

**NOT DESIGNATED FOR PUBLICATION**

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F701096

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| CHARLES J. CAMPBELL, EMPLOYEE                        | CLAIMANT   |
| ROCKLINE INDUSTRIES, EMPLOYER                        | RESPONDENT |
| VALLEY FORGE INSURANCE COMPANY,<br>INSURANCE CARRIER | RESPONDENT |

**OPINION FILED DECEMBER 22, 2008**

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

Claimant represented by HONORABLE EDDIE WALKER, JR.,  
Attorney at Law, Fort Smith, Arkansas.

Respondent represented by HONORABLE MICHAEL ALEXANDER,  
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 May 19, 2008.

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

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

2. On January 9, 2007, the relationship of employee-employer-carrier existed between the parties.

3. On January 9, 2007, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$504.00 for total disability and \$378.00 for permanent partial disability.

4. The claimant has failed to prove by the greater weight of the credible evidence that he sustained a "compensable injury" to his neck or cervical spine on January 9, 2007. Specifically, he has failed to prove the occurrence of physical injury to this portion of this anatomy that occurred on that date that arose out of and occurred in the course of employment and that was caused by a specific incident, as required by Ark. Code Ann. §11-9-102(4)(A)(i).

5. The respondents have denied the occurrence of any compensable injury to the claimant's neck or cervical spine and have controverted this claim in its entirety.

The claimant alleges that he sustained a compensable injury that is governed by the Arkansas Workers' Compensation Act, A.C.A. § 11-9-101 et seq. The claimant's alleged injury is, indeed, an injury that is covered by the Act; however, the claimant has failed to establish the

elements necessary to prove a compensable injury by a preponderance of the evidence.

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.

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OLAN W. REEVES, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

**DISSENTING OPINION**

I must respectfully dissent from the majority opinion. After a de novo review of the record, I find the evidence shows that the claimant sustained a compensable injury to his back while working for the respondent on July 19, 2006, and that the respondent is liable for all reasonable and necessary medical care for the claimant's compensable injury. I also find that the claimant has shown by a preponderance of the evidence he is entitled to temporary total disability benefits from August 25, 2007 until a date to be determined, and therefore, I must respectfully dissent.

The parties stipulated that the claimant sustained a compensable back injury on July 19, 2006. The claimant was sent to the respondent's doctor, Dr. Vandergriff, who took x-rays, noted muscle spasms and prescribed muscle relaxers and physical therapy and gave the claimant a ten-pound lifting restriction. The claimant stated he tried to get

additional treatment afterwards by contacting his employer and the doctor's office but was not able to get treatment.

The employer shall promptly provide an injured employee with 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. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999). Here, the claimant testified that he contacted Valerie Terry, who handles workers' compensation at his employer, about getting more treatment, but she told him to contact the doctor's office about getting treatment. Then the doctor's office told him to contact his employer. The claimant stated twice at the hearing that he was getting "the run-around" from the respondent employer.

It is the function of the Commission to determine the credibility of the witnesses and the weight to be given their testimony. Wal-Mart Stores, Inc. v. Stotts, 74 Ark. App. 428, 49 S.W.3d 667 (2001). When the Commission weighs medical evidence and the evidence is conflicting, its resolution is a question of fact for the Commission. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). The Commission's resolution of the medical evidence has the force and effect of a jury verdict. Allen Canning Co. v. Woodruff, 92 Ark. App. 237, 212 S.W.3d 25 (2005).

I find the claimant to be a credible witness. I find it telling that the respondent has not attempted to deny the claimant's assertion that the respondent gave him the "run around" about providing him with additional medical treatment. The claimant stated this twice during the hearing, once while the respondent's attorney was cross examining him, but the respondent attorney never denied this allegation or attempted to refute it. On appeal the claimant strongly argues that he attempted to get treatment by contacting his employer, but his efforts were frustrated by

respondents. Even though the claimant has the burden of proof, it is remarkable that the respondents would not try to refute this allegation that they kept the claimant from getting the proper treatment he needed.

I would expect a bold accusation to trigger a bold response but the respondents have simply stated on appeal there is nothing in the record to support "his consternation about trying to see a doctor" and quickly move on to their argument that the claimant did not need treatment because he did not seek treatment on his own until December. The respondents rely on the mere fact that the claimant did not get treatment to support their argument that the claimant did not need treatment without addressing this issue of the claimant being obstructed from getting treatment.

The respondents have also argued that since the claimant is a nurse he should have known to go to the emergency room sooner. I find the fact that the claimant is a nurse to be less significant than the fact that the claimant tried to get treatment through the proper procedure but was thwarted by the respondents. The claimant did

finally go to the emergency room to get treatment out of desperation after waiting for the respondents to provide treatment.

The respondent's argument is, in a nutshell, that the claimant waited too long to get treatment so he did not need the treatment. However, I find that the respondents should not be allowed to benefit from frustrating the claimant's efforts to have the respondents provide appropriate medical treatment as mandated by Arkansas workers' compensation law.

The claimant went to the emergency room on December 27, 2006 to get treatment. The medical records from this visit with Dr. Ball show the muscle spasm and that the claimant stated his need for treatment was from the lifting incident at work. Dr. Ball also noted a clinical impression of an acute herniated disc at L4-5 of the claimant's spine and acute myofascial strain. Dr. Ball ordered x-rays, five views of the lumbar spine, which showed an unremarkable lumbar spine. The claimant was diagnosed with a herniated disc, given prescriptions for Flexeril, Vicodin, and

Prednisone, and follow up was recommended with Dr. Cyril Raben. This visit indicates that the claimant was getting treatment for his admittedly compensable July 19, 2006 injury because the symptoms were the same and there is no evidence in the record of any other injury between this visit and July 28, 2008 when the claimant was treated by Dr. Vandergriff.

The claimant returned to the emergency room on several occasions afterward to get treatment for his back injury. Each time he reported the same lower back pain, radiating into his legs, and told the nurses and physicians that he injured his back at work in July 2006 while lifting a patient. The only possible exception to this is a February 13, 2007 visit to the emergency room of the Northwest Medical Center of Washington County. The report of this visit seems to indicate that the claimant injured his back in a January 3, 2007 injury, which the respondents allege and the administrative law judge agreed with. However, the report also notes the initial injury in July 2006 and that the claimant injured himself while assisting a patient. This

report states the claimant was treated at the emergency room and referred to Dr. Raben but was unable to treat with Dr. Raben because of workers compensation issues. This seems to refer to the December 27, 2006 visit to the emergency room where the claimant was treated and referred to Dr. Raben and apparently was not able to get treatment with Dr. Raben because the respondent would not approve the treatment. Furthermore, this alleged injury of January 3, 2007 is inconsistent with the December 27, 2006 visit to the emergency room. If the claimant did not have a need for treatment until a January 3, 2007 injury then it does not explain why he went to the emergency room in December 27, 2006 complaining of the same injury he has had since the July 19, 2006 admittedly compensable injury. Since all of the other reports consistently state that the claimant injured his back while lifting a patient in July 2006, and since every report shows the same symptoms, I find that the one inconsistent report of February 13, 2007 is entitled to very little weight.

The claimant went to the emergency room on several occasions and almost every time the various doctors diagnosed a herniated disc. The claimant ultimately had two MRI's which both show partial disc desiccation at L4-5 and L5-S1, a herniated disc at L4-5 and a bulging disc at L5-S1. The evidence does demonstrate that these conditions shown on the MRI's were the result of the admittedly compensable injury of July 19, 2006. Dr. Knox stated in his reports of October 3, 2007; October 22, 2007; and December 4, 2007 that he recommends a myelogram to determine if a surgical decompressive procedure is necessary to relieve the claimant's pain from the disc herniation.

In conclusion, I find the claimant's testimony credible and that the claimant did prove that medical treatment provided after July 28, 2006 was reasonably necessary. The claimant has asked for more treatment and specifically for a myelogram. The evidence before us does show that the treatment recommendations of Dr. Knox are reasonably necessary in connection with the admittedly compensable injury. The evidence of record clearly shows

that the treatment recommended by Dr. Knox is reasonably necessary in connection with the claimant's lumbar herniated disc.

For the aforementioned reasons I must respectfully dissent.

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PHILIP A. HOOD, Commissioner