

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F302620

DENNIS CARTER,  
EMPLOYEE

CLAIMANT

GEORGIA-PACIFIC CORPORATION,  
SELF-INSURED EMPLOYER

RESPONDENT

SEDGWICK CLAIMS MANAGEMENT,  
INSURANCE CARRIER/TPA

RESPONDENT

OPINION FILED OCTOBER 6, 2005

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

Claimant represented by the HONORABLE SILAS H. BREWER,  
Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE MIKE ROBERTS,  
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed as modified.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed May 26, 2005. The administrative law judge found that the claimant proved he sustained a compensable left shoulder injury on February 28, 2003, and that the claimant proved he sustained a compensable right arm injury on February 28, 2003. The administrative law judge found that the claimant proved he was entitled to temporary total

disability compensation and reasonably necessary medical treatment. After reviewing the entire record *de novo*, the Full Commission affirms as modified the opinion of the administrative law judge. The Full Commission finds that the claimant sustained compensable injuries to his left shoulder and brachial plexus.

I. HISTORY

Dennis Wayne Carter testified that he began working for Georgia-Pacific in about April 1990. The claimant testified on direct examination:

Q. Where were you and the other members of the winder crew at about 2:00 a.m. on February the 28<sup>th</sup>?

A. We were at the calendar stack in front of the third dryer section. We were in the process of threading the sheet from the third dryer section through the calendar stuck to the reel....I was standing like this (demonstrating), and all of a sudden something slams me in the side of my head, okay?

Q. Did you have a hardhat on?

A. No, I didn't....

Q. After you were struck in the head, what happened? What do you remember your movements being?

A. I was knocked to my left side, and I remember reaching out and grabbing hold of the ladder to break my fall.

Q. With which hand?

A. With both hands. I reached out to grab the ladder and dropped to my knees, and basically the rest of it is fuzzy.

Q. Did you lose consciousness?

A. Yes.

Buddy Harrod testified that he was working with the claimant on February 28, 2003, but that he did not witness the accident. Mr. Harrod testified that he heard a "racket" and afterward saw the claimant staggering and grabbing for a ladder. Mr. Harrod testified, "once he got to the ladder and started basically to collapse, it appeared to me, Johnny at that point caught him, and you know, tried to help him, you know, to the floor."

Johnny Everett testified that he had been employed with Georgia-Pacific for over 30 years, and that he was working with the claimant on February 28, 2003. Mr. Everett testified, "I didn't see it when it hit, I only seen him when he come back like that with his neck when he took the impact of it." Mr. Everett testified that he saw the claimant "staggering," and "I knew he was going to fall down, it was just a matter of time and when. And he grabbed the ladder I guess to try to stationary himself, to brace

himself, I guess. And by then I was trying, I was in the process of getting over there to him, because I knew he was hurt real bad."

Ben White testified for the respondents that he did not see the accident, but that he afterward saw the claimant "addled" and about to fall. Mr. White could not recall whether or not he saw the claimant grab the ladder.

In any event, the parties stipulated that the respondents "accepted a claim for a head laceration on February 28, 2003."

Dr. Jim J. Moore examined the claimant and reported to the respondent-carrier on March 20, 2003:

Since this injury he has had a number of symptoms. He complains that his depth perception is poor with monocular vision. He has blurred vision from the right eye. With prolonged standing he feels drained. He has left temporal headaches. He has frequent episodes of tunnel vision. He has tingling of the right hand, occasionally the left. The right foot stays cold. He has a funny sensation in the scalp, almost a numbness. The patient's general health has been good. He does have hypertension and has been treated with various medications by Dr. Thompson, his family physician....

I reviewed the diagnostic studies. The brain MRI is dated 3-04-03 and is I think considered a normal study. The radiologist suggests some left maxillary sinusitis. The skull x-rays, the cervical spine films, the shoulder films are all thought to be normal. There is also a CT of the

head without contrast. This is dated 3-01. This is also considered a normal study.

The patient it is felt has sustained a cerebral concussion by the very nature of the fact that he was rendered unconscious for three to five minutes....

Dr. Moore planned additional testing and diagnosed "Cerebral concussion."

Dr. Edwin Hankins III informed Dr. Moore on May 1, 2003, "I could find no evidence of eye injury or optic nerve involvement due to his head injury."

