

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F607846

BERTHA WEBSTER, EMPLOYEE	CLAIMANT
COLEMAN CABLE, INC., EMPLOYER	RESPONDENT
TWIN CITY FIRE INSURANCE CO., CARRIER/TPA	RESPONDENT

OPINION FILED JUNE 30, 2010

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

Claimant appeared pro se.

Respondents represented by the HONORABLE A. GENE WILLIAMS, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Claimant appeals from a decision of the Administrative Law Judge filed November 24, 2009.

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

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

2. The stipulations agreed to by the parties and recited herein are reasonable and are hereby accepted as fact.
3. The claimant has failed to prove by a preponderance of the evidence that she is entitled to temporary total disability benefits from the date she last worked to a date to be determined.
4. The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable left carpal tunnel injury by gradual onset.

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.

A. WATSON BELL, Chairman

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 pro se claimant's left carpal tunnel syndrome is compensable and that she is entitled to benefits for the same.

On February 9, 2006, the claimant sustained compensable injuries to her left shoulder and neck. A six percent anatomical impairment rating to the claimant's left shoulder was accepted and paid by the respondents. The

current issues were whether the claimant is entitled to temporary total disability benefits from the date last worked to a date to be determined, and whether the claimant sustained a compensable gradual onset left carpal tunnel injury.

The claimant testified that when she was a floor technician, she did not have any problems doing her job. She had no medical issues. When she sustained this injury, she thought it would just go away. She was injured on the 9th, but since she thought it would resolve on its own, she did not go to the doctor until the 13th. The claimant went on that date because she woke up and could not raise her arms. Her doctor told her to not use her hand for a couple of days. She expected improvement, but her arm just got weaker.

The claimant testified that Dr. Hebert took her off work. Dr. Wren did nerve conduction tests and stated that he would prefer her wrist to be splinted or for her not to use her arm at all, but she was placed on a 15-pound weight restriction. She was not allowed to see the reports of the doctors, and the doctors were told not to give her information.

The claimant testified that, at one point, Robin at work said she was going to get the claimant back to work, no matter what.

The claimant testified that she was referred to Dr. Calhoun, who looked at the MRI report and decided to do a myelogram. She never got any information from Dr. Calhoun. She was told that her employer made a job for her, and she had to go do it. She received a letter about the job. It was mailed November 15, and she picked it up on December 1. She was pulling labels off of boxes, with one hand. After she had done the job for two months, she was terminated for having too many attendance points. She was charged attendance points, because she did not call in each day, beginning November 15. The entire time she was off work for her injury, she did not have to call in or bring paperwork in, but they charged her points beginning on November 15.

The claimant testified that she had never heard from Dr. Calhoun. He sent a letter stating that he never released the claimant to work.

The claimant stated that she was also referred to Dr. Siad, who gave her "hydro" shots. The shots did not

work, so she was referred to pain management. Dr. Siad never returned her to work. She was without a doctor for seven months, just using over-the-counter pain medications. She was seeing a pain management doctor in Texarkana and, at the time of the hearing, she was in rehabilitation, looking for a job. Rehabilitation referred her to Dr. Rush, who wanted new MRIs, and then said she needed to go to the neurosurgeon and to try physical therapy.

The claimant testified that her carpal tunnel symptoms did not start until she re-injured her arm. She thought the carpal tunnel and her tendinitis all worked together from the same injury. She was having dental work done as well, because the nerve that affected her arm also affected her mouth.

The claimant stated that Dr. Knight did not tell her to go back to work. He did not examine her. He asked her to hold her arms up. She could not hold her arms up all the way at the hearing, or when she saw Dr. Knight.

The claimant testified that, in October of 2006, Dr. Calhoun did not examine her shoulder to see if she could move it without pain. He read her MRIs and sent her to Texarkana. He did not examine her. He must have made that

part of the report up. In November 2006, Dr. Calhoun never told her that she did not need neurosurgical treatment or surgery. She found out about that later. She knew at the time of the hearing about that recommendation. That was when she told the nurse case manager she would not go to any doctor except her own. At that time, she was not working. She had been taken off work by Dr. Hebert in July. She was never asked to call in to work.

The claimant testified that she was counseled about not calling in, but that was when she was employed, and not when she was off work due to her injury. The procedure was that, if she did not call in or show up, she was docked 5 points. The claimant stated that a lot of "stuff was going on" after she was injured, concerning her attendance points and other things.

The claimant testified that she had a functional capacity evaluation at St. Michael's. The report says that she did not cooperate, but that was not true.

The claimant explained that, at the time of the hearing, she was seeing Dr. Rush. Texas Rehabilitation sent her to him. She went to Texas Rehabilitation for help getting re-employed.

Robin Brown testified that she had been the Human Resources Manager for the respondent-employer for twenty years. She handled attendance records and absence reports. In February 2006, there was policy about calling in sick. There was a scale. If an employee did not call and did not report to work, he or she earned five demerit points. If an employee called less than an hour before the shift was to start, he or she earned three points. If an employee called more than an hour before the shift, he or she would receive two points. If the employee provided a doctor's excuse, he or she would receive zero points, as long as he or she called at least an hour before the shift started. If an employee reached fourteen points, he or she was automatically terminated. If an employee left and returned with a doctor's excuse, he or she received zero points. If it was a workers' compensation claim and they were working, they were supposed to clock out, go to the doctor, bring their documentation back, and they would not be charged points.

Brown prepared the November 15, 2006 letter to the claimant offering her a job within her restrictions. It was sent certified mail to the claimant. Brown had received a

release to return to work for the claimant from Dr. Calhoun, and the company made accommodations so that she could return to work. She did not hear from the claimant after she sent the letter. Brown did not recall speaking to her again after that letter went out. She was not sure if the claimant ever came back to work. She did return to a light-duty job, but she never went back to her regular position. She was paid the same amount of money on the light-duty job as the regular position.

Brown explained that the claimant was given two points for calling in more than an hour before her shift on more than one date, because there were no doctor's excuses turned in.

The claimant was treated for finger numbness for nine days after starting a new job in April 1993. The next record is from November 1993, when she complained of a headache, tingling in arms and legs, and pin pricks in her neck and arms. The next record of arm problems is August 26, 2002 when she mentioned, as an afterthought, left thumb pain. Two years later, she was treated for a strain of her left shoulder in April and May 2004.

An x-ray of the claimant's left shoulder, taken to assess her left shoulder pain, on February 13, 2006 was normal. An x-ray of her cervical spine on the same date showed mild reversal of the normal lordotic curvature, which is probably due to muscle spasm or positioning, and mild degenerative changes of the lower cervical spine.

Dr. Pappas wrote a return-to-work slip for the claimant on February 13, 2006, stating that she could return the next day to light duty, lifting and pushing no more than five pounds.

The claimant saw Dr. Gabbie, at a rehabilitation clinic on February 28, 2006, for left arm and neck pain. He noted:

Onset of her symptoms was sudden on February 9. She pulled on an object pretty hard trying to move it and "felt something." The pain then increased gradually to a fairly severe degree over the next four days. Chief complaints at this time are pain, some numbness that is down into her left hand at times and muscle spasms. Originally, she noticed some decreased strength in her hand as well, but does not identify that quite as much as she did. ... Hopefully, this is just a muscle strain.

On March 24, 2006, an MRI of the claimant's cervical spine was performed, which showed multilevel degenerative changes of the cervical spine as described.

The claimant underwent NCS/EMG testing by Dr. Wren on June 21, 2006. She reported pain in the left arm and tingling in fingers for four months and progressing. Her symptoms were exacerbated by repetitive movements unloading wire 12 hours per day, and rest improved her symptoms. Light duty had not improved her symptoms. The study revealed:

evidence of a mild left carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory components. She had mild 1+/4 denervation isolated to extensor digitorum (C7-8) but unable to assess paraspinals due to poor relaxation. Exam also suggests lateral epicondylitis. Splinting and further work modification or off duty appears appropriate.

The claimant saw Dr. Hamlin on July 10, 2006 for left shoulder pain and pain and numbness in her hand. The claimant reported that on February 9, she was working with a reel of cable and pulled her shoulder, causing a sudden severe pain in the front of her shoulder that caused numbness to the side of her face. She also had numbness of her left hand and aching in her wrist. Dr. Hamlin noted the diagnosis of left carpal tunnel syndrome. He observed normal shoulder and cervical range of motion without pain. Dr. Hamlin felt that he did not have more to offer the

claimant. She had carpal tunnel symptoms, and he recommended a second opinion and a neurosurgical consultation to see if her shoulder problems were referred from her cervical spine.

A Texas Workers' Compensation Work Status Report prepared by Dr. Hamlin on July 10, 2006, stated that the claimant was injured on February 9, 2006 when "turning a reel hurt left shoulder and arm." She could return to work on July 11, 2006, with recommendations to return to full duty and follow up with Dr. Hebert. She had mild carpal tunnel syndrome in left hand and cervical disc disease.

On August 24, 2006, the claimant presented to the emergency room with complaints of a headache and blurry vision. She underwent a CT of her head, which was negative. It was noted that she was taking a muscle relaxer for an injury to her left arm.

On August 27, 2006, the claimant saw Dr. Gabbie, for her cervical strain and left shoulder pain. Dr. Gabbie wrote that the claimant she had good range of motion and strength in her left shoulder. Most of her pain was in her left triceps, trapezius and around and under her left arm. A cervical myelogram was recommended.

Dr. Knight evaluated the claimant on September 12, 2006. He stated that the claimant's EMG findings did not correlate to the negative Tinel's and Phalen's tests or to her symptom complex. He felt that a neurosurgical consultation was reasonable.

Dr. Knight noted on September 25, 2006 that he spoke with the claimant and the nurse case manager. From an orthopedic standpoint, she was at maximum medical improvement and could return to regular work. He recommended neurosurgical evaluation.

On October 2, 2006, Dr. Gabbie released the claimant from the rehabilitation program, noting that the only goal not met was that her strength actually diminished, despite a focus on strengthening. She was to continue home exercises.

Dr. Calhoun saw the claimant for a neurosurgical consultation on October 18, 2006. He stated:

With the patient's EMG findings and with the symptoms more compatible with some left C7 nerve root irritation, it was felt that the best course of action is to proceed with a CT myelogram of the cervical spine. . . If this shows no clear compromise of the left C7 nerve root, then neurosurgical intervention is not warranted.

Dr. Calhoun prepared a note on October 18, 2006, stating that she was under his care for a cervical disc herniation and that she could return to work with no lifting or carrying with her left arm and no use of her left arm.

On November 7, 2006, the claimant underwent cervical myelogram and cervical CT with contrast. The diagnostic tests showed:

1. The preliminary films of the cervical spine show mild reversal of the normal lordotic curvature. Mild to moderate anterior osteophyte formation is present at C5-6 and C6-7. Prevertebral soft tissues are normal. There are no fractures. There is spurring about the joints of luscka bilaterally in the lower cervical region. ..
2. At the C2-3 disc space [normal]
3. At the C3-4 level, a mild anterior extradural defect is present upon the thecal sac. The nerve roots fill symmetrically. Axial images show a small central disc protrusion. No signs of acquired spinal stenosis. No foraminal stenosis.
4. At the C4-5 level, there is no anterior extradural defect upon the thecal sac. There is however, slight diminished filling of the right nerve root sleeve when compared to the left. Axial images demonstrate a right lateral osteophyte, as well as spurring about the joints of luscka producing moderate right foraminal stenosis. Left neuroforamina is widely patent. No evidence of disc protrusion or bulging of the annulus fibrosis. No signs of acquired spinal stenosis.
5. There is a vertical posterior osteophyte or ridge along the majority of the C5 vertebral

- body, just to the right of the midline. This effaces the thecal sac, and may cause slight flattening of the right side of the cord.
6. At the C5-6 level, there is no anterior extradural defects upon the thecal sac. Nerve roots fill symmetrically. Axial images show a right lateral osteophyte originating from the inferior end plate of C5 and superior end plate of C6. This causes effacement of the thecal sac, and flattening of the neuroforamina bilaterally. No signs of acquired spinal stenosis.
 7. At the C6-7 level, a mild anterior extradural defect is present upon the thecal sac. Nerve roots fill symmetrically. Axial images show no evidence of disc protrusion or bulging of the annulus fibrosis. There is however, a small central osteophyte originating from the superior end plate of C7. This causes effacement of the thecal sac, but no acquired spinal stenosis. On a single image, there is a small soft tissue defect within the thecal sac to the right of the midline and this approaches the anterior margin of the cord. This is probably related to some redundant ligaments. A small narrow disc protrusion is considered less likely.
 8. At the C7-T1 and T1-2 [normal]
 9. Cervical and upper thoracic cord has a normal appearance throughout.

Dr. Calhoun wrote on November 14, 2006 that the CT myelogram report showed no significant nerve root impingement at C5-6, C6-7, or C7-T1.

On November 14, 2006, the nurse case manager, V. Applegate, reported that she spoke to the claimant about Dr. Calhoun's release to work, limited duty. Applegate noted

that the claimant wanted to see her own doctor, that she would not return to work one-handed, and that she was very upset. Applegate directed her to speak with her employer.

An undated letter, addressed to no one specifically, from Scott Callaghan at the respondent-employer, described two activities and asked for confirmation that these are appropriate for the claimant and her restrictions.

An envelope was addressed to the claimant, from the respondent employer, with certified mail tabs on it, and posted November 15, 2006.

A letter from the respondent-employer, dated November 15, 2006, to the claimant, referred to Dr. Calhoun's report concerning her condition and ability to work and identified a modified duty position within her restrictions. She was expected to return to work on November 15, 2006 for a shift from 7 a.m. to 3 p.m., Monday through Friday, performing one-handed work. The letter requested that she sign the letter and return it within seven days of receipt. If she did not do so, the offer would be considered rejected.

A form dated December 6, 2006, and signed by Dr. Calhoun, states that the claimant had a cervical herniated nucleus pulposus, which he had been treating since October 18, 2006. She was released on November 14, 2006, and "worker's compensation" was asked to refer her to another doctor.

On December 14, 2006, the claimant underwent an MRI of her shoulder, which showed "an area of tendinosis versus a small full-thickness tear in the distal 1 cm of the supraspinatus as described. The lack of tendon retraction and the small size of the lesion makes tendinosis somewhat more likely."

On December 21, 2006, the claimant underwent a Functional Capacity Evaluation. The claimant related an injury - left shoulder pain - when she pulled a reel of wire on a dolly when left side of neck, left shoulder and left arm were sprained. Her pain report using the visual analog scale was abnormal, but her report using a pain drawing and the dermatome pattern was normal. The tester reported:

Mrs. Webster presents with generally appropriate affect and a cooperative attitude. She denies present or past symptoms of depression and anxiety though she reported considerable difficulty with anxiety on her BBHI. She also had a number of

other complaints that she did not voice during the interview. Her reading comprehension may have affected her responses. She is frustrated with her protracted recovery. She remains hopeful of full recovery. She states that she is eager to return to work as soon as she is medically able. Her BBHI does not indicate any other problems. There appear to be no psychological factors that would prevent her from returning to full employment.

During the FCE, Waddell's testing for symptom magnification was negative. In testing for inappropriate illness behavior, the claimant scored one positive result for a pre-test pain rating of greater than 5, but her results from the other five tests were negative. The tester noted, in general, that inappropriate illness behavior, when deemed significant, should prompt further psychological testing to determine whether or not the patient is out for secondary gain or simply has a poor perception of pain as it relates to his or her dysfunction.

Later in the report, the tester noted that the claimant was "generally uncooperative" during testing, and that the claimant's major limiting factors were poor effort, pain, and apprehension. The claimant self-limited due to pain during dynamic lifting, grip strength, and static lifting, which resulted in inconsistent ratings.

The claimant tested in the Light physical demand classification. The tester recommended work modifications of no lifting above twelve pounds, no pushing above twenty-four pounds and no pulling above fourteen pounds. The tester noted:

The above recommendations may or may not be an accurate reflection of Ms. Webster's true physical ability. The performance indicates a sub-maximal effort given on her part. By no means is the therapist implying intention of giving less than full effort. While subjective reports of pain should not be ignored, they should be considered with caution when selecting job tasks for Ms. Webster.

Dr. Calhoun wrote, on December 28, 2006, that he agreed that she could work full time under the FCE's recommended restrictions.

The claimant returned to Dr. Sample on January 10, 2007, who gave her a full and complete release as of that date, with restrictions as outlined in FCE.

Dr. Fortenberry evaluated the claimant on January 18, 2007. She related to him that her left shoulder pain started acutely on February 9, 2006, when she was turning a large spool to wind a length of cable with the left hand. After his examination, Dr. Fortenberry stated that she had reached maximum medical improvement on or about January 11,

2007. He assessed a six percent impairment rating to the whole person based upon the signs of impingement of the left shoulder and the MRI showing tendinitis, which is consistent with her pattern of pain, and her physical findings.

On February 22, 2007, the claimant was terminated.

The given reason was:

Bertha was terminated for violating Coleman Cables attendance policy. Our policy states that termination occurs when an employee reaches 14 demerit points. On February 22nd Cliff Sanderson came down to audit the attendance records and found that Bertha had accumulated 66 demerit points. We asked Bertha if she had turned in all the doctor excuses for the days she had missed and she replied that she had turned them all in. With Bertha stating that, all her points still apply and we had no choice but to terminate her immediately.

The respondent-employer responded to an unemployment benefits form, stating that the claimant was terminated for violating the absenteeism policy.

Dr. Hassan evaluated the claimant on July 20 2007, and planned an MRI to assess for rotator cuff pathology. He noted that cervical pathology had been ruled out by thorough neurological evaluation, and that she had significantly decreased range of motion with increased scapulothoracic component with forward elevation.

Dr. Hassan wrote a note on January 16, 2008, stating that the claimant had diagnostic testing and treatment without improvement, that there was no shoulder pathology present, and that she was referred to a pain management clinic.

On March 9, 2009, a claims adjuster for the respondent-carrier sent the claimant a letter, explaining that she sent a check to cover the balance owing on her temporary total disability benefits (\$1645) and on her permanent partial disability benefits (\$1155.80).

COMPENSABILITY OF GRADUAL ONSET INJURY

In order to prevail upon a claim for a compensable injury, which is not a specific incident identifiable by place and time of occurrence, the claimant must prove by a preponderance of the evidence that she sustained an injury caused by rapid repetitive motion. Carpal tunnel syndrome is specifically categorizes as a compensable injury falling within this definition. Ark. Code Ann. Sec. 11-9-102(4) (A) (ii) (a). The claimant must prove internal or external harm to the body which arose of out of and in the course of their employment and which required medical services or resulted in disability or death. Ark. Code Ann.

11-9-102(4) (A) (ii) (b). In addition, the claimant must prove by a preponderance of the evidence that the injury was the major cause of the disability or need for treatment. Ark. Code Ann. Sec. 11-9-102(4) (E) (ii). Finally, the claimant must establish a compensable injury by medical evidence supported by objective findings. Ark. Code Ann. Sec. 11-9-102(4) (D).

The claimant has objective findings of injury in the form of electrodiagnostic studies which show that the claimant has mild carpal tunnel syndrome in her left upper extremity. The claimant consistently described her injury as occurring when she was working with wire at the respondent-employer. The clearer accounts in the medical records show that the claimant was pulling the wire on a spool and jerked her shoulder. There is no question that this activity arose out of and in the course of her employment. The claimant has required therapeutic and diagnostic medical treatment for her hand, wrist, and arm pain, numbness, tingling and weakness, and has suffered temporary disability acknowledged by her doctors who restricted the use of her left arm at work and in her daily life.

The claimant has complained of numbness, tingling and weakness in her left arm, wrist, and hand, since she began treating for her February 9, 2006 injury. The record is devoid of any indication that the claimant had such symptoms since May 8, 2004, when her left elbow ached. The claimant went for almost two years without requiring medical attention for any arm pain of any type. Whether the claimant suffered similar symptoms in 1993 or 2002 does not prevent a finding of causal connection between the events of February 9, 2006, and her left carpal tunnel syndrome. She was asymptomatic before February 9, 2006, and after her work-related injury, she was symptomatic. She has proven that her carpal tunnel syndrome is causally connected to the work-related event and that it was the major cause of her need for treatment and disability. She did not need treatment and was not limited before February 9, but, afterwards, she was.

I find the claimant to be a credible witness. She was injured in 2006, and she testified that she was still experiencing problems at the time of the hearing. She also indicated that the circumstances of her termination were suspicious. The claimant was a very frustrated subject of

the workers' compensation system, but this does not make her less than credible. I do note that she was not a terribly effective historian, but again, her injury was in 2006, her course of treatment was frustrating and involved numerous people and modalities without success, and the records provide enough consistency to support her claim.

In particular, I note that the functional capacity evaluation indicates that her performance was, in parts, less than maximal. However, the tester stated in one paragraph that the claimant was cooperative, and in another that she was not. Furthermore, the tester was careful to note that the claimant's inconsistencies could have more to do with poor perception of her pain than malingering. Lastly, I continue to question the validity of a functional capacity test given to a person with unresolved issues expected to engage in the very activities which caused and exacerbate her problems and pain. The idea that she "self-limited due to pain" sounds remarkably reasonable.

Lastly, I find that the claimant was purposefully terminated from her employment. She was assessed fifty-five attendance demerit points from November 15, 2006 forward. However, the letter offering her a job was dated and sent on

November 15, 2006, and it explicitly stated that she had seven days from the receipt of the letter before she was considered to have refused employment. She could not possibly have refused employment on November 15 and, in fact, did not pick up the letter until December 1. The assessment of fifty-five points was a fabrication to terminate an employee suffering an intractable workers' compensation injury. This fact highlights the reasonability of the claimant's frustrations. It also throws into question the rest of the respondent's behavior in this claim.

CONCLUSION

After my de novo review of the entire record, I must respectfully dissent from the majority opinion. I find that the pro se claimant's left carpal tunnel syndrome is compensable and that she is entitled to benefits for the same.

PHILIP A. HOOD, Commissioner