

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F806617

CALVIN DANIEL,
EMPLOYEE

CLAIMANT

MILBANK MANUFACTURING COMPANY,
EMPLOYER

RESPONDENT

SAFETY NATIONAL CASUALTY CORP.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED OCTOBER 13, 2009

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

Claimant represented by the HONORABLE F. MATTISON THOMAS,
III, Attorney at Law, El Dorado, Arkansas.

Respondent represented by the HONORABLE WILLIAM C. FRYE,
Attorney at Law, North Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed May 15, 2009. The administrative law judge found that the claimant proved he sustained a compensable carpal tunnel syndrome injury. The administrative law judge found that the claimant proved he was entitled to surgery as recommended by Dr. Moore. After reviewing the entire record

de novo, the Full Commission affirms the administrative law judge's opinion.

I. HISTORY

The record indicates that Calvin Daniel, age 46, began working for Milbank in September 1999. Mr. Daniel testified that he started out working on a paint line, hanging meter sockets. The claimant testified, "In a normal shift, totally, all together what we would hang at the end of the night would be roughly close to 2000 to 3000 parts." The record indicates that the claimant was laid off in April 2001 and was recalled in May 2001. The claimant began complaining of work-related left shoulder problems in November 2001 and underwent left shoulder surgery in April 2002.

The claimant was laid off in November 2002 and was recalled in January 2003. Dr. D'Orsay D. Bryant, III saw the claimant on February 3, 2003:

The patient is a 40 year old male with a complaint of left shoulder pain. The patient stated that he had a work related injury in November of 2001. The injury was to the left shoulder. He is currently employed at the Milbank Company. He hangs meter sockets on the paint line. He also takes the meter sockets off of the paint line. He stated that all the sockets aggravate and make no difference, both small and big. He has to do a great deal of lifting and carrying objects. He

stated that he has pain and swelling in the left shoulder in his job, with hanging the parts on the paint line. He stated that he has pain particularly with overhead activities or with lifting heavy objects....He stated that he underwent left shoulder arthroscopy in April of 2002....He went back to work in August of 2002, but he has had persistent pain and swelling of the shoulder since that time....

Dr. Bryant's impression was "Left shoulder impingement syndrome, status post arthroscopy and PT."

The parties stipulated that the employment relationship existed at all relevant times, including September 28, 2005. The parties stipulated that the claimant "sustained a compensable wrist injury on September 28, 2005 which was accepted as a medical only claim." The claimant testified that he was injured as a result of "hanging those big sockets, 48-01 sockets....When I was picking them up and hanging them on the hook constantly is when I started feeling the tingling and swelling in my hand....I told Mr. Crawford that I was having a tingling and that my hand was swelling." Dwayne Crawford, a welding and paint supervisor for the respondents, agreed at hearing that the claimant reported he had hurt his wrist. The claimant testified that he continued to perform his work duties.

Dr. Greg Smart reported on October 6, 2005, "Mr. Daniel is seen in clinic today with complaints of right wrist pain. He injured his wrist lifting heavy sockets on 9/28/05. He complains of pain mainly of the right distal forearm." Dr. Smart assessed "Right forearm pain - tendinitis....EBI wrist splint is provided....As requested, he'll be allowed to return duties with splint in place." The claimant continued his work duties and continued follow-up visits with Dr. Smart.

Dr. C. Wayne Daniels, an orthopaedic specialist, corresponded with Dr. Smart on November 21, 2005:

Calvin Daniel is a right-hand dominant, 42-year-old, black male who works for Milbank. He states he has been having increasing pain in the "bone" of his right wrist. This has been going on for several weeks. He had a Medrol Dosepak that you prescribed, which helped somewhat. He lost the positive effect. He states he is actually better on Naprosyn.

X-RAY: THREE VIEWS, RIGHT WRIST - Review of three views of his right wrist shows a normal wrist.