On May 6, 2003, Dr. Moore diagnosed "1. Cerebral concussion. 2. Possible ulnar neuropathy versus cervical radiculitis." Dr. Moore recommended additional diagnostic testing and noted on May 13, 2003:

The MRI shows evidence of osteophytic changes at C5/6. The EMG/NCV suggested evidence of a mild carpal tunnel syndrome worse left than right and also evidence of a very mild injury to the lower brachial plexus on the right side with some subsequent reinnervation suggested in Dr. Gibson, the electromyographer's opinion, a favorable prognosis....

In view of the EMG changes, I believe that the problem is related to trauma that was sustained in the lower brachial plexus. I do not have any recommendations so far as his ongoing shoulder complaints other than an additional orthopedic assessment. So far as the numbness in the fingers are concerned this would be a great part of determination as to when he can return to work and he tells me his particular job is such that this

would be a critical concern as I have discussed with Mr. Baker, the patient and his wife. I will see the patient on call in the future on an as needed basis.

Dr. Moore diagnosed "1. Cerebral concussion. 2. Neuropathy."

(Dorland's Illustrated Medical Dictionary, Twenty-sixth Edition, defines "brachial plexus" as "a plexus originating from the ventral branches of the last four cervical spine nerves and most of the ventral branch of the first thoracic spinal nerves.")

The claimant testified that Dr. Moore released him to light duty on May 13, 2003, but "I couldn't go back to my previous job because of the numbness in this right hand." The claimant testified that the plant supervisor "told me there wasn't any light duty available, that with the number of cutbacks that they had been making, that he didn't see any light duty coming open, that I needed to get healed up before I come back to work."

Dr. Norris Knight reported on May 27, 2003:

This patient was evaluated for his left shoulder, today. He is undergoing evaluation by Dr. Jim Moore in Little Rock, who is a neurosurgeon for an industrial injury. He has had an MRI, which showed C-5 posterior osteophyte with an associate disc bulge and marked right side and mild left side neuroforaminal narrowing at C-5. Mild to

moderate C-3 and C-4, left side neuroforaminal narrowing from osseous hypertrophy. He has, also, had an EMG/NCV, which showed some brachial plexus palsy on the right. Thought, to be reversible. He is seen, as noted, with evaluation of left shoulder. He has pain over the superior trapezius on the left side and the posterior aspect of the shoulder, not particularly aggravated by hand on head position. The injury occurred on February 28, 2003, hit in the head and right shoulder with a 10 lb piece of steel that knocked him unconscious, knocked him down and he fell onto his left shoulder. He has been off work since.

Examination: Shows crepitation on motion, both shoulders, bilateral, mild with tenderness over the infraspinatus muscle just inferior to the spine and acromion and over the superior trapezius. Three view X-ray of the left shoulder plus stress are normal. For the sake of completeness, an MRI needs to be done on left shoulder. However, it is thought that this pathology is cervical and not shoulder except for the physiological degenerative changes in the rotator cuff, incident to aging at the age 43.

A left-shoulder MRI was taken on June 3, 2003, with the following impression:

1. No acute fracture, bone contusion, or significant joint effusion is identified.
2. Findings suggestive of a superior labral tear with resultant suprascapular nerve entrapment due to rather extensive perilabral cyst development as described above.

Dr. Knight noted on June 16, 2003, "MRI reported as showing a subacromial osteophyte, which is old and not W/C. A multi-loculated ganglion, which extends out of the joint

into the suprascapular nerve area and a glenoid labrum disruption. He needs referral to a fellowship trained shoulder surgeon. W/C adjuster will take care of that. Off work in the interim."

Dr. Charles E. Pearce, Jr. examined the claimant on July 8, 2003. Dr. Pearce noted with regard to x-rays, "Radiographs show history of significant bone abnormality." Dr. Pearce's impression was "Left shoulder pain, presumably from a direct blow secondary to an on-the-job injury - MRI finding of possible paraglenoid cyst but with physical findings of rotator cuff pain and weakness." Dr. Pearce recommended the following: "1) Proceed with MR arthrogram to elucidate the superior labrum more clearly and also to give us a better idea of the status of his rotator cuff. 2) If this is negative, we will need to consider a nerve study; in particular, assessing the suprascapular nerve. 3) During this time, he is unable to work...."

An MR left-shoulder arthrogram and MR scan of the claimant's shoulder was taken on July 14, 2003, with the following findings:

Arthrogram: The study demonstrates normal volume of the shoulder joint. No abnormalities were demonstrated of the articular surface. No evidence is demonstrated for rotator cuff tear.

IMPRESSION: Normal arthrogram.

MRI

The study demonstrates evidence for a large paralabral cyst. This cyst measures almost 3 cm in maximal diameter. This cyst is present medial to the posterosuperior glenoid labrum. There is evidence for associated tear of the posterosuperior labrum. Contrast is seen to only partially enter the cyst at this time. The remainder of the glenoid labrum appears intact. No abnormalities are demonstrated of the biceps anchor. Examination of the rotator cuff is unremarkable.

IMPRESSION:

Paralabral cyst is associated with a labral tear involving the posterosuperior glenoid labrum.

The claimant returned to Dr. Pearce on July 29, 2003:

We have done a MR arthrogram, which did show the paraglenoid cyst and perhaps some leakage into the cyst; which may indicate some pathology of the labrum. On further reflection of his mechanism of injury and with apparent witnesses, it sounds as if Mr. Carter could have had an axial pulling mechanism to his injury. He had initially told me that this was a direct blow to the shoulder, which really did not go along with labral pathology.

PHYSICAL EXAMINATION: His main finding outside of very inconsistent pain in his infraspinatus is mild to moderate impingement....

Dr. Pearce's impression was "Left shoulder and arm pain - He has bursitic tendonitis type pain. He may have labral pathology....In order to ferret out exactly what the etiology of his pain is, I think that it would be reasonable to do a diagnostic and hopefully therapeutic injection into

the subacromial bursa. This was done after an aseptic prep."

Dr. Pearce's recommendations on August 21, 2003 included the following: "1) I would like to get a follow up nerve study to rule out suprascapular nerve compression. 2) At the same time, I think that it would be reasonable to try aspiration of the rather large, 3 cm, paralabral cyst under CT guidance - and I will ask Dr. Alexander to do that." Dr. Pearce noted on September 18, 2003, "I am not sure what the holdups have been, but he has not had the cyst aspirated nor has he had a repeat nerve study on his arm; both of which he needs prior to making further decisions on his case."

The claimant's testimony indicated that he did not receive worker's compensation after September 29, 2003.

Dr. Knight reported on December 9, 2003, "This patient has not had his shoulder operated. His shoulder pathology is a glenoid labrum tear with a secondary ganglion with direct pressure on the suprascapular nerve. The accepted treatment for same is arthroscopy with arthroscopic repair of the glenoid labrum and intraarticular evacuation of the ganglion if possible, if not release of the transverse scapular ligament directly is indicated with excision of the

ganglion....Injuries clearly related to his W/C injury when he fell."

The parties stipulated that an administrative law judge appointed Dr. John L. Wilson in April 2004 to conduct an independent evaluation. Dr. Wilson wrote to the respondents' counsel on April 22, 2004:

Mr. Carter was seen on March 25, 2004, with pain in his left shoulder....Examination today reveals mild restriction of glenohumeral motion....MRI of the shoulder reveals a cyst of the inferior glenoid. There is an MRI arthrogram that reveals what appears to be a tear in the labrum.

The following answers are given in response to your questions.

1. Please identify and/all objective findings which do not come under voluntary control. Restricted range of motion. This is passive with my holding the scapula and this is objective.
2. The finding, according to this gentleman's history, was caused by the work related accident. He relates he did not have difficulty prior to that....

The claimant testified that he sought treatment on his own from Dr. Barry Thompson after the respondents controverted the claim. Dr. Barry V. Thompson examined the claimant and reported on May 5, 2004, "I have reviewed all his medical records and his injuries appear to be clearly related to his job injury. The WC company is disputing his injuries and stating they were pre- [existing (sic)]. He has

no history of injuries to these areas prior to his WC accident. His employer will not take him back to work until he can do his full heavy job duties which he is unable to do at the present time." Dr. Thompson assessed the following: "Date of injury 02/28/03 - Superior labral tear & paraglenoid cyst; cerebral concussion; brachial plexus injury on the right (giving him numbness and tingling in the right 4<sup>th</sup> and 5<sup>th</sup> fingers and in the wrist) as a result of his accident."

The claimant testified that Dr. Thompson "prescribed a medication that has helped this brachial plexus injury, it has improved it."

The parties deposed Dr. Jim Moore on July 26, 2004. Regarding his May 13, 2003 examination of the claimant, Dr. Moore testified, "my assessment was that the patient's arm complaints were based upon an injury in the lower brachial plexus....I mean the upper and lower brachial plexus are right up into just above the collar bone." Dr. Moore testified, "I think the blow that he had probably stretched - stressed his head, angling it off."

The claimant's attorney questioned Dr. Moore:

Q. I believe the first report of this condition was on May 6<sup>th</sup> of 2003, where you noted that he

was complaining of trapezius pain and also some nerve numbness along the ulnar nerve distribution....Did you confirm - or did you and how did you confirm that that was related to the ulnar nerve distribution?

A. Well, if you'll look on the examination, it's stated that there is some sensory depression consistent with ulnar nerve on the right side. So, it follows a specific - very much a dermatome pattern that would be consistent with ulnar nerve.

Q. All right. So, in other words, would that be an objective finding?

A. Yes....

Q. So, the blow caused a brachial plexus injury -

A. Yes.

Q. - which in turn caused -

A. Causing the numbness that he was experiencing in the distribution of the right ulnar nerve....The problems - and I could go even further, saying, the problems in the patient's right upper extremity are related to trauma sustained to the brachial plexus at the time of the injury.

The parties deposed Dr. Charles Pearce on September 22, 2004. Dr. Pearce testified, among other things, that he could not state "within a reasonable degree of medical certainty" that the February 28, 2003 accidental injury caused the claimant's left-shoulder condition.

A pre-hearing order was filed on December 20, 2004. The claimant contended that he was entitled to "additional

total disability and medical benefits subsequent to December 25, 2003, and continuing through a date yet to be determined because of a superior labral tear and secondary cyst in the left shoulder sustained as a result of his compensable injuries but belatedly diagnosed, as well as a brachial plexus injury, causing denervation and impairment of the right arm, as well as a C5-6 posterior osteophyte with associated disc bulge and unciniate hypertrophy resulting in marked right-sided foraminal narrowing of the disc space. The claimant further seeks a change of physician to Dr. Barry Thompson."

The respondents contended that the claimant could not prove he was entitled to additional temporary total disability compensation "for any of his alleged injuries to his left shoulder, right arm or neck. Respondents further contend that specific notice of the claimant being released to return to work was not relayed to respondents, and that if the claimant was released to return to work in a light-duty capacity, that no light-duty work is or was available to be provided to the claimant. Respondents further contend that claimant is not entitled to a change of physician to Dr. Barry Thompson, as that treatment has already been

provided by Dr. Thompson and that said treatment is for alleged injuries which are currently being controverted by respondents."

The parties agreed to litigate the issue, "additional benefits."

The parties deposed Dr. Norris C. Knight on December 28, 2004. The respondents' attorney questioned Dr. Knight:

Q. Doctor, on December the 9<sup>th</sup>, 2003, you saw him again, and - one second, Doctor. In that December 9<sup>th</sup>, 2003 report, Doctor, at the bottom of it you make a statement in that report that reads, "The injury is clearly related to his Worker's Comp injury when he fell." What injuries - are you talking about the left shoulder, Doctor?

A. Yes, I am.

Q. Okay. And what injuries of the left shoulder are you referring to?

A. I believe what happened to Mr. Carter is that he was working and this ten pound piece of metal fell on his head and his right shoulder, knocked him unconscious, and he fell to the ground onto his left shoulder, hurting it. That's the history he gave me and the only history of any injury that he has, to my knowledge. I believe that resulted in a tear of the glenoid labrum, which is actually the rim around the socket. And as a sequel to that, he developed the ganglion, which extends outside the joint and presses on the suprascapular nerve, which was causing some shoulder pain....

Q. And had there not been a tear of the labrum, would you agree that the ganglion could not have then developed?

A. Well, a ganglion actually can develop from any joint surface, so the answer is yes, it could have developed in the absence of a tear, but I don't think that's the situation here.

Q. Okay. It's your opinion that there is a labral tear? Is that right, Doctor?

A. I think the probability is there, based on the history of the injury and the probable finding on the MRI and the clear development of a ganglion. I think the whole sequence goes together.

Q. Okay, all right. And if any of that sequence is changed, let's say he did not impact with the ground or any - or anything with his left shoulder. Let's say he fell on his knees rather than his left shoulder. Would that change your opinion?

A. Oh, absolutely. If he didn't actually have an injury to his left shoulder -

Q. You mean an impact?

A. Any kind - it doesn't have to be an impact. It could be a, an injury where the joint is placed in an awkward position. But let's assume he didn't have an injury to the shoulder, then - and he developed the ganglion, then you could postulate that the ganglion came from degeneration of the glenoid labrum, which is age-related.

Q. Yes, sir, and I was about to get to that ganglion. Without that trauma to the left shoulder, it's probably more than likely that the ganglion was more of a degenerative condition that came about through - due to age, is that right?

A. Yeah. If you disregard the history of the trauma, if he didn't have an injury of any kind to his shoulder, then it would be degenerative in nature and not traumatic....

The claimant's attorney questioned Dr. Knight:

Q. Now, Mr. Carter gave a deposition to an attorney from Mr. Roberts' office, and of course I was present at the deposition, and in it Mr. Carter described the mechanism of injury and, in terms that I'm going to try to summarize - I'm looking at the deposition. He said he was hit on the right side of the head around the crown area by this falling metal object, and he fell to the left, grabbed a hold of a ladder to break his fall and then slumped on down to the ground after that. And what I want to ask you is whether in your opinion when he grabbed the ladder and continued on with his fall, would that be the kind of actual pulling that could cause a labral tear?

A. Yes, I believe it could.

Q. Now, if that history is correct, could you testify with a degree, or reasonable degree, of medical certainty that that fall of that type caused this man's labral tear?

A. Yes. I - again, I thought from the whole history as the mechanism of the injury on the job followed by pain, unresolved for quite some time period of time with the MRI finding, I thought the sequence of events was the injury to the shoulder, the labral tear, and the development of the secondary ganglion, which was pressing on the suprascapula nerve, I thought that was the sequence.

Q. All right, sir. The labral tear by definition, if I understand it, is traumatic in nature. I mean it's not the kind of thing that - or is it the kind of thing that develops sort of by way of the aging process?

A. Well, there has to be some, some injury, but it doesn't have to be very big....As we - the older the patient is, the more degenerative changes that are there and the less the injury,

less the amount of injury that is necessary to cause a tear.

A hearing was held on February 25, 2005. The claimant testified with regard to his left shoulder, "I'm limited in the mobility that I can use as far as lifting, picking up with this arm. I assume that, I don't know what's in this shoulder that's causing the problem, but if I force myself to use this shoulder, it causes me great pain."

The administrative law judge found, in pertinent part:

2. Claimant has proven by a preponderance of the evidence that he sustained a compensable left shoulder injury on February 28, 2003;
3. Claimant has proven ... that he sustained a compensable right arm injury on February 28, 2003;
4. Claimant is entitled to temporary total disability indemnity benefits from the date of injury and continuing through a date yet to be determined for each of his injuries to his head, left shoulder, and right arm;
5. Claimant is entitled to all medical benefits, both past and future, for each of his compensable injuries, including the treatment he received from Dr. Barry Thompson on his own, as claimant began seeing Dr. Thompson only after the case was controverted[.]

The respondents appeal to the Full Commission.

## II. ADJUDICATION

### A. Compensability

Ark. Code Ann. §11-9-102(4) (A) defines "compensable injury":

(i) An accidental injury causing internal or external physical harm to the body ... arising out of and in the course of employment and which requires medical services or results in disability or death. An injury is "accidental" only if it is caused by a specific incident and is identifiable by time and place of occurrence[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4) (D). "Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16) (A) (i). The claimant must prove by a preponderance of the evidence that he sustained a compensable injury. Ark. Code Ann. §11-9-102(E) (i).

In the present matter, the Full Commission affirms the administrative law judge's finding that the claimant sustained compensable injuries on February 28, 2003. We find that the claimant sustained compensable injuries to his left shoulder and brachial plexus. The claimant testified that he sustained an accidental injury as the result of a specific incident occurring on February 28, 2003. The claimant testified that he was struck in the head and knocked to his left side, and that he reached out with both hands and grabbed a ladder to break his fall. Two co-

workers corroborated the claimant's testimony that he grabbed the ladder immediately after the accident. Based on electrodiagnostic testing carried out in May 2003, Dr. Moore opined that the claimant had sustained "a very mild injury to the lower brachial plexus on the right side with some subsequent innervation." A left-shoulder MRI taken in June 2003 showed findings suggesting a superior labral tear with resulting suprascapular nerve entrapment." Dr. Knight noted in June 2003 that diagnostic testing revealed "a multi-loculated ganglion, which extends out of the joint into the suprascapular nerve area and a glenoid labrum disruption. He needs referral to a fellowship trained shoulder surgeon."

The impression from a MR scan of the claimant's left shoulder in July 2003 was "paralabral cyst is associated with a labral tear involving the posterosuperior glenoid labrum." Dr. Pearce subsequently noted, "it sounds as if Mr. Carter could have had an axial pulling mechanism to his injury." Dr. Knight opined in December 2003, "His shoulder pathology is a glenoid labrum tear with a secondary ganglion with direct pressure on the superscapular nerve....Injuries clearly related to his W/C injury when he fell."

We recognize Dr. Pearce's deposition testimony indicating that he could not definitively state whether or not the accident caused the claimant's shoulder cyst or labral tear. Nevertheless, the Commission has the duty of weighing medical evidence, and if the evidence is conflicting, its resolution is a question of fact. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). The Commission in the present matter places greater probative weight on the opinion of Dr. Knight. Dr. Knight testified at deposition that he believed the accidental injury "resulted in a tear of the glenoid labrum, which is actually the rim around the socket. And as a sequel to that, he developed the ganglion, which extends outside the joint and presses on the suprascapular nerve, which was causing some shoulder pain." We also place significant probative weight on the expert opinion of Dr. Moore, who stated, "the problems in the patient's right upper extremity are related to trauma sustained to the brachial plexus at the time of the injury."

The Full Commission therefore affirms the administrative law judge's finding that the claimant sustained compensable injuries. The Full Commission finds

that the claimant sustained compensable injuries to his left shoulder and brachial plexus. These accidental injuries arose out of and in the course of employment and required medical services. The accidental injuries to the claimant's left shoulder and brachial plexus were caused by a specific incident identifiable by time and place of occurrence. The claimant established these injuries by medical evidence supported by objective findings not within his voluntary control. These objective findings included the electrodiagnostic studies showing trauma to the lower brachial plexus, and the left-shoulder MRI showing a superior labral tear and perilabral cyst development.

B. Temporary Disability

Temporary total disability for an unscheduled injury is that period within the healing period in which the employee suffers a total incapacity to earn wages. Ark. State Hwy. Dept. v. Breshears, 272 Ark. 244, 613 S.W.2d 392 (1981). "Healing period" means "that period for healing of an injury resulting from an accident." Ark. Code Ann. §11-9-102(12). The healing period is that period for healing of an injury which continues until the employee is as far restored as the permanent character of the injury will permit. Nix v.

Wilson World Hotel, 46 Ark. App. 303, 879 S.W.2d 457 (1994). If the underlying condition causing the disability has become more stable, and if nothing further will improve that condition, the healing period has ended. *Id.* Whether an employee's healing period has ended is a question of fact for the Commission. Ketcher Roofing Co. v. Johnson, 50 Ark. App. 63, 901 S.W.2d 25 (1995).

In the present matter, the claimant sustained a compensable injury to his left shoulder and brachial plexus on February 28, 2003, along with a head laceration and cerebral concussion. The claimant thus entered a healing period for compensable injuries on February 28, 2003. Dr. Moore's subsequent treatment notes indicated that the claimant was off work. Although Dr. Moore attempted to release the claimant to light duty on May 13, 2003, the claimant testified that no light duty with the respondent-employer was available. The preponderance of evidence therefore indicates that the claimant was totally incapacitated to earn wages at that time, and that the claimant remained in a healing period.

Diagnostic testing in June 2003 suggested a superior labral tear in the claimant's left shoulder and perilabral

cyst development. Dr. Knight recommended treatment and kept the claimant off work in June 2003. Dr. Pearce also began treating the claimant. The impression from additional diagnostic testing in July 2003 was, "Paralabral cyst is associated with a labral tear involving the posterosuperior glenoid labrum." Dr. Pearce recommended additional treatment, which recommendation indicates that the claimant remained within a healing period. Dr. Knight noted in December 2003 that the recommended medical treatment for the claimant had not been provided. Dr. Thompson noted in May 2004, "His employer will not take him back to work until he can do his full heavy job duties which he is unable to do at the present time." The claimant testified that he was unable to use his left shoulder to work.

The Full Commission affirms the administrative law judge's finding that the claimant proved he was entitled to temporary total disability compensation from the date of the compensable injuries until a date to be determined. We do not affirm the administrative law judge's finding that the claimant was entitled to additional temporary disability for an injury to his head. The claimant testified that he was struck on the head on February 28, 2003, and the respondents

accepted responsibility for a head laceration. Dr. Moore subsequently diagnosed "cerebral concussion." A brain MRI in March 2003 was normal, as were skull x-rays. We recognize that Dr. Moore also diagnosed "cerebral concussion" on May 13, 2003. Nevertheless, there were no diagnostic findings demonstrating continued cerebral concussion after March 2003. Further, the claimant testified that he was unable to return to work on May 13, 2003, not because of his head, but because of his left shoulder, and because of his right arm complaints resulting from the brachial plexus injury. There was also no indication of record that the claimant remained within a healing period for the head laceration he sustained on February 28, 2003.

C. Medical Treatment

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. Wal-Mart Stores, Inc. v. Brown, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What

constitutes reasonably necessary medical treatment is a question of fact for the Commission. DeBoard v. Colson Co., 20 Ark. App. 166, 725 S.W.2d 857 (1987).

In the present matter, the Full Commission affirms the administrative law judge's implicit finding that the claimant proved he was entitled to all of the medical treatment of record, including treatment provided by Dr. Barry Thompson. The preponderance of evidence demonstrates that the claimant proved he was entitled to treatment provided by Dr. Moore, Dr. Hankins, Dr. Knight, Dr. Pearce, and the independent examiner Dr. Wilson. The Full Commission finds that the treatment provided by each of these physicians was reasonably necessary in connection with the claimant's compensable injuries. The claimant contended that he was entitled to a change of physician to Dr. Thompson. The administrative law judge did not determine that the claimant was entitled to a one-time change of physician to Dr. Thompson pursuant to Ark. Code Ann. §11-9-514(a)(3). Nor did the respondents argue before the administrative law judge or on appeal to the Full Commission that Dr. Thompson's treatment should be at the claimant's expense pursuant to Ark. Code Ann. §11-9-514(b). Likewise,

the respondents did not argue before the administrative law judge or to the Full Commission that Dr. Thompson's treatment was unauthorized pursuant to §11-9-514(c)(3). The respondents instead argue on appeal that Dr. Thompson's treatment was not reasonably necessary pursuant to Ark. Code Ann. §11-9-508(a). The Full Commission finds that Dr. Thompson's treatment was reasonably necessary. The record indicates that the claimant remains within a healing period for his left shoulder and brachial plexus injuries. Further, the claimant testified that he had benefitted from the medication prescribed by Dr. Thompson.

Based on our *de novo* review of the entire record, the Full Commission affirms as modified the administrative law judge's findings of fact. The Full Commission finds that the claimant proved he sustained compensable injuries to his left shoulder and brachial plexus on February 28, 2003. We find that the claimant proved he was entitled to temporary total disability compensation from the date of these injuries until a date yet to be determined. We find that the claimant proved he was entitled to all of the medical treatment of record pursuant to Ark. Code Ann. §11-9-508(a), including the treatment provided by Dr. Barry Thompson. The

respondents are entitled to a set-off pursuant to Ark. Code Ann. §11-9-411(a). The claimant's attorney is entitled to fees for legal services pursuant to Ark. Code Ann. §11-9-715(a) (Repl. 2002). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to an additional fee of five hundred dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b) (2) (Repl. 2002).

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.