

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F203812

JANETT L. HUGHES, EMPLOYEE	CLAIMANT
COUNSELING SERVICES OF EASTERN ARKANSAS, EMPLOYER	RESPONDENT
ZENITH INSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT

OPINION FILED DECEMBER 19, 2005

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

Claimant represented by the HONORABLE CHARLES E. HALBERT, JR., Attorney at Law, Helena, Arkansas, and by the HONORABLE ROBERT J. DONOVAN, Attorney at Law, Marianna, Arkansas.

Respondents represented by the HONORABLE J. MATTHEW MAULDIN, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Respondents appeal an opinion and order of the Administrative Law Judge filed April 20, 2005. In said order, the Administrative Law Judge made the following findings of fact and conclusions of law:

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

2. The stipulations agreed to by the parties are hereby accepted as fact.

3. The claimant's healing period for her cervical spine injury and low back injury ended on or before January 29, 2004.

4. The claimant has shown, by a preponderance of the credible evidence, that she is entitled to additional temporary total disability for the period beginning May 15, 2003, and continuing through January 29, 2004, while being evaluated for a determination as to the cause of her continuing headaches, blackouts, and vascular problems.

5. Respondents are responsible for all hospital, medical, and related expenses for treatment of claimant's admitted, compensable injuries, including, but not limited to reimbursement to appropriate health providers who paid for evaluation of claimant's headaches, blackouts, and vascular problems, and respondents remain responsible for continued, reasonably necessary medical treatment for the claimant's admitted, compensable injuries.

6. Respondents are entitled to a dollar-for-dollar offset for any benefits previously received for the medical services provided under claimant's group health insurance plan pursuant to A.C.A. §11-9-411.

7. The claimant's entitlement to appropriate permanent impairment benefits, as well as the overall extent of claimant's permanent disability has been specifically reserved.

8. Claimant's entitlement, if any, to benefits pursuant to A.C.A. §11-9-113 is, by necessity, likewise reserved.

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 made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the April 20, 2005 decision of the Administrative Law Judge, including all findings of fact and conclusions of law therein, and adopt the opinion as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2002).

Since the claimant's injury occurred after July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as amended by Act 1281 of 2001. Compare Ark. Code Ann. §

11-9-715 (Repl. 1996) with Ark. Code Ann. § 11-9-715 (Repl. 2002). For prevailing on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$500.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I respectfully dissent from the majority opinion. My carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove by a preponderance of the evidence that the claimant is entitled to payment of medical expenses associated with the treatment of her blackouts, headaches, and vascular problems. Instead, the preponderance of the evidence shows that treatment associated with these conditions is not reasonable and necessary for the treatment of the claimant's

compensable injury because these conditions pre-date the claimant's compensable injury, and are, therefore, preexisting. Further, the claimant has failed to prove by a preponderance of the evidence that she is entitled to additional temporary total disability benefits for the above described period. Therefore, I find that the decision of the Administrative Law Judge should be reversed and these benefits denied.

The claimant worked as an adult case manager for the respondent employer at the time of her compensable injury. As such, the claimant's duties included transporting clients to medical appointments. It is undisputed that on March 20, 2002, the claimant sustained injuries to her right knee, neck, and low back as a result of a motor vehicle accident in which she was involved while transporting a client to a medical appointment. Subsequently, the claimant received all reasonably necessary medical treatment for those injuries, including surgeries to her right knee, cervical, and lumbar spine. These surgeries occurred respectively in July, September, and November of 2002. The claimant was declared to be at maximum medical improvement for her right knee on August 1, 2002, and for her spinal injuries as of March 5, 2003. The claimant's primary treating physician, Dr. Gregory

Ricca, released the claimant to return to light-duty work on March 10, 2003.