On examination, his skin is intact. He has no swelling. He has no sensory loss in any digits of his right hand. He has full MP, PIP, DIP, and thumb IP joint motion of his right hand. He has palpable radial and ulnar pulses. Capillary refill is brisk in all digits of his right hand. He is somewhat tender around the ulnar and volar side of the right distal ulna. He is nontender over the TFCC or over the radiocarpal joint anywhere.

Dr. Daniels' impression was "Right wrist pain....He is able to function at work in his brace. I think he should continue to use it as needed. I have written him a prescription for a month's supply of Naprosyn 500 mg twice a day. I will see him back in one month for clinical followup."

The claimant followed up with Dr. Daniels on December 21, 2005:

He has not had any trauma. He complains of pain around the ulnar styloid and some just distal to that now. He does have some tenderness over the region of the TFCC today, which is different from his November 21, 2005, exam. He has no swelling. He has no pain on passive range of motion with flexion, extension, pronation, supination, or radial and ulnar deviation. All of these are full. He has no neurovascular deficits on the right hand. He states when he takes Naprosyn he does tolerably well. He states when he is at home he does not wear his brace, and he does not have much in the way of pain at that time.

I do not think he needs further radiographic workup, such as an MRI, given his lack of pain when he is not working. I think he has an overuse strain-type syndrome in his ulnar right wrist, which is being adequately protected with anti-inflammatory medications and a brace. We provided him with a new brace and refilled his Naprosyn. I will see him back as needed or desired.

Dr. Daniels reported on January 12, 2007: "Calvin Daniel comes back with recurrence of pain in his right

wrist. The brace I had given him has completely worn out. He uses it at work. He is beginning to have some similar symptoms of pain that is diffuse in his left wrist as well. He has some diffuse tenderness to palpation. I do not see anything that is particularly point tender on his wrist except for maybe a little extra tenderness on the ulnar aspect region of the TFCC. He complains of intermittent numbness in his wrist, and Naprosyn is no longer helping. We are going to brace both wrists and give him a Medrol Dosepak. I am going to get an MRI of his right wrist to make sure we do not have a surgical lesion. If his numbness continues, we may have to work him up with electrodiagnostic studies looking at carpal tunnel syndrome although he does not have firm signs of that today. I will see him back after the MRI is done. He may continue working with his braces on."

An MRI scan of the claimant's right wrist was taken on January 17, 2007, with the following impression:

1. Fluid in all three wrist compartments may reflect underlying synovitis.
2. No intercarpal ligament tear or tear of the triangular fibrocartilage.
3. No occult fracture or contusion.
4. Mild pisiform-triquetral joint degenerative changes.

5. Dorsal position of the distal ulna relative to the sigmoid notch in the position scanned may just be positional in character, as noted and discussed above.

Dr. Daniels noted on January 19, 2007:

Calvin Daniel comes back after MRI of his right wrist. It does not show a TFCC tear or intercarpal ligament tear. He does have some mild degenerative changes and synovitis and fluid in all three wrist compartments. I offered him a corticosteroid injection. He would prefer not to do that but to try another Medrol Dosepak. We are going to give him a Medrol Dosepak and check him back in 10 days. He does not have a large effusion today. He only has mild tenderness in his wrist. He has full flexion and extension and radial and ulnar deviation without significant pain. He did improve a little bit with bracing and the first dosepak.

Dr. Daniels noted on January 29, 2007, "He had some disagreement with his employer over the length of his light duty status. He would like to stay on light duty for the remainder of this week then go back on full duty on Monday, February 6. I have no objection to that."

Dr. Daniels reported on April 27, 2007, "Calvin Daniel comes back complaining of right wrist pain....He is having ongoing pain at work....He will get a new brace. On examination, his skin is intact. He has full pain free range of motion. He is not point tender anywhere although he complains of pain in the ulnar aspect of his hand."

