

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F608366

STARLA TRIPP

CLAIMANT

JOHNSON MEDICAL CENTER
SELF INSURED

RESPONDENT

RISK MANAGEMENT RESOURCES, TPA

RESPONDENT

OPINION FILED NOVEMBER 30, 2007

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Fort Smith, Sebastian County, Arkansas.

Claimant represented by GARY DAVIS, Attorney, Little Rock, Arkansas.

Respondents represented by GUY WADE, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held in the above styled claim on October 2, 2007, in Fort Smith, Arkansas. A pre-hearing order was entered in this case on November 1, 2006. This pre-hearing order set out the stipulations offered by the parties and outlined the issues to be litigated and resolved at the present time. Prior to the commencement of the hearing, the claimant announced that she was only seeking temporary total disability benefits for the period of July 27, 2006 through March 17, 2007. A copy of the pre-hearing order, with this amendment noted thereon, was made Commission's Exhibit No. 1 to the hearing.

The following stipulations have been offered by the parties and are hereby accepted:

1. On July 26, 2006, the relationship of employee-self insured employer-TPA existed between the parties.

2. The appropriate weekly compensation rates are \$256.00 for total disability and \$192.00 for permanent partial disability.
3. The respondents have paid no benefits.

By agreement of the parties, the issues to be litigated and resolved at the present time were limited to the following:

1. whether the claimant sustained a compensable injury to her neck, shoulder, and back in a motor vehicle accident on July 26, 2006.
2. The claimant's entitlement to medical services and temporary total disability benefits from July 27, 2006 through March 17, 2007.
3. Controversion and appropriate attorney's fees.

In regard to these issues, the claimant contends:

"Claimant contends that she sustained compensable injuries 7/25/06. Claimant contends entitlement to temporary total disability benefits beginning with the date of the injury and continuing through a date yet to be determined. Respondents have refused to pay said benefits. Claimant has incurred medical expenses which remain outstanding and unpaid. In spite of respondents alleged acceptance of compensability, this matter has been timely controverted for purposes of attorney's fees. Claimant reserves the right to pursue other benefits to which claimant may become entitled in the future.

Claimant's attorney respectfully requests that any attorney's fee owed by claimant on controverted benefits paid by award or otherwise be deducted from claimant's benefits and paid directly to claimant's attorney by separate check, and that any Commission Order direct the respondent to make payment of attorney's fees in this manner."

In regard to these issues, the respondents contend:

“Respondents contend they offered and claimant refused any indemnity benefits in relation to her workers’ compensation injury. Respondents scheduled medical visits with providers claimant failed and/or refused to attend. Subsequent questions have arisen regarding claimant’s entitlement to indemnity benefits and candor with Commission, her employer, and her treating physicians. Respondents have not controverted this claim entitling claimant’s attorney to any fee.”

DISCUSSION

I. CONTROVERSION

In their pre-hearing questionnaire, the respondents maintained that they had not controverted this claim. However, at the pre-hearing conference, the respondents would not stipulate that the claimant sustained compensable injuries on July 25, 2006. Rather, the respondents have required the claimant to prove this fact. The respondents have also paid no benefits in this claim. When these factors are considered together, it is apparent that the respondents have now controverted this claim in its entirety. Thus, should the claimant prevail, the claimant’s attorney would be entitled to the appropriate fee on all benefits awarded directly to the claimant.

II. COMPENSABILITY

The burden rests upon the claimant to prove her allegation that she sustained compensable injuries to her neck, shoulder, and back in an employment related motor vehicle accident on July 25, 2006. In order to meet this burden, the claimant must prove that any injuries sustained on July 25, 2006, satisfy all of the

requirements for “compensable injuries” that are contained in Ark. Code Ann. §11-9-102(4)(D) and §11-9-102(4)(A)(i).

Ark. Code Ann. §11-9-102(4)(D) requires that the claimant establish, by medical evidence, the actual existence of physical injuries to her neck, shoulder, and back. Further, she must show that the existence of these injuries is supported by “objective findings”, as that term is defined by Ark. Code Ann. §11-9-102(16)(A)(i).

In the present case, the medical evidence clearly “establishes” the existence of physical injuries to the claimant’s neck and back (both upper and lower). The rather sketchy emergency room records of July 25, 2006 (discharge instructions), show a diagnosis of cervical and lumbar strain that are due to a motor vehicle accident. The July 26, 2006 office notation of Dr. Dale Barton contains a diagnosis of cervical and lumbar strain secondary to a motor vehicle accident. The August 2, 2006 office notation of Dr. Finley Turner indicates a diagnosis of cervical myalgia and lumbar strain. The August 16, 2006 office notation of Dr. Turner contains a diagnosis of cervical myalgia. The August 28, 2006 office notation of Dr. Jacky Dunn gives a diagnosis of acute cervical strain and occipital neuralgia with radiculopathy right upper extremity and neuropathy of the right upper extremity. Finally, the office notation of Dr. Turner, dated September 11, 2006, notes the claimant’s stated symptoms of pain in her neck and right shoulder with weakness and numbness in the middle, ring, and

small fingers of the right hand and numbness down the ulnar side of the arm, but gives no specific diagnosis.

However, it is my further opinion that the medical evidence fails to “establish” the existence of any physical injury that actually involved either of the shoulder joints, particularly the right shoulder. There is no diagnosis by any of the claimant’s various physicians of physical injury or condition that actually involves these particular anatomical structures. While the medical evidence does show that symptoms were recorded in the area of the claimant’s trapezius muscles or suprascapular area and pain is reported going into the claimant’s shoulders, these symptoms are clearly attributed to injuries to the claimant’s neck and back, as opposed to any injury or condition involving the claimant’s actual shoulder joints.

The initial emergency room record contains no diagnosis of any injury or condition involving the claimant’s actual shoulders. The July 26, 2006 office notation of Dr. Barton notes only complaints of pain in the claimant’s neck and shoulders, but does not diagnose any injury or condition that would involve the shoulder joints themselves. The August 2, 2006 report of Dr. Turner contains no diagnosis of any injury or condition involving the claimant’s shoulders. The August 16, 2006 report of Dr. Turner records that the claimant related that most of her physical therapy had centered around her shoulders, but again there is no diagnosis of any physical injury or condition actually involving the shoulders and the only diagnosis is that of an injury involving the claimant’s

neck or cervical spine. The office notation of Dr. Dunn records a history of complaints involving the claimant's right upper extremity and records the observation of bilateral suprascapular muscle spasms, but again Dr. Dunn appears to attribute these noted abnormalities to an injury or condition involving the claimant's neck or upper spine and does not attribute these to an actual injury or condition involving the shoulder joints. Finally, the September 11, 2006 office notation of Dr. Turner notes that the claimant is continuing to complain of pain in her right shoulder and neck, as well as weakness and numbness in her arm, middle finger, ring finger, and small finger of her right hand, but still does not attribute any of these complaints to an injury or condition which involve the claimant's shoulder.

Therefore, the claimant has satisfied the first requirement of Ark. Code Ann. §11-9-102(4)(D) in regard to the alleged compensable injuries to her neck or cervical spine and her back. However, she has failed to meet this first requirement in regard to any alleged injury to either of her shoulders.

The claimant must next prove that the medically "established" injuries to her neck or cervical spine and her upper and lower back are "supported by objective findings". Under Ark. Code Ann. §11-9-102(16)(A)(i), "objective findings" are those findings which cannot come under the voluntary control of the claimant. Clearly, mere complaints of pain or tenderness, complaints of numbness or tingling, and restrictions on active range of motion would all come

under the voluntary control of the claimant and would not represent “objective findings” as that term is defined by the Act.

