication contract."

On cross examination by Respondent No. 2, the claimant agreed that he has served in the Marine Corps for a couple of years and then was in the non-active reserve. The claimant testified that while in the Marine Corps he did not sustain any injuries and he received an honorable discharge. The claimant testified that he was aware that there was some type of program which gave veterans preferences for jobs but he had not looked for Federal or State Government jobs in order to take advantage of his veteran's preference. The claimant was then asked several questions concerning his various training programs. The claimant testified that his volunteer fire fighting department offered a course on the weekends for two weeks in order to acquire the entry level fireman status. The claimant testified that there are written tests as well as different physical tests which must be complied with before you get a certificate. The claimant testified that a volunteer fire department has less stringent requirements than a larger city paid fire department. The claimant testified that the heaviest

thing he would have to lift on the volunteer fire department would be his breathing apparatus which weighed approximately 25 pounds. The claimant testified that he was an entry level fireman for approximately seven months before he was made fire chief. The claimant testified that during his period of being an entry level fireman, he probably responded to one to two fires a month and has, in fact, responded to a structure fire. The claimant testified that he has been up by a structure but the more experienced firemen would be the ones that actually got up to the structure. The claimant testified that the physical duties which he has performed while fighting a structure fire was using the water hose to shoot water into a fire. The claimant testified that there are always two to three people on a hose and it is an inch and a half in diameter and the handles are always fiberglass handles so they would weigh five to ten pounds. The claimant testified that the mechanics of doing this job also depends on who is on the crew helping hold the hose. The claimant testified that he took his law enforcement training at the Ozark Police Department. The claimant explained that this is a one hundred-hour course and that different instructors teach different segments of the course. The claimant agreed that in his deposition he had testified that while working for the respondent he had made twenty-six physical arrests. The claimant testified that out of these twenty-six physical arrests some of them required physical restraint but certainly not all. The claimant testified that some of the arrests would let him handcuff them until the Fort Smith police arrived but there were

some he had to run down although there were some he could not catch. The claimant testified that there were a few that he would have to wrestle around with and a few times he had to use mace. The claimant testified that with the various training programs he has gone through he has had to take tests for all of them which he has past. The claimant was asked why he was able to do the work of a fireman as well as a security person and not do the work as an automobile mechanic. The claimant explained that doing the auto mechanic repair work required constant bending, lifting, and twisting for eight hours where the fire fighting and security work the physical demands were not constant and if there was something that he was not able to do he just would not do it. The claimant agreed that he worked for the respondent up until January 7, 2005, with restrictions. The claimant testified that after his surgery he made himself a cane in order to help with his balance. The claimant testified that he made his cane because he could not afford to purchase one. The claimant testified that he is not needing to use a cane at this time.

On redirect examination, the claimant testified that following his surgery in the 1990's and after the time he was released by his physician after that surgery, he did not have any treatment for his back up until his injury while working for the respondent. The claimant also testified that he has not seen any doctor nor taken any medications prescribed or over the counter for back complaints prior to his injuries sustained while working for the respondent.

The claimant testified that to date he is still operating under the restrictions which Dr. Moffitt gave him.

Kelly Kimes testified by deposition that she had been working for the respondent for approximately four and a half years and is currently the business manager. Ms. Kimes testified that when the claimant was working for the respondent she was managing the office and also handling the human resources duties which encompassed workers' compensation. Ms. Kimes testified that she was aware that the claimant was under restrictions of no lifting, pushing, and pulling over ten pounds and no twisting. Ms. Kimes testified that the respondent had light duty available for the claimant and did provide him with a golf cart that he could drive so that he could start the various units as well as assess any damage that any vehicle might have. Ms. Kimes testified that at the time the respondent probably had 175 units although not all of them were motorized. This witness testified that at the end of the day the claimant would lock all the units. Ms. Kimes testified that the claimant did not have to do any lifting or changing of batteries. Ms. Kimes testified that the owner caught the claimant changing a battery and the owner told the claimant that changing batteries was not within his restrictions. Ms. Kimes testified that the claimant had a golf cart at his disposal at all times. Ms. Kimes testified that on January 7, 2005, the claimant quit on his own. This witness explained that the claimant had been coming in for approximately one month telling them that he could not handle the work that he was given. This witness testified that the claimant

was told that if he left it was on his own but that the respondent had light duty available for him at all times. Ms. Kimes testified that the claimant told the respondent that he was going to try to get his disability.

