

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F602327 & F608011

JOYCE WELCHER, EMPLOYEE	CLAIMANT
DAVIS NURSING ASSOCIATION, EMPLOYER	RESPONDENT
GUARANTEE INSURANCE CO., CARRIER	RESPONDENT

OPINION FILED JULY 18, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH W. HOGAN, on March 21, 2008 at Pine Bluff, Jefferson County, Arkansas.

Claimant represented by the HONORABLE STEVEN MCNEELY, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE JOHN DAVIS, Attorney at Law, Little Rock, Arkansas.

ISSUES

A hearing was conducted to determine the claimant's entitlement to payment of medical expenses, temporary total disability benefits and attorney's fees.

At issue is whether or not the claimant sustained a gradual carpal tunnel injury and specific neck and back injuries pursuant to Ark. Code Ann. §11-9-102. All other issues are reserved.

After reviewing the evidence impartially without giving the benefit of the doubt to either party, Ark. Code Ann. §11-9-704, I find the evidence does not preponderate in favor of the claimant.

STATEMENT OF THE CASE

The parties stipulated to an employer-employee-carrier relationship on January 31, 2006 and July 11, 2006 at which time the claimant sustained compensable right shoulder injuries at a compensation rate of \$249/\$187.00. Medical expenses and temporary total disability benefits were paid. The claims for other conditions, carpal tunnel syndrome (CTS), neck and back injuries, have been controverted.

The claimant contends she sustained injuries to her right shoulder in a lifting incident on January 31, 2006. As a result, she developed CTS.

The claimant also contends she was attacked on July 11, 2006, re-injuring her right shoulder,

and injuring her neck and back. The claimant seeks continuing medical treatment with Dr. Collins, temporary total disability benefits from September 20, 2007 to October 22, 2007 and February 15, 2008 to February 25, 2008, and attorney's fees.

The respondents contend the claimant did not sustain compensable injuries to her hand, neck or back. There are no objective medical findings to substantiate a work-related injury and no causal connection between the incidents at work and her present condition.

The following were submitted without objection and comprise the evidence of record: the parties' prehearing questionnaires and exhibits contained in the transcript along with the claimant's deposition incorporated by reference.

The following witnesses testified at the hearing: the claimant and co-worker, Delilah Foots, whose testimony was corroborative.

The claimant, age 43 (D.O.B. January 13, 1965) has a ninth grade education. She received training as a certified nurse's assistant (CNA) in 1983 and began work for the respondent-employer in 2002. Her health history includes a 2005 work-related back injury, and motor vehicle accidents (MVA) in 2001 and 2004.

On January 31, 2006, co-worker Delilah Foots asked the claimant to help her put a patient to bed. Ms. Foots let go, and the claimant caught the full weight of the patient. They fell on the bed. The claimant reported the incident to her supervisor, Tracy Alexander. The claimant was eventually diagnosed with a rotator cuff tear of the right shoulder and Dr. Stevens performed surgery on November 30, 2006.

Between the first injury in January and the second injury in July, the claimant experienced symptoms of burning, stinging, and numbness in her right shoulder and arm. She also said she was having trouble walking.

On July 11, 2006, the claimant was sitting with patients as part of her light duty activities. An Alzheimer's patient struck her in the neck and shoulders. Her back, neck and right arm symptoms worsened.

The claimant attributed her right wrist injury to pumping a lift used to transfer patients from their bed to the bathroom.

On cross-examination, counsel pointed out inconsistencies between the claimant's deposition and hearing testimony. The claimant never reported a right wrist injury for either the January 6 or July 6 injury, (Tr. p. 24-25, 53-54). She transferred to the position of bath aide in 2004 at her request because her back was hurting. In her deposition, she testified the January injury resulted in lower back and right shoulder pain but at the hearing she described neck, upper back and shoulder pain, (Tr. p. 13-14, 17-18, 23-25, 25-36, 43-44, 51-52). Counsel also emphasized that the claimant's neck had been injured in prior MVAs, but she did not report a neck injury, (Tr. p. 37-41).

DOCUMENTARY EVIDENCE

Incident reports were completed on three injuries.

In May, 2005, the claimant injured her lower back while assisting a patient in the bathroom.

On January 31, 2006, the claimant injured her right upper back, neck and right shoulder putting a patient to bed.

On July 11, 2006, the claimant injured her upper shoulders in an altercation with a patient.

There is no mention of a carpal tunnel injury.

MEDICAL EVIDENCE

On July 6, 2001, the claimant was treated for headaches, left shoulder and neck pain following an MVA. One of the ER records is handwritten and difficult to read, but apparently the claimant gave a history of a prior MVA four years earlier.

X-rays taken on July 6, 2001 showed no evidence of pathology in the pelvis and hips. Calcification was noted at C6.

The claimant returned to the ER on July 18, 2001 complaining of head neck and back pain. Medication and physical therapy were prescribed for a thoracic and L5-S1 strain.

The claimant was seen in the ER on December 3, 2004 after another MVA and was treated for cervical and left shoulder pain.

The claimant complained of upper back pain on February 1, 2006 after “pulling something” at work. Spasm was noted and medication was prescribed. She was excused from work from February 1, 2006 to February 6, 2006. She was scheduled to return to work on February 7, 2006 at light duty.

In follow-up on February 15, 2006, the claimant complained of pain around the right shoulder blade. She requested more medication and physical therapy. Her off work status was extended from February 1, 2006 to February 17, 2006. She was scheduled to return to work on February 20, 2006 at light duty.

On February 22, 2006 the claimant returned to the doctor complaining of increased back and right scapular pain over the weekend. More medication was prescribed and the claimant was excused from work indefinitely. X-rays of the back and right shoulder taken February 24, 2006 were normal.

An MRI scan was recommended but instead, the carrier sent the claimant to general practitioner, Dr. Gerald Morris. He diagnosed an upper thoracic strain; prescribed medication and more physical therapy. He also recommended light duty, an MRI scan, and consultation with an orthopaedic surgeon.

On March 24, 2006 the claimant saw orthopaedic surgeon, Dr. Marc Stevens. Based on his examination, he doubted the previously scheduled MRI scan would show anything. The April 26, 2006 MRI scan revealed a near full thickness tear with tendinosis and bursitis.

The claimant returned to Dr. Stevens on May 4, 2006 complaining of right shoulder pain and numbness in her right hand radiating from the neck. Dr. Stevens recommended shoulder surgery and an EMG/NCV study to evaluate carpal tunnel syndrome (CTS).

The claimant saw general practitioner, Dr. Lester Alexander on July 12, 2006:

“complaining of pain in her right posterior thorax, cervical and trapezius areas, and the right shoulder. She states that she was injured yesterday when she was attempting to restrain a patient to keep the patient from hurting herself... She states that she had previous injury to this shoulder and she had not recovered from the previous injury when she sustained a re-injury of this yesterday.”

Dr. Alexander diagnosed a strain of the right shoulder; trapezius and thoracic paravertebral muscles, right side; and strain of the rhomboid muscle, right side. Dr. Morris palpated spasms during his examination of the claimant. He prescribed medication and excused her from work for one week. In follow-up on July 19, 2006 and July 26, 2006, Dr. Alexander extended her leave of absence and recommended a consult with an orthopaedic surgeon.

Dr. Morris saw the claimant on August 3, 2006 and his report summarizes the claimant's difficulty in getting medical treatment. Dr. Morris and Dr. Alexander continued to excuse the claimant from work until she could receive orthopaedic treatment.

The carrier sent the claimant to Dr. Earl Peeples on September 13, 2006, for another opinion. He recommended a psychological evaluation (MMPI). Dr. Peeples diagnosed a congenital anomaly of the acromion and hypertrophy of the AC joint which is a degenerative condition predisposing the claimant to tendinitis and damage of the rotator cuff. He opined that if the claimant had CTS, it was unrelated to her accidents. Dr. Peeples agreed with Dr. Stevens' recommendation for surgery to repair the partial rotator cuff tear and correct the congenital anomaly.

The claimant returned to Dr. Alexander on September 13, 2006 and he extended her leave of absence.

The claimant saw Dr. Stevens on October 3, 2006. He explained that an EMG/NCV study would help to determine whether she had CTS or referred neck pain. The study was performed on October 18, 2006 and showed "possible medial nerve compromise, right arm between axilla to elbow."

Dr. Stevens performed surgery on the claimant's right shoulder on November 30, 2006. He diagnosed a labral tear, rotator cuff tear, bursitis and impingement. Dr. Stevens prescribed physical therapy and estimated a six week healing period. He referred the claimant to neurosurgeon, Dr. P. B. Simpson for her neck complaints and recommended consultation with a pain management specialist.

An MRI scan of the neck, taken February 2, 2007 revealed multilevel degenerative disc

disease with disc protrusions from C3-4 to C5-6. There was loss of cervical lordosis which could indicate spasm or positioning of the body during testing.

Instead of following Dr. Stevens' referrals, the carrier sent the claimant to Dr. Brent Sprinkle who recorded "virtually total body pain and numbness to varying degrees in a non-objective, non-physiologic pattern." The claimant complained of pain in her right upper arm, hand, neck, ankle, foot and leg numbness, worse on the right side. Dr. Sprinkle diagnosed preexisting degenerative disc disease of the cervical and lumbar spine and a strain of the cervical and lumbar spine. He recommended repeat diagnostic testing (MRI scan of the back and EMG/NCV studies of the right upper extremity and both legs).

A Functional Capacity Evaluation (FCE) was performed on April 27, 2007 which was determined to be invalid based on the claimant's poor effort and symptom magnification. The claimant was able to work in the medium work category.

Dr. Stevens released the claimant in a report dated May 23, 2007 with 0% impairment, based on the FCE results, clinical range of motion, motor function and objective studies.

After requesting a change of physician, the claimant saw Dr. Kevin Collins on September 20, 2007, complaining of right shoulder pain, neck pain, low back and right leg pain. Her past medical history mentions right ankle pain and a rib cartilage tear on the right. Dr. Collins recommended an MRI of her neck and back, an EMG/NCV study and shoulder arthrogram. He excused her from work (September 20 to October 5, 2007) and prescribed medication.

An EMG/NCV study, performed October 4, 2007, showed mild carpal tunnel in the right hand. There was no evidence of radiculopathy. Dr. Collins excused the claimant from work for two weeks and prescribed physical therapy. On October 22, 2007 the claimant was returned to work at light duty.

An arthrogram, performed December 3, 2007 showed no evidence of a rotator tear. An MRI scan was interpreted as showing tendinopathy of the supra spinatous tendon with myofascial pain.

A February 28, 2008 report discusses the doctor's frustration in dealing with the carrier.

FINDINGS AND CONCLUSIONS

As this claim arose after July 1, 1993, this case is governed by Act 796 of 1993 which must be strictly construed, Ark. Code Ann. §11-9-704, §11-9-717. The claimant has the burden of proving the following requirements, as defined by Ark. Code Ann. §11-9-102, by a preponderance of the evidence of record, which means “evidence of greater convincing force,” Smith v. Magnet Cove Barium Corporation, 212 Ark 491, 206 S.W.2d 442 (1947):

- 1) proof that the injury arose out of and in the course of employment
- 2) proof that the injury caused internal or external physical harm to the body which required medical services or resulted in disability
- 3) proof establishing the injury by objective medical evidence
- 4)(a) proof that the injury was caused by a specific incident identifiable by time and place of occurrence

or

- (b) proof that the injury was caused by rapid, repetitive motion and proof that the injury was the major cause of disability or need for medical treatment.

Compensation must be denied if the claimant fails to prove any one of these requirements. Mikel v. Engineering Specialty Plastics, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

As I interpret the medical evidence, the claimant injured her right shoulder in January 2006 and reinjured her right shoulder in July 2006. The respondents have accepted these injuries as compensable.

The determination of whether the causal connection exists is a question of fact for the Commission to determine based on the evidence of record and the credibility of the witnesses. Jeter v. B.R. McGinty Mech., 62 Ark. App. 53, 968 S.W.2d 645 (1998), Ellison v. Therma-Tru, 71 Ark. App. 410, 30 S.W.3d 769 (2000).

It is the claimant’s burden to prove a causal connection between the work-related accident

and the later disabling injury. Lybrand v. Arkansas Oak Flooring Co., 266 Ark. 946, 588 S.W.2d 449 (Ark. App. 1979). Objective medical evidence is not always necessary if there is a preponderance of non-medical evidence. Horticare Landscape Management v. McDonald, 80 Ark. App. 45, 89 S.W.2d 375 (2002).

If the disability develops soon after the accident and is logically attributable to it, with nothing to suggest any other explanation for the employee's condition, "then the claimant has established a causal connection. However, if there is a span of time between the accident and the disability, a question of fact arises concerning the causal connection. Hall v. Pittman Constr. Co., 235 Ark. 104, 105-106, 357 S.W.2d 263, 264 (1962).

The only injury to the claimant's lower back occurred in 2005. Medical records after the January 2006 injury concern the upper back or thoracic area. By the time she saw Dr. Sprinkle and Dr. Collins in 2007, she was complaining of lower back and right leg problems. I find there is no causal connection between her injuries at work in 2006 and her present lower back problems.

The diagnostic test results show multilevel degenerative disc disease of the cervical spine with corresponding disc protrusions. This suggests a chronic condition, not an acute neck injury. The claimant had previously injured her neck in MVAs. Therefore, I find the claimant's neck condition is not the result of any accident at work.

Dr. Collins has diagnosed CTS in the right hand with no evidence of radiculopathy from the cervical spine. The claimant never reported any problems with her hand to her employer while cranking the lift between 2004 and 2006. There is no mention of a right hand injury in any of the accident reports. Therefore, I find no causal connection between her accidents at work and her present CTS.

Furthermore, the claimant has requested additional temporary total disability benefits for two periods of time after an invalid FCE was performed showing poor effort and symptom magnification. The FCE results indicate the claimant is insincere about the extent of her injuries.

1. The Workers' Compensation Commission has jurisdiction of these claims on January 31, 2006 and

July 11, 2006 at which time the claimant sustained compensable right shoulder injuries at a compensation rate of \$249.00/\$187.00.

2. The claimant has failed to prove by a preponderance of the credible evidence of record that she sustained a gradual CTS injury, caused by rapid and repetitive motion arising out of and in the course of her employment which produced physical bodily harm, supported by objective findings, which was the major cause of disability or the need for medical treatment, pursuant to A.C.A. §11-9-102.
3. The claimant has failed to prove by a preponderance of the credible evidence of record that she sustained compensable back and neck injuries, caused by a specific incident, arising out of and in the course of her employment which produced physical bodily harm, supported by objective findings, requiring medical treatment of producing disability, pursuant to Ark. Code Ann. §11-9-102.
4. The respondents are directed to pay the court reporter's fees and expenses associated with transcribing this hearing within thirty days pursuant to Commission Rule 20.

This claim is respectfully denied and dismissed.

IT IS SO ORDERED.

ELIZABETH W. HOGAN
Administrative Law Judge