BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F808095 (01/09/08)

DOUGLAS E. BLACKWELL, EMPLOYEE	**CLAIMANT**
ABERNATHY MOTOR COMPANY, EMPLOYER	**RESPONDENT**
FIRSTCOMP INSURANCE CO., CARRIER	**RESPONDENT**

OPINION FILED NOVEMBER 4, 2009

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on August 7, 2009, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE LAURA BETH YORK, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE RANDY P. MURPHY, 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 workers' compensation benefits. On March 2, 2009, a pre-hearing conference was conducted, resulting in the initial scheduling of this matter and the issuance of Pre-hearing Order. 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 regarding the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. The parties further stipulated that the claimant's average weekly wage was $800.00, which generates compensation benefits rates of $522.00/392.00, for temporary total/permanent partial disability.

The testimony of Douglas E. Blackwell - the claimant, coupled with the deposition testimony of Ronald Johnson, Jamie Wood, and Dr. Robert E. Abraham, along with medical reports and other documents comprise the record in this claim.

DISCUSSION

Douglas E. Blackwell, the claimant, with a date of birth of November 11, 1962, completed the 10th grade. While the claimant has no technical or vocational technical training, he presents an employment history consisting of mechanic work, explaining:

> I've been a mechanic most of my life. It's on-the-job training. A lot of it's off the computer, you learn stuff on the computer. Mainly just work. All of my life. (T. 11).

Claimant commenced his employment with respondent-employer as a mechanic in 1999, and later advanced to that of chief mechanic. Claimant testified that his job duties included tearing out motors, replacing transmissions, working on front ends and rear ends of vehicles. In terms of his physical activities while discharging his employment duties, the testimony of the claimant reflects that the same included a lot of overhead work as well as a lot of bending over while working on vehicles. Claimant testified that he usually worked a 40-hour work week, five (5) days per week earning twenty dollars ($20.00) per hour. Claimant identified Jamie Lewis as his supervisor while employed by respondent.

The claimant asserts that on January 9, 2008, he sustained an injury within the course and scope of his employment. In describing the mechanics of the January 9, 2008, injury, claimant testified:

> I was putting a transmission in, I dropped my ratchet, I went to pick it up and I come back up, I hit the top of my head and it knocked me to the ground. My co-workers helped me to the desk and I sat over

> there for a while. Then, seems like to me, I sat there for a while and went back to work - started feeling better. Like after that, it just seemed like it kept getting worse and worse and worse, and I kept seeing doctor after doctor. (T. 13).

The testimony of the claimant reflects that the car the he was working on was on a lift, and that when raised up after dropping the ratchet, his head struck the bottom of the rack of the lift. Claimant noted that the "very top" of his head made contact with the metal lift. Claimant conceded that he had previous struck his head in a similar manner while discharging employment duties:

> Yes, ma'am, several times. If you're a mechanic, you're going to have some kind of accident, hit your head, or skinning you knuckles. You try to go right back to work and recover. When I hit my head, I couldn't recover from that. I had to see doctor after doctor. (T. 14).

The testimony of the claimant reflects that he was assisted up following his accident by co-workers Ronald Johnson and Jackie Woods. Claimant described his immediate sensations following the accident:

> I was feeling like I was knocked out. I was seeing stars that I ain't never seen before.
>
> My head hurt bad.
>
> I just kind of sat there and recovered from getting hit. Recovered from hitting my head. I went back to work. Now, I went home early that day, I think, because my head was hurting real bad. (T. 14).

The testimony of the claimant reflects that while his head was hurting really bad following the January 9, 2008, accident, his neck was not hurting bad until a little later. Claimant added that his low back was also hurting the day of the accident. Claimant's testimony reflects regarding any physical residual of the January 9, 2008, head injury:

I did have a little bit of blood, yes, ma'am, I did.

* * *

Well, I've got an indention in th top of my head. (T. 15).

Claimant testified that he was not offered an accident report following the accident, and offered, regarding the party responsible for completing such a report:

> To my ability, I would figure my boss or somebody like that. I've never had, I've never filled out an accident report from this company - for the people I was working for. So, it's either, you're hurt real bad or you go back to work, one (1) or the two (2). (T. 15).

The testimony of the claimant reflects that respondent did not offer to send him to the doctor in connection with the January 9, 2008, accident. The claimant has previously has a worker's compensation claim for an injury to his hand.

The claimant maintains that he sustained injuries to both his neck and back in the January 9, 2008, accident. Regarding the onset of symptoms in his neck, the claimant testified:

> My neck started bothering me after my leg started going numb.
>
> Well, I noticed that I was having a little problem with it [the leg], probably about a month or so after I hit my head. (T. 16).

The testimony of the claimant reflects that the first doctor he saw in connection with his complaints was Dr. Golden. Claimant acknowledged that he did not complaint to Dr. Golden regarding his neck symptoms, but rather his back, which was diagnosed as a lumbar sprain and for which he was provided medication. Claimant testified that he continued to experience symptoms following his visit to Dr. Golden:

> My leg kept going numb, so I kept going, seeing different doctors, to see if I can find out what was wrong with me.

> I went to Dr. Cagle, and he gave me some pain relief. I found out that he's not a very good doctor, so I went to Dr. Hendrix, and he diagnosed me having a broke neck. He said it was imperative for me to have an operation on my neck, because it was damaged. (T. 17).

Claimant acknowledged that the records of Dr. Hendrix do not reflect entries regarding a need for cervical surgery. Nevertheless, claimant testified that he did discuss his neck pain with Dr. Hendrix:

> Yes, ma'am, I did. I had real high blood, my heart, my blood pressure was real high. He asked me why my blood pressure was so high, I said well I'm having some pretty bad neck pain, spasms. And he offered me Hydrocodone, the strongest Hydrocodone and some Valium. And I started taking that, and he let me go back to work. (T. 17-18).

Claimant's testimony reflects that following his treatment with Dr. Hendrix, he was seen by Dr. Eubanks, a surgeon. Regarding which area of his body, neck or back, was most symptomatic at the time of his visit to Dr. Eubanks, claimant testified:

> They was running a real close race. My leg was giving me the most problem, because I couldn't feel it. And they done studies on it, run needles in my leg - seeing what was wrong with it. They said there wasn't nothing wrong with it. But I know there was something wrong with it, because it's my leg and it was going numb. It was just dead, and I was afraid it was going to get worse - that I was going to be in a wheel-chair, and I didn't want that. (T. 18).

Claimant acknowledged that Dr. Eubanks noted that he had chronic neck pain and chronic back pain. Claimant equates "chronic" with severe pain. Claimant attributes his back pain to "a number of years bending over cars" and "hitting my head hard". (T. 19). Regarding the product of his neck pain, claimant offered:

> The hit on my head. Yes, ma'am. A lot of people knows me, and I'm a strong worker, and I'm a very strong person. I work every day. It seems like you get kicked out if you hurt yourself. I understand I hurt myself. It was job-related when I hurt myself. And I was closed off from the world.

> I didn't have no money. Nobody cared nothing about my feelings or, just get on out of here. (T. 19).

Claimant denies ever experiencing pain or problems with his neck prior to January 9, 2008.