Dr. Daniels' impression on July 30, 2007 was "Recurrent synovitis in the right wrist....He has expressed a desire to be on light duty in two weeks if he is not improved." Dr. Daniels noted on August 30, 2007, "He has no swelling today. He has full passive range of motion. He is still tender at the radiocarpal joint....I injected his right wrist with Depo-Medrol and Xylocaine....He is going to return to full duty today as well." The claimant continued to schedule follow-up appointments with Dr. Daniels. Dr. Daniels noted on December 12, 2007, "He states he uses an air gun repetitively for eight hours a day." Dr. Daniels' impression was "Right hand pain." Dr. Daniels reported on January 28, 2008:

Calvin Daniel comes back for followup on his right wrist pain. He continues to have difficulty. The Naprosyn I gave him on his last visit did not help. It has been over a year since 01/17/2007 right wrist MRI, which showed synovitis but no TFCC tear. On examination, he still has tenderness to palpation globally in his wrist with flexion, extension, radial and ulnar deviation. I have recommended outpatient arthroscopy and debridement. He would like to give it some thought. We will go ahead and start the workman's compensation approval process. I will see him back in about a month.

The respondents' Work Record exhibit indicates that the claimant was laid off on or about February 15, 2008 for lack of work.

Dr. Daniels reported on March 10, 2008:

Calvin Daniel is a 45-year-old right-hand dominant black male whom I have seen extensively since November 21, 2005. He has had ongoing wrist pain. He has been treated with conservative treatment now for over two years with bracing or corticosteroids or nonsteroidal anti-inflammatory medicines, and injections. MRI showed mild degenerative changes and synovitis. That was obtained in early 2007 on January 17, 2007. I think it is time to be more aggressive. We are going to do an outpatient arthroscopy and debridement as indicated....

BACK/EXTREMITIES: Back, bilateral upper extremities, and bilateral lower extremities are grossly within normal limits except for the right wrist, which has diffuse pain on palpation. It is not swollen. There are no neurovascular deficits in the right upper extremity.

Dr. Daniels' impression was "Chronic synovitis in the right wrist. PLAN: Outpatient arthroscopy and debridement of his wrist as indicated." A claims representative for the respondent-carrier informed a member of Dr. Daniels' office on March 28, 2008, "Please be advised that as of this date we have not authorized any surgical procedure under workers' compensation for this claimant. If Mr. Daniel elects to go forward with the procedure it will need to be billed to his personal health insurance carrier. Should our position

change in the near future you will be the first advised of same." The claimant testified, "When I went to have the surgery, I didn't find out that the surgery was cancelled until I got there."

Dr. Michael M. Moore, an orthopaedic specialist, corresponded with the respondent-carrier on May 13, 2008:

Mr. Calvin Daniel was seen at the **Arkansas Hand Center** on May 13, 2008, for an independent medical evaluation. Mr. Daniel is a pleasant 45-year-old right hand dominant gentleman who reports that he performed repetitive work using his right hand for approximately nine years. Mr. Daniel worked on the flow line, which involved him building parts. He describes his work as requiring frequent and forceful gripping using his right hand. Approximately one year after beginning work he noted pain, swelling, and numbness in the right hand. During the past eight years his symptoms have persisted. He denied a distinct incident of trauma. According to the medical records, Mr. Daniel first reported the problem on September 28, 2005....An MRI scan of the right wrist performed on January 17, 2007, revealed fluid in all three wrist compartments, which the radiologist felt might represent synovitis. In addition, there was evidence of mild pisotriquetral joint degenerative arthritis. There was no evidence of an intercarpal ligament tear. Mr. Daniel presents today for evaluation. He describes intermittent pain, swelling and numbness in his right hand and arm. The symptoms will awaken him at night and are aggravated when he drives his car....

There is no evidence of swelling, inflammation, erythema, or edema in the hand, wrist, or forearm....

X-rays including AP and lateral x-rays of the right hand and wrist were ordered. The x-rays do not reveal any evidence of degenerative changes or inflammatory disease.

