

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F512721

LINDA GREEN,
EMPLOYEE

CLAIMANT

ARKANSAS DEPARTMENT OF CORRECTION,
EMPLOYER

RESPONDENT

PUBLIC EMPLOYEE CLAIMS DIVISION,
INSURANCE CARRIER

RESPONDENT

OPINION FILED AUGUST 14, 2008

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

Claimant is Pro Se.

Respondent represented by the HONORABLE RICHARD S. SMITH,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed October 17, 2007. The administrative law judge found that the claimant proved she suffered a compensable carpal tunnel injury. After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. The Full Commission finds that the claimant did not prove she sustained a compensable carpal tunnel injury.

I. HISTORY

The parties stipulated that Linda Faye Green, age 49, sustained "a compensable head injury" on November 9, 2005. The claimant testified, *pro se*, that she hit a cabinet and cut her head. The claimant received emergency treatment on November 9, 2005 for a laceration to the forehead. An emergency department note dated November 10, 2005 indicated that the claimant had bent over and had hit her head on the hinge of a cabinet door. A "2 ½ cm laceration to forehead" was noted. The claimant was treated and was released to return to regular work.

The claimant treated with Dr. Gerald Morris on November 17, 2005:

This lady works at the Department of Corrections as an officer. Seven days ago, on the 10th, she was bending forward and scraped her forehead on a filing cabinet. She went to the emergency room and was given some Darvocet. She has been working and comes in today for follow up. She still has a painful, crusting lesion in the forehead and she has some blurry vision....

There is a 1 ½ " wide x ½ " linear crusting abrasion....There is minimal swelling of the left upper lid. The eyes are fine. The pupils are equal and reactive. Snellen examination is 20/30 right and left....

I showed the lady how to do simple cleaning, apparently she had not been told this or it did not register with her when she was in the

emergency room....I gave her a note for no work until the 21st....

Dr. Morris assessed "1. Contusion and abrasion of the forehead. 2. Eyelid contusion."

The claimant followed up with Dr. Morris on November 21, 2005: "Snellen examination on the 17th was right 20/30 and left 20/30. Today Snellen examination is right 20/20 and on the left where there is some swelling of the eyelid is 20/40....We have called and received permission for her to see the ophtalmologist. She is going to Dr. McFarland's today....I have gotten her a note for no work as it is my understanding that the Department of Corrections will not let injured individuals work where there is danger and I am not sure with vision disturbance that this lady could work safely." Dr. Morris assessed "Resolving abrasion and contusion of the forehead and left eyelid contusion."

An x-ray of the claimant's cervical spine was taken on November 30, 2005, with the impression, "Mild spondylitic changes at the C4-5 and C5-6 levels. Otherwise, normal exam."

Dr. Morris reported on November 30, 2005:

Ms. Green comes in for one of several follow ups over the last month or so we have seen her. She works for the Department of Corrections. This is

an injury on the job. We saw her on the 17th, seven days prior, on the 10th, she was bending forward, scraped her forehead, and bumped her right arm more so on the left in a kind of a fall at her work place....Today she comes in and tells me that she had a very minor problem that she did not think much of and did not mention it the first, second, or third visit that she was here; which is arm pain, now it is getting much worse. She has typical neuritic "toothache" pain in her right arm from her neck through her arm to her fingers with tingling and some numbness. This has now become a problem that she wants to discuss. I feel it is certainly related to the fall she had on the early part of November....

This lady still has some dizziness. This will be followed by Dr. Silas. She has exquisite pain to touch at the trapezius, upper thoracic area with pain radiating out her biceps into the forearm and into the thumb, index, and middle finger. This follows the nerve dermatome. She has toothache pain, pain to palpation, and also some loss of sensation. She states that about a week ago she noticed that she could not write down someone's phone number so she is losing some strength and use of her hand. Again please note that she has not worked for almost a month, since the day of her injury.

We did a neck x-ray and saw loss of cervical curvature with some very minor arthritic degeneration and early spurs of the midcervical vertebrae. This did not look to be terribly unusual. We fitted her with a neck collar. We gave her a Form-3 saying no work until she sees Dr. Silas, which will be the 16th of January. She knows the secretary. She will continue to call and try to make an appointment for a sooner visit....

Dr. Morris assessed "1. Forehead contusion. 2. Eyelid swelling. 3. Right arm neuritis."

Dr. David J. Silas, a neurologist, examined the claimant on January 20, 2006: "This is a 48-year-old female who states she was injured at work when bending over, lost her balance, and hit the top of her head on a cabinet and then jerked backwards quickly and injured her neck....The patient has not worked since 11/15/2005 due to her neck pain. She wakes up at night with the pain on the right side of her neck and is unable to move her head from side to side without pain....Strength is abnormal with decreased strength in the right upper extremity at 4+/5 and decreased grip in the right hand. The right upper extremity is definitely weaker than the left and patient is right-handed....X-rays done at the time of her initial injury were reviewed and it showed straightening of the curvature of the cervical spine, showing the muscle spasms. A CT of the head was reviewed, done 12/05/2005, and was negative."

Dr. Silas' impression was "Cervical disc injury with myelopathy." An MRI of the claimant's cervical spine was taken on January 25, 2006, with the impression, "1) Mild to moderate canal stenosis at the C4-C5, C5-C6, and C6-C7 levels due predominately to degenerative disc osteophyte changes. By prior reports, this is not significantly

changed since the previous studies. No significant foraminal narrowing is identified at any of the levels, although there is mild foraminal narrowing at the C5-C6 and C6-C7 levels." The claimant continued to follow up with Dr. Silas.

Dr. Silas reported on March 23, 2006:

This is a 47-year-old female who injured herself recently when she bent down and hit her head on a cabinet and jerked it back and then hit the back of her head, causing pain in her neck. The patient continues to have pain in her neck, radiating into her right shoulder with weakness of the right upper extremity. She has been put on pain medication, muscle relaxants, and a cervical collar with minimal improvement....The patient has had an x-ray of the cervical spine with an MRI that was done 01/25/06 which is abnormal and shows multiple areas of mild to moderate canal stenosis of C4-5, C5-6, and C6-7, which may be causing her problems. Patient needs a referral for a neurosurgeon....

Nerve conduction velocity examination done today was abnormal and showed an increased motor latency of both the median nerve at 6.0 milliseconds and the ulnar nerve at 3.8 milliseconds with a slowing of all three nerves conduction velocity with the median nerve being the slowest at 20 m/sec and normal greater than 50 m/sec. The ulnar nerve has a slowing at 33.3 m/sec and the radial nerve has slowing at 41.6 m/sec. Patient does have physiological indication of possible neck injury and needs to be referred for neurosurgery evaluation.

Dr. Silas' impression was "Cervical disc disease" and he stated, "The patient works for the prison system as a

security guard and with the weakness and inability to turn her neck without pain would be at risk to return to work. It is doubtful that this patient will improve sufficiently without surgery to return to work. Will await final disposition upon Dr. Simpson's evaluation."

Dr. P.B. Simpson, Jr., a neurosurgeon, examined the claimant on May 12, 2006:

She has two problems. One is numbness and paresthesias in her R hand in the median nerve distribution. This has been going on since Jan and has been waking her up at night. She has been worked up by Dr. Silas and was found to have carpal tunnel with a distal latency of 6.0 on the R side. She also has stiffness of her neck. I saw her back in 1994 for that. She has some degenerative changes. She had an MRI of her neck which shows that she has some spinal canal stenosis of a mild to moderate degree, especially at C4-5 with central disk bulging and there may be osteophyte there. She does not have any long track signs at all....She is complaining mainly of paresthesias in her R hand....We will go ahead and do her R carpal tunnel release on Tues. If she does alright and has further complaints or development of long track signs, we can work her up for her other problems.