On cross examination by Respondent No. 2, the Second Injury Fund, Ms. Kimes testified that she was working for the respondent when the claimant was hired as well as when he left his employment. Ms. Kimes was asked if when an injured employee returns to work are they required to provide an off work slip or a note from their treating physician and this witness responded, "Yes." Ms. Kimes agreed that at some point she received a note from a doctor outlining the physical restrictions for the claimant which restricted him to ten pounds lifting and no bending, stooping, and twisting, etc. Ms. Kimes testified that the respondent followed these restrictions for the claimant and even talked with his assigned case worker to make sure they were following the correct guidelines. Ms. Kimes testified that if the claimant's restrictions had been altered by one of his treating physicians they would have followed that change and that no doctor ever sent a slip of paper saying that the claimant could not work at all.

On examination by the claimant's attorney, Ms. Kimes testified that prior to receiving the restrictions from Dr. Moffitt, the claimant worked as the night security guard. This witness testified that the claimant primarily worked in the evenings but there were occasions when the respondent would have him come in during the day to help them out. Ms. Kimes testified that after

the claimant received his restrictions, he did not work as many hours at night but worked more in the day. Ms. Kimes testified that the claimant contends that his first injury was in April, however he did not notify them or go to the doctor until August, therefore it would be sometime after August that they were aware of his restrictions. Ms. Kimes testified that initially the claimant went to his own doctor for his injuries. Ms. Kimes stated that no one was disputing that the claimant was injured in April. Ms. Kimes testified that in August the claimant indicated that he had been hurt several times and the respondent had him write out a letter detailing his different injuries. Ms. Kimes testified that the claimant reported that one time he was on a lift and the floor broke and he fell through. This witness testified that another time he was chasing some man and the third event was he was carrying a desk with another employee when he fell. This witness testified that the claimant was helping move furniture from their Fort Smith office to their Alma office. Ms. Kimes testified that the claimant volunteered to do things for the respondent but of course he was compensated for his time. Ms. Kimes testified that the claimant was a good employee and that she would consider him to be honest. Ms. Kimes testified that prior to the claimant's injuries and being assessed restrictions, his job duties did not include starting the various units and checking to see if the units were locked. This witness testified that after the claimant was put on restrictions, that was when he was told that the respondent could keep him working by checking the units. Ms. Kimes testified

that the claimant would have to climb stairs to get up into the vehicles to inspect them and that some of these units had guard rails to assist with climbing the stairs. Ms. Kimes testified that it was unlikely that the claimant was ever told to lift or change out a battery. This witness explained that everyone knew that the claimant was on light duty and that any changes in his job duties were supposed to come through her. Ms. Kimes testified that she was aware that through the claimant's case worker/nurse that the claimant had reported to his doctor that the respondent made him carry a gun and that he, the claimant, did not feel like he could carry a gun with all the pain medication he was on. This witness stated that she understood that the claimant had told his doctor that he was made to change batteries. Ms. Kimes testified that on the day the employment relationship ended between the claimant and the respondent, the claimant came in and told the respondent that he was going to quit because he just did not feel like he could do the work that they were offering him. Ms. Kimes testified that the claimant was told that that was solely his decision but if he chose to work he could come in the next day and there would still be light duty work available for him. Ms. Kimes denied that she ever told the claimant that there was no work available for him within his restrictions. Ms. Kimes was asked if the claimant had any company property that they asked him to turn in. Ms. Kimes responded, "I don't remember. I know that he had security guard uniforms. I'm assuming that we had him turn those in. I don't remember." Ms. Kimes was asked if the claimant had all of his

uniforms and stuff with him when he came in to quit and Ms. Kimes responded, "I do not remember."

