BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F504532

FARNIE SCOTT, EMPLOYEE	**CLAIMANT**
ENVIRONMENTAL FILTERS, INC., EMPLOYER	**RESPONDENT**
WESTPORT INSURANCE CO., CARRIER	**RESPONDENT**

OPINION FILED SEPTEMBER 11, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on August 3, 2007, at Jonesboro, Craighead County, Arkansas.

Claimant appeared pro se.

Respondents represented by the HONORABLE WILLIAM C. FRYE, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above style claim to determine the claimant's entitlement to additional workers' compensation benefits. On May 29, 2007, a pre-hearing conference was conducted in this claim from which a Pre-hearing Order of the same date was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties contentions relative to the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Farnie Scott, the claimant, Daniel Morris, and Justin Collins, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Farnie Scott, the claimant, with a date of birth of May 4, 1972, is a high school graduated, who commenced his employment with respondent as a machine welder on March 22, 2004. Claimant testified that prior to his employment by respondent he worked in construction as a general laborer. Claimant's testimony reflects that he attended a vocational technical school, Delta Vo-Tech, which is now Arkansas State Technical College, in Marked Tree, approximately ten (10) years earlier where he completed a six-week course in truck driving.

Claimant testified that he worked as a truck driver for Builders Transport for about five (5) months and had a commercial drivers' license. Claimant's testimony reflects that he worked factory jobs thereafter. One of the factory jobs identified by the claimant was Mid South in Marked Tree. Claimant has lived in Marked Tree all of his life.

The testimony of the claimant reflects that he his hours during his employment by respondent were from 7:00 a.m. until 3:30 p.m., and that he earned $9.50, per hour. Claimant generally worked a 40-hour work week. With respect to his job duties in the employment of respondent, claimant testified:

> I took this, what is called wire mesh, what I done is like weld the seams together on it, welded the seams like where it was rolled, I would like welt it together. (T. 16).

Claimant denied having physical limitations or restrictions on his activities prior to his employment with respondent. Claimant specifically denied having any problems with either his back or legs prior to he is employment with respondent. The testimony of the claimant reflects that prior to March 31, 2005, he was physically able to perform his job without any difficulties or problems.

In describing the mechanic of the March 31, 2005, accident which serves as the basis for

the present claim, the claimant testified:

> I was standing up on the top level storage rack counting material because we was doing inventory. I remember when I done my last count I looked I guess across the room and I seen Cindy and Tim standing over by the water fountain and I turned back around and I glanced down and Justin he was standing below and I took like two steps and it sounded like I heard a pop sound and all I know is I was falling in mid air. And I fell from the top level down to the next level. And the boxes of material, I guess the best I remember the boxes of material, once I hit the bottom, they was - - I was engulfed in them like a horseshoe shape all around my shoulders and everything. And one of the boxes had burst open on my, I believe on my, yeah, on my left side. And I was in a daze, you know, disoriented. In a seated position. Landed in a seated position. (T. 17-18).

Claimant estimated the he fell a distance of between 8 and 10 feet. Further the testimony of the claimant reflects that the accident occurred between 10:30 and 11:00 a.m.

Claimant asserts that the did not receive medical treatment for the injuries growing out of the March 31, 2005, accident until the following day, when he was seen by Dr. Saito, at the direction of respondent. In describing the injuries he experienced immediately following the accident, claimant's testimony reflects:

> Well, I was in a daze. Well, I know my back it was hurting, my lower back. My legs, they was weak. My head was hurting. It's a possibility, I don't even remember, that I could have possibly been hit from behind but I can't, you know, it's hard for me to, you know, my mind went blank. When I actually made contact I was in a daze. My mind went blank. But it's a possibility that my back head got hit. But my head hurt, my lower back, my legs, they was weak, you know. (T. 19).

Claimant added that his arms were also hurting following the accident. Claimant acknowledged that he continued to work on March 31, 2005, following the accident, finishing his shift. Clamant noted that the afore was not without pain. Claimant has not worked any place since the March 31, 2005.

In addition to being seen by Dr. Saito and at St. Bernard's Medical Center, the testimony of the claimant reflects that he was seen by Dr. Terence Braden. Claimant treated with Dr. John Brophy, a Memphis neurosurgeon, for a period of time prior to obtaining a change of treating physician to Dr. Guy L'Heureux pursuant to the entry of an August 29, 2005, Order by the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission.