The claimant currently contends that she developed blackouts, headaches, and vascular problems as a compensable consequence of her injury of May 20, 2002. During her hearing of February 25, 2005, the claimant complained that she experiences heart palpitations and headaches so severe that they cause her heart and her blood pressure to do "weird things". In addition, the claimant testified that she experiences daily loss of feeling in her right leg, bilateral swelling of both her feet with unpredictable alternating hot and cold sensations, and a loss of sensation in her right hand. However, a review of the claimant's medical history reveals that the claimant suffered from these same symptoms well before her compensable injury of March 20, 2002. For example, the claimant was diagnosed with mitral and tricuspid heart valve prolapse in 1990, which caused her to experience heart palpitations, chest pains, and irregular heart beat. In addition, the claimant was previously diagnosed with TMJ, which caused her to have frequent reoccurring ear infections, headaches, and nausea. Further, the claimant has a positive medical history for hypoglycemia, gastroesophageal reflux disease, eye problems such as

photophobia, pain, and visual disturbances, heat intolerance and polyuria, asthma, and possible lupus. These conditions had been treated by various physicians for at least a decade prior to the claimant's compensable injury of 2002.

The most contemporaneous treatment that the claimant had received for any of her preexisting conditions prior to her March 20, 2002, accident, was in January of 2001. At that time, the claimant complained to her general practitioner, Dr. James Meredith, of joint stiffness during her annual physical examination. In his report of that examination, Dr. Meredith stated that "years ago she had been told she had positive ANA and probably had lupus." Dr. Meredith also assessed the claimant at that time with arthritis. Then, on September 5, 2001, the claimant was examined by Dr. Gary Woodward at the Otolaryngology and Facial Surgery Centre in Jonesboro for complaints of recurrent ear infection. A review by Dr. Woodward of the claimant's systems was positive for headache, visual problems, heat intolerance, chest pains and shortness of breath, puritis, abnormal bruising, and hay fever. In his report of her follow-up visit on September 7, 2001, Dr. Woodward stated that he observed TMJ crepitus upon

examination of the claimant, and he noted that the claimant's TMJ syndrome remained unchanged.

Although the claimant's neck and back injuries were accepted as compensable, the medical records confirm a positive history of neck and back problems associated with an auto accident in which the claimant was involved in 1993. Ironically, the claimant's two confirmed auto accidents were almost identical in that both incidents involved another vehicle allegedly pulling out in front her. After her 1993 accident, the claimant reported to her treating physician, Dr. Shelby White, that she was experiencing a "vague sort of discomfort and abnormal sensation" in her right shoulder and arm with "tingling down into her fingers." In addition, she reported to Dr. White that her fingers turned purple and swelled, that her right shoulder drooped, and that she experienced mild neck and back tenderness. At one point, the claimant reported to Dr. White that any type of use of her right arm caused her to have recurrent arm pain, and that she experienced one episode where her entire right arm went numb. Finally, the claimant complained of neck soreness and "constant" frontal headaches with a duration of two to three days per episode.

In an almost complete turnabout, however, on July 8, 1994, the claimant informed Dr. White that chiropractic treatment had "all but stopped" her headaches and nausea, and that it had helped improve the "spot on her low back." She further reported to Dr. White that her insurance company had recommended settlement regarding her 1993 automobile accident.

As previously mentioned, as a result of her automobile accident on March 20, 2002, the claimant sustained injuries to her knee, neck, and lower back. The record reveals that subsequent to the claimant's accident, she was referred by her employer to Dr. Metcalf who, in turn, referred her Dr. John D. Brophy for a second opinion. In his clinic note dated June 17, 2002, Dr. Brophy mentions that the claimant was transported to a hospital in Forrest City following her accident, where X-rays were taken. No record of this emergency treatment is found within the record. An MRI of the claimant's cervical and lumbar spines was taken in April of 2002 at the direction of Dr. Varner, and the claimant was referred for three weeks of physical therapy. Dr. Brophy reported that the claimant's chief complaint was related to upper extremity diffuse paresthesias, which was most noticeable while driving. On walking, the claimant complained of paresthesias of

her entire right lower extremity, which reportedly improved with rest. Dr. Brophy's neurological examination of the claimant showed mostly normal results, with the possible exception of decreased light touch sensory at the right C7-8 dermatomes. Dr. Brophy's review of the claimant's diagnostic testing revealed that she had multilevel degenerative changes in her cervical spine, with broad based bulging seen at C5-6 without definite evidence of nerve root compression. Moreover, there was evidence of a bulging disc, eccentric to the left at C6-7, also without evidence of spinal cord or nerve root compression. A review of the claimant's lumbar spine MRI showed multilevel degeneration at L3-4, L4-5, and L5-S1, with central bulging at L3-4 and a bulging disc eccentric to the right at L4-5. This study showed no evidence of nerve root compression at these levels. Dr. Brophy diagnosed the claimant with cervical and lumbar myofascial pain syndrome, which he associated with cervical spondylosis without clinical evidence of radiculopathy or myelopathy. In addition, Dr. Brophy assessed the claimant with upper and lower extremity paresthesias, which was considered non-dermatomal. Accordingly, Dr. Brophy made recommendations as follows:

The results of the cervical and lumbar MRI scans were reviewed with

Ms. Hughes. In my opinion, her symptoms would improve with gradual home exercise. I am unable to identify any objective reason why she could not return to work at full duty. She is currently scheduled to undergo follow-up evaluation with Orthopedics later this week.

The claimant testified that she was dissatisfied with Dr. Brophy's diagnosis, so she sought treatment under the direction of Dr. Glenn Dickson, who ultimately referred her to Dr. Gregory Ricca. On August 8, 2002, cervical spine and lumbar spine myelogram and CT scans were conducted at the direction of Dr. Ricca. These studies confirmed the claimant's disc degeneration as revealed in earlier diagnostic testing, and showed an apparent compromise of the right C6 nerve sleeve. In his discharge summary following these tests, Dr. Ricca stated:

I do not see a clear cause of the patient's symptoms on her studies through the pathology at C5-6 may account for some of her neck pain, bilateral shoulder pain, and some of the pain radiating into the right upper extremity.

Dr. Ricca noted that the claimant experienced nausea and headache after this testing was completed, and he ordered the claimant off of work until an EMG/NCV study was conducted. Concerning these various tests, the claimant testified that Dr. Ricca determined that she

had a ruptured disc in both her neck and spine, which necessitated surgery.

In the meantime, in a letter dated November 12, 2002, Dr. Dickson responded to inquiries by case manager, Ms. Diane Patton, concerning the status of the claimant's right knee as follows. First, Dr. Dickson responded that the claimant had reached maximum medical improvement from her right knee injury as of August 1, 2002. Second, Dr. Dickson indicated that the claimant had sustained no permanent partial impairment as a result of this injury.

On January 17, 2003, the claimant allegedly felt a pop in her back when she squatted to lift a relatively thin stack of paper from beneath a counter at work. At that time the claimant had been placed on light duty and she stated that she reported this incident to her employer. The claimant presented to Dr. Ricca on January 28, 2003, with complaints of low back pain and pain radiating into her left hip and anterior left thigh, with a tingling sensation into her interior left leg. In addition, the claimant complained to Dr. Ricca of recurrent pain into her right lower extremity that radiated all the way down into her right foot. The claimant described her symptoms to Dr. Ricca as "having an alien in her right foot." The claimant also reported

that she was experiencing alternating temperature variances in her feet. More particularly, the claimant informed Dr. Ricca that at times her feet would become ice-cold and pale, then at other times they would become hot and red, and that these symptoms would alternate between feet. Dr. Ricca believed these symptoms were the result of vascular hyperactivity in claimant's lower extremities. In addition to her lower extremity complaints, the claimant reported continuing neck pain and pain in her posterior right forearm that radiated into the 3rd digit of her right hand. She also complained of pain in the 4th and 5th digits of her right hand. Finally, the claimant reported that she was experiencing incontinence, she stated that driving worsened her symptoms, and she claimed she was unable to work. In spite of the claimant's myriad of complaints, a thorough examination by Dr. Ricca offered no objective medical explanation for the claimant's symptoms. For example, Dr. Ricca's physical examination of the claimant revealed good range of motion in both areas of the claimant's spine, with no observable muscle spasms. Further, X-rays that had been taken of the claimant's lumbar and cervical spine on January 17, 2003, revealed normal findings. Therefore, Dr. Ricca ultimately expressed that he was concerned about symptom

magnification on the claimant's part, and that he considered his entire examination of the claimant to be benign. Moreover, and more importantly, Dr. Ricca opined that the claimant's vascular instability was unrelated to her compensable injury, and he recommended that she be seen by a rheumatologist in order to determine whether she may be suffering from systemic lupus erythematosus "like her mother", from fibromyalgia, or some other autoimmune disorder.

Although eventually conceding in testimony that the incident of January 17, 2003, had only worsened her symptoms by approximately five to ten percent, the claimant at first testified that she thought her back had been broken at the time of this incident, and that her legs felt as if they each weighed 2,000 pounds, which was clearly an exaggeration of her symptoms.

The claimant's tendency to exaggerate her symptoms became increasingly more evident throughout the remainder of her medical treatment. For example, an MRI taken of the claimant's lumbar spine on February 1, 2003, revealed post-surgical changes on the right at L3-4 and L4-5, in the form of protrusions at those levels, but no disc herniation was indicated, as the claimant claimed to subsequent health care providers. Further, a functional capacity evaluation conducted on February 19,

2003, confirmed Dr. Ricca's earlier suspicions that the claimant was engaging in symptom magnification. More particularly, the evaluator, Mr. David M. Brick, noted that whereas the claimant was observed exiting her vehicle in the parking lot of the testing facility and ambulating with a normal gait to the entrance, she began limping immediately upon entering. Moreover, the claimant did not present under any acute distress, and she displayed good muscle tone and cervical mobility with spontaneous movement during her interview and evaluation. However, the claimant gave a guarded effort and tended to self limit due to complaints of pain during her more formal testing. Finally, the evaluator reported that the claimant gave a mixed performance throughout her examination which revealed many inconsistencies and indicated symptom magnification. Mr. Brick stated that the claimant's subjective complaints were accompanied by "an aura of inappropriate illness behaviors." Overall, the results of this FCE indicated that the claimant was making an expected recovery from her surgeries, and that she was able to perform light, sedentary type work with occasional lifting of 25 pounds, although she could probably exceed that level. In other words, this test revealed that the claimant was capable of performing her work duties with the

respondent employer in her current position, and that she could exceed her current job demands if necessary.

On March 5, 2003, Dr. Ricca wrote that the claimant's recent MRI showed no significant pathology in her lumbar spine, and that he had referred her to Dr. Roberts for her other complaints. Dr. Ricca opined that the claimant was at maximum medical improvement for her cervical and lumbar spine injuries, and he stated that she could return to light-duty as of March 10, 2005. Dr. Ricca assigned the claimant with a permanent partial impairment rating of 15% to the body as a whole for her spinal surgeries, and he released her from his care.

Finally, Dr. Ricca stated:

I provided the patient a return to light-duty work restriction of driving. I did this because the patient reported to me that driving caused her significant discomfort. I do not have any objective findings that show that this patient cannot drive for long periods of time.

The claimant testified that she had been warned by her employer after her release by Dr. Ricca in late March of 2003, that if she did not return to her regular duties, which included driving, she would be terminated. The claimant further testified she had been told by the respondent carrier that since she had reached maximum medical improvement and been released by

Dr. Ricca, they would no longer continue to pay for her medical treatment. The claimant testified that she returned to work at her regular duties for "three or four days". Then, on April 1, 2003, the claimant was allegedly involved in a "near-miss" automobile accident which she claims aggravated her neck condition and caused her to suffer an onset of new symptoms. These symptoms included black-out spells, sweating, heart palpitations, shortness of breath, and severe headaches. After this latest alleged driving incident, the claimant returned to work for the respondent employer on restricted duty. The claimant stated that she was eventually told by the respondent employer that if she could no longer fulfill her regular case management duties, she was no longer needed. Therefore, the claimant testified that she left her employment with the respondent employer on May 15, 2003. The claimant testified that she has not returned to work.