The medical records set forth that the claimant had a laminectomy on December 28, 1998, at the L4-5 on the left level performed by Dr. Ronald Williams. The medical records which are extensive in this case sets forth that the claimant was next seen on June 28, 2004, with complaints of lower back pain and these complaints continued until the claimant was seen by Dr. Michael Standefer on October 6, 2004. Dr. Standefer notes that the claimant has undergone at least three injuries while working for the respondent. The doctor sets forth that the claimant has had persistent low back pain and associated left lower extremity pain as a result of these events. Dr. Standefer writes after examination and review of the claimant's MRI that he has multilevel degenerative disc disease with attendant disc bulge at L3-4, L4-5, and L5-S1. Dr. Standefer writes that he considers the disc bulge at L4-5 as probably being the underlying source of the claimant's pain as there is moderate channel stenosis at that level. Dr. Standefer writes that after talking to the claimant it sounds to him as though the claimant's job related mishaps were sufficiently severe to account for his pain. Dr. Standefer again writes on October 26, 2004, after reviewing the claimant's myelogram and post myelogram CT that he would not recommend surgical treatment at this time. Dr. Standefer recommended physical therapy and perhaps LESI injections. The claimant began being seen by Dr. Gary Moffitt on November 12, 2004, as a result of his various injuries and back

complaints. Dr. Moffitt writes that he has reviewed the claimant's MRI as well as his mylograms. Dr. Moffitt notes that the claimant is complaining of significant pain in his lower back which is going down his leg all the way to his toes. After examination, Dr. Moffitt adjusted the claimant's medications and recommended that he begin physical therapy. Dr. Moffitt returned the claimant to work with the restrictions of not to lift, pull, or push more than ten pounds and that he will need to limit bending and twisting at the waist as well as a need to go from sitting to standing to walking as needed. The claimant began physical therapy sessions under the direction of Jon Lee through Dr. Moffitt's office. The claimant continued to be seen by Dr. Moffitt as well as undergo physical therapy through Dr. Moffitt's office throughout November and into late December. The physical therapist notes on December 21, 2004, that the claimant reports that he continues to have lifting tasks assigned to him and that he continues to work in activities that are not compatible with his work restrictions. Dr. Moffitt also notes on December 23, 2004, that the claimant reports that he is having to do work that is really more strenuous than his restrictions, noting that he had to change a battery in a vehicle which weighed over forty pounds and he had to bend over to do this. The claimant reported to Dr. Moffitt that he is walking on uneven surfaces which hurts his back and that he is having to climb stairs. The claimant also reports that the respondent's lot where he works is fifteen acres and he has to walk this area up to twenty times a day. After examination, Dr. Moffitt recommended an

aggressive exercise program for the claimant and released him to work at his same restrictions noting that he definitely should be limited as to how much bending he is doing at the waist and walking on uneven surfaces. The claimant was seen by Dr. Gary Moffitt on January 6, 2005, where the claimant reports that he is not doing well and is back to work at modified duty but states that the respondent is not following his restrictions. The claimant reports that he has to pull himself up into the trailers as he climbs the stairs and that is a 200-pound pull which causes his back to hurt and says that his legs are not working well as he is going down stairs. The claimant's medications were adjusted, it was recommended that he continue his exercises as well as his same restrictions for work. Dr. Moffitt filled out a work related activities form on January 20, 2005, where he sets forth that the claimant has lumbar strain superimposed on degenerative disc disease. Dr. Moffitt then sets out what the claimant is capable of doing as far as sitting, standing, walking, climbing, lifting, and carrying. Dr. Moffitt was asked what clinical findings support his conclusions and the doctor wrote "severe spasm and weakness in back, stiffness." Dr. Moffitt indicated that the objective signs of pain were spine deformity, x-ray as well as muscle spasm. Dr. Moffitt indicates that the claimant would miss more than four days per month as a result of his back problems and writes that the claimant had a lumbar fusion in 1996, has had recurrent injuries and has a radiculopathy that is not responding to treatment. At the recommendation of Dr. Moffitt the claimant began physical

