

**NOT DESIGNATED FOR PUBLICATION**

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION  
CLAIM NO. F803166

APRIL EVANS, EMPLOYEE	CLAIMANT
VAN BUREN SCHOOL DISTRICT, EMPLOYER	RESPONDENT
RISK MANAGEMENT SERVICES, CARRIER	RESPONDENT

OPINION FILED JANUARY 20, 2010

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

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

Respondents represented by HONORABLE CONSTANCE CLARK, Attorney at Law, Fayetteville, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Claimant appeals from a decision of the Administrative Law Judge filed July 30, 2009.

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 August 15, 2007, the relationship of employee/self-insured employer/third party administrator existed between the parties.

3. On August 15, 2007, the claimant earned wages sufficient to entitle her to weekly compensation benefits fo \$504.00 fo total disability and \$378.00 for permanent partial disability, should such benefits have been appropriate.
4. The claimant has failed to prove that, on August 15, 2007, she sustained a "compensable injury" to her coccyx. Specifically, the claimant has failed to prove by medical evidence, which is supported by "objective findings", the actual existence of any physical injury or damage to her coccyx, as required by Ark. Code Ann. § 11-9-102(4) (D).
5. The claimant has failed to prove by the greater weight of the credible evidence that, on August 15, 2007, she sustained a "compensable injury" to her lumbar spine. Specifically, the claimant has failed to prove by the greater weight of the credible evidence that the August 15, 2007 fall likely or probably caused or contributed to the lumbar difficulties that she may have experienced after that date. Thus, the claimant has failed to satisfy the definitional requirements for a "compensable injury", as contained in Ark. Code. Ann. § 11-9-102(4) (A) (i).
6. The respondents have denied the occurrence of any compensable injury to the claimant's lumbar spine or coccyx and have controverted this claim in its entirety.

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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A. WATSON BELL, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

**DISSENTING OPINION**

After my de novo review of the entire record, I must respectfully dissent from the majority opinion. I find that the claimant proved the compensability of her sacral

and lumbar injuries and is entitled to medical and indemnity benefits for the same.

For the claimant to establish a compensable injury as a result of a specific incident, the following requirements of Ark. Code Ann. §11-9-102(4) (A) (i) (Repl. 2002), must be established: (1) proof by a preponderance of the evidence of an injury arising out of and in the course of employment; (2) proof by a preponderance of the evidence that the injury caused internal or external physical harm to the body which required medical services or resulted in disability or death; (3) medical evidence supported by objective findings, as defined in Ark. Code Ann. §11-9-102 (4) (D), establishing the injury; and (4) proof by a preponderance of the evidence that the injury was caused by a specific incident and is identifiable by time and place of occurrence. Mikel v. Engineered Specialty Plastics, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

The claimant consistently reported a fall at work in the medical records and at the hearing, and her testimony was corroborated by her co-worker, Lisa Mayfield. There was no testimony to contradict this testimony. On the afternoon of August 15, 2007, the claimant, a teacher, was

entering her classroom, after a professional development program and on her way to begin preparing for a parent-teacher meeting the following evening. She was speaking to a fellow teacher, and as she moved into her classroom, she lost her balance on the stairs, falling from the top of her stairs to the ground, landing on her bottom. She also bumped her head. The claimant was performing employment services when she was moving from one job duty, professional development, on one part of the school campus, into her classroom to perform another job duty, to prepare for a back-to-school event. I find that the claimant proved by a preponderance of the evidence that she sustained an injury arising out of and in the course of her employment, and that there was a specific injury, identifiable by place and time.

The claimant testified that she suffered immediate pain, that she required assistance to rise, and that while she was able to drive the twelve miles to her home, it was necessary for her to be taken to the emergency room that same evening because of the severity of her pain. The claimant's testimony and the medical records are consistent, stating that she required an injection of Stadol, doses of Phenergan and a prescription for Lorcet Plus. Dr.

Standefer, the claimant's neurosurgeon, testified at deposition that Stadol is a powerful synthetic narcotic, the use of which indicated that the claimant was in severe pain. He also explained that Phenergan is an anti-nausea medication which has a calming or sedative effect, useful in addressing pain as well. Lastly, he explained that Lorcet Plus is an oral synthetic narcotic which is used to control significant pain as well.

The claimant also testified that she had never had pain like the pain she suffered after the fall, immediately or later as her radicular pain began. She explained that she had pain in her pelvic area, but that it was not back pain like the pain she suffered after the fall. She had pain prior to that incident, which was suspected to relate to kidney stones. The medical records indicate that on July 30, 2007, the claimant went to Dr. Sutterfield complaining of continued pain "in side kidney area." The doctor noted pain in her flank and groin, and diagnosed flank and pelvic pain. Renal and pelvic ultrasounds, performed on August 1, 2007 were within normal limits. The claimant returned on August 14, 2007, reporting continued pain "in lower back on left side." Dr. Sutterfield noted that the claimant "still

has pain left flank with no fever." She diagnosed "flank pain," noted her history of kidney stones, and planned a spinal CT scan. CT scans of her abdomen and pelvis were performed on that dated, revealing a gallstone in contracted gallbladder, but no proximal or distal urinary tract stones. Dr. Standefer noted that the claimant's description of low back left side pain on August 14 reflects layman's language and not the existence of lumbar pain. In reviewing the records, and the claimant's testimony, which is clear that the claimant did not have lumbar, sacral or coccygeal pain before her fall, I find that the claimant had flank and groin pain prior to August 15 and that the pain in her low back and tail bone did not exist prior to her fall on August 15, 2007. It is also relevant to note that the claimant has undergone gynecological surgery for recurrent flank and groin pain, resulting in the removal of a recurrent cyst and a polyp, with plans for a hysterectomy to finally address the cyst pain. I also find that the claimant has proven by a preponderance of the evidence that her fall on August 15, 2007 caused internal or external physical harm to the body which required medical services or resulted in disability.

I note that the majority places weight on the clinical history for the MR scan on August 17, 2007, which stated "back strain with left side pain." On August 14, the MR scan was ordered for the claimant's left-sided pain, and on August 15, the claimant suffered a fall which caused her back pain. The clinical history noted on that MR report does not show that the claimant had a history of back strain prior to the fall.

I note the majority's concern that the claimant reported to Dr. Standefer that she had back pain and bilateral radiation since August 15, 2007. I note that the claimant was very specific about her fall and her coccygeal pain according to the emergency room records. Dr. Hamby's records do not address causation at all or any type of timeline, although her low back pain and radicular pain, her fractured coccyx and her history of kidney stones were mentioned. It appears that the claimant reviewed all of her potential problems with Dr. Hamby. Dr. Standefer noted her fall, her low back pain, bilateral numbness, as well as her broken tailbone. He is not specific about the timeline of her pain either. However, on October 15, 2007, Dr. Miller who administered the lumbar epidural steroid injections,

noted that her current condition of back and buttock pain had existed for one month. I find that the claimant was not untruthful in her descriptions of her pain, and that the record supports her testimony that her pain increased over time. Dr. Standefer's notes are an example of imprecision in note-taking, not of any embellishment on the claimant's part.

The last hurdle for the claimant, for both the injury to her coccyx and her lumbar spine, is the presence of objective findings to evidence the injuries.

As to the injury to the claimant's coccyx, I find that the emergency room medical record, documenting Dr. Chavis' observation, on August 15, 2007, of "anterior dislocation distal coccyx" is sufficient to satisfy the requirements of an objective finding of injury. This conclusion is supported by the doctor's diagnosis of a fractured coccyx and the treatment, including the use of two powerful narcotic medications to address the claimant's pain and the provision of a "donut" pillow to ease some of the patient's discomfort on sitting. The existence of an x-ray report stating that there was no fracture observed on that date does not change my opinion, as Dr. Chavis, the

emergency room physician, stated that he observed the dislocation on x-ray. Clearly, his interpretation of the x-ray image was that there was indeed an anterior dislocation of the distal coccyx.

As to her lumbar spine, a herniated nucleus pulposus at L4-5 was identified on August 17, 2007, which is certainly an objective finding. Dr. Standefer explained at deposition that this herniation could have existed prior to the fall or could have occurred at the time of the fall, but that based upon the patient's history and the medical records, the herniation became symptomatic because of the fall. In particular, he noted the absence of any complaint of true low back pain or radicular symptoms and the absence of the aggressive treatment of her pain prior to the evening of August 15, 2007. The claimant saw Dr. Hamby, her family doctor, with complaints of back pain and radiation, related to the fall, on September 11 and 18, and October 2, 2007, at which time she was referred to Dr. Standefer. On October 2, 2007, Dr. Hamby observed spasm in her lower back, another objective finding of injury. Dr. Standefer proceeded in her care with physical therapy and lumbar epidural steroid injections, which resulted in improvement but not a

resolution of her pain. Ultimately, Dr. Standefer determined that surgery was not an option and that physical therapy seemed to provide the most benefit. I find that the existence of the herniated nucleus pulposus at L4-5 and of lumbar spasms satisfies the statutory requirement of objective findings of injury.

The claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her coccyx and to her lumbar spine when she fell at work on the afternoon of August 15, 2007, as evidenced by objective findings in the form of radiological reports, MR scans and the observation of lumbar spasm. The causal connection is clear. The claimant suffered from pelvic pain, eventually determined to be related to a gynecological condition, prior to her fall. At the time of the fall, she suffered a new type of pain, particular in her coccyx, and pain which developed in her lumbar spine and radiated into her buttocks and legs. This coccygeal and lumbar pain was new, as of August 15, 2007, and consistent with the type of injury she sustained on that date, according to Dr. Standefer. The presence of pain in her flank and groin area does not undermine the causal connection between the claimant's

coccygeal and lumbar symptoms are the fall of August 15, 2007 in the slightest.

There is no testimony or medical record in support of a permanent impairment rating for the claimant's fractured coccyx. The American Medical Association's Guides to the Evaluation of Permanent Impairment, (4<sup>th</sup> Ed. 1993) (the Guides) do not contain an easily identifiable rating either. In my review of the Guides and the medical record, I find that the claimant has sustained a permanent anatomical impairment in the amount of 5% based upon the anterior dislocation of her distal coccyx. Under the diagnosis-related estimates approach, a vertebral body dislocation without loss of motion, motion segment integrity or radiculopathy is valued at 5%. (Guides, p. 3/102, DRE Lumbosacral Category II: Minor Impairment) The claimant has sustained a vertebral body dislocation according to Dr. Chavis in the form of an anterior dislocation of the distal coccyx. The record does not support a finding that her radiculopathy is related to the coccygeal injury, and there is no evidence of loss of motion or motion segment integrity. Thus this Guide section is the most applicable to her injury. In comparison, Table 75 of the Guides

provides ratings for the compression of one lumbar vertebral body, valued by the percentage of compression, the fracture of a posterior element, and a reduced dislocation of one vertebra. While each of these is close to describing the claimant's injury, none actually fit. I note that under Table 75, the compression of one cerebral body, in the amount of under 25% is worth 5% and the reduced dislocation of one vertebra is worth 6%, which are consistent with the rating under DRE Lumbosacral Category II. I find that the claimant is entitled to a 5% permanent anatomical impairment rating for her anterior dislocation of the distal coccyx, pursuant to the Guides.

Dr. Standefer opined that the claimant would be entitled to a seven percent permanent anatomical impairment rating for the herniated nucleus pulposus at L4-5, according to the Guides. I find that this is the accurate rating for the claimant's lumbar injury, under Table 75, Section II. C.

Based upon my de novo review of the entire file, I would award medical and indemnity benefits to the claimant for the compensable injuries to her coccyx and lumbar spine. The claimant proved by a preponderance of the evidence that

she suffered compensable injuries to those parts of her spine.

For the foregoing reasons, I must respectfully dissent from the majority opinion.

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PHILIP A. HOOD, Commissioner