Dr. Silas discharged the claimant on May 24, 2006 to follow up with Dr. Simpson.

Dr. Simpson stated on June 26, 2006, "This lady has a carpal tunnel syndrome. She also has some mild neck problems. She has some spondylotic changes with some mild

canal stenosis seen on her MRI, but I do not believe this is part of her problem at this time. I believe her neck problem at this time is the cause of her present symptoms."

The record indicates that Dr. James Alan Pollard, an orthopaedist, saw the claimant on August 21, 2006:

This is a 47 y/o R hand dominant female referred today by Dr. Williams for evaluation of CTS.

The pt has a hx of an injury in November 2005. She was working as a correctional officer at the Arkansas Department of Corrections. She was mopping when she bumped her head into a cabinet. She fell and landed hard on her R hand and wrist. She also wrenched her neck around when she struck the cabinet. She subsequently had problems with neck pain and she has also had problems with symptoms of CTS in the R hand....

Apparently, there has also been some concern about cervical radiculopathy....

The pt is also complaining of pain in her R elbow. She has had some problems with the R elbow since her initial fall, but this has been worse recently. She describes diffuse pain in the R elbow....

X-RAYS: R elbow, R hand and wrist were taken today in our office. AP and lateral radiographs of the R elbow are normal. There is no fx, dislocation, or degenerative change. Three views of the R hand and wrist are normal. There is no fx, dislocation, or degenerative change of the R hand or wrist....

Report of NCVs done by Dr. Silas 03-23-06 are included in the chart. Dr. Silas' interpretation was that this was an abnormal NCV of the RUE with

findings "indicating a probable carpal tunnel syndrome". Dr. Silas also noted some abnormal sensory conduction velocities of the other 2 nerves of the RUE which he felt were secondary to a sensory axonal polyneuropathy. Dr. Silas indicated no evidence of ulnar nerve entrapment. He did indicate that cervical pathology could not be ruled out.

Dr. Pollard's impression was "1) R CTS 2) R elbow lateral epicondylitis. 3) Possible cervical radiculopathy RUE." Dr. Pollard noted, "The pt certainly has classic symptoms of CTS in the R hand and she has a NCV study which is consistent with CTS of the R hand....I have explained that if we elect to proceed with surgical treatment of the R CTS, this should help with whatever aspect of her symptoms are secondary to CTS, but obviously this would have no effect on her cervical radiculopathy....With regards to the pt's elbow pain, I think she has lateral epicondylitis."

Dr. Pollard performed a "Right carpal tunnel release" on September 12, 2006. The pre- and post-operative diagnosis was "Right carpal tunnel syndrome."

Dr. Simpson reported on September 27, 2006, "Ms. Green apparently had a carpal tunnel release done by Dr. Pollard on 9/12/06....I saw her back today because she still has pain in her neck....I have really nothing to offer her surgically. She is not a candidate for surgical

decompression. She describes more of a cervical strain that anything else at this time."

The parties stipulated that the claimant received a change of physician to Dr. Steven Cathey. Dr. Cathey examined the claimant on March 19, 2007 and stated in part: "The patient presents with chronic neck and lower back pain that she relates to an occupational injury suffered while she was working as a guard for the Arkansas Department of Correction....As far as her occupational injury is concerned, I believe she has reached maximum medical improvement." Dr. Cathey signed a note on March 19, 2007 indicating that he had been treating the claimant for cervical strain and that the claimant would "never" be able to return to work. "Pt will file for disability," Dr. Cathey wrote.

A pre-hearing order was filed on May 22, 2007. The parties stipulated that the respondents "have accepted the claim for a head and neck injury and have paid temporary total disability benefits and medical benefits from November 10, 2005, through the present." The claimant contended that she "should be evaluated and treated as necessary by the Arkansas Spine Center for continued problems in her neck and

back which she contends are related to her original fall and that she should also be treated for carpal tunnel syndrome." The respondents contended that the evidence did "not establish the compensability of the carpal tunnel syndrome claim. Respondents further contend that the claimant had a compensable aggravation of her pre-existing head and neck condition and that all benefits have been paid."

An administrative law judge found, among other things, that the claimant proved she suffered a compensable carpal tunnel injury. The respondents appeal to the Full Commission.

II. ADJUDICATION

Ark. Code Ann. §11-9-102(4) (A) (Repl. 2002) 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 employee's burden of proof shall be a preponderance of the evidence. Ark. Code Ann. §11-9-102(4) (E) (i). Preponderance of the evidence means the evidence having greater weight or convincing force. *Metropolitan Nat'l Bank v. La Sher Oil Co.*, 81 Ark. App. 269, 101 S.W.3d 252 (2003).

An administrative law judge found in the present matter, "6. The claimant has proven by a preponderance of the evidence that she suffered a compensable carpal tunnel injury on November 9, 2005, and is entitled to payment of all medical expenses incurred as a result of her prior surgery." The Full Commission reverses this finding. The claimant did not prove that she sustained a compensable injury to her right upper extremity or right carpal tunnel on November 9, 2005.

The parties stipulated that the claimant sustained a compensable head injury on November 9, 2005. The claimant was treated for a laceration to her forehead. The evidence does not demonstrate that the claimant also injured her right upper extremity or right carpal tunnel on November 9, 2005. The initial medical records show that the claimant

sustained a forehead laceration and did not fall and injure her right upper extremity or right carpal tunnel. The Full Commission recognizes Dr. Morris' assessment of "right arm neuritis" on November 30, 2005 and Dr. Morris' statement, "I feel it is certainly related to the fall she had on the early part of November." The Full Commission must attach minimal weight to Dr. Morris' conclusion in this regard, which conclusion was based on the claimant's inaccurate history and was not corroborated by the record. See, *Roberts v. Leo Levi Hospital*, 8 Ark. App. 184, 649 S.W.2d 402 (1983). Nor was the claimant a credible witness before the Commission. The evidence and record before the Commission shows that the claimant did not fall and injure her right upper extremity or right carpal tunnel when the claimant sustained a laceration to her forehead on November 9, 2005. The Full Commission also notes Dr. Simpson's finding in May 2006 that the numbness in the claimant's right had begun the previous January, not on November 9, 2005 when the claimant sustained a forehead laceration.

The instant claimant did not prove that she sustained an accidental injury causing physical harm to her right upper extremity or right carpal tunnel. The claimant's

right carpal tunnel syndrome did not result from the November 9, 2005 compensable laceration to the claimant's forehead. The claimant did not prove that the right carpal tunnel release performed by Dr. Pollard on September 12, 2006 was reasonably necessary in connection with the November 9, 2005 accident.

Based on our *de novo* review of the entire record, the Full Commission reverses the administrative law judge's finding that the claimant proved she sustained a compensable carpal tunnel injury on November 9, 2005. This claim is denied and dismissed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. McKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion finding that the claimant did not prove she sustained a compensable carpal tunnel injury.

There is no dispute that the claimant suffered a serious compensable injury on November 9, 2005 when she slipped on a wet floor, caught herself falling, and hit her head on a cabinet. In the process of breaking her fall, the claimant testified that she put her hands on a table "making pressure on my hands". Subsequently, the claimant was found to have problems with her head, eye, neck, arm, hand, and fingers. While the record contains numerous medical reports concerning the treatment of the claimant's multiple injuries, only the records concerning the carpal tunnel syndrome will be considered below, as this is the only condition now in issue.

The claimant was initially seen in the emergency room. Later, she came under the treatment of Dr. Gerald Morris. On November 30, 2005, Dr. Morris wrote:

Today she comes in and tells me that she had a very minor problem that she did not think much of and did not mention it the first, second, or third visit that she was here; which is arm pain, now it is getting much worse. She has typical neuritic

"toothache" pain in her right arm from her neck through her arm to her fingers with tingling and some numbness. This has now become a problem that she wants to discuss. I feel it is certainly related to the fall she had on the early part of November.... (emphasis added)

The claimant was then seen by Dr. David J. Silas, Sr., a neurologist. Dr. Silas performed nerve conduction velocity studies which were abnormal. Dr. Silas said that the studies indicated "a possible carpal tunnel syndrome". Because of the abnormal studies, Dr. Silas sent the claimant to a surgeon for evaluation.

The claimant was next seen by Dr. P.B. Simpson, a neurosurgeon. On May 12, 2006, Dr. Simpson said:

She has two problems. One is numbness and paresthesias in her R hand in the median nerve distribution. This has been going on since Jan and has been waking her up at night. She has been worked up by Dr. Silas and was found to have carpal tunnel with a distal latency of 6.0 on the R side.

* * * *

We will go ahead and do
her R carpal tunnel
release.

The claimant was seen by Dr. James Allan
Pollard, orthopedic surgeon, on August 21, 2006. On
that date, Dr. Pollard said:

The pt certainly has
classic symptoms of CTS in
the R hand and she has a
NCV study which is
consistent with CTS of the
R hand.

* * * *

I discussed this with the
pt and I have explained
that if we elect to
proceed with surgical
treatment of the R CTS,
this should help with
whatever aspect of her
symptoms are secondary to
CTS, but obviously this
would have no effect on
her cervical
radiculopathy.

On September 12, 2006, Dr. Pollard performed surgery for
the treatment of carpal tunnel syndrome.

After careful consideration of the evidence
concerning the claimant's development of carpal tunnel
syndrome, the Administrative Law Judge found this

condition to be compensable. The majority opinion reverses this well reasoned decision finding that the evidence did not support the conclusion that the incident of November 9, 2005 inflicted any harm to the claimant's right hand. I believe that the evidence does, in fact, demonstrate the occurrence of a right hand injury at the time of the acknowledged compensable accident.

In Hall v. Pittman Construction Co., 235 Ark. 104, 357 S.W.2d 263 (1962), the Arkansas Supreme Court said:

If the claimant's disability arises soon after the accident and is logically attributable to it, with nothing to suggest any other explanation for the employee's condition, we may say without hesitation that there is no substantial evidence to sustain the commission's refusal to make an award.

A finding of compensability in this case calls for proof, by a preponderance of the evidence, of a specific incident, identifiable by time and place of occurrence, arising out of and in the course of employment, causing physical harm to the body, requiring

medical treatment or resulting in disability, which is established by medical evidence and supported by objective findings. Ark. Code Ann. §11-9-102(4)(E)(i); §11-9-102(4)(A)(i); and §11-9-102(4)(D).

All of the above cited statutory prerequisites for compensability have been met. The claimant had a serious injury on November 9, 2005. The accident was one which could have easily resulted in an injury to the hand and wrist when the claimant caught herself falling. Shortly thereafter, she began to experience problems with her right hand and was diagnosed by nerve conduction velocity studies to have carpal tunnel syndrome in that hand. Dr. Morris stated that the carpal tunnel syndrome was "certainly related to the fall she had in the early part of November". The successive treating specialists, a neurologist, a neurosurgeon, and an orthopedic surgeon, confirmed the diagnosis of carpal tunnel syndrome and did not disagree with the statement by Dr. Morris that the claimant's fall was the cause of the disorder. There was no evidence presented even remotely suggesting that the claimant's carpal tunnel syndrome preexisted her injury

or that there was any subsequently occurring independent intervening cause for her condition. The claimant's disability arose soon after the accident, was logically attributable to it and there was nothing to suggest any other explanation for the condition. Under these circumstances, the claimant certainly proved the compensability of this claim by a preponderance of the evidence.

For the reasons stated above, I must respectfully dissent from the majority opinion denying benefits to this deserving and legitimately injured worker.

PHILIP A. HOOD, Commissioner