Claimant acknowledged a 1992, motor vehicle accident which resulted in medical treatment at Arkansas Methodist Hospital for complaints of left shoulder pain and pain in the left side of his neck, however noted that it was mostly confined to the shoulder. Claimant denies experiencing problems following his recovery from the injury growing out of the motor vehicle accident. The testimony of he claimant reflects that his injury from the 1992, motor vehicle accident did not prevent him from working.

In 1998, the claimant was in another motor vehicle accident, and again received medical treatment at Arkansas Methodist Hospital. Claimant complained of neck pain and a head injury as a result of the 1998, motor vehicle accident. Claimant acknowledged that he was diagnosed with mild degenerative changes in his cervical spine while receiving medial treatment for the 1998, accident. Claimant denies that he received any further treatment for the 1998, injury, or that he experienced pain or problems in his neck after recovering from the injury. Further, claimant maintains that the injuries received in the 1998, motor vehicle accident prevent him from working.

Regarding the present claim, claimant asserts that he begin experiencing problems with his neck, which he attributes to the January 9, 2008, accident, two (2) to three (3) months later, when his legs started going numb. Claimant acknowledged that he first complained of leg pain in January 2008, and maintains that he was having neck pain as well. In explaining the inconsistency of the afore, claimant testified:

> Well, when my legs start going numb, it actually turned me towards, you know, why is my leg going numb. So, I went to see the doctor, and they couldn't determine what the problem was. It was either it was my lower back - until I found out my neck was crushed. (T. 22).

At one point claimant's testimony reflects that he was not having any pain in his neck until the neck problem was diagnosed by Dr. Hendrix.

Claimant concedes that he has had problems with his low back prior to January 9, 2008, from time to time. The claimant attributed his low back complaints prior to January 9, 2008, to repetitive motion of bending over and working on cars. Claimant denies that his prior low back/side complaints had components of leg pain or leg numbness before January 9, 2008. In distinguishing his low back complaints and symptoms subsequent to January 9, 2008, from those pre-dating the accident, claimant testified:

> Well, I started getting some side pain in my neck, after that, and my leg kept getting worse and number and number and number.
>
> Well, the longer I stood on it, the worser (phonetic) it got; seemed like, if you stood on it for twenty (20) or thirty (30) minutes, standing up, then I had to go sit down.
>
> Yes, ma'am, it was worse after I hit my head. (T. 23).

Claimant denies that he had any prior neck or back problems that prevent him from working before to January 9, 2008.

Claimant testified that he was eventually referred to Dr. Robert E. Abraham. The testimony of the claimant reflects, regarding the medical treatment rendered to him under the care of Dr. Abraham:

> He provided surgery to my neck and its ongoing; he's got me on a pain management course for my pain in my neck and my lower back. (T. 23).

Claimant underwent cervical surgery under the care of Dr. Abraham in September 2008. Claimant testified that he was taken off work on August 21, 2008. In September 2008, Dr. Abraham performed an interior discectomy and fusion at C5 through C7. Claimant underwent physical therapy following the surgery, and was released to return to work in December 2008, with a forty (40) pound lifting restriction and no extended over head.

The claimant is also treating with Dr. Abraham for his low back complaint. The testimony of the claimant reflects that Dr. Abraham has recommended against low back surgery. Claimant testified that he is scheduled to receive pain management for both his low back and neck beginning August 20, 2009. Claimant's personal insurance is paying for the medical treatment he has received. Claimant testified that respondents paid for some of his medicines.

Claimant testified that once he returned to work on December 1, 2008, with a restricted duty release, his employment was terminated. Respondent-employer did not have work available for the claimant within his medical restrictions. The claimant filed for and received unemployment compensation benefits of $400.00, weekly commencing December 2008. Claimant has been applying for jobs since receiving unemployment compensation. Claimant has not applied for Social Security disability benefits.

The testimony of the claimant reflects that he takes pain medicine for his neck and back. Claimant is able to drive. Claimant testified regarding his ability to walk comfortably:

> About twenty (20) minutes. I can stand and walk for about twenty (20) minutes, and the pain in my side and my lower back and my neck, I just have spasms and they just knot up. I'm a pretty athletic person and, after the surgery, my neck just knots up. (T. 27).

Claimant continued, regarding other limitations:

> I can sit for a little while.. Yes, ma'am.
>
> Well, you know, thirty (30), forty (40) minutes, you know I can sit down; then I can stand up for a little while, then sit back down. (T. 27).

Claimant testified that he takes both pain medicine and muscle relaxer every day.

Claimant denies that he received temporary total disability benefits from respondents while he was off work from August 21, 2008, through December 1, 2008. Further, claimant's testimony reflects that he did not receive any short-term or long-term disability benefits. In describing how his bills are being paid, claimant testified:

> Well, sort of like, some of my bills got paid and some of them didn't, you know - borrowing money from my brother, and my mother-in-law; we was scraping by; my wife, she's got her little disability check and my unemployment. (T. 28-29).

In describing his activities on a daily basis, claimant's testimony reflects:

> Well, I either go fishing or look for a job, you know I got two contacts to make every week for unemployment benefits, clean the house, help my wife with the house some, I got two dogs that likes to run. I do a lot of fishing. (T. 30).

Claimant testified that he was not treated by Dr. Earl Peeples.

During cross examination claimant testified that he has received $400.00, a week in unemployment compensation benefits since December 2008. Claimant confirmed that his personal insurance, Aetna, was secured through respondent-employer. Claimant acknowledged the occurrence of motor vehicle accidents in 1992, 1994, and 1998. Claimant received a settlement out of the 1992, motor vehicle accident.

Claimant's testimony reflects that he has worked hard as a mechanic all of his life. Further, that the work entails a lot of bending, lifting, and overhead work. Claimant asserts that

following his January 9, 2008, accidental blow to the head his back pain gradually worsened.

Claimant testified that he does not inform prospective employers, two per week as a condition of receiving unemployment compensation benefits, that he is pursuing a worker's compensation claim. Claimant is of the opinion that he probably can do some light mechanic work.

The claimant testified that following his January 9, 2008, accident, after attempting to shake off the effects of same, he returned to work and completed the job he was performing at the time of the accident. Claimant offered that he might have taken off work early on January 9, 2008. Claimant concedes that he returned to work the following day and continued working his regular duties.

Claimant maintains that on January 9, 2008, following his accident, he requested medical treatment. Claimant acknowledged that he continued working until he was taken off work on August 21, 2008. Claimant has not worked any place since August 21, 2008.

The testimony of the claimant reflects that the he went to Dr. Golden, who has been his family doctor for ten (10) years, on his own to get checked out. Further, claimant testified that Dr. Golden diagnosed his complaint as a lumbar sprain. Claimant did not complain of neck pain during the initial post-January 9, 2008, visit to Dr. Golden. The claimant was treated and released by Dr. Golden on January 28, 2008. Claimant's testimony reflects that he did not relay to Dr. Golden the occurrence of the January 9, 2008, work incident, but rather sought medical treatment for his low back, noting that his side was hurting and getting worse. The testimony of the claimant reflects that he did not tell anybody at that point of an on-the-job injury claim.