After the claimant left her employment with the respondent employer, she underwent several diagnostic studies in order to determine the nature and cause of her reported symptoms. More specifically, on June 12, 2003, the claimant underwent a carotid ultrasound and tilt table procedure under the direction of Dr. Ziad Awar for symptoms of dizziness and syncope.

The results of the first test were normal, revealing no plaque formation or stenosis in the claimant's carotid system. A mild increase in systolic flow velocity was noted in both common right and left carotids, more so proximally, consistent with cardiac output state/aortic stenosis. Likewise, the tilt table procedure resulted in normal findings. It was noted, however, that the claimant developed significant headache, nausea, retching and subsequent bradycardia after sublingual nitroglycerin was administered. Dr. Awar stated that the claimant's bradycardia was a "vasovagal reaction related to the patient's nausea and retching," and that it did not represent a neurocardiogenic component. In addition to the ultrasound and tilt table procedure, Dr. Awar referred the claimant for a 24 hour Holter monitor evaluation under the direction of Dr. Levinson. The results of this study, which was conducted on July 9, 2003, were benign. In addition, on July 9, 2003, the claimant underwent an echocardiogram under the direction of Dr. Levinson. Other than confirming the claimant's pre-existing mitral valve and tricuspid valve prolapse, the results of this test revealed normal findings.

On July 23, 2003, the claimant underwent a head magnetic resonance angiogram (MRA) under the direction of Dr. Ron South. Dr. Gerdes, who conducted

this study, reported that the claimant's right carotid circulation was unremarkable, while the claimant's left internal carotid circulation showed a mild irregularity without significant stenosis. There was a "questionable presence" of minimal attenuated lumen of the proximal left posterior cerebral artery, which was believed to "simply be an artifact". Otherwise, the claimant's intracranial circulation was unremarkable.

Dr. South ultimately referred the claimant for an evaluation by Dr. Victor Biton at the Arkansas Epilepsy Program. Dr. Biton conducted ambulatory monitoring of the claimant on August 1, 2003, through August 2, 2003, to determine if the claimant was having seizures. The results of that monitoring revealed normal EEG activity, and no epileptiform was identified. Likewise, no ictal events were captured and no push button events were recorded. Dr. Biton repeated this monitoring over the following two days. This time, Dr. Biton reported the following:

At 16:03:26, the patient was out of the camera view at the beginning. Later on, she came into the room. She plugged into the video unit. She started rocking in her rocking chair. She then pushed the event button and looked at the time. She documented "around 1500 got sleepy, laid back in chair, think I went to sleep or something, pushed the button after I came to myself."

chest felt tight and heavy, neck hurts, felt dizzy and nauseated."

In spite of the claimant's above statements, there were no associated changes on the claimant's EEG to indicate that an ictal epileptic event had occurred, and there were no changes on the claimant's EKG to suggest the occurrence of an arrhythmia related event. On September 10, 2003, the claimant presented to Dr. Ben Naidoo for recurrent fluctuating heart rate and near syncope events. She also reported to Dr. Naidoo that she was experiencing severe migraines which caused extreme fluctuations in her blood pressure. Dr. Naidoo monitored the claimant's heart activity for thirty days with an event monitor. Although the claimant continued to report what she described as "black out episodes" and that her heart would race, the monitoring results did not support these alleged events. In fact, the claimant's monitoring results were all within normal limits. In light of these benign findings, Dr. Naidoo referred the claimant for a neurological evaluation.

An MRI of the claimant's cervical spine was taken on January 22, 2004, the results of which were reviewed by Dr. Abraham on January 29, 2004. This study showed a minimal central bulge at C3-4, and a minimal to moderate herniation at C6-7, greater on the left. In his

report, Dr. Abraham stated, "Hold on any operative treatment." An MRI of the claimant's lumbar spine taken on February 1, 2004, showed post-operative changes only, with no new abnormalities. On February 12, 2004, the claimant was seen for a one time evaluation, at her own request, by Dr. Reginald Rutherford. In his summary of that evaluation, Dr. Rutherford reported that the claimant informed him that she had seen Dr. Abraham one week prior, and that he had advised her that she would likely require further cervical surgery. As indicated above, there is no documentation in the medical records which indicates that Dr. Abraham specifically made this recommendation. However, in a letter to the claimant's counsel dated April 9, 2004, Dr. Abraham stated that the claimant's current problems with her cervical and lumbar spine were related to her March 20, 2002, injury. Dr. Abraham offered no opinion regarding the etiology of the claimant's other complaints.

In slight contrast to Dr. Abraham's opinion, Dr. Rutherford gave no indication whatsoever that the claimant might require additional surgery to her lumbar or cervical spine. Concerning this, Dr. Rutherford stated:

There is nothing indicated on either [MRI] study which would support additional lumbar or cervical spinal surgery in Ms. Hughes' case.

...

In my opinion, Ms. Hughes is a poor candidate for further spinal surgery which is not recommended.

After a thorough review of the records, clinical examination, and taking into account the history provided to him by the claimant, Dr. Rutherford suspected that "conversion reaction is the predominant problem present." Therefore, he recommended that she complete EEG inpatient monitoring with Dr. Biton. "If this supports conversion, stated Dr. Rutherford "then psychological evaluation and counseling should be pursued."

The claimant did not return to Dr. Biton as scheduled, and on February 29, 2004, he wrote the following summary of her condition:

Conclusion: I did not find any objective evidence to support a diagnosis of epilepsy. The patient's typical episodes were captured while she was monitored. Those were not associated with any changes on the EEG to suggest ictal epileptic event or to the EKG to suggest an arrhythmia related event. The patient was instructed to contact me if she has any other types of events. If needed, she will undergo inpatient monitoring. At this time, I do not feel that is necessary.

Subsequently, the claimant was referred to Dr. Judy White Johnson for psychological evaluation. Dr.

White's report of that evaluation, which was conducted on February 3 & 4, 2005, is lengthy. Suffice it to say that many inconsistencies - perhaps more appropriately "exaggerations" - between the medical records and comments the claimant made to Dr. White concerning her condition are found within the doctor's detailed report. In her concluding comments, Dr. White states the following:

Ms. Hughes expects medical solutions to her problems and is unlikely to acknowledge the possibility of psychological factors having a role in her symptoms. Whatever physical problems were diagnosed, treatment will be complicated by her psychological pattern of functioning. Expect her physical symptoms to increase in times of stress. Expect there to be clear secondary gain associated with symptoms.

The overall pattern of these findings is consistent with Somatization and Conversion Disorder.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. § 11-9-508(a) (Repl. 2002). In the present claim, the employer respondent provided all reasonable and necessary medical treatment, including surgeries, for the claimant's compensable knee, neck, and back injuries which resulted from her

automobile accident of March 20, 2002. As previously mentioned, the claimant was released by her respective physicians for those injuries in August of 2002, for her compensable knee injury, and in March of 2003, for her back injuries. Thereafter, numerous objective diagnostic tests consistently showed that the claimant had sustained no new injuries to her previously injured areas, and that further treatment for her original compensable injuries was not warranted. In addition, the lack of objective physical findings reported by numerous treating and consulting physicians further demonstrates that the claimant had reached the end of her healing period for her compensable injuries as indicated, and that additional treatment for those conditions was unnecessary.

Injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. Norma Beatty v. Ben Pearson, Inc., Full Workers' Compensation Commission Opinion filed February 17, 1989, (Claim No. D612291). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba,

Inc., Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553). Finally, the respondent is only responsible for medical services which are causally related to the compensable injury. I find that the claimant has failed to prove by a preponderance of the evidence that her blackouts, headaches, and vascular problems are causally connected to her compensable knee and back injuries. Rather, the preponderance of the evidence clearly demonstrates that these problems are associated with other conditions which were preexistent to her automobile accident of March 2002. Lastly, the preponderance of the evidence shows that the majority of the claimant's current health related complaints are the result of a conversion disorder and somatization, as was definitively identified by Dr. White in January of 2005. This conclusion is strongly supported by the claimant's exaggerated statements concerning her symptoms to various medical providers throughout the course of her treatment. Ultimately, none of those health care providers could find an objective, physical explanation for the claimant's complaints. In addition, the claimant's subjective testimony showed that her interpretation of the severity of her numerous alleged medical problems was markedly greater than the objective

findings concerning these conditions, which was consistent with Dr. Whites's diagnosis. Questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. White v. Gregg Agricultural Ent., 72 Ark. App 309, 37 S.W.3d 649 (2001). Clearly, in light of the claimant's psychological component to her perceived illnesses, the claimant's testimony concerning the nature and severity of her physical conditions is of little probative value to the final determination of this claim. Therefore, the claimant's testimony should be given little weight.

For the reasons set forth above, I find that the claimant has failed to prove by a preponderance of the evidence that her blackouts, headaches, and vascular problems are causally connected to her compensable injury of March 20, 2002.

Lastly, the claimant has failed to prove by a preponderance of the evidence that she is entitled to additional temporary total disability benefits for her compensable injury. Temporary total disability is that period within the healing period in which an employee suffers a total incapacity to earn wages. K II Constr. Co. v. Crabtree, 78 Ark. App. 222, 79 S.W.3d 414 (2002). When an injured employee is totally incapacitated from

earning wages and remains in his healing period, he is entitled to temporary total disability. Id. The healing period is statutorily defined as that period for healing of an injury resulting from an accident. Dallas County Hosp. V. Daniels, 74 Ark. App. 177, 47 S.W.3d 283 (2001). The healing period ends when the employee is as far restored as the permanent nature of his injury will permit, and if the underlying condition causing the disability has become stable and if nothing in the way of treatment will improve that condition, the healing period has ended. Crabtree, supra. The question of when the healing period has ended is a factual determination for the Commission. The record reveals that the claimant's healing period for her compensable injury ended no later than March 5, 2003. Furthermore, the claimant has failed to prove by a preponderance of the evidence that she was totally incapacitated from earning wages after that date. On March 5, 2003, Dr. Ricca stated that he was releasing the claimant to the light duty work restriction of driving, but he added that he was doing so only because the claimant reported to him that driving caused her significant discomfort. Dr. Ricca specifically noted, "I do not have any objective findings that show that this patient cannot drive for long periods of time." Furthermore, the claimant's FCE

showed that she was completely capable of performing her case management job duties without restrictions. Shortly after returning to her regular duties, the claimant was allegedly involved in yet another driving incident, which she claimed caused her to experience an onset of new symptoms. As previously discussed, the claimant had been treated for many of these same symptoms for years prior to most recently alleged work related driving incident. Moreover, by her own admission, the claimant was ultimately not fired from her position with the respondent employer. The claimant voluntarily left her employment with the respondent employer on May 15, 2003, and although there is no objective medical reason why she cannot return to work, she has remained unemployed since that time. Clearly, the claimant has failed to prove that she remained within her healing period after she was released by Ricca on March 5, 2003, and she has failed to prove that she has been totally incapacitated from earning wages since May 15, 2003. Therefore, I find that the decision of the Administrative Law Judge concerning additional temporary total disability benefits should also be reversed. Accordingly, I respectfully dissent from the majority opinion.

KAREN H. McKINNEY, Commissioner