

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F806092 & G000327

THERESA WHITAKER,
EMPLOYEE

CLAIMANT

UAMS,
EMPLOYER

RESPONDENT

PUBLIC EMPLOYEE CLAIMS DIVISION,
INSURANCE CARRIER

RESPONDENT

OPINION FILED JUNE 8, 2011

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

Claimant represented by the HONORABLE KRISTOFER E.
RICHARDSON, Attorney at Law, Jonesboro, Arkansas.

Respondent represented by the HONORABLE TERRY D. LUCY,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed in part,
affirmed in part as modified.

OPINION AND ORDER

The respondents appeal an administrative law judge's
opinion filed January 12, 2011. The administrative law
judge found that the claimant was entitled to additional
medical treatment. The administrative law judge found that
the claimant proved she sustained wage-loss disability in
the amount of 63%. After reviewing the entire record *de*
novo, the Full Commission reverses the administrative law

judge's opinion in part and affirms in part as modified. The Full Commission finds that the claimant did not prove treatment provided by Dr. Johnson was reasonably necessary in connection with the claimant's compensable injury. We find that the claimant sustained wage-loss disability in the amount of 15%.

I. HISTORY

Theresa Jewell Whitaker, now age 53, testified that she attended school until the 10th grade but subsequently obtained a G.E.D. The claimant described her employment history as including factory work, housekeeping, and employment with grocery stores. The claimant's testimony indicated that she became employed as a Caregiver One for the respondents in 2007. The parties stipulated that an employment relationship existed on February 20, 2008. The claimant testified on direct examination:

Q. So start with February 20, 2008, tell the Judge what you were doing and what happened.

A. We were in the classroom and we were cleaning out a cabinet. There was one child there and he had gotten behind me and had laid down on the floor and I didn't know he was there....I went to take a step back and when I did I went over him and I fell straight back and hit the floor.

Q. What, if you recall, what parts of your body did you hit?

A. All of it.

Q. What landed first?

A. They said that my head bounced twice. And my back, I fell straight backwards onto my back....They called an ambulance because I couldn't get up.

According to the record, Cammie Sifford, R.N., saw the claimant at Pocahontas Medical Clinic on April 15, 2008 and noted, "50 y/o WF presents to clinic for follow up on her low back pain. She has completed three weeks of physical therapy with marked improvement." Cammie Sifford assessed "Cervical and lumbar strain with leg parathesias. P: She is to return to work without restrictions. Encouraged to continue home physical therapy program and use heat as needed. She may also continue Mobic as directed prn. No follow up appointment planned."

The parties stipulated that an employment relationship existed on June 10, 2008. The claimant testified on direct examination:

Q. What happened that day?

A. We had just come in from outside with the kids. And we had them all sitting at the table and the other worker had left the room to do something and I realized that I had the key to the gate in my pocket. So I went to the door to holler at her to go hang it up. And one of the kids screamed and I turned around to see what was

happening and there was another little girl on the floor and I fell over her and fell on my side.

Q. Which side did you fall on?

A. The right.

Q. What part of your body hit first?

A. My head and my arm.

The claimant testified that she did not work after the June 10, 2008 accident. The claimant saw Dr. Henry Stroope on June 17, 2008:

Theresa Whitaker is seen today for a Worker's Compensation injury, which occurred to her right shoulder in April when she was at her day care, tripped over one of the children, and fell catching herself with her right elbow. She thinks she noticed a deformity of her shoulder immediately and had onset of terrible right shoulder pain. Her shoulder pain persisted. The deformity did not. She did not really feel an audible clunk or click in her shoulder but rather just noticed immediately the deformity which later apparently resolved spontaneously. She has some swelling about the shoulder and has had bitter shoulder pain ever since. She finds it difficult to lift her arm. She can only do minimal activity with her arm.

Clinical exam shows active forward elevation to only about 45 degrees, abduction about 40 degrees, and external rotation about 30 degrees. She is very tender over the greater tuberosity of the right shoulder. There is no obvious swelling or bruising. Right upper extremity is neurovascularly intact. She has positive impingement signs in her right shoulder.

X-ray examination of the right shoulder including repeat views of the clavicle are reviewed. She has no evidence of fracture about the right proximal humerus or distal clavicle. The acromioclavicular joint and glenohumeral joints appear to be normal.

She also had x-rays of her right hand done at the time of her injury. Review of those x-rays shows a lesion in the base of the middle phalanx of the right ring finger. This shows an expansile lesion in the base of the middle phalanx with erosion of the cortex volarly on the lateral view and expansion of the bone at the base. This seems to be the most consistent with a giant cell tumor of bone.

Dr. Stroope assessed "1. Probable rotator cuff tear of the right shoulder secondary to her fall at work. 2. Giant cell tumor of the middle phalanx of the right ring finger base or other benign lesion. I doubt that this is related to her work injury and is only seen as an incidental finding on x-ray." Dr. Stroope treated the claimant with an injection and scheduled an MRI scan of the right shoulder. An MRI of the claimant's right shoulder was done on June 27, 2008, with the following impression:

1. Somewhat limited examination due to patient motion artifact.
2. Abnormal signal involving the distal undersurface of the supraspinatus tendon. Findings may represent a partial supraspinatus tear. A small amount of fluid is present in the subacromial bursa.
3. Degenerative change involving the acromioclavicular joint.

Dr. Stroope reported on July 15, 2008:

Ms. Theresa Whitaker is seen in followup today for right shoulder injury, which occurred at work when she had a fall.

Clinically today she is still having some posterior shoulder pain along the posterior aspect of the rotator cuff. Review of her MRI which was completed recently did not show a rotator cuff tear. In fact, the study was essentially normal other than some supraspinatus tendinopathy, but no rotator cuff tear. She has a complaint today of some numbness and tingling in her right hand and states that she is having some lateral right neck pain.

Dr. Stroope assessed "1. Rotator cuff sprain to the right shoulder. 2. Radicular symptoms, right upper extremity, which could represent a ruptured disc or some other nerve entrapment syndrome in her right upper extremity secondary to her fall. PLAN: I would recommend MRI scanning of the cervical spine to rule out a herniated disc or other etiology for the numbness and tingling and we will see the patient back after that is available. Currently I don't believe that she will have a surgical lesion around her shoulder."

An MRI of the claimant's cervical spine was performed on July 21, 2008, with the following findings:

The appearance of the cerebellar tonsils is normal. No abnormal signal is seen in the cervical spinal cord. There is normal marrow

signal seen in the visualized bone marrow of the cervical vertebrae. The craniocervical junction and C1-C2 levels appear normal. The odontoid process appears normal. The C2-C3 level appears normal.

The C3-C4 level appears normal.

The C4-C5 level appears normal.

The C5-C6 level shows a diffuse posterior disc bulge. There is some left sided uncovertebral joint hypertrophy. This causes mild left sided foraminal narrowing.

The right intervertebral foramen is patent.

The C6-C7 level appears normal.

The C7-T1 level appears normal.

No abnormality is seen in the visualized thoracic levels.

IMPRESSION: There are mild degenerative disc changes at C5-C6 as described above with a posterior disc bulge.

Dr. Stroope noted on August 5, 2008, "Review of the MRI of her cervical spine shows some multilevel uncovertebral joint hypertrophy secondary to some degenerative arthritis but really no nerve root entrapment. She also has a posterior bulging disc at C5-6, but again there is no spinal cord compression or nerve root entrapment. As far as her shoulder is concerned, she is better. She can forwardly elevate her arm overhead now without much in the way of discomfort. She states that the physical therapy that she is doing is helping significantly. At this point, I have not found anything that I can make better with an operation. I think she is responding to physical therapy, and I would

recommend that we continue her physical therapy until I see her back in three weeks. At that time, hopefully, I can return her to work status."

The record indicates that Dr. Alex Baltz referred the claimant for an MRI of the lumbar spine, which was done on August 14, 2008:

FINDINGS: The tip of the conus medullaris is located at the L2 level. Evaluation of the bone marrow shows a mass in the right side of the L4 vertebra which measures 1.9 cm. in diameter. This shows increased signal on the T2 and T1 sequences consistent with a hemangioma. No other abnormal marrow signal changes are identified. The intervertebral discs, neural foramina, and posterior elements appear normal above the L5 vertebra. The paraspinal soft tissues appear normal. There is a central disc bulge of the L5-S1 intervertebral disc. This extends into both neural foramina and causes mild bilateral neural foraminal stenosis. The posterior elements are within normal limits.

IMPRESSION:

1. There is a mild central bulge of the L5-S1 intervertebral disc which causes mild neural foraminal narrowing which is not felt to be of clinical significance.
2. There is a mass seen within the right side of the L4 vertebra which measures approximately 2 cm. in diameter and which is consistent with a hemangioma.

Dr. Terence P. Braden, III saw the claimant and provided a consultation on September 9, 2008:

She reports that she initially fell back in February of 2008 and has had back pain

ever since, which improved somewhat but did not completely improve. She then reports that she slipped and fell on 6-10-2008 while working as a caregiver at a daycare. She said she fell sideways, hit her right elbow on the ground. She had right shoulder pain, neck discomfort and back pain. She has been referred today for lumbosacral strain. Dr. Henry Stroope she reports has been treating the other injured areas.

She reports that the pain is located in the back. It is a constant pain. It is primarily in the right leg, sometimes into the left....She said she has participated in therapy since July three times a week for approximately 18 to 21 visits. She said this has given her some improvement....

Ms. Theresa Whitaker is a 51-year-old female who reports to have an injury to her lumbosacral spine in February. She reports she always had some residual back pain but her MRI scan from that didn't show any distinct abnormality. She then again injured herself on 6-10-2008 with back pain and bilateral lower extremity pain and a recent MRI scan shows a central disk at L5-S1 which could be causing pressure intermittently on the bilateral nerve roots. This appears to be the cause of her ongoing symptoms and is related to the injury that she sustained on 6-10-2008.

Assessment and Plan:

1. Her diagnosis would be low back pain secondary to central disk protrusion with intermittent low extremity symptoms possible radiculopathy.
2. The current symptoms are a result from the 6-10-2008 injury.
3. She has completed an extensive number of outpatient therapy on her lumbosacral spine. I don't think further physical therapy is going to give her any improvement. It would be this examiner's recommendation that she be seen pain management for consideration of lumbosacral injections to see if this would aid with the discomfort in the low extremities. It would also

be recommended that bilateral EMG nerve conduction studies be performed to see if there is any nerve root compromise causing it.

4. She can be returned back to an alternate duty setting in a sedentary type position with no lifting.

Dr. Stroope reported on September 25, 2008:

I am still seeing Ms. Theresa Whitaker for care. Currently, she is undergoing supervised physical therapy, and she has gotten significant improvement with that. Currently, I do not believe that she has a surgical lesion in her shoulder that I can make better with an operation. She has not been released from my care yet so she has not achieved maximal medical improvement. I anticipate that at her next follow-up visit. Regardless, she will have no permanent impairment as a result of her injury.

Dr. Stroope noted on October 8, 2008, "Ms. Theresa Whitaker is seen today for posterior right shoulder pain. On presentation today, she is doing markedly better. She has gained full range of motion of her shoulder. She doesn't really have any significant pain today; therefore, I would have her continue her exercises on a home program, and she will follow-up with me as needed."

Dr. Braden referred the claimant to Dr. Calin A. Savu, who examined the claimant on October 15, 2008: "Ms. Whitaker is a pleasant 51 year old woman with a history of low back pain which appears to have been triggered by a fall she suffered on 6/10/08....DIAGNOSIS: Axial lumbar pain in a

patient who suffered a blunt trauma but problem mechanism also includes rotational component. In the absence of any neurological findings as well as referral of pain in a dermatomal distribution, axial sources of pain will be facet arthropathy and discogenic pain. THERAPY PLAN: Therefore a series of lumbar medial branch blocks, SI joint injections, and SI joint injections will be considered....Once some consistent pain relief is obtained, aggressive physical rehabilitation should be implemented and I would expect Ms. Whitaker to be able to make a full comeback within the next four to six weeks. In the meantime, symptomatic therapy will be continued unchanged." The claimant testified that she did not benefit from treatment provided by Dr. Savu.

Dr. Braden provided the following assessment on December 2, 2008:

1. We know that she has a mild central disk bulge at L5-S1 causing mild neural foraminal narrowing which based upon a previous scan on August 14th read by the radiologist was not felt to be clinically significant.
2. Dr. Savu has been doing an excellent job trying to give an appropriate pain intervention.
3. I'd recommend that if the medial branch blocks are not successful in giving her any relief that proceeding further into the rhizotomy may not be of any benefit for her and she will have reached her maximum medical improvement for the injury she reports to have sustained. I'll wait to hear from the case manager and adjustor how the medial

branch blocks have done to relief (sic) her discomfort.

The claimant followed up with Dr. Braden on January 13, 2009:

Ms. Theresa Whitaker is a 51-year-old white female who reported to have sustained an injury in initially February of 2008 and then again on June 10, 2008 while working as a caregiver in a day care. Her initial scan done after her injury in February of 2008 did not show any distinct abnormality based upon radiologist's report. The scan done after her injury in June 10, 2008 showed a central disc at L5-S1 in the lumbosacral spine. She has had adequate and aggressive treatment conservatively for this lumbosacral spine.

Assessment & Plan:

1. It is this examiner's opinion that she has reached maximum medical improvement for the injury she reports to have sustained.
2. It is unknown what her actual capabilities are and a Functional Capacity Evaluation would give us an indication of a safe return to the work environment.
3. Based upon the length of time since her injury and the aggressiveness of her care, as well as conservative measures that have been employed, she has reached maximum medical improvement. This would be as of this date 1-13-2009.
4. Her impairment based upon the AMA Guides to Evaluation of Permanent Impairment, IV edition, would be a 7% impairment to the whole person based on Table 75, page 113 of the guides.

The parties stipulated that the claimant was assessed a 7% anatomical impairment on January 13, 2009, and that the respondents accepted and paid the rating.

A Functional Capacity Evaluation was done on February 9, 2009:

Ms. Teresa Whitaker is referred to Functional Testing Centers, Inc. for the purpose of undergoing a comprehensive functional capacity evaluation to determine her current functional status. Ms. Whitaker is referred with complaints of pain in her low back which she attributes to her work duties required while employed by Kids First. Ms. Whitaker is referred for this FCE by Dr. Terrence Braden of Jonesboro, AR.... The results of this evaluation indicate that Ms. Whitaker gave an unreliable effort, with 12 of 48 consistency measures within expected limits. Analysis of the data collected during Ms. Whitaker's evaluation indicates that she did not put forth consistent effort during her evaluation. Ms. Whitaker exhibited extremely high coefficients of variation with repeated trial testing. She also exhibited numerous signs of self limiting behaviors as well as attempts to manipulate the testing results....

Although Ms. Whitaker reported and demonstrated numerous limitations, she also exhibited numerous signs of self limiting behavior and also exhibited numerous attempts to manipulate the testing results. Therefore, the functional limitations reported by Ms. Whitaker are not considered valid limitations and her actual current functional status remains unknown at this time due to unreliable effort.

CONCLUSIONS

Ms. Teresa Whitaker completed functional testing on this date with unreliable results. Although Ms. Whitaker demonstrated the ability to perform work in at least the LIGHT level as defined by the US Dept. of Labor's guidelines over the course of a normal work day, she also exhibited numerous inconsistencies which were sufficient to invalidate her entire evaluation. Therefore, the

above documented functional status should not be considered an accurate representation of Ms. Whitaker's actual functional status....

A representative of Systemedic Corporation corresponded with Dr. Braden on February 11, 2009 and stated in part:

1. Due to the circumstances of the FCE being invalid, due to unreliable efforts and "self limiting behavior and numerous attempts to manipulate the testing results" could Ms. Whitaker resume her pre-injury position with Kids First in Pocahontas from a physical medicine/rehabilitation standpoint. Please note that this is a subsidiary of UAMSC and lifting up to 50 lbs. could be required. She reportedly would be working with 4 and 5 year olds.
2. If not, please outline current limitations and restrictions.
3. Is there any need for future medical care specifically in regards to Ms. Whitaker's injury of 6/10/08? If so, please outline.

Dr. Braden wrote in answering question no. 1, "Yes but with 20 lb. lifting restriction." Dr. Braden answered question no. 2 stating, "20 lbs. lifting - no real way to test with her poor FCE effort." Finally, Dr. Braden wrote "No" to question no. 3.

The record indicates that Cammie Sifford referred the claimant to Dr. John A. Campbell, who reported on April 3, 2009:

The patient is a 51-year-old woman that used to work in the daycare industry up in Pocahontas. She was on the job back in February of 2008 and tripped over a child and fell backwards hitting

her head on a concrete floor and says her head bounced twice....She had another fall in June of 2008 tripping again and, again, had some weakness in the legs and tried some treatments with pain specialist. She has felt poorly every (sic) since and has noticed increasing falls....She has not been back to work for many months....

MRIs of the lumbar and cervical spine both from March of 2008 and then again in the summer of 2008 are reviewed both online from Lawrence Medical Center and also an outside disk from Five Rivers Medical Center from July and August of this last year. There is a slight bulging disk seen at C5-6 on the C-spine MRI, but otherwise normal. Lumbar spine MRI shows a slight bulging disk at L5-S1, but otherwise normal.

ASSESSMENT/PLAN: Patient with interesting constellation of symptoms, but really no neurosurgical issues. I believe she was coming into my office today with a presumption that she was seeing a neurologist. I think she would benefit from consultation with a neurologist. Her tongue fasciculations and gait disturbance are somewhat concerning for possible motor neuron problems. To that end I will refer her over to Dr. Demetrius Spanos for further evaluation.

ADDENDUM: I did prescribe a cane for her to use today that might make it a little safer and easier for her to ambulate.

Dr. Demetrius S. Spanos examined the claimant on April 9, 2009:

The patient is a 51-year-old, right-handed, female with no significant past medical history who tripped over a child in February of 2008. She apparently struck the back of her head but there was no loss of consciousness. Following this she had a second event in June, again falling over a child, this time onto her right side. Since then

she has had "burning sensation" extending from her hip to the thigh on the left side. Also, she feels that her legs are "shaky" and she has had some subsequent falls related to this....

Today on examination I did not appreciate the presence of tongue fasciculation, which was witnessed by Dr. Campbell. I will pay attention to this on subsequent follow-up to see if this was coincidentally a quiescent phase. The patient's exam and symptoms none the less are not consistent with motor neuron disease. Limb pain and paresthesias are not typical early in the disease process. She has already undergone imaging of the cervical and lumbar spine and I've recommended neurophysiologic testing. My suspicion is that the left lower extremity pain is likely related to piriformis syndrome given that it worsens when she sits for long periods of time or drives for long periods of time. Nerve studies will also ensure that she does not have peripheral neuropathy although bilateral paresthesias would be an unlikely event following head injury. If neuropathy is present, further labs will be ordered.

The right upper extremity symptoms given that they do not stem from cervical pathology may stem from peripheral etiology and nerve studies will be done. This will evaluate for presence of carpal tunnel syndrome, which would explain the numbness and drip (sic) strength loss.

Finally, I've asked that imaging of the brain be done since this was the original impact site. I will see her again in a month for further recommendations. Today, the patient furthermore indicated she has been experiencing cognitive impairment. This predates the injury but has certainly gotten worse since last February. I will obtain a baseline mini mental status exam and monitor the patient's changes.

Dr. Spanos recommended "1. Nerve conduction studies of the lower extremities with particular attention to the left sciatic nerve. 2. Nerve conduction study of the right upper extremity. 3. MRI of the brain with gadolinium. 4. Mini mental status exam."

Motor Nerve Conduction studies were done on April 9, 2009 and Dr. Spanos reported on that date:

IMPRESSION: Normal nerve conduction velocity studies of the left upper and lower extremities.

CONCLUSION:

1) Nerve conduction velocity testing of the left lower extremity shows no evidence of entrapment neuropathy or polyneuropathy by nerve conduction velocity testing. The sural and superficial peroneal sensory nerves as well as the tibial and peroneal motor nerves show normal axonal and myelin function.

2) Nerve conduction velocity testing of the left sciatic nerve shows no evidence of piriformis syndrome.

3) Nerve conduction velocity testing of the left upper extremity shows no evidence of entrapment neuropathy or polyneuropathy.

An MRI of the claimant's brain was taken on April 9, 2009:

Diffusion studies show no evidence of acute infarction. No mass effect seen. No hemorrhage present. Cortex was normal. White matter normal. Basal ganglia normal. Capsular structures are normal. Cerebellum normal. Brainstem normal. Internal auditory canals normal. Base of skull intact. Sella normal. When contrast was given no abnormal enhancement was detected. No abnormal

enhancement present. Tonsils slightly ectopic but not dysplastic. Only 2 to 3 mm below the foramen magnum.

CONCLUSION: Minimal tonsillar ectopia within normal limits. No dysplasia of the tonsils. Negative study.

Dan Johnson, Ph. D., a clinical neuropsychologist, provided a "Neuropsych Consult" on August 28, 2009 and reported in part:

Ms. Whitaker was referred for neurocognitive evaluation by Dr. Demetrius Spanos, M.D., patient's neurologist, to assess presence and severity of neurocognitive and/or neurobehavioral decline and explore potential contributing etiologies....

In February 2008 the patient was working at a daycare facility. She noted that she took a step backwards and tripped over a child that was laying down, hitting her head on the concrete once initially and then again as her head "bounced" per her report....The patient fell again in June 2008, this time falling sideways over a child, landing on her right side. She notes that it is possible her head struck the floor, but "not sure." She notes right upper extremity problems, increased lower back pain, shoulder issues, and has not returned to work. The patient's medical history includes prior concussion with brief loss of consciousness secondary to MVA in 1994, depression, anxiety, tobacco usage, and occasional headaches....

Impression:

Based on current neurocognitive findings, medical/imaging records, clinical interview, behavioral observations, and patient is experiencing declines in cognition and exacerbation of emotional distress since her series of falls from February - June 2008.

Overall level of cognition wasn't overly impaired but well below expectations. In addition, she demonstrated variable/inconsistent attention-concentration, slowed processing speed, declines in expressive language skills, and noticeable declines in upper extremity speed, dexterity, and strength bilaterally when compared to same age peers. Emotionally, the patient has very significant amounts of distress highlighted by considerable cognitive confusion, anxiety, paranoia/suspiciousness, depression, and focus on health concerns. She has a premorbid history of depression/anxiety and treatment, but these issues have been magnified since 2008. Her physical pain and weakness is also significant factor interfering with day-to-day activities and sleep. Etiologically, it's likely the patient experienced a concussion and perhaps some mild sheer/strain type damage during her falls (especially the February fall per description). She appears to fit a post-concussive type picture which is unfortunately not uncommon in concussions with significant physical injury/sequelae and exacerbating of pre-existing emotion distress.

Recommendations:

- 1) While I certainly defer all medication management to my physician colleagues, Ms. Whitaker's emotional state is concerning. Given the constellation of symptoms she may benefit from an agent such as Depokote used as a mood stabilizer or Risperdal at low dose. She is on 90 mg of Cymbalta currently. In addition, if we can boost her attention and processing speed, it's likely that it will have a trickle-down effect on overall cognition and processing speed - perhaps an agent such as Concerta or even Adderal may assist - ALL med recommendations, ONLY if deemed prudent from physician perspective.
- 2) Repeat neurocognitive examination in 2-3 months or sooner as indicated by acute change in cognitive, emotional, or behavioral status.

A pre-hearing order was filed on September 13, 2010. The claimant contended, among other things, that she was entitled to additional reasonably necessary medical treatment. The claimant contended that she was entitled to wage-loss disability over and above her permanent physical impairment rating. The respondents contended that the claimant reached maximum medical improvement on or about January 13, 2009 and that all appropriate benefits, including a 7% anatomical impairment rating, had been paid. The parties agreed to litigate the issues of additional medical benefits, wage-loss benefits, and fees for legal services.

Dr. Johnson reported on October 8, 2010:

Ms. Whitaker, date of birth 07/08/1957 was referred for neurocognitive evaluation by Dr. Demetrious Spanos, M.D., patient's neurologist, to assess presence and severity of neurocognitive and/or neurobehavioral decline and explore potential contributing etiologies. She was initially assessed on 8/28/2009 and has presented for follow-up evaluation on 11/11/2009, 2/15/2010, 5/24/201, and 10/05/2010....

Current Impressions:

In the patient's subsequent follow-up's she has made progress, but continues to experience significant attention/concentration problems which adversely impact a number of cognitive domains. Emotionally, the patient has low to mid severe depressive and anxiety symptoms which quite honestly have not gotten significantly better.

In fact, her most recent emotional/behavioral assessment findings were fairly consistent with her original 8/29/2010 scores. She is overwhelmed very easily and noticeably anxious with occasional panic attack symptoms that disrupt her life for several days afterward. At present time, given the patient's attention/concentration and psychiatric status the patient would likely have a very difficult time successfully navigating the necessary requirements of employment.

An administrative law judge filed an opinion on January 12, 2011. The administrative law judge found, among other things, that the claimant was entitled to additional medical treatment. The administrative law judge found that the claimant sustained wage-loss disability in the amount of 63%. The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a) (Repl. 2002). The claimant must prove by a preponderance of the evidence that she is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission.

Hamilton v. Gregory Trucking, 90 Ark. App. 248, 205 S.W.3d 181 (2005).

An administrative law judge found in the present matter, "4. Medical treatment rendered to the claimant under the care of Dr. Alex Baltz/nurse practitioner Cammie Sifford, [as] well as referrals therefrom, to include Dr. John Campbell, Dr. Demetrius S. Spanos, and Dr. Dan Johnson was reasonably necessary in connection with the treatment of the claimant's compensable injuries." The Full Commission finds that the claimant did not prove treatment provided by Dr. Johnson was reasonably necessary.

The respondents do not appeal the administrative law judge's finding that the claimant sustained a compensable injury on February 20, 2008. The claimant testified that she fell backwards over a child on February 20, 2008, and the claimant testified that she hit "all" of her body. The claimant testified, "my head bounced twice." The evidence does not corroborate the claimant's testimony that her head "bounced" on the floor as a result of the accidental injury, and the medical evidence does not demonstrate that the claimant sustained any trauma to her head. Cammie Sifford, R.N., noted on April 15, 2008 that the claimant was

suffering from low back pain. Ms. Sifford encouraged the claimant to continue home physical therapy and did not report an injury to the claimant's head.

The respondents do not appeal the administrative law judge's finding that the claimant sustained a compensable injury on June 10, 2008. The claimant testified that she again fell over a child and hit "my head and my arm." The evidence does not corroborate the claimant's testimony that she hit her head on June 10, 2008. Dr. Stroope reported beginning June 17, 2008 that the claimant felt pain in her right shoulder. Dr. Stroope assessed "probable rotator cuff tear of the right shoulder." A cervical MRI scan in July 2008 showed mild degenerative changes at C5-C6. Dr. Stroope reported on August 5, 2008 that the claimant's shoulder symptoms had improved and stated, "I have not found anything that I can make better with an operation." An MRI of the claimant's lumbar spine showed mild bulging which was clinically insignificant and also showed a "mass" at L4. No treating physician of record has recommended surgical treatment for the claimant's back, lumbar spine, neck, cervical spine, or shoulder.

Dr. Braden noted in September 2008 that the claimant fell sideways on June 10, 2008 and "hit her right elbow on the ground." Dr. Braden recommended conservative treatment and also opined that the claimant could return to sedentary work. The claimant was provided physical therapy, and she was also referred for pain management with Dr. Savu. Dr. Braden reported on January 13, 2009, "It is this examiner's opinion that she has reached maximum medical improvement for the injury she reports to have sustained." Dr. Braden answered a questionnaire dated February 11, 2009 and opined that the claimant did not need additional medical care for the June 10, 2008 injury.

Cammie Sifford referred the claimant to Dr. Campbell, who reported on April 3, 2009 that the claimant tripped over a child in February 2008 "and fell backwards hitting her head on a concrete floor and says her head bounced twice." Dr. Spanos reported in April 2009 that the claimant "struck the back of her head" as a result of the February 2008 accident. Dr. Spanos' recommendations included, "I've asked that imaging of the brain be done since this was the original impact site." The Commission is entitled to review the basis for a doctor's opinion in deciding the weight and

credibility of the opinion and medical evidence. *Swift-Eckrich, Inc. v. Brock*, 63 Ark. App. 118, 975 S.W.2d 857 (1998). In the present matter, there is no probative evidence demonstrating that the claimant sustained an injury to her head as a result of the compensable injuries occurring on February 20, 2008 or June 10, 2008. We must assign minimal weight to the statements of Dr. Campbell and Dr. Spanos, based on the uncorroborated history given them by the claimant, that the claimant fell and hit her head on February 20, 2008 or June 10, 2008. The record before the Commission does not demonstrate that an MRI of the claimant's brain on April 9, 2009 was reasonably necessary in connection with the compensable injury of February 20, 2008 or June 10, 2008. We further note that the MRI of the claimant's brain on April 9, 2009 was a negative study.

The claimant also erroneously informed Dr. Dan Johnson, a clinical neuropsychologist, that her head "bounced" on a concrete floor as a result of the February 20, 2008 accident. Dr. Johnson stated on August 28, 2009, "Etiologically, it's likely the patient experienced a concussion and perhaps some mild sheer/strain type damage during her falls (especially the February fall per

description.)” Again, there is no probative evidence before the Commission demonstrating that the claimant sustained an injury to her head, or that the claimant sustained a traumatic brain injury as the result of either compensable accident in this case. The Full Commission does not affirm the administrative law judge’s finding that treatment provided by Dr. Johnson or medication prescribed by Dr. Johnson was reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a) (Repl. 2002). The probative evidence before the Commission does not demonstrate that the claimant sustained an injury to her head, a traumatic brain injury, or any cognitive impairment as a result of the compensable accidents occurring in February 2008 or June 2008.

B. Wage Loss

The wage-loss factor is the extent to which a compensable injury has affected the claimant’s ability to earn a livelihood. *Eckhardt v. Wills Shaw Express, Inc.*, 62 Ark. App. 224, 970 S.W.2d 316 (1998). In considering claims for permanent partial disability benefits in excess of the employee’s percentage of permanent physical impairment, the Commission may take into account, in addition to the percentage of permanent physical impairment, such matters as

the claimant's age, education, work experience, and other matters reasonably expected to affect her future earning capacity. Ark. Code Ann. §11-9-522(b)(1) (Repl. 2002).

An administrative law judge found in the present matter, "5. When the claimant's age, education, work experience, and other matters reasonably expected to affect her future earning capacity are considered, the evidence preponderates that the claimant sustained a lost (sic) of earning capacity of 63% in addition to her anatomical impairment as a result of the compensable injuries of February 20, 2008, and June 10, 2008." The Full Commission does not affirm the administrative law judge's finding that the claimant sustained a loss of wage-earning capacity in the amount of 63%. The claimant is only age 53 and has a G.E.D. certificate. The claimant has worked in a number of employment settings, including factories, housekeeping, and groceries. The claimant became employed with the respondents in 2007 as a Caregiver One. The claimant sustained a compensable injury on February 20, 2008 and was subsequently assessed with cervical and lumbar strain.

The claimant sustained another compensable injury on June 10, 2008. The claimant was subsequently treated for

pain in her right shoulder, pain in her neck, and low back pain. The evidence of record does not demonstrate that the claimant sustained an injury to her head, and the evidence of record does not demonstrate that the claimant sustained a traumatic brain injury. Dr. Braden pronounced maximum medical improvement on January 13, 2009 and assigned the claimant a 7% whole-person impairment rating. The parties stipulated that the respondents accepted and paid a 7% anatomical impairment rating. The claimant underwent a Functional Capacity Evaluation on February 9, 2009. It was reported that the claimant "gave an unreliable effort" during the Functional Capacity Evaluation and "She also exhibited numerous signs of self limiting behaviors as well as attempts to manipulate the testing results." It was concluded that the claimant "demonstrated the ability to perform work in at least the LIGHT level as defined by the US Dept. of Labor's guidelines over the course of a normal workday, she also exhibited numerous inconsistencies which were sufficient to invalidate her entire evaluation."

A representative of Systemedic Corporation informed Dr. Braden on February 11, 2009 that, in order for the claimant to return to work for the respondent-employer, the claimant

could be required to lift up to 50 pounds. Dr. Braden replied that the claimant had a 20-pound lifting restriction. The evidence therefore indicates that the claimant may not be able to resume her regular work duties for the respondent-employer. However, the record also indicates that the claimant is able to perform full-time work in at least the Light-work category. Based on the claimant's relatively young age, reasonable intelligence, and diverse employment experience, we find that the claimant sustained wage-loss disability in the amount of 15%. The preponderance of evidence does not support Dr. Johnson's conclusion in October 2010, "given the patient's attention/concentration and psychiatric status the patient would likely have a very difficult time successfully navigating the necessary requirements of employment."

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove that treatment with Dr. Johnson was reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a) (Repl. 2002). The claimant proved that she sustained wage-loss disability in the amount of 15% in addition to the claimant's 7% anatomical impairment. The claimant proved that her

compensable injuries were the major cause of the claimant's 7% anatomical impairment and 15% wage-loss disability. The Full Commission therefore reverses the administrative law judge's opinion in part and affirms in part as modified.

The claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715 (Repl. 2002). For prevailing in part on appeal, the claimant's attorney is entitled to an additional fee of five hundred dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

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 that the claimant hit her head in the February 20, 2008 incident. As such, the treatment provided by neuropsychologist Dr. Dan Johnson is reasonably necessary medical treatment. As for

the extent of claimant's permanent impairment above and beyond her anatomical impairment rating, I agree with the Administrative Law Judge that the claimant's head injury must be considered when determining wage loss. I find, as did the Administrative Law Judge, that the claimant has sustained 63% wage-loss disability.

Reasonably Necessary Medical Treatment

The claimant's credible testimony and the medical records document that the claimant's head struck the concrete surface in the February 20, 2008 accident. After the initial medical treatment received at Five Rivers Medical Center in connection with the February 20, 2008 accident, the claimant came under the care of Dr. Alex Baltz, her primary care physician.

In workers' compensation law, an employer takes the employee as he finds him, and employment circumstances that aggravate pre-existing conditions are compensable. Heritage Baptist Temple v. Robison, 82 Ark. App. 460, 120 S.W.3d 150 (2003). An aggravation of a pre-existing non-compensable condition by a compensable injury is itself compensable. Oliver v. Guardsmark, 68 Ark. App. 24, 3 S.W.3d 336 (1999).

The credible evidence in the record reflects that, following the claimant's February 20, 2008 accidental injury, in which her head struck the concrete surface, she experienced greater difficulties with her memory. As a consequence of her continuing complaints of neck pain and stiffness following her evaluation by Dr. Terence Braden, and the February 9, 2009 Functional Capacity Evaluation, the claimant was referred for a neurological evaluation by her primary care physician. As reflected in the medical records above, while under the mistaken belief that he was a neurologist, the claimant was seen by Dr. John Campbell on April 3, 2009. Based on the results of his evaluation of the claimant, Dr. Campbell referred her to Dr. Demetrius Spanos, a Jonesboro neurologist, for further evaluation. Dr. Campbell also prescribed a cane for the claimant.

Following an evaluation and diagnostic studies under the care of Dr. Spanos, the claimant was ultimately referred to Dr. Dan Johnson, a clinical neuropsychologist, for a neurocognitive evaluation. After administering testing, Dr. Johnson concluded that, while the claimant "has a premorbid history of depression/anxiety and treatment", the issues have been magnified since 2008. The testimony of

the claimant, along with that of her husband, coupled with the assessment of Dr. Johnson, shows that the claimant experienced a concussion during the February 20, 2008 accidental fall. Dr. Johnson noted that the claimant fit a post-concussive type picture, which is not uncommon in concussions with significant physical injury. Here, the head injury exacerbated the claimant's pre-existing emotional distress.

I find, as did the Administrative Law Judge, that the claimant has sustained her burden of proof by a preponderance of the evidence that the medical treatment rendered to her under the care of her primary care physician, along with referrals therefrom to include Drs. Campbell, Spanos, and Johnson, is reasonably necessary and causally related to the treatment of her compensable injuries, including a concussion and aggravation injuries related to the concussion.

Wage-Loss Disability Benefits

Ark. Code Ann. §11-9-522(b)(1) provides:

In considering claims for permanent partial disability benefits in excess of the employee's percentage of permanent physical impairment, in addition to the percentage of permanent physical impairment, such factors as the

employee's age, education, work experience, and other matters reasonably expected to affect his or her future earning capacity.

The claimant was 53 years old at the time of the hearing. The claimant completed the 10th grade and later obtained her GED. With the exception of five to six years following the birth of her daughter, the claimant has worked consistently since leaving school. The claimant's work history can be divided into several areas; grocery store industry, factory settings, and health aid/caregiver. The claimant also at one time was self-employed in the housecleaning area.

The claimant underwent a function capacity evaluation which yielded unreliable results. Nevertheless, the FCE recites that the claimant demonstrated the ability to perform work in, at least, the light level. Dr. Braden, who assessed the extent of the claimant's anatomical impairment, placed a 20-pound lifting restriction on her employment activities. It is noted that the claimant continues to use a cane as prescribed by Dr. Campbell to assist her in walking. Dr. Johnson opined that, in light of the claimant's attention, concentration and psychiatric status, the claimant would likely have a very difficult time

successfully navigating the necessary requirements of employment. I find, as did the Administrative Law Judge, that the evidence, including that of residual effects from a concussion, shows that, when the claimant's age, education, work experience, and other matters reasonably expected to affect her future earning capacity are considered, the claimant has sustained wage-loss disability of 63% over and above her anatomical impairment.

PHILIP A. HOOD, Commissioner