Claimant acknowledged that on March 31, 2008, he saw Dr. Cagle on his own. Claimant

explained:

> I was looking to find out what's wrong with me, because I knew something was wrong. (T. 42).

At the time of Dr. Cagle's visit claimant complained of right leg pain. Claimant noted that his right leg was going numb. Claimant did not remember providing a history to Dr. Cagle of "back pain, lower injury to the right leg, history of injury back twelve years ago fell out of a grain bin". (T. 42). Claimant acknowledged that while employed at Riceland Foods, he fell out of a grain bin twelve (12) years ago. Claimant testified that the Riceland Foods accident occurred in 1995. Claimant did not tell Dr. Cagle about the January 9, 2008, accidental head injury at respondent-employer, nor did he complain of neck pain.

The claimant was next seen by Dr. Hendrix. Regarding his discussion with Dr. Hendrix, claimant testified:

> I told him I was experiencing lower back pain and I was getting numb in my leg. (T. 44-45).

Further, claimant maintains that he told Dr. Hendrix that he had hit his head at work. Claimant testified that he was seen by Dr. Hendrix on two (2) occasions. Claimant acknowledged that when he first saw Dr. Hendrix on May 18, 2008, he relayed that he had been experiencing some lower back pain for several years. Regarding the omission of any entry in the notes of Dr. Hendrix regarding the blow to the head suffered at work, claimant offered:

> Apparently, he did not. He told me that, Dr. Hendrix told me not to mention none of this, because workman's comp wouldn't take care of none of this.
>
> That's what he told me.
>
> He said, you don't be, don't be talking about the workman's

> comp till you get your neck took care of; he said, because if you don't, you won't get your neck took care of, you will probably end up in a wheelchair, yes, sir, that's what he told me. (T. 46).

Claimant insist that he complained of neck pain and low back pain at the time of his visit to Dr. Hendrix.

The claimant testified that he went to Dr. Eubanks, a Jonesboro neurosurgeon, on his own. A June 18, 2008, report of Dr. Eubanks reflects that the claimant complained of neck pain. While the June 18, 2008, report of Dr. Eubanks is the first medical report in the record reflecting complains of neck pain, claimant maintains the same was not his first reporting of neck complaints to a medical provider, noting his earlier reporting to Dr. Hendrix. Claimant acknowledged that he did not tell Dr. Eubanks of the work incident at respondent-employer. Claimant acknowledged undergoing diagnostic studies, to include EMG, and MRIs of the cervical and lumbar spine on or about June 30, 2008.

The testimony of the claimant reflects that he was referred by Dr. Hendrix to Dr. Abraham. The claimant testified that Dr. Abraham treated him initially for his neck complaint because it was more serious that the low back complaint. Since his September 2008, surgery and subsequent release from same on December 1, 2008, claimant notes that his primary residual problems are his neck and right leg. Regarding the improvements realized from his neck surgery, claimant testified:

> It did hurt; it's better than it was; I can move it a little bit better, but, about that high (indicating) is as high as I can lift - about like that (indicating) . I got a steel plate. (T. 53).

Claimant testified that should he returned to work, his primary limiting complaints would center on residuals associated with his neck injury.

During re-direct examination, claimant again confirmed that when he hit his head on January 9, 2008, he fell to the floor and had to be assisted up by two (2) co-workers. Claimant asserts that the reason he did not initially report his injury as a workers' compensation injury, "I didn't - I didn't even think it would be workers' comp". (T. 55-56). Claimant further testified, regarding his conversation with Dr. Hendrix:

> Well, he told me if I go ahead and tell them I'm in workman's comp, then I wouldn't get no operation - that's what he told me, basically. (T. 56).

Regarding his failure to report his complaints to Dr. Golden as work-related, claimant testified:

> Why I did not report it as workman's comp injury - because I was having a leg problem with my leg, and I knew that something was wrong with me, but I didn't know what. (T. 57).

Claimant maintains that he started having the problem with his leg "soon after I hit my head". (T. 57). Claimant added:

> Right, I seen several doctors, just trying to figure out what was wrong with my muscles. (T. 57).

Ronald Johnson, who has been employed by respondent-employer as a mechanic for three (3) years, testified by deposition, which was obtained on July 28, 2009. Mr. Johnson testified that he recalled the claimant hitting his head at work on January 9, 2008:

> I seen him hit his head. He fell to his knees, and me and Jamie Wood helped him up and set him in a chair. (JX. #1, p. 4).

The testimony of Mr. Johnson reflects that while the claimant was "dazed for little bit" following the accident he did resume working. Mr. Johnson is unsure how long the claimant was dazed, however testified that the claimant did not complain of having any headaches or blurry vision on the day of the accident. Mr. Johnson was not aware of the claimant leaving work early on the day

of the accident. Mr. Johnson testified that the claimant did complain about hurting and on one occasion complained that his neck and shoulders were hurting a couple of weeks following the accident.

James Garland Wood, Jr., also referred to as Jamie Wood, is the service manager for respondent-employer. Mr. Wood's testimony was obtained by deposition on July 28, 2009, and made a part of the record as Joint Exhibit #2. As service manager for respondent-employer, Mr. Wood had supervisory responsibility over the mechanics. The testimony of Mr. Wood reflects that while employees reported accidents to him, it was not responsible for completing necessary paperwork associated with an accident, but rather that of Jennifer Woods, the office manager of respondent-employer.

Mr. Wood testified that the claimant's work area or bay, was in close proximity to his desk. While not recalling the specific date of January 9, 2008, Mr. Wood did recall the claimant hitting his head at work:

> I was in the shop, as a matter of fact. I've sen him hit his head several times on his rack, turning around too fast and hitting his head. The reason I said no to the question before that was because I don't know any specific dates. He never came to me and said, "Hey, I've hurt myself. I need to go to the doctor."
>
> All he did was - like I said, I've seen him hit his head on several occasions. I'm going to say more than three. (JX. #2, p. 5).

The testimony of Mr. Wood reflects that the claimant was not a complainer. In response to whether the claimant came to him and complained of neck and back pain, Mr. Wood testified:

> No, ma'am. What he did was he came to me and - well, he missed work one day. As a matter of fact, he missed two days in a row. When he came back to work, I said, "Hey, Doug, where you been ?" He said, "I had to go to the doctor." I said, "What for?" He said, "I've got numbness in my leg. So I went to the doctor and had it checked out."

> Then he told me he was going to have to go back to the doctor again, and he was doing it through his insurance at work. (JX. #2, p. 6).

Mr. Wood denies that the claimant ever indicated that the above complaint was a work related injury:

> No, ma'am. He had been injured on the job before. He had stuck a piece of wire in his hand about a year prior to that, and he went to the doctor. Then he went in to the Office Manager, and we filled out the necessary paperwork to get him reimbursed for his medication and his day off work. So he knew the procedure on how we done our workman's comp. (JX. #2, p. 6).

The testimony of Mr. Wood reflects that it was mid-year when the claimant relayed receiving medical treatment for his leg numbness.

Claimant was described as a good worker by Mr. Wood. Mr. Wood's testimony reflects that if a position was available and if the claimant could physically perform the job duties of the position he would hire him back. Mr. Wood testified the he did not recall the claimant ever complaining about headaches after hitting his head and that he never saw the claimant bleeding following the accident. Mr. Wood added, however:

> Now, he had a knot on his head - that particular day when it knocked him down to his knees, he had a knot on his head; and I took my had and felt it. I was telling Randy that it's not uncommon for us to hit our head. I hit my head in there yesterday.
>
> If you move around too fast when you're doing your job, you can turn around and bump into a tire or the side of your rack or whatever. It's real common in there in the shop for that to happen. (JX. #2, p. 9).

Mr. Wood estimated that over the course of three (3) years he had witnessed the claimant hit his head three (3) or four (4) times.

The medical in the record reflects that the claimant was seen on January 28, 2008, by Dr. Stephen Golden at the First Care - Stadium Acute Care Center. The chart document generated in

connection with the afore visit does not reflect a "history of present illness", however it does reflect an impression of "lumbar sprain/strain, lumbar region", for which the claimant was prescribed Medrol (pak) and Skelaxin "for muscle spasm". The claimant underwent x-rays of his lumbar spine which was interpreted as showing mild degenerative joint disease but no acute bony changes with disc spaces well maintained.. The January 28, 2008, chart document noted that if the claimant did not improve he should return and an MRI would scheduled. The January 28, 2008, chart document reflects the claimant's group insurance, QualChoice. (CX. #1, p. 1-2).

The medical reflects that the claimant was seen by Dr. Roger Cagle on March 31, 2008, with chief complaints of right leg pain and right hip pain. Under the entry "History of Present Illness", the report noted back pain lower into right leg and a history of injury to back twelve (12) years ago from a fall out of a grain bin. The March 31, 2008, report reflects diagnoses of low back pain and muscle spasms. The March 31, 2008, report of Dr. Cagle reflects that the claimant was directed to return after a CT of the lumbar spine, which was scheduled for April 7, 2008, 8:30 a.m. at Arkansas Methodist Medical Center. The March 31, 2008, report also reflects that a June 3, 2008, appointment had been scheduled with Dr. Eubanks' office. (RX. #1, p. 16-17). The April 7, 2008, CT of the claimant's lumbar disclosed mild degenerative change of the lumbar spine. (RX. #1, p. 18-19).

On May 14, 2008, the claimant was seen by Dr. Barry Hendrix with a chief complaint of siatic nerve problem. The office note regarding the afore visit reflects a history of present illness of "low back pain lumbar, chronic condition". The office note also reflects that the claimant denied "fall . direct trauma". The May 14, 2008, report reflects that the claimant was assessed with back pain and provided medication. The claimant was not provided a follow up scheduled

appointment. The claimant's scheduled June 3, 2008, appointment with Dr. Eubanks was also noted in the report of Dr. Hendrix. (RX. #1, p. 20-21).

The medical in the record reflects that the claimant was again seen by Dr. Cagle on June 2, 2008. While the record reflects a return to work release effective June 3, 2008, the release contained restrictions of "no standing, lifting, stooping, bending" and "light work permitted". (CX. #1, p. 8).

A June 18, 2008, report of Dr. K. Dewayne Eubanks, a Jonesboro neurosurgeon, reflects that the claimant was seen pursuant to a referral of Dr. Cagle. The June 18, 2008, report further reflects, in pertinent part:

> **HPI:** Mr. Blackwell is a 46 year old right handed mechanic who is seen at the request of Dr. Cagle for evaluation of low back pain and right buttock, hip, and lower extremity pain and secondary complaints of neck pain that he would like evaluated. This is the chronic problem that has slowly gotten worse over the years. The pain specifically is in his low back and tends to be more on the right than the left but is bilateral. It goes down his right buttock and hip and then she shows the medial thigh and leg down to the medial ankle and foot. The pain is more in his back than his leg. He is having occasional episodes of numbness and paresthesias he claims but it sounds like it is very rear and I am not sure as to how much it is related to his pain. No pain on the left lower extremity. No bowel or bladder changes. His sex life has been affected mainly due to neurologic dysfunction.
>
> His pain in his neck is generalized and pain generally over in his shoulders. He is a mechanic and has worked for 12 years at Abernathy Motors. He is obviously a heavy manual laborer with think calluses over most of the palmers surface of the hands and fingers.
>
> * * *
>
> He is currently on Hydrocodone 7.5mg q 4-6 degrees (for the last 3 months only he claims), Diazepan 10mg BID, Meloxicam 15mg qd, and "Dewitt's OTC pain reliever".

I wen through the muscle relaxants and he has already tried Skelaxin, Soma and something else and he says these have not helped him. Other than the medications he has tried bed rest, exercise, heat, massage, TENS unit, and claim about 5 years or so age he had some sort of an injection. He had a Prednisone dose pack for something a while back but does not recall exactly when or for what.

PMS: Arthritis, Depression/anxiety, migraines, hypertension, hyperlipidemia, angina/chest pain, bilateral ankle fracture, right tibial fracture.

* * *

ROS: Joint pain, severe headaches, and memory loss.

PHYSICAL EXAMINATION: HT: 5'10" **WT:** 250 **BMI:** 36 **BP** 115/72

General: Pleasant sincere appearing well muscled healthy appearing man in general other than his gravely voice due to his smoking and the other stigmata of tobacco abuse. He seems sincere and straightforward with his complaints and has a good insight into this probably being mostly a degenerative problem.

HEENT: Atraumatic and normocephalic. Nasopharynx and oropharynx are clear.

Neck: Range of motion is mildly limited. He has a thick neck. No Spurling's or Lhermitte's sign. No palpable crepitus. No specific point tenderness.

Back: Range of motion is normal. No specific point tenderness but generalized tenderness to palpation of the lumbar region. No tenderness over the trochanters or the SI joints of any significant degree.

* * *

Neurological: His strength is normal in all groups with no atrophy or faciculations anywhere. He has normal sensation throughout upper and lower extremities except for the palmer surfaces of the hands and fingers due to extremely thing calluses almost everywhere.

Deep tendon reflexes are 1+ and equal diffusely in his upper extremities, 2+ and equal diffusely in his lower extremities and toes are down going

and no Hoffman's sign.

DIAGNOSTIC STUDIES: He has a CT scan of the lumbar spine. (He has a piece of metal in his finger but he say it is brass) I told him he could have an MRI sacn.

His CT scan shows some mild to moderate lumbar stenosis at L4-5 mild at L3-4 some mild trefoil shape to his canal at L4-5 and L5-S1 but otherwise I do not see any gross abnormalities other than diffuse degenerative disease.

IMPRESSION:

1. Chronic low back pain.
2. Chronic neck pain
3. Possible right lower extremity radiculopathy intermittently, suspect L4 versus L3 versus L5.

We will need EMG/NCVs to help with this. Also MRI scan of the lumbar spine and complete lumbar spine x-rays.

We will need cervical spine MRI scan and x-rays.

I think most of his pain is likely degenerative in nature and I have explained to him that he might have a radicular component and if he does and we can be reasonably assured of its exact location than we might be able to help this surgical. Otherwise his treatment is going to be non-surgical and went through all that with him.

I do not have anything to add to Dr. Cagle's treatment except we will try a Medrol Dose Pak.

We might as well go ahead and send him to physical therapy and chiropractic for both problems. He understands that even if we find a clear cut nerve root compression on the right in the lumbar spine that might be expected to help him with the radiating leg pain and maybe some of his back pain but I suspect the vast majority of this pain is degenerative in nature and will need to be treated as above with consideration of pain clinic management as the next option.

We discussed work. He says he has to stop and sit down every once in a while for a few minutes and then can return to work. I think this is very reasonable. I have encouraged him to continue working rather than try to retire or quit as I think this would be more beneficial to

him. (CX. #1, p. 9-11).

On June 30, 2008, the claimant underwent the diagnostic studies as recommended by Dr. Eubanks, to include MRIs of lumbar and cervical spine and NCV/EMG studies. The June 30, 2008, radiology report reflects, in pertinent part:

> At the L3/L4 level, facet joint hypertrophy is present, but no spinal stenosis, disc herniation or nerve root displacement is identified
>
> At the L4/L5 level, disc desiccation is present. A broad based disc bulge is identified effacing the thecal sac, but no spinal stenosis or frank disc herniation. A disc bulge appears at and caudal to the exiting nerve root. Facet joint hypertrophy is present.
>
> At the L5/S1 level, degenerative change of the facet joints is seen. No spinal stenosis, disc herination or nerve root displacement is identified. (CX. #1, p. 13).

The June 30, 2008, radiology report regarding the MRI of the claimant cervical spine, reflects in pertinent part:

> At the C3/C4 level, mild neural foramen narrowing on the left is secondary to nondiscogenic degenerative change and a disc bulge. No spinal stenosis or frank disc herniation identified. The disc bulge has a central component. This does not efface the thecal sac.
>
> At the C4/C5 level a focal central disc bulge is present. No spinal stenosis or disc herniation. No neural foramen narrowing.
>
> At the C5/C6 level, disc desiccation is present and a disc herniation is present centrally with and eccentric component on the left effacing the thecal sac. No spinal stenosis. Neural foramen narrowing is present bilaterally, greater on the left at the C5/C6 level secondary to a nondiscogenic degenerative change.
>
> At the C6/C7 level, degenerative osteophyte formation from the posterior end plates is identified effacing the thecal sac in combination with a disc bulge at this level, eccentric to the right. This effaces the

> thecal sac and compromises the neural foramen on the right at this level. Effective AP diameter of the spinal canal at this level is 7 mm consistent with acquired spinal stenosis. (RX. #1, p. 30).

X-rays of the claimant's lumbar spine obtained on June 30, 2008, resulted in the impression of "Nondiscogenic degenerative changes. No instability identified". (CX. #1. p. 15). Likewise x-rays of the cervical spine resulted in the impression of "nondiscogenic degenerative changes at the C5/C6 and C6/C7 levels". (RX. #1, p. 33).The June 30, 2008, NCV/EMG study concluded:

> This is a normal study showing no evidence of active denervation or chronic reinnervation sign. There is no sign of polyneuropathy or myopathy. (CX. #1, p. 16).

The medical evidence reflects that following the June 2008, visit with Dr. Eubanks and subsequent diagnostic studies, on July 16, 2008, claimant was again seen by Dr. Hendrix. The July 16, 2008, progress notes relative to the claimant's visit reflect:

> **HPI**
> Lower back:
> 45 year old male presents with c/o low back pain lumbar, chronic condition.
> Denies: Fall. Direct trauma.
> Constitutional:
> He now has neck pain. He has complete numbness in the left leg. (CX. #1, p. 19).

The progress notes reflect that the claimant wanted a referral as well as a refill of his meds. The claimant was assessed with "back pain and spinal stenosis NOS". Further, the progress notes associated with the claimant July 16, 2008, visit reflect treatment for "back pain". A August 21, 2008, appointment was scheduled for the claimant with Dr. Abraham. Dr. Hendrix also issued a light duty release with restrictions until the claimant was seen by Dr. Abraham. The restrictions recited in the July 16, 2008, light duty included no lifting over 15 pounds, no pushing over 20

pounds, and no repetitive neck movements, "Re: spinal stenosis". (CX. #1, p. 20).

On August 21, 2008, the claimant was seen by Dr. Robert E. Abraham, a Jonesboro neurosurgeon, pursuant to the referral of Dr. Hendrix. The August 21, 2008, report regarding the claimant, reflects, in pertinent part:

> **Chief Complaint**
> Mr. Blackwell is here for a new patient appointment. DOUGLAS has complaints of neck and back pain.
>
> * * *
>
> **HPI**
> Mr. Blackwell is a 46-year-old white male with pain in the neck and low back pain. He states he hit his head on a car lift rack back in January while at work. On January 28, he went to see Dr. Golden and he did a xray and gave him some steroids. He has seen Dr. Cagle who sent him to see Dr. Eubanks. Dr. Eubanks wanted him to see chiropractor and do PT. He did neither. He saw Dr. Hendrix and he placed him on Hydrocodone and Valium and sent him here. He has had films on his neck and back and had EMG/NCV studies.
>
> Presently, he has a pressure in the back of the neck. He has pain down the shoulders to the biceps. He states his hands are numb and tingly. The numbness is pretty even. He states he is having neck spasms. He has been taking Hydrococone and Valium. Dr. Hendrix has refused to refill. He states he has had no medication for the past month.
>
> The lower back pain in the right side mostly. He states that the pain radiates from his R low back around to his groin and down his R leg medially to his foot. He has pain in his L foot with numbness and tingling in both feet. He also has numbness in his L quadricep. The n/t did not start in his L leg and foot until after his nerve conduction studies were done. He states when he bends over he has terrible pain. He can get relief briefly with standing or sitting. He states he has problems with going to sleep. He states he tosses and turns all night.
>
> He states he has no bowel or bladder dysfunction.
>
> He has pain in his neck if he coughs really hard.

* * *

- - Cervical Spine - -
Flexion: 30
Extension: 30
Rotation: 30/30
Muscle spasm: mild ps
Tenderness: mild in bil. neck

- - Lumbar Spine - -
Flexion: 70
Extension: 10
Lateral Flexion: 15/15
Muscle Spasms: mild
Heel/Toe: decreased heel

* * *

Test Conclus.
Pt Lumbar MRI revealed: DJD at L 4/5 with diffuse disk bulge more to L.
Pt Cervical MRI revealed: L paracentral disk bulge at C 5/6 and large R and central HNP at 6/7.

Assessment
1. Lumbar Radiculopathy
2. Cervical Radiculopathy.

Plan
1. Patient counseled
2. T myelo
3. Continue meds
4. RTC after # 2

(CX. #1, p. 22-25).

On September 18, 2008, the claimant underwent a total myelogram under the direction of Dr. Abraham. (CX. #1, p. 26-27). In his September 18, 2008, office note regarding the claimant, Dr. Abraham relayed, in pertinent part:

Physical Exam
Patient's physical exam remains unchanged from last visit.
Test Conclus.
Pt. Cervical Myelogram Revealed: min. central bulge at C2-5, C5/6

severe L paracentral cord compression. C 6/7 R paracentral disk bulge and extensive osteophyte.
Pt. Lumbar Myelogram Revealed: L 4/5 bulging disk with R> L LRS secondary to disk bulge.

Assessment
1. Cervical Radiculopathy
2. Lumbar spinal stenosis.

Plan
1. Patient counseled
2. Operative therapy ACDF C 5/6 and 6/7
3. Get pre op done
4. RTC after # 2

(CX. #1, p. 28).

On September 26, 2008, the claimant under went an anterior diskectomy with fusion C5-6 and C6-7 with allograft bone and plates utilizing the Synthes Ventral plate. (CX. #1, p. 33-35). The claimant was seen in follow-up by Dr. Abraham on October 30, 2008, at which time the report reflects that the claimant was doing well, however was still having some muscle spasms in the cervical spine. Claimant was directed to return to the clinic in three (3) months. (CX. #1, p. 38-39).

The claimant was seen by Dr. Abraham pursuant to the above follow-up, on February 12, 2009. The report of the afore visit reflects, in pertinent part:

HPI
Mr. Blackwell is here in followup after his ACDF. He is having ringing in his ears and a crick in his neck. He is doing most of his activities. He tried to go back to work and he was laid-off. He is not having any problems with his arms. (CX. #1,p. 40).

Following his examination, the claimant was directed to return to the clinic in four (4) months, to continue his meds as well as him limited activities.

The medical in the record reflects that the claimant was seen on June 2, 2009, by Dr.

Bobby A. Thompson for complaints of left hip pain along with a dental abscess. The June 2, 2009, report reflects, in pertinent part:

> Lower back:
> c/o low back pain also wants to discuss chronic low back pain. Pt had MRI 6/30/08. This showed arthritic changes with broad-based disc bulge at L4/5. Pt has pain radiate down to lift hip to his calf. Worse with standing or lifting. He usually can lie down and stretch out and it will help with pain.
>
> * * *
>
> **Physical Examination:**
>
> * * *
>
> Back:
> Gross findings: normal in appearance. T-spine: normal, non-tender. L-spine: normal, non-tender. Paraspinal musculature: tenderness on the left side of the L-spine. SI joints: non-tender.(CX. #1, p. 42).

On June 15, 2009, the claimant was again seen by Dr. Abraham. The office note of the afore visit reflects, in pertinent part:

> **HPI**
> Mr. Blackwell is here in followup. He is having problems with infected tooth, mental status changes per wife, hip pain, back pain, and neck pain. Is in a lawsuit with wcc. He is drawing unemployment and does not want any type surgery. He states he has fired Dr. Hendrix as his PCP because he has stated that Mr. Blackwell is a drug seeker. Mr. Blackwell does not want any records released to Dr. Hendrix.
>
> He states he has had bs over 400, but he can drink a beer and take pain meds and his bs goes down to about 120 every time.
>
> He has hip pain on the L side. He has problems walking greater than a couple of blocks.
>
> * * *
>
> **Physical Exam**
> Cervical Spine

Muscle Spasms: none

Lumbar Spine
Muscle Spasms: min in the ps areas
(CX. #1, p. 45).

Respondents provided the claimant's medical record to Dr. Earl Peeples, who performed a medical review of the medical record. In July 27, 2009, Dr. Peeples relayed/identified the medical records of the claimant, as well as the various providers, that he had reviewed. The July 27, 2009, report reflects, in pertinent part:

> A full myelogram and CT was performed on September 18. Attenuations of the contrast medium were noted at L4-L5 and in the mid-cervical region. The report from Dr. John Phillips indicated cervical and lumbar degenerative changes as well as degenerative changes in the thoracic region. Dr. Phillips' myelogram report at L2-L3 indicated "degenerative bulging discs with ligamentum flavum buckling bilaterally, at L3-L4 degenerative bulging discs with degenerative facet disease and ligamentum flavum buckling, at L4-L5 severe degenerative bulging disc with degenerative facet disease and ligamentum flavum buckling." There was "severe stenosis of the lateral recesses." (No traumatic language was utilized to describe any part of the lumbar spine CT.)
>
> In the cervical region, multilevel degenerative bulging was noted at C2-C3, C3-C4, and C4-C5. Osteophytes were noted at C5-C6 circumferentially, along with degenerative bulging. At C6-C7 there was circumferential osteophytosis. Degenerative changes were noted even at C7-T1. (No traumatic lesions were described the in cervical spine, which had degenerative lesions at every level except C1-C2.) No specific major cord compression or neurological compression was noted.
>
> Even though the initial neurological exam by Dr. Abraham did not reveal a focal neurological deficit, he offered and carried out a two level anterior cervical fusion at C5-C6 and C6-C7, apparently on chronic progressive degenerative changes and stenosis without neurological deficit.
>
> Surgery was performed out September 26, 2008. Operative note was reviewed. It does not contain traumatic diagnosis or description of traumatic findings.

SUMMARY:
Dr. Abraham operated Mr. Blackwell for nontraumatic cervical stenosis which had narrowed the cervical spinal canal to 7 mm. This stenosis is an acquired, progressive, genetically perdisposed, condition that is not related to specific trauma. Of conspicuous importance in this chart, is the multilevel and extensive degenerative changes seen on the various radiographic studies throughout the lumbar and all of the cervical spine. The description of the presence of osteophytes, which developed gradually in response to degeneration, is associated with a narrow or stenotic spinal canal at C6-C7, the reason for surgical intervention. There is no objective evidence of traumatic abnormality which required surgical intervention.

The onset of symptoms or the increasing difficulty of symptoms subsequent to a specific date, be it in January 2008 or another date, reflects the progress of this degenerative multilevel condition, which by its nature, narrows the spinal canal slowly. Causation is not established because symptoms were noted after an incident where the head was bumped or struck in an over-head rack.

"Post hoc, ergo propter hoc" (after the thing, therefore because of the thing) is false logic and not a basis on which to establish causation.

Dr. Abraham's surgery was the intervention for the acquired condition of spinal stenosis in a neurologically intact individual with a stable cervical spine. It was done to prevent further narrowing and spinal cord compression at the operated level. There is no traumatic indication of surgery in this individual. There is no neurological deficit or evidence of traumatic anatomy or instability.

Mr. Blackwell's treatment and the pathologic conditions connected are not related to a specific injury or trauma. They are related to acquired lumbar and cervical spinal stenosis, a non-traumatic condition.

The opinions stated in this report were based on the medical information in the form of medical reports provided to me. Should additional medical information or records be provided, it is possible my opinions might be modified or changed. Medicine is an inexact science; however, the opinions stated above are based on a reasonable degree of medical certainty.
(RX. #1, p. 37-39).

On July 10, 2009, the deposition of Dr. Robert E. Abraham was obtain, and made a part of this record. Dr. Abraham, a Jonesboro neurosurgeon, is board certified in neurosurgery and

has practiced medicine in Jonesboro for almost seven (7) years. Dr. Abraham testified that his initial contact with the claimant was August 21, 2008, pursuant to a referral by Dr. Barry Hendrix. The claimant was last seen by Dr. Abraham on June 15, 2009. Dr. Abraham noted that the claimant's return appointment is after an MRI scan of the lumbar spine is obtained. Regarding the results of his June 15, 2009, physical examination of the claimant, Dr. Abraham testified:

> Patient has stable vital signs. His neuro-muscle spasms are tenderness in his cervical spine. He had minimal muscle spasms in the paraspinous regions in his lumbar spine. Minimal tenderness in the left SI joint. Motor and sensory functions were intact. His reflexes showed no major abnormalities. (RX. #2, p, 8).