therapy through Dr. Moffitt's office on February 2, 2005. Jon Lee, the physical therapist, notes on this date that the claimant is in considerable pain with spasm being noted. The claimant continued with the physical therapy as well as seeing Dr. Moffitt through February with little change or improvement in his symptoms. Dr. Moffitt writes on March 31, 2005, that the claimant is much worse today and is having trouble standing up noting that the claimant is leaning forward in a flexed position. Dr. Moffitt prescribed medications, continued him with the same work restrictions, and recommended an MRI. The claimant underwent an MRI on April 13, 2005, where the findings are noted as severe channel stenosis and recurrent disc herniation at the L4-L5 level in the right posterolateral aspect and central disc herniations are also seen at the L3-L4 and L5-S1 levels. Dr. Moffitt writes on April 18, 2005, that he has reviewed the claimant's MRI and indicates that the findings from this test correlate with the claimant's symptoms. Dr. Moffitt notes that, in his opinion, the claimant is a candidate for surgery and recommended that he be seen by a neurosurgeon. The claimant was referred to the University of Arkansas Medical Center and was seen by Dr. John Fox on August 18, 2005. After examination of the claimant and review of his MRI, Dr. Fox recommended that the claimant undergo an L4-L5 redo micro lumbar discectomy which was scheduled. The claimant underwent surgery at the UAMS Medical Center on August 22, 2005, to repair a ruptured disc at the L4-5 on the right. Dr. John L. Fox writes on August 25, 2005, that the claimant was discharged from the hospital on August 25, 2005. Dr.

Gary Moffitt writes on September 29, 2005, that the claimant had undergone surgery at the med school where a free fragment was found which was causing nerve root encroachment. Dr. Moffitt notes that the claimant is on disability and as soon as he is covered by Medicaid, he would recommended that he begin pain management in the Fort Smith area. The claimant continued to be seen by Dr. Moffitt as a result of his worsening symptoms. The claimant has undergone another MRI at the UAMS Medical Center which sets forth findings of post operative changes with a right sided diskectomy at L4-5 with enhancement of the track extending to the L4-5 disc interspace, central disc protrusion at L3-4, and a defused disc osteophyte complex at L5-S1.

Dr. Moffitt, in his deposition taken on January 12, 2007, indicated that he started treating the claimant on November 12, 2004. After some bit of discussion about the claimant's treatment program, it was agreed that the claimant had a left sided herniation at L5-S1 and an annular tear at L4-5 as well as a disc protrusion at that level. Dr. Moffitt testified that the claimant had degenerative disc disease at the time he was first seen by the doctor. Dr. Moffitt stated, "And it is well known that patients with that particular process will be prone to have more disc problems occur in the future and more disc herniations." Dr. Moffitt was asked about his comment that the claimant had failed back syndrome following his second back surgery. Dr. Moffitt explained that failed back syndrome occurs in a patient who has had back surgery and continues to have severe chronic pain in their

back. Dr. Moffitt stated that this pain is associated with granulation tissue and scarring occurring around the nerve. Basically stating that the surgery did not work in relieving or resolving the claimant's symptoms. Dr. Moffitt agreed that, in his opinion, the claimant's condition is permanent. Dr. Moffitt was shown the claimant's nerve conduction study which showed that the findings were consistent with a compromise of the L4 and/or L5 nerve roots bilaterally and also evidence of an S1 nerve root compromised bilaterally. Dr. Moffitt indicated that these findings were not surprising to him and confirmed his fear that the claimant was going to suffer from nerve root damage. Dr. Moffitt also agreed that this condition is permanent and will result in the claimant having chronic pain, weakness, and poor functioning of the lower extremities.