It is my opinion Mr. Daniel's clinical history and physical examination are most consistent with a right carpal tunnel syndrome. It should be noted that his clinical history and physical examination did not suggest any evidence of right wrist synovitis. I did not have the MRI scan for review.

Mr. Daniel did report an eight year history of intermittent pain, swelling and numbness in the right hand. If he performed work activities which required frequent forceful gripping and lifting using his right hand and arm, it is my opinion this type of work activity could aggravate the symptoms associated with carpal tunnel syndrome.

If Mr. Daniel were my patient, I would recommend his right hand and wrist be evaluated with a triphasic bone scan. The bone scan would help to determine whether there was any evidence of inflammatory or degenerative disease. In addition, blood studies would be performed to rule out inflammatory arthritis. Finally, I would recommend that Mr. Daniel's right hand be evaluated with a nerve conduction and EMG study. I would determine whether Mr. Daniel required any further evaluation or treatment based on the results of each of these studies. These statements are made within a reasonable degree of medical certainty....

A Limited Triple Phase Bone Scan of the Bilateral Hands was done on May 29, 2008, with the following opinion:

"Subtle but asymmetric increased right hand and wrist soft

tissue uptake possibly from reflex sympathetic dystrophy.
Recommend clinical and plain film correlation."

Dr. Reginald J. Rutherford reported on May 29, 2008:

Mr. Daniel is seen for electrodiagnostic testing to further investigate clinical suspicion for carpal tunnel syndrome....The nerve conduction study is abnormal confirming right carpal tunnel syndrome. Changes are moderate in degree. Study of the ulnar nerve is normal as is electromyographic examination right upper extremity there being no evidence for radiculopathy or plexopathy. In summary present study demonstrates evidence for right carpal tunnel syndrome. Changes are moderate in degree.

The claimant followed up with Dr. Moore on May 29, 2008:

A triphasic bone scan performed on May 29, 2008, was unremarkable except for subtle increased activity in the right hand and soft tissue of the wrist. The radiologist felt this could be related to reflex sympathetic dystrophy. Mr. Daniel's clinical history and physical examination are not consistent with reflex sympathetic dystrophy. A nerve conduction and EMG study performed by Dr. Reginald Rutherford earlier today was consistent with a moderate right carpal tunnel syndrome....

Mr. Daniel describes pain and numbness in his right hand and arm. The symptoms will awaken him at night. His clinical history, physical examination, and the nerve conduction and EMG study are consistent with a right carpal tunnel syndrome. As stated above, his clinical history, physical examination, and objective studies are not consistent with right wrist synovitis.

Today I discussed treatment options with Mr. Daniel. The options included splinting, injection and splinting, or carpal tunnel surgery. Mr. Daniel reports that the pain and numbness in his right hand have not significantly improved with splinting. He has requested to proceed with a right carpal tunnel release. I felt this was a reasonable decision....The surgery will be performed on an outpatient basis in the near future....

A pre-hearing order was filed on November 13, 2008. The claimant contended that he "suffered a wrist injury while working for the respondent-employer on 9/28/05. That claim was accepted as a medical only claim....Claimant returned to work and continued to work until April 2007, when claimant who was continuing with his job or (sic) rapid repetitive motion, began to experience problems with his carpal tunnel syndrome again....Respondents sent the claimant to see Dr. Moore, who diagnosed the claimant as having carpal tunnel syndrome of the right wrist. Dr. Moore scheduled surgery. The respondents then denied the claim and laid the claimant off, February 2008, and has refused to pay for surgery that Dr. Moore says needs to be done. Without the needed medical treatment, the claimant continues to suffer problems with his wrist....The claimant is

entitled to the surgery by Dr. Moore, and additional medical treatment until the end of his healing period...."

The respondents contended that the claimant "suffered a wrist sprain while lifting a socket on a paint line on 9/28/05. This was accepted as a medical only claim....The respondents contend that carpal the tunnel (sic) syndrome that Dr. Moore is wanting to treat is not a compensable consequence of the claimant's wrist problems."

The parties agreed to litigate the following issues:

1. Compensability of carpal tunnel syndrome that arose on or about 9/28/05 or later.
2. If compensability is overcome, whether claimant is entitled to temporary total disability from 2/18/08 to a date to be determined, all associated medical, and attorney's fees.

The parties deposed Dr. Moore on December 9, 2008. Dr. Moore agreed that he had diagnosed the claimant as having carpal tunnel syndrome on the right. The claimant's attorney questioned Dr. Moore:

Q. And - so your diagnosis and you're willing if it's approved to perform right carpal tunnel release on Mr. Daniel?

A. Correct....

Q. Based on your review of the testing and your examination of Mr. Daniel, is it your opinion, to a reasonable degree of medical certainty, that Mr.

Daniel is a candidate for right hand carpal tunnel release?

A. Yes, based on his clinical history, physical examination and nerve conduction study.

The respondents' attorney questioned Dr. Moore:

Q. And as we sit here today, what can you say within a reasonable degree of certainty is he has carpal tunnel?

A. I can.

Q. As far as what the cause is, you can't say within a reasonable degree of medical certainty what's causing that?

A. No.

A hearing was held on February 18, 2009. The claimant testified regarding his right hand, "I don't hardly have any feeling in it." The claimant testified that his symptoms had worsened since leaving his employment.

An administrative law judge filed an opinion on May 15, 2009. The administrative law judge found that the claimant did not prove he was entitled to temporary total disability benefits from February 18, 2008 to a date yet to be determined. The claimant does not appeal that finding. The administrative law judge otherwise found that the claimant proved he sustained a compensable injury to his right wrist in the form of carpal tunnel syndrome. The administrative

law judge found that the claimant proved he was entitled to reasonably necessary medical treatment, including surgery recommended by Dr. Moore. The respondents appeal to the Full Commission.

II. ADJUDICATION

Ark. Code Ann. §11-9-102(4) (Repl. 2002) provides:

(A) "Compensable injury" means:

(ii) An injury causing internal or external physical harm to the body and arising out of and in the course of employment if it is not caused by a specific incident or is not identifiable by time and place of occurrence, if the injury is:

(a) Caused by rapid repetitive motion. Carpal tunnel syndrome is specifically categorized as a compensable injury falling within this definition[.]

(E) BURDEN OF PROOF. The burden of proof of a compensable injury shall be on the employee and shall be as follows:

(ii) For injuries falling within the definition of compensable injury under subdivision (4) (A) (ii) of this section, the burden of proof shall be by a preponderance of the evidence, and the resultant condition is compensable only if the alleged compensable injury is the major cause of the disability or need for treatment....

(14) (A) "Major cause" means more than fifty percent (50%) of the cause.

(B) A finding of major cause shall be established according to the preponderance of the evidence[.]

Preponderance of the evidence means the evidence having greater weight or convincing force. *Smith v. Magnet Cove Barium Corp.*, 212 Ark. 491, 206 S.W.2d 442 (1947). Because carpal tunnel syndrome is by definition a gradual-onset

injury, it is not necessary that the claimant prove his injury was caused by rapid repetitive motion. *Kildow v. Baldwin Piano & Organ*, 333 Ark. 335, 969 S.W.2d 190 (1998).

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).

An administrative law judge found in the present matter, "3) The claimant has proven by a preponderance of the evidence that he sustained a compensable injury to the right wrist in the form of carpal tunnel syndrome." The Full Commission affirms this finding. The claimant became employed with the respondents in September 1999. The claimant credibly testified that he hung meter sockets in his work, handling 2,000 to 3,000 parts per shift. The claimant underwent surgery for a compensable left shoulder condition in April 2002. Dr. Bryant noted in February 2003 that the claimant's work involved hanging meter sockets on a paint line.