Dr. Abraham observed that with the exception of the lumbar spine - - tenderness and muscle spasms - - the claimant had an essentially normal examination on June 15, 2009.

The testimony of Dr. Abraham reflects that prior to the June 15, 2009, visit, the claimant had been seen on February 12, 2009. Further, the testimony of Dr. Abraham reflects that at the time of the February 12, 2009, visit, the claimant did not register complaints of the lumbar spine. Dr. Abraham's testimony reflects that the claimant reached maximum medical improvement from the September 26, 2008, cervical disc surgery as of June 15, 2009.

Dr. Abraham testified that he does not recall if he had any of the claimant's prior medical records at the time of the initial August 21, 2008, visit. Dr. Abraham testified that he did see the claimant's lumbar and cervical MRI scans. The afore scans has been order by Dr. Dewayne Eubanks, a Jonesboro neurosurgeon. Dr. Abraham testified that he did not see the radiology report or a report of Dr. Eubanks' impression of the lumbar MRI scan. The testimony of Dr. Abraham reflects that he reviewed the claimant's cervical MRI scan which showed a left paracentral disc bulge at C5-6 and a large right and central HNP at C6-7, which provided a basis

for his recommendation for the myelogram, which confirmed the MRI findings.

Dr. Abraham described the C5-6 disc herniation as a free fragment disc. Dr. Abraham added that the C6-7 disc was not totally ruptured through the ligamentous structures. Regarding his findings during the September 26, 2008, cervical disc surgery, Dr. Abraham testified:

> Patient's findings at surgery showed a C5-6 soft disc that was central and left, and a C6-7 central and right greater than left. Osteophytes with minimal soft disc at those levels. (RX # 2, p. 15).

Dr. Abraham identified the osteophytes as findings consistent with degenerative changes. Dr. Abraham testified that the soft discs can be from trauma or other things as well as degenerative changes.

The testimony of Dr. Abraham reflects that as of the last date he saw the claimant, it appeared that the cervical surgery was successful in alleviating his cervical complaints. Although the claimant has reached maximum medical improvement relative to his cervical spine, as far as restrictions/limitations on his activities, Dr. Abraham offered:

> His limitations so far as his cervical concern it would be - - it would be hard to - - hard to separate those from his lumbar.
>
> Because I would probably, until I got his - - got his work-up done for his lumbar region, I would probably limit what he does, you know, secondary to that. Generally, patients that have neck surgery, I don't like for them to have heavy lifting, and heavy, meaning anything over 50, 50 pounds.
>
> If patients lift 70, 80 pounds, they're almost universally are going to start having trouble.
>
> * * *
>
> Heavy lifting, work overhead, work above shoulder height. Those are the things that usually aggravate their trouble. (RX. #2, p. 16-17).

While Dr. Abraham had the benefit of the claimant's history of having hit his head on a car

lift rack in January 2008, at the time of the initial August 21, 2008, visit, he did not have information as to whether the claimant's first complaints were to the cervical spine or lumbar spine. Dr. Abraham did not have information of when the claimant began complaining of cervical problems following the January 9, 2008, incident. Dr. Abraham candidly acknowledged, "I'm not sure how I could do that" when asked if he could objectively relate the claimant's problems to any specific incident. (RX. #2, p. 17). Dr. Abraham acknowledged that the findings on the clamant's cervical test and surgery could be chronic or acute.

Regarding any evidence or findings to show an acute injury in the claimant, Dr. Abraham's testimony reflects:

> Right. Patients that have a soft disc like his, basically they're usually not going- - going to have that for extended periods of time.
>
> I mean, usually, if they have a soft disc herniation like that, they're going to complain for some pain. (RX. #2, p. 18).

In the case of disc herniation due to trauma, Dr. Abraham testified:

> A lot of times, when you say immediate, most patients will do something, injury themselves, and usually over a period of hours they'll start complaining of pain.
>
> Over - - that - - that's one of the usual things. We'll see a patient that will hurt himself, and then the next day their pain is - - is pretty severe.
>
> And on - - on other occasions, you'll see a patient, especially in a lumbar region where they - - they've hurt themselves and they say, I knew exactly when this happened, the pain was here or it did this or it did that. So, it - -it kind of varies. (RX. #2, p. 18-19).

Dr. Abraham was provided a copy of a June 18, 2008, report of Dr. Eubanks regarding his assessment of the claimant's low back problems (low back pain, right buttock, hip, and lower

extremity) and secondary neck pain as being chronic that had slowly gotten worse over the years, which he had not previously seen. Dr. Abraham noted that the claimant did not provide him any indication that his complaints were ongoing. The testimony of Dr. Abraham reflects that he cannot relate the claimant's lumbar problems to any specific incident.

Regarding a treatment plan or prognosis relative to the claimant's lumbar spine, the testimony of Dr. Abraham reflects:

> Well, I know that the patient has difficultly in the lumbar spine from his - - from his previous MRI scan and also from his mylogram.
>
> At this - - at this point, I mean, those studies were done almost a year ago.
>
> If I'm going to treat him now, especially if I'm thinking about doing surgery on him, I'd like to see what - - what more current information would look like. (RX. #2, p. 20-21).

Dr. Abraham continued, based on the claimant's previous lumbar MRI:

> Well, no. Basically that he had a paracentral disc bulge, DJD with a L4-5 disc bulge more to the left.
>
> Many times patient with a bulging disc, I try to stay away from surgery with them. There are other things you can do besides surgery, especially if you have the time, if the patient has no major weakness or sensory loss in the leg that - - that may indicate that he may have some permanent damage to his nerve. Then you have the luxury of kind of working with them conservatively. (RX. #2, p. 21).

During cross-examination, Dr. Abraham acknowledged that the reported January 2008, hit to the head by the claimant, coupled with prior hits to the head over the years, could have been the one to push him over the edge resulting in the herination. Dr. Abraham explained:

> Actual loading is a - - is a - - is a real problem in the cervical spine and you can definitely rupture a disc like that. (RX. #2, p. 22).

Dr. Abraham further testified that hitting the head on the very top is something that can cause a herniated disc in the neck. Dr. Abraham elaborated with respect to loading or repeated hits to the head:

> Usually with actual loading like that, if you're going to rupture a disc, it will be something fairly acute. It's not something that - - that he would be out like working on a - - on the railroad or something or using, you know, like, heavy lifting continuously. That kine of thing will tend to wear on the patient. But things like an incident like that where he raises up, and especially if he doesn't have like a hard had on and he hit his- - and he kind of, like, with a lot of force hits his head, that can definitely cause a ruptured disc. (RX #2, p. 23).

Dr. Abraham testified that in releasing the claimant to return to work following his cervical injury and surgery, that same would be restricted to light to medium work. The testimony of Dr. Abraham reflects that overhead work would be fairly hard on the claimant. Without any treatment Dr. Abraham testified that he would be hard pressed to assess the claimant as having reached maximum medical improvement with respect to his lumbar spine.

Dr. Abraham's testimony reflects that while he has not personally observed the claimant experiencing difficulty with memory, based on sitting and talking with him for 20 to 30 minutes, the claimant's wife had reported some. Regarding any prescription of pain medicine, Dr. Abraham testified:

> After surgery, patients that - - that especially if they have residual pain, a lot of time I'll give those patients pain meds along with muscle spasm - - along with muscle relaxants if they have muscle spasms. And occasionally I'll use anti-inflammatories. But the pain meds and muscle relaxants they, you know, if the patients need those, I will, you know, let them have them.
>
> In my records, I don't see that I - - that I made a note that I gave him [claimant] any meds. (RX. #2, p. 25).

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 appropriate statutory provisions and applicable case law, I make the following:

FINDINGS

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

2. On January 9, 2008, the employee-employer-carrier relationship existed among the parties, when the claimant earned an average weekly wage of $800.00, generating compensation benefits rates of $522.00/$392.00, for temporary total/permanent partial disability.

3. On January 9, 2008, the claimant did not sustain an injury to his cervical or lumbar spine arising out of and in the course of his employment.

CONCLUSIONS

The claimant asserts that as a result of a blow to the head on January 9, 2008, while within the course and scope of his employment, he sustained injuries to his cervical spine and lumbar spine which required medical treatment and resulted in periods of temporary total incapacitation. Claimant seeks corresponding temporary total disability and medical benefits as well as controvert attorney fees. Respondents deny that the claimant sustained injuries to his cervical or lumbar spine within the course and scope of his employment and have controverted the claim in its entirety.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision. The claimant asserts a specific incident injury of January 9, 2008, as the basis for workers' compensation benefits in the present

claim. In order to receive workers' compensation benefits, a claimant must establish (1) that the injury arose out of and in the course of the employment, (2) that the injury caused internal or external harm to the body that required medical services, (3) that there is medical evidence supported by objective findings establishing the injury, and (4) that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. §11-9-102 (4) (Supp. 2007). Further, the claimant bears the burden of proving a compensable injury by a preponderance of the credible evidence. Ark. Code Ann. §11-9-102 (4)(E)(i) (Supp. 2007). Should the claimant fail to prove any one of the requirements by a preponderance of the evidence, compensation must be denied. *Mikel v. Engineered Specialty Plastics,* 56 Ark. 126, 938 S.W.2d 876 (1997).

In the instant claim, it is not disputed that on January 9, 2008, while within the course and scope of his employment the claimant sustained a blow to the top of his head which caused him to fall to his knees, required the assistance of co-workers to help him up and to a seat, and resulted in a knot on the top of his head. The credible evidence reflects that after being dazed momentarily, the claimant resumed work and completed his work day.

The medical in the record reflects that the claimant had suffered prior injuries to his neck as a result of automobile accidents. Further, the evidence preponderates that the claimant experienced complaints of low back pain, for which he had received medical treatment prior to January 9, 2008. The claimant did request medical treatment from respondents for either head, neck, or low back complaints associated with the January 9, 2008, work-related incident, either on the date of the occurrence or prior to being seen by his family doctor, Dr. Stephen Golden, on January 28, 2008.

While the claimant testified that Dr. Golden had been his family physician for a number of years, at the time of the January 28, 2008, visit, he did not relay a history of the January 9, 2008, work incident as the basis for visit or the source of his low back pain, which was his principle complaint. The claimant did not register any neck complaints during the January 28, 2008, visit to Dr. Golden.. Three (3) days later, March 31, 2008, the claimant sought and obtained treatment under the care of Dr. Roger Cagle for his low back complaints of pain.

The claimant was seen by Dr. Cagle on three (3) separate occasions in connection with his low back complaints of pain. The claimant was ultimately referred to Dr. Eubanks, a neurosurgeon, by Dr. Cagle. The records of Dr. Cagle do not reflect that the claimant relayed history of a work-related accident. Further, the is no evidence in the records of Dr. Cagle, whom the claimant selected of his own volition, of a complaint of neck pain being registered by the claimant.

The claimant was last seen by Dr. Cagle on June 2, 2008. Prior to the afore visit to Dr. Cagle, the claimant was seen by Dr. Barry Hendrix on May 14, 2008. Claimant asserts that he registered complaints of neck pain to Dr. Hendrix and that the disclosed the January 9, 2008, work-related accident as the basis for same. Dr. Hendrix's records are devoid of the afore. Further, when seen by Dr. Cagle on June 2, 2008, there was no mention of neck pain or the January 9, 2008, work incident.

The claimant was seen by Dr. Eubanks on June 18, 2008, pursuant to the referral of Dr. Cagle. Dr. Eubanks' report does reflect that while the claimant's chief complaint was low back pain he also had secondary neck pain. Following his physical examination of the claimant and review of diagnostic studies, Dr. Eubanks assessed the claimant's complaints of low back and

neck pain as chronic in nature, for which conservative treatment measures were recommended.

The claimant returned to Dr. Hendrix on July 16, 2008, at which time Dr. Hendrix's progress note of the visit displayed "he now has neck pain". The afore contradicts the claimant's assertion of having relayed complaints of neck pain at the time of his initial visit to Dr. Hendrix of May 14, 2008. The claimant was subsequently referred to Dr. Abraham by Dr. Hendrix.

At the time of the clamant's July 16, 2008, visit to Dr. Hendrix and subsequent referral to Dr. Abraham the medical in the record reflects that his chief complaints centered on his neck and shoulders. While under the care of Dr. Abraham the claimant ultimately underwent cervical surgery on September 26, 2008.

Dr. Eubanks, a Jonesboro neurosurgeon, opined that the claimant's complaints were chronic and degenerative in nature, following physical examination and diagnostic studies. A similar assessment was rendered by Dr. Earl Peeples following his review of the claimant's pertinent medical records, to include those of his treatment under the care of Dr. Abraham. Dr. Abraham does not definitively attribute the herniated disc in the claimant's cervical spine, for which he treated surgically, to a specific incident work-related incident. Further, the evidence reflects that Dr. Abraham was unaware of the claimant's treatment under the care of Dr.Eubanks and the assessment of same.

While it is undisputed that in workers' compensation law, the employer takes the employee as he finds him, and employment circumstances that aggravate pre-existing conditions are compensable, there is no credible evidence in the record to reflect that the January 9, 2008, work-related injury to the claimant's head aggravated, accelerated, or combined with the claimant pre-existing degenerative disc and joint disease to produce the disability for which compensation

is sought in the instant claim. *St. Vincent Medical Center v. Brown,* 53 Ark. App. 30, 917 S.W.2d 550 (1996); *Nashville Livestock Commission v. Cox,* 302 Ark. 69, 787 S.W.2d 64 (1990). The claimant has failed to sustain his burden of proof by a preponderance of the credible evidence that he sustained an injury to his cervical spine or lumbar spine within the course and scope of his employment with respondent on January 9, 2008, which caused internal or external harm to the body that required medical service. This claim is respectfully denied and dismissed.

IT SO ORDERED.

_____

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE