

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F110680

RICHARD HAWKINS, EMPLOYEE	CLAIMANT
INTERNATIONAL PAPER COMPANY, EMPLOYER	RESPONDENT
SEDGWICK CLAIMS MANAGEMENT, CARRIER	RESPONDENT NO. 1
SECOND INJURY FUND	RESPONDENT NO. 2

OPINION FILED NOVEMBER 13, 2003

Upon review before the FULL COMMISSION, Little Rock, Pulaski County, Arkansas.

Claimant represented by HONORABLE ZAN DAVIS, Attorney at Law, Little Rock, Arkansas.

Respondent No. 1 represented by HONORABLE MICHAEL J. DENNIS, Attorney at Law, Pine Bluff, Arkansas.

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

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

The claimant appeals from a decision of the Administrative Law Judge filed March 14, 2003.

The Administrative Law Judge entered the following findings of fact and conclusions of law:

1. The employee-employer-carrier relationship existed at all relevant times.
2. The claimant's average weekly wage was \$13.55 per hour for a forty hour week.

3. The preponderance of the evidence reflects that the claimant did not sustain a compensable neck or back injury on December 6, 2000. Since compensability has not been shown, there is no reason to address the other issues.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings of fact made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion, which affirms and adopts the Administrative Law Judge's decision finding that claimant failed to prove by a preponderance of the evidence that he sustained a compensable injury.

The claimant contends that he suffered a compensable injury on or about December 6, 2000, while placing coils in a winder. (Coils are the cores around which large bundles of paper are wrapped). According to the claimant, he felt a sudden pain in his neck and back while "throwing" a coil. The claimant testified that he notified his immediate supervisor of the injury and later that day visited the first aid station and reported the injury again. There does not seem to be any dispute that this injury was promptly reported to the respondent employer. However, the respondent contends that claimant's neck and back problems did not arise out of any incident at work.

The medical history in this case is complicated. The claimant testified that on the date of his injury, he felt a burning and stinging pain in his neck and upper back. He completed his shift and continued to work for a few weeks

after the injury. After being off work for several days around the Christmas holiday, the claimant went to his family physician, Dr. Horace Johnson. Dr. Johnson then referred the claimant to Dr. Charles Watson at the Pain Control Center in Little Rock, Arkansas.

In a progress noted dated January 2, 2001, Dr. Watson reviewed the claimant's medical history and diagnosed lumbar radiculopathy and myofascial pain syndrome. In setting out the claimant's medical history, Dr. Watson noted that the claimant had undergone a cervical fusion in 1986. Much of the rest of the information in Dr. Watson's reports is confusing and contradictory. For example, he stated, referring to the cervical fusion, that the claimant had done well until about a month ago. However, he later said that the symptoms began "two to three months ago." Dr. Watson also described the claimant as having a "constant dull aching pain," but in the same sentence referred to it as "intermittent." Then, in the next sentence, he stated that the claimant had a burning pain. The doctor also referred to the claimant having seen a chiropractor who did spinal manipulations which were ineffective, but did not indicate when this treatment occurred or what body part was

treated. He later stated in the same report that the claimant's past medical history was "unremarkable." The report also contains some typographical errors. The claimant is at times referred to as a she and the reports state that the claimant's age is 29, when he was in fact 49.

At Dr. Watson's request, the claimant underwent an MRI scan of his cervical and lumbar spine. The lumbar MRI was negative. However, the cervical MRI revealed what the radiologist referred to as "small posterior osteophytes at C2-C3 and C3-C4." The radiologist added that there was no disc herniation and that the cervical cord signal was normal.

Following the MRIs (which were performed on January 10, 2001), the claimant returned to see Dr. Watson on January 15, 2001. In the progress note of that date, Dr. Watson stated that the claimant has, in the past, been seen by a neurologist because of pain in his back. Dr. Watson also sets out complaints of a constant dull aching pain, intermittent sharp burning pain, and that, "most of the time he has numbness and tingling with minimal amounts of pain." Once again, not only are the statements in the progress notes inconsistent, but Dr. Watson does not

indicate which parts of the body are involved. This is significant because the claimant would later be diagnosed with congenital problems in his lower back which undoubtedly were responsible for some of the claimant's pain. Some of the apparent inconsistencies in Dr. Watson's progress notes can probably be attributed to his failure to distinguish which parts of the claimant's body were causing which symptoms.

Dr. Watson began to treat the claimant conservatively with injections, medications, and hot and cold packs. In a progress note dated January 29, 2001, the claimant was referred back to Dr. Johnson with a recommendation that he get a neurology consultation. Dr. Johnson apparently referred the claimant to Dr. P. B. Simpson, a Pine Bluff neurosurgeon. The claimant saw Dr. Simpson on February 5, 2001 and continued to see him for approximately one month. During that time, Dr. Simpson had the claimant undergo another series of MRIs to his thoracic, cervical, and lumbar spine. Dr. Simpson occasionally referred to problems with the MRIs in that the claimant was unable to remain still which resulted in unclear images. He also referred to possible defects at T1-

T2 but determined that there was no significant compression of the spinal cord. In a report dated March 12, 2002, Dr. Simpson stated that he had reviewed the claimant's MRIs and CT scans and did not see anything significant. Dr. Simpson then released the claimant to be seen by his regular treating physician.