The parties stipulated that the claimant sustained a compensable wrist injury on September 28, 2005. The

claimant's credible testimony indicated that his symptoms developed gradually as the result of hanging large sockets at work. The claimant began treating with Dr. Smart in October 2005 for right wrist and forearm pain resulting from lifting heavy sockets at work for the respondents. Dr. Daniels began treating the claimant in November 2005 and diagnosed right wrist pain. Dr. Daniels noted that the claimant was able to function at work while wearing a brace on his right forearm. Dr. Daniels noted in December 2005 that the claimant's pain subsided when the claimant was not at work. Dr. Daniels' impression was "overuse strain-type syndrome in his ulnar right wrist." The claimant continued to work with a brace and continued follow-up visits with Dr. Daniels.

An MRI scan of the claimant's right wrist in January 2007 showed fluid in all three wrist compartments. Dr. Daniels noted in December 2007 that the claimant used an air gun repetitively at work. Dr. Daniels reported in January 2008 that he planned to perform surgery on the claimant's right wrist. The claimant was laid off on or about February 15, 2008 for lack of work (the record does not indicate that the respondent-employer laid off the claimant because of his

work-related symptoms). The respondent-carrier did not authorize surgery recommended by Dr. Daniels. Instead, the claimant was sent for an evaluation by Dr. Michael M. Moore. Dr. Moore's evaluation on May 13, 2008 corroborated the claimant's testimony that his work had involved frequent and forceful gripping of the right hand for approximately nine years. Dr. Moore opined that the claimant's clinical history and physical examination were "most consistent with a right carpal tunnel syndrome." Dr. Moore recommended additional diagnostic testing. Dr. Rutherford reported on May 29, 2008 that a nerve conduction study was "abnormal confirming right carpal tunnel syndrome." Dr. Moore recommended a right carpal tunnel release.

The Full Commission finds that the claimant proved by a preponderance of the evidence that he sustained a compensable injury in the form of right carpal tunnel syndrome. The Full Commission finds that the compensable injury caused physical harm to the claimant's body and arose out of and in the course of employment. The compensable injury was not caused by a specific incident and was not identifiable by time and place of occurrence. The claimant established a compensable injury by medical evidence

supported by objective findings, namely, the May 29, 2008 nerve conduction study which was abnormal and which confirmed right carpal tunnel syndrome. This objective medical finding could not come under the voluntary control of the claimant. The claimant proved by a preponderance of the evidence that the compensable injury was the major cause of the need for treatment. Our decision that the claimant proved he sustained a compensable injury is based on the claimant's credible testimony, the corroborating medical records, and Dr. Moore's reports and testimony.

B. 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) (Repl. 2002). The claimant must prove by a preponderance of the evidence that he is entitled to requested 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).

An administrative law judge found in the present matter, "4) The claimant has proven by a preponderance of the evidence that he is entitled to all reasonable and necessary medical treatment related to his compensable right carpal tunnel syndrome injury, including but not limited to all treatment contained in the record to the claimant's right upper extremity and the right carpal tunnel release surgery now recommended by Dr. Moore." The Full Commission affirms this finding. We have determined that the claimant proved that he sustained a compensable injury in the form of right carpal tunnel syndrome. The record demonstrates that the treatment of record received by the claimant on and after September 28, 2005 was reasonably necessary in connection with the compensable injury. Dr. Moore opined that a right carpal tunnel release was a reasonable treatment for the claimant. The Full Commission finds that Dr. Moore's expert opinion is credible and entitled to significant evidentiary weight. The administrative law judge's decision is affirmed.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant proved he sustained a compensable injury in the form of right carpal tunnel

syndrome. The claimant proved that all of the medical treatment of record on or after September 28, 2005 was reasonably necessary in connection with the compensable injury. The claimant also proved that a right carpal tunnel release as recommended by Dr. Moore was reasonably necessary. We therefore affirm the administrative law judge's findings. For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to a fee of five hundred dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.