

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F907508

RICHARD LITTLE,
EMPLOYEE

CLAIMANT

TYSON POULTRY, INC.,
SELF-INSURED EMPLOYER

RESPONDENT

OPINION FILED MARCH 30, 2011

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

Claimant represented by the HONORABLE EVELYN E. BROOKS,
Attorney at Law, Fayetteville, Arkansas.

Respondent represented by the HONORABLE E. DIANE GRAHAM,
Attorney at Law, Fort Smith, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondent appeals an administrative law judge's opinion filed September 13, 2010. The administrative law judge found that the claimant proved he sustained a compensable cervical spine injury. After reviewing the entire record *de novo*, the Full Commission reverses the administrative law judge's opinion. The Full Commission finds that the claimant did not prove he sustained an injury to his neck or cervical spine.

I. HISTORY

The claimant, age 54, testified that he became employed with Tyson in about August 2006. The parties stipulated that the claimant sustained a compensable injury to his left shoulder on February 1, 2007. The claimant testified that he slipped on ice and fell on his left side: "I was walking and my feet went out from underneath me and I went down. I went down hard. I tried to catch myself. Automatic reflex to try to catch myself. I figured, well, I'm a little sore and got up and went on."

The claimant received medical treatment on February 12, 2007:

The patient is an employee of Tyson Foods Pork Group, date of injury 02-01-07 at approximately 10 a.m. The patient's description of the accident - "Fell on ice." Further history indicates he has had three surgeries on his left shoulder in the past for a rotator cuff tear, has been seen by Dr. Raye Mitchell. He was evaluated in the ER at WRMC, was placed on Percocet and Naprosyn. He reports the ER doctor told him it appeared he separated his shoulder, but the x-ray report states no bony abnormalities....

The assessment was "1. Left shoulder pain....He can return to work, but I recommend we leave him on a right-handed job with his left shoulder at rest." An MRI of the claimant's left shoulder was done on February 20, 2007. The

impression included "1. Postoperative changes identified in the region of the rotator cuff tendon, acromioclavicular joint and distal clavicle."

Dr. Terry J. Sites examined the claimant on March 8, 2007:

This is a first time orthopedic evaluation by me of the above named patient, a 50 year old male who is referred for orthopedic consultation by Dr. Craig Cooper regarding his left shoulder. This includes review of numerous records from 3 previous left shoulder surgeries performed by Dr. Raye Mitchell. He notes his pain is deep and aching in nature, anterolaterally with some radiation down the mid arm. He has had some occasional numbness and tingling over the dorsoradial forearm and into all fingers....

The patient notes on 02-01-07 he slipped on the ice and fell onto his left side. He was seen at WRMC on 02-09-07, had x-rays and was given Percocet and Naprosyn. He saw Dr. Cooper on 02-12-07, had an MRI and was given Vicodin and placed on single-arm duties, and referred here.

I reviewed the films and report. There is some abnormal signal in the supraspinatus tendon, which should be expected following three previous surgeries. There is good tendon on the footprint, and some peritendinous fluid but no specific or discrete tear or retraction. He has had ongoing pain, is still taking narcotic analgesics....

PE: Examination reveals full neck motion without referred pain. He has some tenderness to palpation over his previous incision bilaterally, with a groove defect and popping in this area with range of motion, likely related to scar tissue around the humeral head with internal and external

rotation with his elbow at his side, he has some pain with this....

Dr. Sites' impression was "1. Left shoulder rotator cuff tendinopathy, with possible re-tear or incomplete healing." Dr. Sites initially treated the claimant conservatively but recommended shoulder surgery after an April 5, 2007 follow-up visit.

Dr. B. Raye Mitchell noted on May 3, 2007, "Richard fell on the ice on February 2, suffering an injury to his left shoulder....A MRI has been done of the shoulder since the fall, which shows a possible rotator cuff tear....Strength does suggest he has a cuff tear, but he has always be (sic) a little chronically weak since his previous rotator cuff injury." Dr. Mitchell referred the claimant to Dr. Matthew J. Coker. Dr. Coker noted on May 21, 2007, "He has undergone four surgeries for rotator cuff problems. The last one was a couple of years ago. He was doing well until February 1st of this year. He slipped on the ice, fell, and landed on the left side and tried to catch himself with his arm. He sustained an injury to the left shoulder."

Dr. Coker performed surgery on June 5, 2007: "1. Left rotator cuff tear. 2. Left distal clavicle resection. 3.

Acromioplasty." The post-operative diagnosis was "1. Left rotator cuff tear. 2. Acromioclavicular joint arthrosis."

Dr. Coker noted on July 3, 2007, "He presents today for evaluation of the left shoulder. He underwent a rotator cuff repair four weeks ago. He states he has more pain now, burning sensation up into the trapezius muscle, up into the neck and kind of goes down into the jaw a little bit....I have asked him to stay away from narcotics as much as possible. At four weeks out, he is too far out for me to give him any more. We are going to start some therapy for the left shoulder and I will see him back in two weeks. If he is still having significant problems at that point, we will refer him to a chronic pain specialist and continue the therapy. I have also discussed the possible need for evaluation by a spine specialist. At this point, I do not think it is necessary, but we will keep that possibility open if he continues to have the pain up into the neck."

The claimant followed up with Dr. Coker on July 20, 2007: "I did evaluate his neck today and he has no pain with range of motion and negative Spurling test. He does complain of some radicular symptoms down in the hand, but it does not follow the distribution of the nerves and therefore

I am not convinced that it is a true problem. Because of the continued pain and the fact he has talked about needing narcotics for a longer period of time than that I am accustomed to treating him with, it may be that this is already a problem with him for dependence and therefore I would like for him to see Dr. Taylor to see what she can do for him. He will follow up with me in 6 weeks for re-evaluation."

Dr. Coker noted on August 31, 2007, "At six weeks after surgery, he had excellent motion and was doing very well. He was healing up nicely but still had some residual pain. Although examination of the cervical spine was negative, there was concern about some numbness and tingling or radicular symptoms, but I was hoping it was related to the shoulder. He states that this has continued to be a problem and has actually taken a step backwards with the shoulder....I have stopped his narcotic pain medication at this point. Therefore, I think he would be best served by a neurology consult for EMG nerve conduction studies. We will have him follow-up with me after this....I will do an injection of the left shoulder at this time."

Dr. Michael W. Morse provided a consultation on September 24, 2007:

The patient had a slip and fall in February, 2007. He slipped on a sidewalk between some hog houses. He underwent rotator cuff repair for a recurrent tear. He has done well recently except he has some numbness and tingling in his left hand and all the digits in the left wrist and occasionally pain up into the left forearm. He states he really did not notice the numbness until after his surgery.

He also has neck pain with a burning sensation in the left trapezius and supraspinatus area....He does not really remember much about the slip and fall in February....

Nerve conduction velocity shows left carpal tunnel syndrome, left tardy ulnar neuropathy with no active denervation.

IMPRESSION:

1. Left rotator cuff injury with subsequent repair.
2. Left carpal tunnel syndrome. He had no symptoms prior to the fall. I suspect he was in so much pain, it masked the symptoms until he had his surgery. I will let Dr. Coker decide what to do about the carpal tunnel in terms of injection, surgery, conservative management, etc.
3. Tardy ulnar neuropathy. This appears to be chronic and probably not related to the fall.
4. Possible cervical radiculopathy. I want to check an MRI of the cervical spine. I will plan to see him back afterwards.

Dr. Morse gave the following impression after an MRI of the claimant's cervical spine on October 9, 2007:

Posterior fossa structures, craniocervical junction, cervical and upper thoracic vertebral

bodies show normal alignment and no pathologic signal intensities. There is no spinal stenosis or disc herniation. The C2-3 level appears normal. The C3-4 level shows degenerative disc disease, disc space narrowing, spur formation, and spondylitic changes resulting in bilateral neural exit foraminal narrowing left greater than right. There is some effacement of the subarachnoid space but no cord compression. The C4-5 level shows spondylitic changes with mild bilateral neural exit foraminal narrowing. The C5-6 level shows degenerative disc disease, disc space narrowing, spur formation, and spondylitic changes resulting in significant bilateral neural exit foraminal narrowing. There is effacement of the subarachnoid space with no cord compression. The C6-7 level shows spondylitic changes with minimal bilateral neural exit foraminal narrowing. There appears to be a small disc bulge on the left that may compromise the neural exit foramina on the left. The remainder of the study is unremarkable.

Dr. Morse noted on October 11, 2007, "Mr. Little returns. I am seeing him for a slip and fall at work. He has significant stenosis at C5-6 and multilevel degenerative changes elsewhere. The spondylitic changes were pre-existing, however, he was asymptomatic prior to the slip and fall. I reviewed the films with the patient and his caseworker. I would like him to see Dr. Luke Knox for consideration of epidural steroids, surgical intervention, spine rehabilitation, etc. I will be happy to see him back on an as needed basis."

Tana White, a PA-C with Northwest Arkansas Neurosurgery Clinic, corresponded with Dr. Morse on November 5, 2007:

Richard Little was seen in the Neurosurgery Clinic on November 5, 2007 for consultation of his acute neck pain. As you know, Mr. Little is a 50-year-old, left-handed male, who complains of the acute onset of neck pain related to a fall in February of 2007. He reports that he was walking across a sidewalk between two hog houses owned by Tyson's, when he slipped and fell. He states that he used his left arm to brace his fall. He reports that he first had intense left shoulder pain, but after the shoulder was adequately treated, he then recognized his severe neck pain. He reports a generalized neck pain, which radiates across the left shoulder and deltoid, laterally to the wrist, with constant left hand numbness....

He has marked spasms of the paracervical spine....

A review of his cervical spine x-ray, as well as his cervical spine MRI, demonstrates loss of disc height at C3-4 and C5-6, and loss of normal cervical lordosis. There is evidence of neuroforaminal narrowing at the level of C3-4 on the right, as compared to the left. There appears to be a grade-I retrolisthesis of C3 on 4, with evidence of a herniated intervertebral disc at the level of C3-4, C5-6, and C6-7. Also noted on the MRI scan is ligamentous hypertrophy, especially apparent at the level of C6. There appears to be abnormal signal at the level of C3, which may indicate nonspecific inflammation of the vertebral body at that level. Also noted is a mild to moderate degree of cervical spinal stenosis, most notable at the level of C5-6. There is also loss of predental space, most apparent on the lateral x-ray studies. There also appears to be a radiographic abnormality at the level of C3 on the AP film. I will confer with Dr. Knox to review this possible abnormality.

Ms. White's impression was "1. Cervical herniated intervertebral disc, likely secondary to recent fall and trauma, at the level of C3-4 and C5-6. 2. Bilateral cervical radiculopathy. 3. Traumatic cervicalgia. 4. Weakness."

Dr. D. Luke Knox provided an x-ray report on November 5, 2007:

AP, lateral, flexion, extension, and oblique of the cervical spine, demonstrating normal craniocervical alignment and normal anterior, middle, and posterior columns. There is significant degenerative disc changes noted at C3-4 and again at C5-6, without any evidence of overt instability on flexion and extension views. There is rather prominent posterior osteophyte formation at the C5-6 level. There is no evidence of bony lesion. There are normal soft tissue planes.

Dr. Knox saw the claimant on November 8, 2007: "He is followed for neck and left arm pain. I am somewhat suspicious that his neck and left arm pain is related to the miserable disc space findings we see at C3-4. However, there is a significant component that is related to the C5-6 level. Due to the multifocality of findings on his plain films and MRI scan, I am inclined to certainly wait and see if physical therapy may not take hold. He is set up to start this next week after he gets back from a deer hunting

expedition. I will plan to follow him up in two months to see how he is doing. If he is not significantly improved at that point, we will reconsider the possibility of surgical endeavors, which would necessitate anterior cervical discectomy and fusion at C3, C4, C6, and C6."

The claimant followed up with Dr. Knox on January 3, 2008:

He has been followed for severe cervical radiculopathy secondary to herniated discs. He continues to be plagued with significant discomfort. I have arranged for him to undergo cervical epidural steroids. Through the course of our evaluation today, he had significant complaints of bilateral hand numbness, night numbness, etc. I believe it would be prudent to have him go ahead and get electrical studies to see if we may not be able to define a cervical radiculopathy. I will have him return to see me after we have had a chance to complete the above in about six weeks. I would certainly like to see Mr. Little avoid surgical options if at all possible.

ADDENDUM: Through the course of my dictation, Mr. Little reminded me that he had already had the electrical studies, which actually had demonstrated a component of carpal tunnel syndrome. He has a chronic tardy ulnar nerve palsy. His cervical radiculopathy was rather unrevealing on the electrical studies, this being done this past September. We will hold on redoing those for the time being and go ahead and proceed with the cervical epidural steroids.

The claimant testified on cross-examination that he did not see Dr. Knox after January 3, 2008.

The impression following an arthrogram of the claimant's left shoulder on January 8, 2008 was "Full thickness tear of the rotator cuff." Dr. Coker performed a "Left rotator cuff repair with augmentation" on January 22, 2008. The post-operative diagnosis was "Left recurrent rotator cuff tear."

The claimant signed a Form AR-C, Claim For Compensation, on May 20, 2008 and described the cause of injury: "I injured my neck and my left shoulder when I fell while working."

Dr. John P. Park performed a "Rotator cuff reconstruction with infraspinatus musculotendinous advancement, left shoulder" on August 20, 2008. The post-operative diagnosis was "Large rotator cuff tear; retracted left shoulder." Dr. Park performed a "reverse total shoulder arthroplasty" on October 8, 2009.

A pre-hearing order was filed on December 31, 2009. The claimant contended that he injured his "left wrist" on February 1, 2007. The respondent contended, among other things, that the claimant did not injure his left wrist or neck on February 1, 2007.

The parties agreed to litigate the following issues:

1. Compensability of the claimant's neck injury of February 1, 2007.
2. Related medical.

The parties deposed Dr. Knox on May 28, 2010. The respondents' attorney questioned Dr. Knox:

Q. Do you know, sitting here today, whether or not back in late '07, early '08, the two times that you saw Mr. Little, whether or not he actually had herniated discs in his cervical spine?

A. I don't think I can state today that he had herniated discs....

Q. Is a miserable disc a really, really bad disc space?

A. I suspect I would probably consider that a true statement.

Q. Okay. Do you know when that miserable disc - well, when that disc space became miserable?

A. No.

Q. Ms. White, in her report, under the impression section, when she says that he's got a herniated disc at 3-4 and - at C3-4 and C5-6, says, and I quote, "Likely secondary to recent fall and trauma," end quotes. Do you know what that opinion of hers was based on?

A. His history.

Q. Okay. And if Mr. Little is either an inaccurate historian or an untruthful historian, that opinion would be very suspect. Would that be correct?

A. I guess that would be a true statement, yes....

Q. If a person has muscle spasms as a result of trauma, how soon after the trauma would you expect those muscle spasms to appear?

A. That's oftentimes a difficult question. It can be immediate onset. Sometimes it can be delayed for some time. I believe it could be - I'd certainly want to see it within several weeks anyway.

Q. So if trauma - if a specific trauma caused muscle spasms, you would expect those muscle spasms to be present either immediately or within a couple of weeks?

A. Typically....

Q. Do you know, or do you have an opinion, Dr. Knox, as to whether or not Mr. Little's fall at Tyson on February 1, 2007 caused any cervical spine problems, or necessitated any need for treatment?

A. Ask me that question again.

Q. Do you have an opinion as to whether or not Mr. Little's fall at Tyson on February 1, 2007 caused any cervical spine problems or necessitated any cervical treatment?

A. I believe his fall probably resulted in the neck and arm pain that ultimately resulted in the need for this treatment, yes.

Q. And what is that based on, sir?

A. His history....

A hearing was held on June 15, 2010. The claimant described the symptoms in his neck: "I have - lot of times I have to sit up in a chair to sleep because I can't lay

down, because my neck - there's no way to get my neck comfortable where I could even go to sleep it hurts so bad. Sometimes I have to just reshift to even watch TV and turn a certain way to do anything, because I can't turn my head at times because of the pain." The claimant testified that he wanted to resume treating with Dr. Knox.

An administrative law judge filed an opinion on September 13, 2010. The administrative law judge found that the claimant proved he sustained "a compensable cervical spine injury."

The respondent appeals to the Full Commission.

II. ADJUDICATION

Act 796 of 1993, as codified at Ark. Code Ann. §11-9-102(4) (Repl. 2002), provides:

- (A) "Compensable injury" means:
 - (i) An accidental injury causing internal or external physical harm to the body ... arising out of and in the course of employment and which requires medical services or results in disability or death. An injury is "accidental" only if it is caused by a specific incident and is identifiable by time and place of occurrence[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4) (D) (Repl. 2002). "Objective findings" are those findings which cannot come under the voluntary control of

the patient. Ark. Code Ann. §11-9-102(16) (A) (i) (Repl. 2002). Objective medical evidence is necessary to establish the existence and extent of an injury but not essential to establish the causal relationship between the injury and a work-related accident. *Wal-Mart Stores, Inc. v. VanWagner*, 337 Ark. 443, 990 S.W.2d 522 (1999).

The employee has the burden of proving by a preponderance of the evidence that he sustained a compensable injury. Ark. Code Ann. §11-9-102(4) (E) (i) (Repl. 2002). 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).

An administrative law judge found in the present matter, "2. The claimant has proven by a preponderance of the evidence that he suffered a compensable cervical spine injury on February 1, 2007." The Full Commission reverses this finding. We find that the claimant did not prove he sustained a compensable injury to his neck or cervical spine. The parties stipulated that the claimant sustained a compensable injury to his left shoulder on February 1, 2007. The claimant testified that he slipped on ice at work and fell on his left side. The preponderance of evidence does

not demonstrate that the claimant injured his neck or cervical spine when he slipped and fell on February 1, 2007. The initial medical assessment on February 12, 2007, following the accidental injury, was "Left shoulder pain." There was no indication that the claimant also injured his neck or cervical spine when he slipped and fell on February 1, 2007. An MRI of the claimant's left shoulder was done on February 20, 2007 and there was no indication from a treating physician that diagnostic testing of the claimant's neck or cervical spine was also necessary.

Dr. Sites began treating the claimant on March 8, 2007 and did not report that the claimant had injured his neck or cervical spine in the February 1, 2007 accident. Dr. Sites reported, "Examination reveals full neck motion without referred pain." Dr. Sites' impression was Left shoulder rotator cuff tendinopathy. Dr. Mitchell specifically noted regarding the claimant on May 3, 2007, "He sustained an injury to the left shoulder." Dr. Mitchell did not report a neck injury. Dr. Coker noted on May 21, 2007, "He sustained an injury to the left shoulder." Dr. Coker performed surgery on the claimant's left shoulder on June 5, 2007. Dr. Coker reported pain in the claimant's neck beginning

July 3, 2007 but did not report that the claimant had sustained an injury to his neck. Dr. Morse described "neck pain with a burning sensation in the left trapezius and supraspinatus area" on September 24, 2007. Dr. Morse's impression on September 24, 2007 included "Possible cervical radiculopathy." The evidence before the Commission does not demonstrate that the "Possible cervical radiculopathy" reported on September 24, 2007 was the causal result of the February 1, 2007 accidental injury.

An MRI on October 9, 2007 revealed a number of degenerative abnormalities in the claimant's cervical spine, but the record does not show that any of these abnormalities were causally related to the February 1, 2007 accidental injury. Dr. Morse reported on October 11, 2007, "He has significant stenosis at C5-6 and multilevel degenerative changes elsewhere. The spondylitic changes were pre-existing, however, he was asymptomatic prior to the slip and fall." Dr. Morse referred the claimant to Dr. Knox.

The evidence before the Commission does not demonstrate that the claimant sustained an injury to his neck or cervical spine at the time of the compensable injury to the claimant's left shoulder on February 1, 2007. The Full

Commission recognizes the history the claimant gave Tana White on November 5, 2007, *i.e.*, "acute onset of neck pain related to a fall in February of 2007." We also recognize Dr. Knox's testimony given at deposition, "I believe his fall probably resulted in the neck and arm pain that ultimately resulted in the need for this treatment." It is within the Commission's province to weigh all of the medical evidence and to determine what is most credible. *Minnesota Mining & Mfg. v. Baker*, 337 Ark. 94, 989 S.W.2d 151 (1999). In the present matter, we attach more significant evidentiary weight to the initial medical reports of record which showed that the claimant injured only his left shoulder on February 1, 2007. The probative weight of the evidence does not demonstrate that the claimant also injured his neck or cervical spine on February 1, 2007. Based on the evidence before us, we must attach minimal weight to the opinions of Tana White and Dr. Knox regarding causation of the claimant's neck and cervical problems.

The Full Commission finds that the claimant did not prove by a preponderance of the evidence that he sustained a compensable injury to his neck or cervical spine. The claimant did not prove that he sustained an accidental

injury causing internal or external harm to his neck or cervical spine. The claimant did not prove that he sustained an injury to his neck or cervical spine which arose out of and in the course of employment, required medical services, or resulted in disability. The claimant did not prove that he sustained an injury to his neck or cervical spine which was caused by a specific incident identifiable by time and place of occurrence on February 1, 2007. The claimant did not establish a compensable injury to his neck or cervical spine by medical evidence supported by objective findings. The Full Commission finds that the abnormalities shown in the claimant's cervical spine beginning October 9, 2007 were not causally related to the February 1, 2007 accidental injury. In addition, we find that the "spasms" reported by Tana White on November 5, 2007 were not causally related to the February 1, 2007 accidental injury.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove he sustained a compensable injury to his neck or cervical spine on February 1, 2007. We reverse the administrative law judge's finding that the claimant proved he sustained "a

compensable cervical spine injury on February 1, 2007." The claimant did not prove he was entitled to Dr. Knox's treatment recommendations related to the claimant's neck or cervical spine. Said recommendations were not reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a) (Repl. 2002). This claim is denied and dismissed.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion. After a de novo review of the record, I find the claimant has proven by a preponderance of the evidence that he suffered a compensable injury to his cervical spine that is supported by objective findings. He is entitled to reasonable and necessary medical treatment as was recommended by Dr. Luke Knox.

The medical evidence reports objective findings that support a cervical spine injury. Dr. Knox's letter, dated November 5, 2007, states that the claimant's cervical spine x-rays and MRI showed herniated intervertebral discs at the levels of C3-4, C5-6, and C6-7. They also showed inflammation at those levels, and stenosis at C5-6. Under "Impression" it states, "Cervical herniated intervertebral disc, likely secondary to recent fall and trauma, at the level of C3-4 and C5-6." Then, on November 8, 2007, Dr. Knox states, "I am somewhat suspicious that his neck and left arm pain is related to the miserable disc space findings we see at C-4." He also states that, if the claimant is not significantly improved after physical therapy, "we will reconsider the possibility of surgical endeavors, which would necessitate anterior cervical discectomy and fusion at C3, C4, C5, and C6."

Furthermore, in the July 3, 2007 report from Dr. Matthew Coker, four weeks after his shoulder surgery, the claimant is complaining of pain and a burning sensation going up into his neck and down into his jaw. The claimant again is complaining of pain in his cervical area in Dr. Coker's August 31, 2007 note. In Dr. Michael Morse's

October 11, 2007 report, he notes that the claimant is suffering from significant stenosis at C5-6 and, although the spondylitic changes were pre-existing, they were asymptomatic prior to the slip and fall. He also states that the claimant should see "Dr. Luke Knox for consideration of epidural steroids, surgical intervention, spine rehabilitation, etc." In the last report by Dr. Knox on January 3, 2008, he, like Dr. Morse, also suggests cervical spine injections.

Dr. Knox supported his written reports in his deposition. He continued to indicate cervical injury and symptoms. The October 9, 2007 MRI report unquestionably showed "a small disc bulge on the left that may compromise the neural exit foramina on the left." Dr. Knox confirmed that this disc bulge would be consistent with a disc herniation. He also stated that this type of compromise of the neural exit foramina at the cervical level of C6-7 would cause pain in the shoulder blade, shoulder, arm, and into the hand. This is a reasonable explanation for the fact that the claimant was complaining about shoulder pain from the beginning, while the neck pain did not become evident until the shoulder was treated. When the shoulder began to

become less painful, the claimant could differentiate between the shoulder pain and the neck pain. Dr. Knox went on to explain that the pain from the neck injury could be confused with the pain of a severe shoulder injury, or be masked by that injury, as in the case of the claimant. He also explained that, if a person who had degenerative disc disease or spinal stenosis had a traumatic fall, it would not be unusual to then have a herniated disc. Given the scenario of a person having a traumatic fall and then experiencing cervical pain, he did indicate that the fall would be the cause for the need for treatment. Dr. Knox relates the neck pain to the fall. When he was asked if he had an opinion as to whether the February 1, 2007 fall caused the cervical spine problems and necessitated treatment, he replied, "I believe his fall probably resulted in the neck and arm pain based on the claimant's history."

Additionally, there is no credible evidence to suggest that the claimant's cervical spine injury is related to anything other than his fall at work. The specialist, Dr. Knox, relates the neck injury to the fall at work. The consulting neurologist, Dr. Morse, relates the neck injury to the fall at work. Contrary to the majority, I assign

greater weight to the testimony of specialists than to the testimony contained in the initial medical reports. As explained above, the claimant's neck injury was masked by a more prominent shoulder injury.

Here, despite a history of minor neck injuries, the claimant was not seeing a doctor for any neck injuries before the fall at work. He was not taking any medication for any neck injuries before the fall at work. He did not have any pain or problems before the fall at work. Clearly, the preponderance of the evidence shows that the claimant's neck problems are related to the fall at work.

For the aforementioned reasons I must respectfully dissent.

PHILIP A. HOOD, Commissioner