In the present case, I find that the existence of the diagnosed physical injuries to the claimant’s neck or cervical spine and upper back are supported by “objective findings”. Clearly, no objective findings are noted in the extremely limited portion of emergency room records that have been tendered into evidence. The “tenderness” involving the paracervical muscles, the trapezius muscle, and the lumbosacral area, which is noted by Dr. Barton in his physical examination on July 26, 2006, would not constitute “objective” findings. However, the “stiffness” of the paracervical muscles and trapezius muscle, which is noted by Dr. Barton in this same report, could arguably be an “objective” finding. The limitation of range of motion noted by Dr. Turner, in his physical examination of the claimant on August 2, 2006, would not be an “objective” finding. The same is true for the loss of range of motion of the cervical spine that was noted by Dr. Turner in his examination of August 16, 2006. However, the significant muscle fullness and spasms involving the cervical region and suprascapular area, which are noted by Dr. Dunn during her examination on August 28, 2006, would unquestionably represent an “objective” finding. Therefore, in regard to her neck or cervical spine and upper back, I find that the claimant has satisfied the second requirement of Ark. Code Ann. §11-9-102(4)(D), in regard to her cervical and upper back injuries.

However, the evidence presented fails to show any “objective findings” to support the existence of any physical injury or condition involving the claimant’s lower back or lumbar spine. According to the July 28, 2006 report of Dr. Barton, x-rays of the claimant’s lumbar spine, which were taken at the emergency room on July 25, 2006, were interpreted as normal. During his physical examination, on that same date, he noted only “tenderness” in the lumbosacral area, which would not represent an objective finding. The subsequent progress notes of Dr. Turner and Dr. Dunn also fail to record the observation of any muscle spasms, stiffness, or any other arguably “objective” abnormality involving the claimant’s lower back or lumbar spine. Thus, the claimant has failed to satisfy the statutory requirements of Ark. Code Ann. §11-9-102(4)(D) in regard to any alleged injury to her lower back or lumbar spine.

Next, the claimant must prove that the medically established and objectively supported physical injuries or conditions involving her neck or cervical spine and upper back satisfy the definition requirements of Ark. Code Ann. §11-9-102(4)(A)(i). These definitional requirements are:

- (1) That the physical injury or condition must arise out of and occur in the course of her employment;
- (2) That the injury or condition must be caused by a specific incident;
- (3) That the physical injury or condition must be identifiable by time and place of occurrence;

(4) That the physical injury or condition must cause internal or external physical harm to her body, and

(5) The physical injury or condition must require medical services or result in disability.

After consideration of the evidence presented, it is my opinion that the claimant has satisfied the foregoing definitional requirements, in regard to her neck or cervical spine and her upper back injuries. Specifically, she has proven that the injuries to these portions of her body arose out of and occurred in the course of her employment, were caused by a specific incident, are identifiable by time and place of occurrence, caused internal physical harm to her body, required medical services, and resulted in disability (at least on a temporary basis).

The claimant testified that she was experiencing no difficulties with her neck or cervical spine and upper back prior to the occurrence of an employment related motor vehicle accident on July 25, 2006. Her testimony, in this regard, is supported by the fact that she was able to perform the rather strenuous employment activities for the current respondent, without apparent complaint or difficulty, for several months prior to July 25, 2006.

The claimant next testified that she first began experiencing difficulties with these portions of her body immediately following the employment related motor vehicle accident on July 25, 2006. Her testimony, in this regard, is supported by the facts that she immediately sought medical treatment for these injuries and immediately reported her accident and these injuries to the

respondent. Her testimony, concerning this onset of difficulties, is consistent with all the histories she related to her various treating physicians.

Clearly, the motor vehicle accident of July 25, 2006, could have logically produced the injuries that have been diagnosed to her cervical spine and upper back. The evidence fails to show any other incident or activity that would be a reasonable or logical cause of the injuries diagnosed. I find the claimant to be a credible witness, in regard to her testimony concerning the circumstances surrounding the initial onset of symptoms that would be indicative of the occurrence of the injuries diagnosed.

Clearly, the observed muscle spasms, which involved the claimant's neck or cervical spine and upper back, would show the presence of internal physical harm to the claimant's body. These spasms would also show that the internal harm was of such magnitude that medical treatment would be reasonably necessary, as well as at least a limited period of rest and significant physical restrictions.

In summary, I find that the claimant has proven that she sustained "compensable injuries" to her neck or cervical spine and upper back on July 25, 2006. Thus, she would be entitled to appropriate benefits for these compensable injuries.

III. BENEFITS

Under Ark. Code Ann. §11-9-508, the claimant would be entitled to reasonably necessary medical services for her compensable injuries, at the respondents' expense. However, Ark. Code Ann. §11-

9-514 confers upon the respondents the right to select the initial treating physician. However, subdivision (b) of this subsection relieves the respondents from liability for the expense of even reasonably necessary medical services, if such services are “unauthorized”.

The evidence presented shows that the claimant initially sought medical treatment from the emergency room of the Johnson County Regional Medical Center. The medical services provided to the claimant by and at the direction of personnel at the emergency room of the Johnson County Regional Medical Center appear to be necessitated by or related to the claimant’s compensable injuries (primarily to determine the nature and extent of the claimant’s injuries). These services were also of a type commonly recognized as medically appropriate to accomplish their intended purpose.

The necessity of these services was immediate and urgent. Thus, these services would represent “emergency” medical services, under Ark. Code Ann. §11-9-514(b). As “emergency” medical services, they could not be considered “unauthorized” under the express wording of this subdivision. The respondents would be liable for the expense of these, subject to the Commission’s medical fee schedule.

The record shows that the claimant reported her accident and injuries to the respondent, on July 25, 2006, and was given a form AR-N, which she completed and signed. This form AR-N informed her of her rights and obligations, as required by Ark. Code Ann. §11-9-514(c).

Korrine Lancaster, a claims adjuster for the respondent, testified that, on the day following the accident and injuries, she contacted the claimant and advised her that the respondents would provide her with appropriate medical services by a physician of their choosing. The next day, she again contacted the claimant and informed her that an appointment had been scheduled with a Dr. Kuykendall in Clarksville, Arkansas. Finally, she testified that, after the claimant failed to appear for her scheduled appointment with Dr. Kuykendall, she again spoke the claimant and was informed by the claimant that she “was not going under workers’ compensation, but was going to file under liability” and that she was going to be treated by her own doctor and would not go to the company selected doctor. This testimony is not refuted or contradicted by the claimant in any way. I find it to be credible and an accurate depiction of the conversations described.

I recognize that the respondents have subsequently controverted this claim in its entirety. However, this does not, in and of itself, exempt the claimant from complying with the provisions of Ark. Code Ann. §11-9-514. Subdivision (f) of this subsection clearly indicates that the provisions of §11-9-514 extend to even controverted claims. Under this subdivision, the provisions of Ark. Code Ann. §11-9-514 continue to apply, even in controverted cases, where the respondents have made a previous offer of medical treatment. In the present case, the greater weight of the evidence shows that the respondents did, in fact, make such an offer, which the claimant voluntarily refused.

Therefore, I find that the medical services provided to the claimant by and at the direction of her family physicians at the Millard-Henry Clinic constituted "unauthorized" medical services, under Ark. Code Ann. §11-9-514.

Pursuant to the provisions of subdivision (b) of this subsection, the respondents cannot be held liable for the expense of these services. However, the respondents must continue to offer appropriate treatment by a physician of their choosing, or lose their right to avail themselves of the provisions of this subsection.

Next is the matter of the claimant's entitlement to temporary total disability benefits for the period of July 27, 2006 through March 16, 2007. The burden rests upon the claimant to prove her entitlement to these benefits. In order to meet this burden, the claimant must prove that, during this time, she continued within her healing period from the effects of her compensable injury and was prevented by her compensable injury from performing all forms of regular gainful employment for which she would otherwise be qualified.

The issue of the duration of the healing period is a medical question, which must be resolved on the basis of the medical evidence presented. The healing period continued until the claimant has achieved the maximum benefit of time and medical treatment in the resolution or stabilization of the actual physical damage caused by the compensable injury. Once this underlying physical damage has totally resolved or at least stabilized, at a

level where nothing further in the way of time or treatment offers a reasonable expectation of improvement, then the healing period has ended. The mere continuation of chronic complaints is not sufficient, in and of itself, to extend the healing period.

In the present case, the medical evidence shows that the claimant was under active medical treatment from the date of her compensable injury through September 11, 2006. On September 11, 2006, the claimant continued to complain of pain, weakness, and numbness involving her neck, right shoulder, right arm, and the last three fingers on her right hand. However, a physical examination performed on that date noted no objective abnormalities, i.e. no spasm, stiffness, tightness or rigidity of any of the muscles in the claimant's neck, shoulders, upper back, or right upper extremity, no swelling/redness, no atrophy, no abnormal reflexes, etc. A cervical MRI that had been performed on August 30, 2006 was interpreted as negative and showed no impingement on the spinal cord or exiting nerve roots that would substantiate the claimant's continued subjective neurological symptoms, in her right shoulder, arm, and hand. Although Dr. Turner recommended neurological testing in the form of a EMG/NCV of her right upper extremity, the likelihood of such testing revealing a radiculopathy as the source of the subjective complaints would be almost non-existent in light of the normal cervical MRI.

After consideration of all the evidence presented, it is my opinion that the claimant has proven by the greater weight of the medical evidence that she continued within her healing period from

the effects of her compensable injuries from the date of those injuries, on July 25, 2006, through at least September 11, 2006. However, the medical evidence presented is not sufficient to conclude, at this time, that her healing period extended beyond September 11, 2006.

In regard to actual disability, the initial emergency room record shows that the claim was taken off work or medically restricted from work "until cleared by a PCP" (primary care physician). The July 26, 2006 office notation of Dr. Barton does not indicate that the claimant was "cleared" or released to return to work in any capacity (even light duty), on that date. His report does note that the claimant is to participate daily in physical therapy. When the claimant saw Dr. Turner on August 2, 2006, he too failed to release the claimant to work in any capacity. The same is true for the report of Dr. Turner dated August 16, 2006. The August 28, 2006 report of Dr. Dunn failed to release the claimant to return to any type of employment and noted the observation of "severe muscle spasms" in the cervical and upper back area. Finally, the September 11, 2006 report of Dr. Turner again failed to release the claimant to return to any type of employment.

I am gravely concerned that the evidence shows that the claimant provided the respondent and even offered into evidence off work slips, which were purportedly signed by her various treating physicians, and an accidental injury form (Claimant's Exhibit No. 1, page 7) that are of extremely dubious authenticity. The

respondents have offered a notation from Dr. Turner, which expressly states that the off work form, dated August 16, 2006, did not originate at the Millard-Henry Clinic and did not bear his signature. A review of the other purported off work slips show that they are essentially identical in form to the one dated August 16, 2006. In this regard, I would note that I have had the opportunity to see numerous authenticate off duty slips from the Millard-Henry Clinic and that none of them have been in the form or style of the slips provided to the respondents and this Commission by the claimant. It is obvious, even to the untrained eye, that the purported signatures of Dr. Turner, Dr. Barton, and Dr. Dunn bear not only an uncanny similarity to each other, but also bear the same similarity to the form and style of the claimant's signature. I have placed absolutely no weight and credit on the various off work forms and slips contained in Claimant's Exhibit No. 1 in determining whether she has, at any time, been disabled from performing regular gainful employment.

However, after consideration of all the evidence presented, it is my opinion that the greater weight of the credible evidence establishes that the claimant had no reasonable expectation of obtaining regular gainful employment in the open job market and was rendered totally disabled by her compensable injuries during the period of July 25, 2006 through September 11, 2006.

IV. CONFORMING THE PLEADINGS AND THE PRE-HEARING ORDER TO THE PROOF

As a final point, I would note that the pre-hearing questionnaires and the pre-hearing order repeatedly indicate the date of injury as July 26, 2006. I would also note that during the hearing, the claimant testified that the accident and injury occurred on July 26, 2006. The respondents' witness, Korrine Lancaster, also indicated that she talked to the claimant the day after the injury or July 27, 2006.

However, it is obvious that all of these are in error. It is apparent from the initial emergency room record and the AR-N that was in this case, that the actual date of the motor vehicle accident and resulting injuries was July 25, 2006. Therefore, the pre-hearing questionnaires and the pre-hearing order should be amended to insert July 25, 2006 for July 26, 2006. The incorrect date given by the claimant and the respondents' witness, in their testimony, will be considered as a mere mistake brought about by the error in the pleadings.

FINDINGS OF FACT & CONCLUSIONS OF LAW

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

2. On July 25, 2006, the relationship of employee-self insured employer-third party administrator existed between the parties.

3. On July 25, 2006, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$256.00 for total disability and \$192.00 for permanent partial disability.

4. On July 25, 2006, the claimant sustained compensable injuries to her neck or cervical spine and upper back. Specifically, the claimant has established by the medical evidence, which is supported by “objective findings”, the actual existence of physical injuries to these portions of her body. Further, she has proven by the greater weight of the credible evidence that such injuries arose out of and occurred in the course of her employment, were caused by a specific incident, are identifiable by time and place of occurrence, resulted in internal physical harm to these portions of her body, required medical services, and resulted in temporary disability.

5. The claimant has failed to prove that she sustained a “compensable injury” to her shoulder. Specifically, she has failed to establish by medical evidence, which is supported by objective findings, the actual existence of any physical injury to what would be commonly considered the “shoulder”. Thus, she has failed to satisfy the statutory requirement of Ark. Code Ann. §11-9-102(4)(D) in regard to an injury to this portion of her body.

6. The claimant has failed to prove that she sustained a “compensable injury” to her lower back. Specifically, she has failed to prove that the existence of any actual physical injury to her lower back is supported by “objective findings”, as that term is defined by Ark. Code Ann. §11-9-102(16)(A)(i). Therefore, she has failed to satisfy the requirement of Ark. Code Ann. §11-9-101(4)(D) in regard to an injury to this portion of her body.

7. The claimant is entitled to reasonably necessary medical services for her compensable injuries. Such reasonably necessary medical services would include the services provided her by personnel at the emergency room of Johnson County Regional Medical Center on July 25, 2006. Such services would also include any further reasonably necessary medical services the claimant might require by a physician of the respondents' selection. The respondents would be liable for the expense of these services, subject to the medical fee schedule established by this Commission.

8. The medical services provided to the claimant for her compensable injuries by and at the direction of the physicians at the Millard-Henry Clinic constitute "unauthorized" medical services within the meaning of Ark. Code Ann. §11-9-514 (b). Therefore, under the provisions of this subdivision, the respondents are not liable for the expense of these services.

9. The claimant has proven by the greater weight of the credible evidence that she is entitled to temporary total disability benefits from July 26, 2006 through at least September 11, 2006. Specifically, the claimant has proven that during this interval, she continued within her healing period from the effects of her compensable injuries and was also rendered totally disabled from performing regular gainful employment by these injuries.

10. The respondents have now controverted the claim in its entirety.

11. A reasonable fee for the claimant's attorney is the maximum statutory attorney's fee on all benefits herein and herein after awarded directly to the claimant.

ORDER

The respondents shall be liable for the expense of medical services provided to the claimant by and at the direction of physicians at the emergency room of Johnson County Regional Medical Center on July 25, 2006. The respondents shall also be liable for any and all reasonably necessary medical services subsequently provided the claimant for her compensable injuries by a physician of the respondents selection. This liability is subject to the medical fee schedule established by this Commission.

The respondents shall not be liable for any expenses incurred as a result of medical services provided to the claimant by and at the direction of physicians at the Millard-Henry Clinic, as such services represent "unauthorized" medical services, under Ark. Code Ann. §11-9-514.

The respondents shall pay to the claimant temporary total disability benefits for the period beginning July 26, 2006 and continuing through September 11, 2006.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the temporary total disability benefits herein awarded. One-half of this fee shall be the obligation of the respondents in addition to such benefits. The remaining one-half of this fee shall 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.

MICHAEL L. ELLIG
ADMINISTRATIVE LAW JUDGE