Claimant acknowledged receiving physical therapy pursuant to the directions of Dr. Braden and Dr. Brophy. Further, the testimony of the claimant reflects that he was prescribed pain medication while under the care and treatment of Dr. Brophy. As a result of becoming unsatisfied with his medical treatment under the care of Dr. Brophy claimant requested and was granted a change of treating physician relative to his compensable injury to Dr. L'Heureux. Claimant asserts that he was seen on two (2) occasions by Dr. L'Heureux. Further, the testimony of the claimant reflects that during his last visit to Dr. L'Heureux he was discharged from the care of same.

Claimant maintains that at the time of his last visit to Dr. L'Heureux he was still experiencing residuals of his March 31, 2005, compensable injury:

> I was having pains in my back, my lower back. My head was, according to my notes here, my head was still hurting. And I guess weak in my arms. (T. 23).

Claimant added the he was also experiencing some tingling in his feet. Claimant testified that he continues to experience symptoms of "sparkling" his feet as well as pain in his heel along with headaches. The testimony of the claimant reflects that the afore symptoms have been present since the accident. Claimant also attributes his high blood pressure to the accident as well as "a tremendous amount of stress". (T. 23). The testimony of the claimant reflects that he current

medication consist of Tylenol and Aleve, both over-the-counter medications.

Claimant maintains that when he attempted to return to Dr. L'Heureux following the October 28, 2005, visit, he was denied access by the claims adjuster, Ms. Sheila Hall:

> Yeah, back around this time here. And she had told me that they paid me all that they was gong to pay me. And they wasn't going to pay me anything and she didn't sound very happy so, but I had called her and like I say, she didn't sound very happy. We paid you all that we're going to pay you and we're not going to pay you anything else. So, I attempt to do that. Okay. Now are you asking have I tried any other time besides that, also or?
>
> * * *
>
> I guess when I contacted, I guess you all and they denied me also. She said that they wasn't going to pay me. (T. 24).

Claimant's testimony reflects that when he attempted to contact Dr. L'Heureux to schedule an appointment he learned that he had retired. Claimant's testimony reflects regarding his attempt to schedule an appointment with Dr. L'Heureux prior to his retirement:

> Well, I tried, like I said, I tried with the insurance company and they said that they wasn't, you know, going to pay. I mean I don't have any insurance or anything so I couldn't afford to go back to the doctor on my own. Because he had released me to go back to work, so I mean I don't have any insurance or anything. I mean a doctor ain't going to see you, you know, if you can't pay, so. (T. 25-26).

Claimant asserts that he is physically unable to return to work due to residuals from his accident. Further, the testimony of the claimant reflects that he has not sought work due to the afore. Claimant added:

> Well, yes, I mean this accident has changed my life considerably. You know, I mean I'm in pain. I mean, I'm having pains, you know, that I didn't have before this accident. And there's a lot of things that I'm not able to do, you know, because of this accident, you know. And it was just a normal workday for me until this accident occurred. And it has changed

my life considerably, you know. (T. 26-27).

The testimony of the claimant reflects that he last received a check relative to his March 31, 2005, accident in December 2005, and the same represented the final payment of his impairment. Claimant acknowledged receiving a milage check subsequent to the December 2005 check. Claimant testified that he could not recall ever having a work related injury prior to the March 31, 2005, accident in the employment of respondent. Claimant's testimony reflects, "that the first time I injured myself like that". (T. 30-31).

Claimant maintains that he did not have a regular doctor prior to the March 31, 2005, accident. Further, claimant denies experiencing headaches or high blood pressure prior to the March 31, 2005, accident. Finally, claimant denies that he sought or required medical treatment relative to his back prior to the March 31, 2005, accident. Claimant acknowledged the existence of a child support lien. Claimant concedes that the symptoms that he attributes to the March 31, 2005, accident have "fluctuated". (T. 34).

On cross examination, claimant acknowledged receiving correspondence from respondents, to include notice scheduling his deposition and a request for production requesting that he sign a release and a list of the doctors that he had seen. Claimant asserts that he did not sign the authorization because the disclosure of his health information was voluntary. Claimant concedes receiving on July 13, 2007, a letter requesting that he sign the HIPPA form. Claimant did not sign the document, asserting that he had filed a Form C with the Arkansas Workers' Compensation Commission which had a medical release authorization on it.

Claimant acknowledged that his deposition was obtained by respondents, and that when questioned about whether he had ever been in a motor vehicle accident he responded that he did

not have any comment on that. Claimant responded likewise to questions of whether he had a current bodily injury claim pending with State Farm Insurance Company for his neck and back. During the hearing when questioned regarding his refusal to answer the questions during the deposition claimant testified:

> Well, I mean it was, I don't know, she said it was a deposition, a list of questions that she was asking me. That I wasn't under oath or anything but, so I mean I didn't have any comment.
>
> * * *
>
> Why did I refuse? I said well, she's questioning me about workers' compensation, you know, and that's what this is all about, workers' compensation. (T. 39).

After establishing the pertinent identifying information (name, address, and date of birth), claimant was asked if he was involved in a motor vehicle accident on December 7, 2006, in Jonesboro. Claimant asserted that he had no comment regarding the afore. Documents were introduced by respondents establishing the afore. (RX. #4). With respect to prior workers' compensation claim, claimant responded, on cross-examination, that he had never received workers' compensation benefits as in the present claim.

Claimant acknowledged that he owned a car and that he is able to drive himself. Regarding his negative response during his deposition to having had prior vocational training claimant testified that he must have missed that question. During the deposition claimant responded "no comment" to the question of whether he wanted to return to respondent doing the same job as he was doing at the time of the accident. Regarding his refusal to provide his Social Security number during the deposition, claimant testified that respondent already had the information from his employer.

Regarding his medical treatment subsequent to the March 31, 2005, accident, claimant acknowledged going to Dr. Braden and Dr. Brophy and receiving physical therapy and lumbar epidural injections. Claimant asserts that the afore did not help any. Regarding a June 7, 2005, report of Dr. Braden noting an absence of findings during the physical examination of the claimant that would explain his symptoms, claimant conceded that if the same was in the report he did not dispute it. Claimant, likewise conceded the contents of the July 13, 2005, report of the physical therapist reflecting that his complaints of movements were inconsistent with the extent and type of injuries he suffered. The physical therapist notes also noted many red flags and symptom magnification. Claimant acknowledged that Dr. Brophy discussed symptom magnification with him. Claimant also acknowledged that Dr. Brophy released him to return to regular duty after July 15, 2005. Claimant asserts that he told Dr. Brophy that he disagreed with his findings.

On October 10, 2005, claimant was seen by Dr. L'Heureux. While acknowledging that Dr. L'Heureux indicated in his report "signs of symptom magnification" claimant maintains that there are "inconsistencies" in the report. Specifically, claimant notes that the report describes him as a 53-year-old-black male. Claimant was referred by Dr. L'Heureux for a functional capacity evaluation. Claimant acknowledged that Dr. L'Heureux stressed the importance of putting forth his maximum effort in order to obtain a valid evaluation of the FCE. On October 24, 2005, claimant underwent the functional capacity evaluation. The test results reflect that the claimant gave an unreliable effort. (RX. #1, p. 36-46). Claimant disagreed with and disputed the functional capacity evaluation results. Following the October 24, 2005, functional capacity evaluation claimant returned to Dr. L'Heureux on October 28, 2005, who shared the test results

with him. Claimant acknowledged that he questioned the ability of all of the healthcare professional that had treated him in connection with the March 31, 2005, accident. Specifically, the claimant testified:

> Well, I said the insurance company's been paying them. They're all working together. (T. 53).

Claimant maintains that he did not include Dr. L'Heureux in the afore assessment. Claimant acknowledged that all of his doctors had released him to return to work.

In terms of his claim for vocational rehabilitation claimant testified that he has an interest in "possible real estate" and computers. Claimant has not exerted any efforts on his own in furthering the afore. Claimant denies any knowledge of his uncle having a pallet business or assisting/helping in that business.

Mr. Daniel Morris testified on behalf of the claimant. Mr. Morris' testimony reflects that he was employed by respondent for three years "off and on" "probably from 2002 to 2004". (T. 57). Mr. Morris was not employed by respondent on March 31, 2005, at the time of the claimant's accident. Regarding his acquaintance with the claimant Mr. Morris testified that he was "raised up with him". (T. 57). Mr. Morris' testimony reflects that he had worked with the claimant at respondent prior to the March 31, 2005, accident and that the claimant's physical condition was good.

Mr. Morris testified that he saw the claimant the day following the March 31, 2005, accident. The testimony of Mr. Morris reflects that he "pretty much" sees the claimant every other day or so. Regarding his observation of the claimant since the March 31, 2005, accident, Mr. Morris testified that the claimant is not normal, walking stiff like his back was hurting, and

that some days are better than others. Mr. Morris testified that the drove the claimant to doctor's appointments in Memphis a couple of time and to rehabilitation in Jonesboro. Mr. Morris testified regarding the claimant's limitations since the accident:

> Yeah, there's a difference, you know. Some days I come by and he just ain't, you know, physically able to do a lot. Some days, you know, not as bad. That's all I can really say, you know. But I be around him enough to know if he's having a bad day, you know what I mean? (T. 60).

On cross-examination Mr. Morris testified that he was not aware of the claimant helping his uncle a "pallet business". Mr. Morris added that the claimant's uncle dose not "really have a business". Mr. Morris offered that the uncle draws disability or something. Mr. Morris testified that he was not aware of the claimant having a motor vehicle accident in December 2006. Mr. Morris continued regarding the vehicular accident:

> No, because - - I think he was like in a truck or something, but he wasn't working for no one.
>
> No, sir. Well, I mean yea, he was in an accident I believe, what, last year or something, first of the year. I don't really know exactly.
>
> I know of the accident but I don't know, this is something different isn't it? It's kind of irrelevant, ain't it? (T. 61-62).

Mr. Morris conceded that he was familiar with the claimant's vehicular accident. Mr. Morris asserts that he does not know the extent or the kind injuries the claimant suffered as a result of the motor vehicle accident.

The claimant also had available to testify Mr. Percy Smith regarding a statement he overheard which was made by an individual, Chris Henson, who was not present to testify.

Mr. Justin Collins testified that he has been employed by respondent for four (4) years

and was so employed on March 31, 2005, at the time of the claimant's accident. Mr. Collins' testimony reflects that while he has seen the claimant around he has not been in his presence any appreciable time since the March 31, 2005, accident. Mr. Collins testified that he had seen the claimant three (3) times since the March 31, 2005, accident:

> Yes, sir. I just see him. We live in the same town and I just run into him. I think I seen him at the grocery store one time and I saw him at the gas station probably two or three, two times. (T. 65).

The testimony of Mr. Collins reflects that his observation of the claimant on those occasions that he had seen him since the March 31, 2005, accident was that his physical movements were no different that prior then before the accident. (T. 66).

The testimony in the record reflects that Mr. Collins was in close proximity of the claimant at the time of the March 31, 2005, accident. Mr. Collins' testimony reflects that the claimant was "kind of shook up" following the accident. Mr. Collins noted that when the claimant was questioned whether he was okay following the accident claimant responded that he was.

The medical in the record reflects that the claimant was seen by Dr. Kim Saito on April 1, 2005, the day following the March 31, 2005, accident. Claimant presented with complaints of low back pain and right heel pain growing out of the accident. X-rays were obtained of the claimant's lumbar spine and right foot at St. Bernards Regional Medical Center pursuant to the directions of Dr. Saito. Claimant was provided medication by Dr. Saito, directed to rest and use ice for pain, and to remain off work until the x-ray report was obtained. (RX. #1, p. 1). The x-ray report reflects the conclusion, regarding the claimant, as "essentially negative examination". (RX1, p. 2).

Pursuant to a April 5, 2005, emergency room visit to St. Bernards Medical Center, claimant underwent CT scan of his lumbar at the direction of the attending emergency room physician. The April 5, 2005, CT scan report reflects, in pertinent part:

> **CONCLUSION:** Very pronounced circumferential disc protrusion at L4-L5 with compromise of the L4 and L5 nerve roots. The foramina are compromised as well as the lateral recesses and canal. Possible superior protrusion of disk material is seen in both foramina. MRI recommended for further evaluation. (RX. #1, p. 5).

The claimant was seen in follow-up on April 7, 2005, by Dr. Saito. After noting the claimant's continued symptoms and April 5, 2005, emergency room visit, as well as the results of his physical examination of the claimant, the April 7, 2005, clinic note of Dr. Saito reflects plans to have the claimant see a neurosurgeon as well as rest. (RX. #1, p. 6).

On April 19, 2005, the claimant was seen by Dr. Terence P. Braden, III, D.O. After reciting the history of the March 31, 2005, accident and medical treatment received relative thereto, the April 19, 2005, office note of Dr. Braden reflects:

> He reports that his problems in his bilateral elbows as well as intermittent pain in his bilateral wrist, they are not present all the time. It is present intermittently. He also complains of back pain and intermittent pain in his legs. It is poorly localized. Sometimes he thinks it goes down toward the right foot but he is not really sure. Coughing and sneezing doesn't make it any worse. Sitting for a long period of time, standing for a long period of time seems to exacerbate his symptoms. He can not get rest by lying down at night. He said the only thing he has taken is Tylenol since that is what he has over-the-counter and he has it at home.
>
> He reports he never had back injury in the past, he's never had any symptoms such as this in the past.
>
> * * *
>
> **SUMMARY:**
>
> ____________Mr. Farnie Scott is a 32-year-old male who has sustained a fall on 3/31/2005

> with continued symptomatology. It is difficult really to ascertain any evidence of neurological compromise secondary to the give way weakness and the amount of discomfort that he has. Of course though, he has not had any of the medications filled that were given to him, which may give him some improvement.
>
> I presented to Mr. Scott that we could give him some Prednisone which may give him relief if the area of the back is truly causing his symptom. I explained to him the complications of aseptic necrossis, blood sugar, etc. He did not wish to take those risks. I instead gave him Celebrex and explained the risks of the Celebrex to him and he was more desirous of taking that. I also gave him Tylox as well as Skelaxin to give him some improvement.
>
> We're going to get an MRI scan to get a better look at his L4-L5 area as well and based upon this we will be deciding further what needs to be instituted.
>
> I could find no evidence of neuromusculosketal compromise in the bilateral upper extremities, neither by palpation nor examination.
>
> He will see me back in this office in approximately one week. (RX. #1, p. 8-10).

On April 26, 2005, the claimant underwent the recommended MRI lumbar spine scan at St. Bernards Medical Center. The MRI scan disclosed the presence of small bilateral disc protrusions at the L4-L5 level which mildly narrow the neuroforamina bilaterally and may dynamically affect the bilateral L4 nerve root. (RX. #1, p. 11-12). A May 3, 2005, office note of Dr. Braden relative to the claimant reflects, in pertinent part:

> I think that based upon his mechanism of injury, as well as his ongoing symptomology that an epidural steroids injection would certainly be appropriate. We are going to make this referral to Dr. Green in Memphis. We will also be calling in medication for him until he can see Dr. Green to have this done.
>
> We are going to continue him on his alternate duty status. (RX. #1, p. 13).

On May 16, 2005, the claimant was seen at Surgery Center at Saint Francis in Memphis by Dr. Phillip Green with an admitting diagnosis of lumbar radicular pain syndrome for which he

underwent a lumbar epidural steroid injection with fluoroscopy at L4-L5, per the referral of Dr. Braden. (RX. #1, p. 14-15). Claimant was seen in follow-up by Dr. Braden on June 7, 2005. The office note relative to the June 7, 2005, visit reflects, in pertinent part:

> Mr. Scott continues to complain of back pain. He now reports that he has tingling that does down into his bilateral feet. He says sometimes it feels as though it is on the top of his feet, sometimes he feels as though it is on the bottom of his feet. He no longer has problems with his elbow or his wrist.
>
> He has completed an epidural steroid injection by Dr. Green in Memphis and he reports its given him about a 20% improvement. He has not been in the work environment.
>
> He does not report any further cervical spine discomfort.(RX. #1, p. 16).

As a consequence of the June 7, 2005, visit, Dr. Braden elected to have the claimant continue with a bout of epidural steroids. Dr. Braden noted that if the claimant did not improve by at least 40 to 60% by the epidural steroid injections a surgical opinion would be appropriate.

The claimant next underwent a steroid injection under the direction of Dr. Green on June 13, 2005. (RX. #1, p. 13). A June 20, 2005, office note of Dr. Braden reflects that the claimant would be seen by Dr. John Brophy, a Memphis neurosurgeon, for a neurosurgical opinion. (RX. #1, p. 18).

The claimant was seen by Dr. Brophy on June 27, 2005, relative complaints growing out of the March 31, 2005, accident. After detailing his review of the prior pertinent medical records and examination the claimant, the June 27, 2005, report of Dr. Brophy reflects, in pertinent part:

> IMPRESSION: Lumbar myofascial pain syndrome associated with lumbar spondylosis without definite clinical evidence of radiculopathy or radographic evidence of nerve root compression.
>
> RECOMMENDATIONS: The clinical situation was reviewed with Mr.

> Scott. I have suggested a trial of a work conditioning program which will be set up near his home for five visits over the next two weeks. He is cleared to return to work at sedentary duties with no lifting over 10 pounds and no repetitive stooping or bending and follow-up evaluation in approximately two weeks. (RX. #1, p. 20-21).

On June 30, 2005, claimant underwent a physical therapy initial evaluation at NEA Orthopaedic & Sports pursuant to the referral of Dr. Brophy. In addition to the initial visit of June 30, 2005, the claimant was seen at the Orthopaedic & Sports on July 5, 2005; July 6, 2005; July 8, 2005; and July 11, 2005. (RX. #1, p. 27-28). On July 13, 2005, a Progress Summary was generated by NEA Orthopaedic & Sports relative to the claimant. The Summary reflects, in pertinent part:

> **Objective Findings:** Farnie reports no change in symptomology over the last 2 weeks. His complaints and movement patterns remain inconsistent with the extent and type of injury suffered. Many "red flag" behavioral patterns were noted during treatment sessions.
>
> **Clinical Assessment:** Chronic back pain. Symptom Magnification.
>
> **Recommendations:** Highly recommend FCE to be performed by Rick Byrd to identify objective discrepancies between subjective complaints and physical performance. (RX. #1, p. 29).

The claimant was again seen by Dr. Brophy on July 14, 2005. The July 14, 2005, clinic note reflects that a physical examination was performed and that Dr. Brophy reviewed the results of the claimant's various test with him. The clinic note concludes:

> IMPRESSION: Back pain and lower extremity pain associated with lumbar spondylosis without definite clinical evidence of radiculopathy or definite radiographic evidence of nerve root compression.
>
> RECOMMENDATIONS: The clinical situation and treatment options were reviewed in detail with lengthy explanations for Mr. Scott. His options include progression of a home walking endurance exercise program and clearance to return to work at full duty. Option two is administrative closure

> with Workers' Compensation and seeking alternative employment. Option three is further evaluation with myelography to verify there is no evidence of nerve root compression. The myelogram procedure was described and the complications discussed including but not limited to infection and spinal headaches requiring treatment with a blood patch. Mr. Scott has requested administrative closure as he plans to seek alternative employment. He will be cleared to return to work at full duty without restriction on 15 July, 2005 with a PPI rating (according to the AMA Guidelines, 5th Ed.) of five percent (5%). He is dispensed from the clinic Feldene 20 mg. po q d, #90. He was counseled concerning the risks of GI irritation and not to mix this with other anti-inflammatories. He will undergo follow-up evaluation as needed. (RX. #1, p. 30).

Pursuant to a Change of Physician Order, the claimant was seen by Dr. Guy J. L'Heureux, a West Memphis orthopedic surgeon, on October 10, 2005. The October 10, 2005, report of Dr. L'Heureux reflects a history of the claimant's March 31, 2005, accident, as well as the identity of medical providers relative to complaints growing out of the accident and the medical treatment rendered to and on behalf of the claimant, although the report does erroneously list the claimant's age as 53 years old. The report further reflects regarding the results of Dr. L'Heureux's physical examination of the claimant:

> He appears to be in good general condition. He is alert and oriented. His blood pressure is 139/92, pulse 84 and respiration 14. He is 5'7" and weighs 215 pounds.
>
> The patient is definitely guarding his gait. He is wearing a lumbar support, which I ask him to remove. He has no evidence of spasm in the mid to low lumbar area. He is complaining of pain at palpation and fairly light palpation of the mid to low lumbar area. Flexion is limited by 90% as well as extension. Straight leg raises in a sitting position 70 degrees bilateral and very guarded. Rotation are limited at lease 60% as well as leaning right and left. Deep tendon reflexes: Knees and ankles, present and symmetrical. Motor: No evident weakness, although I have to cue him in order to do dorsiflection and plantar flexion of the feet. The patient is able to get on his toes, but says he doesn't have the balance to get on his heels. Sensitivity appears normal to me. Tibialis posterior are pulsatile bilaterally. Waddle sign for compression and rotation is very positive.

> I have reviewed a CT provided to me and also the MRI of the lumbar spine.
>
> From my evaluation, I do not find any sign of radicular abnormality. I do find signs of symptom magnification since the patient is going slowly and making all kinds of slow movements and attempts just to bend forward about 10% and then changing position completely to do extension, which he limits by 90%.
>
> Therefore, my diagnosis is the same as Dr. Brophy, lumbar myofascial strain syndrome. In order to determine his ability to work, I will recommend an FCA and according to the results will make final recommendation. For the time being, the pay is to stay off work. I do give him a prescription for Darvocet N 100 #24 one q.8h if pain. I did explain to him that he needed to give a maximum effort in his FCA in order to be valid. (RX. #1, p. 33-34)

On October 24, 2005, the claimant underwent a functional capacity evaluation at Functional Testing Centers, Inc., pursuant to the direction of Dr. L'Heureux. The conclusion generated as a result of the FCE was that the results were unreliable and the presence of inappropriate pain behaviors with symptom magnification. (RX. #1, p. 36-47).

The claimant was last seen by Dr. L'Heureux on October 28, 2005. The October 28, 2005, office note relative to the claimant's visit reflects, in pertinent part:

> I explained to him that with all this in hand I do not have any objective signs to keep him from work and it is my opinion that he should return to his regular work. I also do not seen the need for any restrictions or any limitations in his work.
>
> I also explained to him that in my opinion he has reached maximum medical improvement.
>
> I do agree with the partial permanent impairment established by Dr. Brophy of 5% to the body as a whole.
>
> The patient then asks me what is his next recourse and I tell him that he can ask for a hearing with a judge if he is not satisfied with the care that he has received so far.

> Finally, Mr. Scott is discharged to return to his regular work without restriction on Monday, October 31, 2005. He is discharged from my care. I do agree with the diagnosis of Dr. Brophy, lumbar myofascial pain syndrome without clinical evidence of radiculopathy. (RX. #1, p. 47).

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, application of the appropriated statutory provisions and case law, I make the following:

FINDINGS

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

2. On March 31, 2005, the relationship of employee-employer-carrier existed among the parties.

3. On March 31, 2005, the claimant earned wages sufficient to entitle him to weekly compensation benefits of $231.00/$173.00, for temporary total/permanent partial disability.

4. On March 31, 2005, the claimant sustained an injury arising out of and in the course of his employment, and for which he has been paid appropriate temporary total disability benefits as well as all reasonably necessary medical benefits.

5. The claimant's healing period ended on July 15, 2005, as a result of the March 31, 2005, compensable injury.

6. The claimant has a permanent partial disability in the amount of 5% to the body as a whole.

7. The claimant has failed to sustain his burden of proof that vocational rehabilitation is warranted or appropriate as a result of the March 31, 2005, compensable injury.

CONCLUSIONS

On March 31, 2005, the claimant sustained a compensable injury to his low back within the course and scope of his employment with respondents. In addition to the workers' compensation benefits (indemnity and medical) paid to and on his behalf claimant maintains that he remains symptomatic and in need of additional medical treatment as a result of the accident. Further, claimant asserts that he is unable to return to former employment and requires vocational rehabilitation or retraining. Alternatively, claimant maintains that the extent of his permanent disability exceeds the 5% permanent physical impairment, and that he is entitled to corresponding indemnity benefits in excess of the anatomical impairment. Respondents maintain that the claimant has been paid all appropriated workers' compensation benefits relative to the March 31, 2005, accident.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to additional workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

The claimant was employed by respondent from March 22, 2004, through March 31, 2005. While the claimant continued to work March 31, 2005, following the accident and completed his regular shift, he has not discharged employment duties in the employment of respondents since.

The credible evidence in the record reflects that when claimant notified respondent on April 1, 2005, that he desired medical treatment in connection with the March 31, 2005, accident the same was provided by Dr. Kim Saito at the expense of respondents. Respondents paid for the cost of the claimant's medical treatment through October 28, 2005.

In addition to Dr. Saito, claimant received medical treatment in connection with the March 31,2005, accident, under the care of Dr. Terrence Braden, Dr. John Brophy, and Dr. Guy L'Heureux. The claimant has undergone various diagnostic studies and physical therapy relative to complaints growing out of the March 31, 2005, accident.

On July 14, 2005, Dr. Brophy cleared the claimant to return to work full duty without restrictions effective July 15, 2005. In addition to assessing the claimant with a 5% permanent physical impairment, pursuant to the AMA Guidelines, 5th Ed, the July 14, 2005, clinic note of Dr. Brophy reflects that the claimant relayed that he planned to seek alternative employment. The evidence in the record reflects that the claimant has not sought employment since his March 31, 2005, accident. During the time that the claimant was under primary care of Dr. Brophy there was a recommendation by NEA Orthopaedic & Sports that a functional capacity evaluation be obtained in light of the claimant's inconsistent results while undergoing physical therapy.

Following the entry of a Change of Physician Order the claimant came under the care of Dr. Guy L'Heureux. Dr. L'Heureux concurred in the diagnosis and impairment rating previously rendered by Dr. Brophy regarding the claimant. Additionally Dr. L'Heureux did obtain a functional capacity assessment. Dr. L'Heureux discharged the claimant from his care during the October 28, 2005, visit.

Claimant asserts entitlement to additional temporary total disability and medial benefits as a result of the compensable March 31, 2005, accident. A claimant is entitled to temporary total disability benefits during his healing period if he shows by a preponderance of the evidence that he has a total incapacity to earn wages. *Carroll General Hospital v. Green,* 54 Ark. App. 102, 923 S.W. 2d 878 (1996). The healing period is defined "as that period for healing of an

injury resulting from an accident". Ark. Code Ann. §11-9-102 (12).

The evidence in the record preponderates that the claimant reached the end of his healing period relative to the March 31, 2005, accident on July 14, 2005. Thereafter his entitlement to temporary total disability benefits ceased. Claimant was released to return to work without restrictions effective July 15, 2005, by Dr. Brophy. The evidence further reflects that the claimant was released to return to work without restrictions by Dr. L'Heureux at the time he was discharged from the care of same during the October 28, 2005, visit. The claimant has failed to sustain his burden of proof by a preponderance of the credible evidence that the remained within his healing period subsequent to July 14, 2005, relative to the March 31, 2005, compensable injury. Accordingly, the claimant's claim for additional temporary total disability benefits is respectfully denied and dismissed.

The evidence clearly reflects that the claimant was discharged from the care of Dr. L'Heureux during the October 28, 2005, visit. There is credible evidence in the record to reflect that the claimant was involved in a motor vehicle accident subsequent to his October 28, 2005, discharge from the care of Dr. L'Heureux. The subsequent motor vehicle accident has no nexus to the claimant's employment with respondent or the March 31, 2005, compensable accident. Claimant has failed to sustain his burden of proof by a preponderance of the credible evidence that further medical treatment is reasonably necessary in connection with the March 31, 2005, compensable accident. The claimant's claim for additional medical benefits is respectfully denied and dismissed.

The claimant was released to return to regular work without restrictions on two (2) separate occasions, July 14, 2005, and October 28, 2005. While the claimant has been assessed

with a 5% permanent physical impairment there are no medical restrictions limiting his physical activities or the type of employments that he may pursue. Claimant has not undergone surgery relative to his low back injury nor is he taking prescription medication in connection with the March 31, 2005, accident. The claimant has failed to sustain his burden of proof by a preponderance of the evidence that he has sustained a loss of earing capacity or wage loss disability in excess of the 5% anatomical impairment, base on his age, education or work experience. Claimant claim for wage loss or permanent partial disability in excess of the anatomical impairment is respectfully denied and dismissed.

Likewise since the claimant has been released to return to regular work without restrictions, he has failed to demonstrate that vocational rehabilitation is appropriate in the instant claim. This claim is respectfully denied and dismissed.

IT IS SO ORDERED.

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Andrew L. Blood, ADMINISTRATIVE LAW JUDGE