On cross examination by Respondents No. 1, Dr. Moffitt explained that what he meant when he wrote that he was treating the claimant for a lumbar strain superimposed upon degenerative disc disease, was that the claimant had a lot of symptoms which came from muscles that were spasming or were inflamed. Dr. Moffitt also stated that due to the claimant's prior laminectomy this surgery would affect the integrity of the claimant's lumbar spine, noting that he would be more prone to injury in the future. Dr. Moffitt agreed that when he wrote on December 23, 2004, that most of the claimant's issues were muscular in nature he was referring to the muscle spasms. Dr. Moffitt agreed that on March 24, 2005, when he saw the claimant there was a significant change in his condition.

Dr. Moffitt agreed that he ordered a repeat MRI which revealed that the claimant had severe channel stenosis and recurrent disc herniation at L4-5 level in the right posterior lateral aspect and a central disc herniation at L3-4 and L5-S1. Dr. Moffitt agreed that this was a new objective finding and, in his opinion this finding was the need for the surgery performed by Dr. Fox.

On cross examination by Respondent No. 2, the Second Injury Fund, Dr. Moffitt agreed that a circumferential disc bulge with central protrusion and annular tear and scar is a degenerative type of condition as opposed to a traumatic type condition. Dr. Moffitt agreed that Dr. Standefer's report dated October 6, 2004, did not mention right leg pain, did not identify a herniated fragment of any sort, and that Dr. Standefer's diagnosis for the claimant was L4-5 degenerative disc disease. After some discussion, Dr. Moffitt also agreed that the finding of hypertrophy of the ligamentum flava is also a degenerative condition. Dr. Moffitt testified that when he first saw the claimant his complaints were all in the left leg. Dr. Moffitt agreed that the various examinations which he gave the claimant in his office were all normal and that as of January 20, 2005, the claimant's diagnosis was that of lumbar strain. Dr. Moffitt agreed that at least on February 17, 2005, the claimant was not having any complaints or symptoms with his right leg. Dr. Moffitt agreed that his March 31, 2005, report was the first time that the claimant had mentioned right leg pain. Dr. Moffitt agreed that with someone like the claimant who has had degenerative disc disease for a number of years, one could experience a herniated

disc fragment at any time with little or no effort being exerted. Dr. Moffitt read the report of the MRI done on April 13, 2005, which revealed severe channel stenosis and recurrent disc herniation at L4-5 in the right posterior lateral aspect as well as central disc herniation at L3-4 and L5-S1. Dr. Moffitt agreed that if the claimant had these same findings following his April and July events of 2004, he would have had quite a bit of pain and experienced right sided symptoms at that time. Dr. Moffitt was asked that in light of all the questions and information that had been discussed in this deposition was it still his opinion that the claimant's work incidents in April or July 2004 caused a low back strain? Dr. Moffitt responded, "Yes."

On redirect examination, Dr. Moffitt agreed that the MRI done on August 16, 2004, made no mention of stenosis at L4 and L5 but did mention stenosis at L5-S1. Dr. Moffitt then looked at the discharge summary from 1998 which showed that the claimant had midline ruptured disc at L4-5 and stenosis at L5-S1. Dr. Moffitt testified that he would agree with Dr. Standefer that the claimant had post operative changes since his surgery in 1998. Dr. Moffitt testified that when one has symptoms from muscle strain, this pain is usually localized to the muscle area, however it can radiate into the lower extremity but not below the knee. Dr. Moffitt testified that when he saw the claimant, he recalls that he had complaints of radiating pain below his knee. Dr. Moffitt testified that it was his belief that Dr. Fox did surgery on the claimant to relieve the nerve root pressure due to a large L4-L5 disc

herniation on the right. Dr. Moffitt was asked a series of questions concerning the claimant's character and Dr. Moffitt responded that he perceived the claimant to be honest and not a malingerer and was not a chronic abuser of narcotics. Dr. Moffitt further explained that the claimant had expressed a desire to reduce the amount of medication he was on as well as the types of medications he was taking.

On recross examination by Respondents No. 1, Dr. Moffitt remembered that he no longer would see the claimant due to the claimant violating the prescription policy. Dr. Moffitt further stated that the claimant was aware of this situation.

The parties have stipulated that the claimant sustained a compensable injury to his back on April 1, 2004. The claimant has testified to two other injuries and claims have been filed for these injuries both occurring in July 2004. The respondent was made aware of these injuries one being the cherry picker incident and the second one being the desk moving incident and Ms. Kimes in her testimony indicated that there was no question that these events occurred. The MRI which the claimant underwent on August 16, 2004, sets forth that the claimant has disc desiccation at L3-4, L4-5, and L5-S1. It is also noted that at L3-4 there is a mild disc bulge with some overlaying scarring or granulation tissue, at L4-5 there is a circumferential disc bulge with a posterior central disc protrusion and annular tear as well as enhanced scar or granulation tissue anterior to the thecal sac at this level and at L5-S1 there is a posterior disc herniation more prominent to the

left of midline with bilateral stenosis and left lateral recess narrowing. Dr. Standefer, after reviewing the claimant's MRI and examining the claimant, writes that the claimant has multilevel degenerative disc disease with attendant disc bulging at L3-4, L4-5, and L5-S1. Dr. Standefer writes that the annular rent at L4-5 and lateralization of the disc bulge/protrusion at L5-S1 to the left are pertinent findings that are suspicious for these particular discs being symptomatic. Dr. Standefer opines that the disc bulge at L4-5 is probably the underlying source of the claimant's pain as there is moderate channel stenosis at this level. Dr. Standefer also writes that after taking a history from the claimant as to his various injuries it sounds to the doctor as though the claimant's job related mishaps were sufficiently severe to account for his pain. The medical records set forth that the claimant has continued under an aggressive program of physical therapy, medication, as well as home exercises and work restrictions. Even after the claimant stopped working for the respondent his symptoms continued and even progressed to the point where on March 31, 2005, Dr. Moffitt notes that the claimant is in severe pain and is bent over. Dr. Moffitt at that point ordered a second MRI which revealed additional findings this time extending to the right for which he referred the claimant to a neurosurgeon at UAMS. As the records reflect the claimant underwent back surgery performed by Dr. Fox on August 22, 2005. Subsequent to this surgery the claimant has continued to have problems with his back and Dr. Moffitt, in his deposition, opined that the claimant

has failed back syndrome. Dr. Moffitt in his letter of September 29, 2005, has written that the claimant would benefit from a referral to a pain specialist in the Fort Smith area. The claimant has continued to be treated by a variety of doctors for his ongoing low back problems. It seems quite clear that although the claimant had pre-existing degenerative disc disease as well as an earlier surgery, the injuries which he sustained while working for the respondent exacerbated these previous conditions and subsequently his symptoms have spiraled downward. Dr. Moffitt, in his deposition, testified that it was his opinion that he was treating the claimant for a back strain, noting that a back strain can have radicular symptoms down to the knee but not below the knee. It is noted in Dr. Moffitt's records from the very beginning as well as in the physical therapist's notes that the claimant has had continuing complaints of pain from his low back down into his toes or foot.

I find, therefore, that Respondents No. 1 should continue to pay medical treatment for this claimant's compensable injury low back injury. I further find that the claimant has proven by a preponderance of the evidence that he is entitled to temporary total disability from January 8, 2005, to the date of this opinion. The claimant continued to work for the respondent under work restrictions of no lifting, pulling, or pushing more than ten pounds and no bending, stooping, squatting, or climbing. The claimant's testimony and some of the records reflect that his work for the respondent was not in total compliance with these

restrictions. The claimant has testified that he tried as long as he could to work at the jobs the respondent provided for him but it came to a point where it became too painful for him to fulfill these tasks and he reported this to the respondent. There of course is a conflict in the testimony as to whether the claimant quit or was told to leave if he could not perform the work required. It is my opinion that the weight of the more credible evidence is that the claimant approached the respondent about the difficulties he was having with his work and was told that if he could not perform the tasks required of him to turn in his equipment and leave. Although Ms. Kimes testified that she did not remember, she did state that she was assuming that the respondent asked the claimant to turn in his uniforms and keys. If in fact the respondent continued to have work available for the claimant it would seem unlikely that they would require him to turn in his keys and uniforms.

One of the issues to be addressed is the correct impairment rating for this claimant. There is no evidence from the doctors as to impairment ratings being given to this claimant for any of his back surgeries or back treatments. Therefore, based on the A.M.A. Guides, Forth Edition, Table 75, the claimant would be entitled to a 7 percent whole body impairment rating as a result of his 1998 back surgery. The claimant underwent a second diskectomy on August 25, 2005, at the UAMS Medical Center. In accordance with A.M.A. Guides, Forth Edition, Table 75, for a second operation the claimant would be entitled to an additional 2 percent impairment.

This would give the claimant a total impairment rating of 9 percent to the body as a whole. Respondent No. 1, therefore, should pay to this claimant a 2 percent impairment rating to the body as a whole. I find that the claimant has failed to prove by a preponderance of the evidence that he is permanently and totally disabled. From listening to the claimant's testimony you can tell that he is an intelligent gentleman who in the past has had a good work ethic. The claimant is mobile and mentally alert and although he has several restrictions that would hinder him from many types of employment, I think with his training and intelligence that he would be employable. I further find that the claimant is entitled to wage loss in the amount of an additional 9 percent giving him a total impairment rating of 18 percent to the body as a whole. I do not find that the Second Injury Fund is liable in this matter. The testimony sets forth that the claimant had very little to no problems following his first surgery and entered a very aggressive and active retraining program in law enforcement, fire fighting, emergency services type training, and security work. Although this work may not be as physical as his mechanic work, by the claimant's own testimony he was fully able to do his duties until he sustained his compensable injuries while working for the respondent. This finding of wage loss is based on the claimant's education, training, physical limitations, age, and work experience.

FINDINGS & CONCLUSIONS

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

2. On April 1, 2004, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to his back on April 1, 2004.

4. The claimant is entitled to a weekly compensation rate of \$281.00 for temporary total disability and \$211.00 for permanent partial disability.

5. Medical expenses have been paid to May 19, 2005.

6. Temporary total disability was paid to January 7, 2005.

7. The claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment subsequent to May 19, 2005, at Respondents NO. 1's expense. See discussion above.

8. The claimant has proven by a preponderance of the evidence that he is entitled to temporary total disability from January 8, 2005, to the date of this opinion to be paid by Respondents No. 1. See discussion above.

9. The claimant is entitled to a 2 percent whole body impairment rating for his second surgery which should be paid by Respondent No. 1. See discussion above.

10. The claimant has failed to prove by a preponderance of the evidence that he is permanent and totally disabled. See discussion above.

11. The claimant has proven by a preponderance of the evidence that he is entitled to wage loss over and above his combined

impairment rating in the amount of 9 percent to the body as a whole which should be paid by Respondents No. 1. See discussion above.

12. There is no Second Injury Fund liability found in this matter. See discussion above.

13. Respondents No. 1 have controverted these claims in their entirety.

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

ORDER

The claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment subsequent to May 19, 2005, to be paid by Respondents No. 1.

The claimant is entitled to temporary total disability from January 8, 2005, to the date of this opinion, March 12, 2007.

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

The claimant has proven that he is entitled to wage loss in the amount of 9 percent to the whole body over and above his impairment rating which should be paid by Respondents No. 1.

There is no Second Injury Fund liability in this matter.

Respondent No. 1 shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

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

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

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE