NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F702969

RHODIS SMITH, EMPLOYEE	CLAIMANT
YOURGA TRUCKING, INC., EMPLOYER	RESPONDENT NO. 1
AMERICAN HOME ASSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT NO. 1
SECOND INJURY FUND	RESPONDENT NO. 2

OPINION FILED FEBRUARY 16, 2010

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

Claimant appears Pro Se.

Respondents No. 1 represented by the HONORABLE MELISSA WOOD, Attorney at Law, Little Rock, Arkansas.

Respondent No. 2 represented by the HONORABLE DAVID SIMMONS, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

The claimant appeals an administrative law judge’s order and opinion filed June 10, 2009. The administrative law judge made the following findings of fact and conclusions of law:

1. There was a March 14, 2007, compensable injury.
2. The compensation rates are $484/363.

3. The claimant has failed to prove by a preponderance of the evidence that the additional testing by Dr. David Gilliam is reasonable and necessary and related to the compensable injury.

4. The claimant has failed to prove by a preponderance of the evidence that he remained in his healing period and was totally unable to earn wages from June 19, 2007, to a date to be determined.

After reviewing the entire record *de novo*, it is our opinion that the administrative law judge's decision is supported by a preponderance of the evidence, correctly applies the law, and should be affirmed. The Commission recognizes that the claimant is not required to offer objective medical evidence to prove the existence of an injury and to show that his healing period continues. *Chamber Door Indus., Inc. v. Graham*, 59 Ark. App. 224, 956 S.W.2d 196 (1997). We find from a preponderance of the evidence that the findings of fact made by the administrative law judge are correct and are, therefore, adopted by the Full Commission.

Therefore, we affirm and adopt the June 10, 2009 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 would award the claimant additional tests and treatment by Dr. Gilliam, including an MRI of the knee and electrodiagnostic testing of his left upper extremity. I would also award temporary total disability benefits from June 19, 2007 to a date to be determined and attorney's fees.

Under Arkansas workers' compensation law, employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark Code Ann. Sec. 11-9-508(a)(Supp. 2005). Wal-Mart Stores, Inc. v. Brown, 82 Ark. App. 600, 120 S.W.3d 153 (2003). Injured workers have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary for treatment of the compensable injury. Norma Beatty v. Ben Pearson, Inc.,

Full Commission Opinion filed February 17, 1989 (D612291). What constitutes reasonable and necessary medical treatment is a question of fact for the Commission. Wackenhut Corp. v. Jones, 73 Ark. App. 158, 40 S.W.3d 333 (2001). Reasonable and necessary medical services may include those necessary to accurately diagnose the nature and extent of the compensable injury; to reduce or alleviate symptoms resulting from the compensable injury; to maintain the level of healing achieved; or to prevent further deterioration of the damage produced by the compensable injury. Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911 S.W.2d 593 (1995). A claimant does not have to support a continued need for medical treatment with objective findings. Chamber Door Industries, Inc. v. Graham, 59 Ark. App. 224, 956 S.W.2d 196 (1997).

The claimant was seen in the Baptist Hospital emergency room on March 14, 2007, after he fell out of an eighteen-wheeler truck onto his left leg, braced with his left arm. He was diagnosed with a left knee contusion and left shoulder fracture. An x-ray report from that date showed a minimal cortical irregularity suggesting a subtle impacted fracture, degenerative

changes in the left acromioclavicular joint and no acute injury in the left leg.

On April 3, 2007, the claimant saw Dr. Pearce, reporting a fall from about eight feet onto his left side. He reported that his shoulder had improved, but his knee was still painful. On physical exam, there were no positive findings in the left shoulder. He had a healing abrasion and mild joint line pain in his left knee, but no other positive findings. Dr. Pearce noted that the x-rays showed a potential small fracture in his left shoulder but no bony abnormality of the left knee. His impression was left shoulder pain with a need to rule out occult fracture and left knee pain with a need to rule out internal derangement. He recommended an MR scan of both left knee and shoulder. The claimant was unable to work until after tests were completed.

The claimant underwent MR scans of the left knee and left shoulder on April 12, 2007, which revealed:

> Left knee: degenerative cleavage tears in both medial and lateral menisci; moderate tricompartmental chondromalacia
>
> Left shoulder: os acromial with moderate-severe degenerative changes at the syndesmosis and AC joint; multifocal mild interstitial tendinopathy of the supraspinatus, infraspinatus and subscapularis tendons.

Dr. Pearce reviewed the MR scan results on April 17, 2007, noting no acute injuries in the left knee, and performed a physical examination of the claimant which was essentially unchanged. His diagnosis was left shoulder rotator cuff tendinosis and left knee chondromalacia. He recommended a left shoulder injection, formal therapy and ibuprofen. The claimant could return to work on April 18, 2007, but sitting only, using his right arm only and no driving.

The claimant returned to the emergency room on May 5, 2007. He reported that he fell in March off an 18 wheeler, had a small fracture in his left shoulder or rotator cuff injury and a left knee injury. He reported that he had been in physical therapy and tried to return to work that week to light duty. After two twelve-hour shifts, he was "really hurting." He reported no new injury. He did not have pain medications but did have some muscle relaxers.

On May 8, 2007, the claimant saw Dr. Pearce, who noted that while the claimant was released to "a quite sedentary job, which is basically recording coming and goings of vehicles onto the workplace property with no lifting and really little to no standing or walking,"

he was required to open a large heavy gate which caused increased pain. The claimant also reported that he had been terminated. Dr. Pearce's physical examination of the left shoulder revealed no objective findings, only mild pain with impingement. His examination of the left knee revealed well-healed abrasions, but no other findings. Dr. Pearce's diagnosis was left shoulder rotator cuff tendinosis and left knee chondromalacia exacerbation from recent fall. Dr. Pearce stated that the claimant could return to work at the same light duty. He wanted to have a nerve study done to rule out possible injury to long thoracic or suprascapular nerves or other underlying abnormality. He recommended a whole body scan to assess for possible occult abnormality. He prescribed Lortab for pain.

The EMG/NCV study was performed on May 23, 2007. The report reflected:

> ...No electrodiagnostic evidence of a cervical radiculopathy, brachial plexopathy, long thoracic, suprascapular, or focal ulnar neuropathy is seen in the extremity tested today.
>
> No electrodiagnostic evidence of a generalized sensory or motor peripheral neuropathy is seen in the extremity or extremities tested today.
>
> A very minimal left median sensory only focal neuropathy at the wrist is seen.

> The exam was somewhat limited by patient tolerance.

On May 25, 2007, x-rays of the claimant's left shoulder were performed, showing moderate degenerative changes in the left acromioclavicular joint, but an otherwise negative left shoulder. The cortical irregularity which was seen in March was not found in this study.

Dr. Pearce noted on June 19, 2007 that the claimant's bone scan was normal, and his nerve conduction study was normal except for very minimal left median nerve sensory slowing. Dr. Pearce also noted that the claimant was discharged from therapy. Dr. Pearce wrote that the claimant had "an awkward exaggerated limp and I think this is not at all physiological." Dr. Pearce wrote of his physical examination of the claimant:

> Examination of his shoulder - he has pain behavior throughout range of motion, which is full. He has give away type findings as far as strength is concerned. I find no objective abnormality about his shoulder.
>
> The same is virtually true for the knee. He says that his knee swells, but there is no swelling today. He has exaggerated pain behavior with range of motion.

Dr. Pearce's impression was that the claimant had complaints of left shoulder and knee pain as the reported result of his March injury, but with no objective findings. He concluded that the claimant reached maximum medical improvement on June 19, 2007. He released him to regular duties on June 20, 2007, without restriction. Dr. Pearce stated that the claimant had no permanent anatomical impairment rating. The claimant was free to return if needed, but if he did, "it is conceivable that a functional capacity evaluation may be indicated to further confirm my above impression."

The claimant saw Dr. Rutledge on July 11, 2007. The claimant had attempted to get a change of physician to Dr. Rutledge, but he was not within an MCO. Because the claimant required treatment and had a relationship with Dr. Rutledge, he continued to see him. Dr. Rutledge observed the claimant's apparent distress due to his left shoulder and neck pain. On examination:

> Neck: Reveals tenderness of the left neuro exit sites. Range of motion of the C-spine is complete in rotation to the right, but limited to 45 degrees to the left. He has pain with extension and flexion. There is pain with lateral bending. Cervical compression test produces pain in the left upper extremity. The left trapezius is quite tender and tense...

> Extremities: The examination of the shoulder, there is exquisite tenderness at the distal clavicle and the coracoid area on the left. The range of motion of the left shoulder is inhibited. He has poor abduction, adduction, and internal and external rotation. This is suggestive of a partial rotator cuff tear or tendinitis. The knee itself has some scar at the tibial plateau centrally. He has a mild effusion and tenderness anteriorly. There is no joint instability.
>
> Impression: I believe this patient has multiple injuries from this fall to include a contusion with internal derangement of the left knee and a shoulder injury possibly a rotator cuff injury. This should have shown in MRI. I also think he has a cervical pathology such as a ruptured disc from this fall. The symptoms are suggested of radiculopathy from a ruptured herniated disc.
>
> Plan: In any event today, I am going to do a therapeutic trial with dexamethasone 8 mg along with 2 cc of 0.5% Marcaine to be injected intraarticular into the left shoulder. I am also prescribing hydrocodone/APAP 10/650 3-4 times a day as needed for pain and ibuprofen on schedule twice daily p.c. This patient remains unable to work. I am again going to request medical records from Dr. Charles Pearce. I am going to obtain radiographs from ProScan Imaging and Southwest Hospital. I would like to get medical records from Dr. Peete and from Baptist Medical Center for each of these emergency room visits. ..

An MRI was performed on July 13, 2007 of the claimant's

cervical spine:

> The vertebral body heights are well maintained without evidence of anterior wedging or compression. No evidence of acute or subacute fracture is seen. There is mild reversal of

the normal cervical lordosis. There are also sterile degenerative endplate changes, most marked at the C4-5 level.

C2-3 and C7-11: There are shallow mixed left foraminal protrusions at each of these levels, resulting in mild left-sided exiting neural foraminal stenosis and abutment of the exiting C3 and C8 nerves.

C3-4: A left-paracentral/foraminal protrusion with associated annular tear results in light flattening of the ventral cord.

C4-5: Mixed broad-based displacement with a superimposed shallow soft disc displacement results in light flattening of the ventral cord as well as bilateral exiting neural foraminal stenosis, left worse than right.

C5-6: Mixed broad-based displacement causes light contouring of the ventral cord.

C6-7: Shallow mixed broad-based bulge results in only minimal central canal stenosis.

T1-2 and T2-3: No dominant disc abnormality is identified. No central canal stenosis, foraminal stenosis or nerve root compression is seen.

Conclusion:
1. Left-paracentral/foraminal protrusion at the C3-4 level with associated annular tear results in light flattening of the left side at the ventral cord.
2. Mixed broad-based displacement with a superimposed shallow soft disc displacement at the C4-5 level results in light flattening of the ventral cord.
3. Shallow mixed left foraminal protrusions at the C2-3 and C7-T1 levels result in abutment of the exiting left C3 and C8 nerves. ...

The claimant did receive a change of physician to Dr. Gilliam and saw him on September 24, 2007. Dr. Gilliam’s assessment was:

> 1. Left shoulder pain - likely secondary to acute trauma to left synchondrosis at the os acromiale.
> 2. Left knee pain - medial and lateral meniscus tears by MRI, designated as “degenerative” by MRI radiologist.
> 3. Left C2-3 and C7-T1 foraminal stenosis, and left sided central canal stenosis at C3-4 and central canal stenosis at C4-5. There is also mild bilateral foraminal stenosis at C4-5, worse on the left.

Dr. Gilliam recommended that the claimant continue taking ibuprofen, that he perform a home straight leg raise exercise program for the knee and for impingement type symptoms in the shoulder, and that an MRI of the left knee be repeated. He also recommended an EMG/NCV if the claimant’s left upper extremity did not improve, to rule out cervical nerve root impingement as a source of those symptoms.

On December 5, 2007, Dr. Rutledge saw the claimant. After reviewing the MRI results, his impression was that the claimant had degenerative disc disease of the cervical spine and an acute herniated nucleus pulposus with an annular tear as a result of his trauma sustained on the job in March of 2007. He also

injured his left knee and left shoulder. He prescribed Lortab and ibuprofen. He stated that the claimant was "totally physically impaired due to these injuries and this may be permanent in nature."

On December 18, 2007, Dr. Rutledge noted that the claimant reported one episode of right anterior thigh numbness. He repeated that the claimant had a herniated disc of the cervical spine with degenerative disc disease of the C-spine, internal derangement of the left knee, a recent episode of paraesthesias of the right thigh, and an acute herniated nucleus pulposus with annular tear of C3-C4. He prescribed medications and exercises and stated that the claimant as "totally physically impaired."

The claimant returned to Dr. Rutledge on January 28, 2008. He observed bilateral tenderness in cervical area, with "tenseness" of left trapezius muscle. The motion of his cervical spine was limited, and a cervical compression test produced local pain. The left shoulder was tender, with painful and restricted motion. In the left knee, crepitus was noted, but no effusion. There was tenderness in the knee and pain with flexion beyond 90 degrees. Dr. Rutledge's impression was a herniated nucleus pulposus

at C3-C4 with annular tear and internal derangement and contusion of the left shoulder both as a consequence of an on-the-job injury occurring in March of 2007. Additionally, he had a contusion with internal derangement of the left knee that remained quite symptomatic. Since the carrier was not paying on the claim, physical therapy was not available. Dr. Rutledge encouraged the claimant to use moist heat and to continue his ibuprofen and Lorcet regimen.

On November 6, 2008, Dr. Pearce wrote the following, when asked if the new MRI of the left knee and new EMG/NCV tests requested by Dr. Gilliam were reasonable and necessary:

> As you know, it has been over a year since I have seen Mr. Smith, but the time I last saw him on 06/19/2007, as you know, both of those tests had been done and did not show any acute significant abnormality. In reading the physical examination portion of Dr. Gilliam's note, there are no significant objective findings as it pertains to the knee including a negative McMurray's sign which pertains to meniscal pathology, which I think was the question as it pertains to the knee. Although, as there are some minor findings as it pertains to the left shoulder according to his exam, again, there are no significant findings.
>
> In addition, I had previously ordered a screening bone scan which showed no abnormal uptake. Therefore, I would say that I am reasonably certain that these tests would not yield significant new information.

> Apparently cervical MRI had been done at some point and showed some possible nerve root abutment. I am not sure of the date of the scan, nor have I seen the actual scan or report.
>
> Additionally, I was asked did Mr. Smith ever display any signs or symptoms of a cervical spine injury and the answer is no, but the likely reason his cervical spine was assessed is there was no significant finding for complaints of left upper extremity pain as it pertained directly to his shoulder.

At deposition, Dr. Gilliam, an orthopedic surgeon, explained his opinions in more detail. In essence, Dr. Gilliam desired another MR scan and nerve study, because the prior studies and his physical examination were somewhat inconsistent and because the studies were inconclusive. The claimant's chondromalacia of the left knee could be caused by either degenerative processes or trauma, and that condition can cause crepitus, which Dr. Gilliam observed, and pain. Cleavage of the meniscus in his knee could be traumatic or degenerative, and Dr. Gilliam took issue with the radiologist's opinion that the cleavage was degenerative. He felt that this was something that could not necessarily be determined by MR scan. Furthermore, Dr. Gilliam explained:

> to qualify as tear, the abnormal signal has to actually propagate all the way to the surface of the meniscus. So, my concern is that this

> is what was seen on this MRI, but it was described as degenerative cleavage tear, which would imply that the degenerative change tracked all the way to the surface and was a complete tear. But my physical findings would indicate that there probably wasn’t a complete tear and only intra-substance degenerative changes. So that’s why I recommended a repeat MRI.

Dr. Gilliam also discussed the cervical MR scan. He noted that C3-4 impingement often causes shoulder pain and can cause pain even further down the arm. It can cause numbness, tingling and weakness in certain muscles around the shoulder. Dr. Gilliam did not find the central canal stenosis at C4-5 to be as significant a finding, because his symptoms were on the left side, but the stenosis was central and not left sided. The narrowing at C2-3 was on the left side, which could cause left neck pain, shoulder pain, numbness, left-sided tingling, and weakness, depending on the severity and the duration of the nerve compression. C3-4 affects the upper shoulder and neck region, superior, while C7-T1 is further down in the hand, fingers and thumb, and symptoms could include pain, numbness and tingling in those digits, and decreased grip strength. The left foraminal protrusion at C7/T1 can cause impingement on the nerves that exit those areas and that go down the arm.

Dr. Gilliam explained that there are two types of stenosis, or narrowing, that can occur. Central stenosis is narrowing around the large canal where the spinal cord goes up and down, such as the claimant's stenosis at level C4-5. Foraminal narrowing is the narrowing of the foramen, or holes where the nerves exit the bony spine, caused by foraminal protrusion of disc material which impinged the individual nerves that come out of the neck, down the shoulder and the arm. This is, in layman's terms, a slipped disc. The report is not clear but is apparently describing slipped disc material.

Due to these cervical findings, Dr. Gilliam felt that further work-up was warranted to determine exactly the source of the claimant's left upper extremity symptoms. He recommended a nerve conduction on the left upper extremity to see if there was significant impingement on the nerves, enough impingement to cause nerve conduction changes in the left upper extremity. Dr. Gilliam stated that if the impingement was causing the claimant's complaints, present for six months, then the claimant required treatment because the problem was not going to resolve

on its own. Surgery may or may not be warranted, but there are many non-surgical options as well.

Dr. Gilliam also stated that without further study and treatment, he could not state that the claimant had reached maximum medical improvement. Once the studies were conducted, if the cervical findings were the source of his pain, then a trial of non-operative treatment would be warranted. He stated that the nerve conduction study and the MR scan were reasonable and necessary medical treatment.

Dr. Gilliam stated that the nerve conduction study would be helpful in determining the source of the patient's left upper extremity symptoms and to rule out cervical nerve root impingement. He was not aware of the first nerve study, but he stated that the fact that the study was interrupted and incomplete due to the claimant's pain would make that study insufficient. The first study was negative, but Dr. Gilliam stated that "just because a nerve conduction test is negative doesn't mean that the findings in the cervical spine are not the source of the pain. All it means is that the nerve root hasn't been compressed long enough or severe enough to cause changes in the way it conducts impulses."

Dr. Gilliam stated that the MR scan of the left knee should be repeated because the MRI report and his physical findings were inconsistent with each other.

Dr. Gilliam recommended a home exercise program for his knee and shoulder and explained that formal physical therapy would be the next step, if the home program was unsuccessful. He stated that the exercise programs were reasonable and necessary medical treatment. Dr. Gilliam explained:

> Physical therapy helps several ways. It helps in range of motion, it helps in strengthening. And in his specific case, I think it would help with the patella, or kneecap tracking by specifically strengthening certain muscles that control the kneecap tracking. And I think that would probably, maybe not eliminate, but certainly decrease the kneecap pain and chondromalacial symptoms he was having in the knee. So, I think therapy would be helpful for the knee. And I mentioned it might also be helpful for the shoulder.

Dr. Gilliam would also consider cervical steroid injections for both diagnostic and therapeutic purposes.

Dr. Gilliam noted that trauma can cause degenerative changes to become symptomatic. An asymptomatic os acromiale could become symptomatic secondary to a fall or other trauma. In the April 12, 2007 MR scan of the claimant's left shoulder, the bony

edema noted could “certainly” be traumatic in origin or an inflamed degenerative process. The cleavage tear could occur with trauma or with degenerative processes.

Dr. Gilliam did not test the claimant for malingering or symptom magnification. He does not test for malingering unless it is indicated, and it was not indicated in this case.

Dr. Gilliam’s testimony was that the claimant had symptoms which were inadequately addressed by his treatment to the date of his examination of the claimant, and that he felt further diagnostic testing would identify what was and was not wrong with the claimant’s knee and shoulder. He also had treatment recommendations, conservative in nature, to address the claimant’s complaints, including physical therapy and injections. In reviewing the records of Dr. Pearce and Dr. Gilliam, I find that Dr. Pearce’s treatment ended too soon, and that Dr. Gilliam is following a reasonable and necessary course of diagnostic and therapeutic care.

I do not credit Dr. Pearce’s opinion that the claimant presented with symptom magnification, as neither Dr. Rutledge nor Dr. Gilliam made any such observation.

I find that Dr. Gilliam's diagnostic and therapeutic care plan is reasonable and necessary treatment of the claimant's compensable injury, including a new MR scan, a new nerve conduction study, cervical steroid injections, and home and formal physical therapy.

Temporary total disability for unscheduled injuries is that period within the healing period in which a claimant suffers a total incapacity to earn wages. Ark. State Highway & Transportation Dept. v. Breshears, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period ends when the underlying condition causing the disability has become stable and nothing further in the way of treatment will improve that condition. Mad Butcher, Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982). The healing period has not ended so long as treatment is administered for the healing and alleviation of the condition. Breshears, supra; J.A. Riggs Tractor Co. v. Etzkorn, 30 Ark. App. 200, 785 S.W.2d 51 (1990).

The claimant is entitled to temporary total disability benefits from June 19, 2007 to a date yet to be determined. He was released to full duty on June 20, 2007, by Dr. Pearce, but I find that the claimant was

not yet at maximum medical improvement on that date. I credit Dr. Gilliam's opinion that the claimant has not reached maximum medical improvement where diagnostic and therapeutic measures have not been utilized to address his continued complaints. There are both objective and subjective findings, in the form of MR scans and physical examinations, supporting this conclusion, including the slipped cervical discs, crepitus and tears in the knee, and shoulder pain and tightness.

As to the respondent's offer of light duty, I find that the claimant credibly testified that he accepted the light duty work and attempted to perform the job, but that the duties included more walking and lifting than was described in the job description, and more than his restrictions or his abilities allowed.

Lastly, I find that the claimant's attorney is entitled to a fee, as the claim for additional medical benefits and temporary total disability benefits was controverted in its entirety.

After my de novo review of the entire record, I would award additional medical benefits to the claimant for treatment by Dr. Gilliam, temporary total disability benefits from June 19, 2007 to a date yet to be determined, and attorney's fees.

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

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PHILIP A. HOOD, Commissioner