When the claimant continued to have difficulties, he eventually saw Dr. Warren Long, a neurosurgeon in Shreveport, Louisiana. Dr. Long reviewed copies of the various MRIs performed on the claimant and stated that he could find nothing out of the ordinary in the thoracic spine and in regard to the cervical spine stated, "the scan at this time shows only a problem in the neck at C3-4 to my way of thinking." In a report dated May 8, 2001, Dr. Long extensively summarized the claimant's problems and stated that he totally agreed with Dr. Simpson. At Dr. Long's direction, the claimant underwent another CT scan of the cervical spine on May 25, 2001. The scan was interpreted as revealing a mild central disc protrusion at C2-C3 with no significant effacement of the thecal sac, and significant degenerative disc changes at C3-C4 with a moderate to large central disc bulge and a large osteophytic change causing

central and marginal encroachment on the thecal sac and neural foramina. Dr. Long also directed the claimant to undergo a full body myelogram of the entire spine. The report from this procedure identified a large central epidural defect at C3-C4 causing significant central and marginal encroachment upon the neural foramina. The report also noted a central epidural defect at C5-C6 consistent with either a herniated disc or an osteophyte. As a result of the findings of these tests, particularly as it related to the C3-C4 area of the claimant's neck, Dr. Long referred the claimant to Dr. Marco Ramos, a neurosurgeon in Shreveport, Louisiana. Dr. Ramos had the claimant undergo another cervical MRI. Dr. Ramos reviewed the findings of this MRI in a report dated June 25, 2001. In that report, Dr. Ramos stated that the claimant had a significant extradural defect at C3-C4 and to a lesser degree at C4-C5. He also noted that the C3-C4 abnormality extended into the body of C4, creating a defect going beyond the limits of the disc space itself. At Ramos' suggestion, the claimant opted to undergo a surgical correction of this problem. The surgery was performed on July 11, 2001. The claimant had an

uneventful recovery from the surgery but did continue to complain of pain in his lower back.

The record has been consistently misinterpreted to support a denial of this claim. For example, Dr. Watson's initial report has been summarized in the following manner:

That record reflects that the claimant told his treating physician that he did well from his 1986 neck surgery until approximately October or November 2000. He stated that his symptoms began in those months and then in approximately December 2000, his pain became constant in his neck, shoulder, and upper back. He told the treating physician that he saw a chiropractor and that the treatment made his condition worse. It is notable that the claimant said nothing to that initial treating physician about a work related injury. It is noted that the claimant's lumbar back films were normal on December 28, 2000.

In the first place, the above-referenced quote does not accurately set out Dr. Watson's statement.

Dr. Watson stated the following:

"The patient is status post interior cervical fusion in

1986. Postoperatively, she (sic) did well until about a month ago."

As indicated above, Dr. Watson's patient history has several contradictions in it. However, it says nothing about the claimant's symptoms having begun in October or November of 2000. Further, Dr. Watson does not differentiate between the pain the claimant is suffering from his neck and that from his lower back. He also does not indicate when the claimant saw a chiropractor. A more logical interpretation of Dr. Watson's report is that the claimant began having problems with his neck approximately one month before the visit. Since the date of the visit was January 2, 2001, one month prior would have been in early December 2000, the time frame in which the claimant testified that he injured his neck.

Additionally, Dr. Ramos stated in his deposition that he visually observed a herniated disc that was compressing the claimant's nerve roots and spinal cord. While Dr. Ramos indicated that an osteophyte was also a factor in the physical problems being suffered by the claimant, he stated that the disc herniation, which he believed was the result of the claimant's job related

injury, was the major cause of the problems. The majority finds that Dr. Ramos was wrong in his finding of a herniated disc. However, Dr. Ramos is a Board certified neurosurgeon with 23 years of experience. The Commission is not at liberty to arbitrarily disregard Dr. Ramos' findings and substitute its own medical judgement for that of a trained medical professional. See Hapney v. Rheem Manufacturing Co., 342 Ark. 11, 26 S.W.3d 777 (2000); Jordan v. J.C. Penney Co., 57 Ark. App. 174, 944 S.W.2d 547 (1997); and Freeman v. ConAgra Frozen Foods, 344 Ark. 296, 40 S.W.3d 760 (2001).

Further, the majority flatly states that in late December of 2000, the claimant was loading and lifting firewood to use during a widespread and lengthy power outage at that time and that this activity could have caused his injury. However, there is simply no evidence of this in the record. During the claimant's deposition, he denied lifting firewood during a power outage. He also stated that while he did have a fireplace, his son-in-law was living with him and did any lifting of firewood.

Many of the factual conclusions made by the majority are unsupported by any evidence in the record and are reached entirely through speculation and conjecture,

something the appellate courts have expressly forbidden. The majority has even gone so far as to conclude that a Board Certified neurosurgeon was not able to correctly identify a herniated disc, even though he visually observed it while performing surgery.

Based upon my review of the evidence in this case, I find that claimant has met his burden of proving by a preponderance of the evidence that he sustained a compensable injury. Accordingly, the opinion of the Administrative Law Judge should be reversed.

SHELBY W. TURNER, Commissioner