BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. H000399

GLENN GREGG, EMPLOYEE	**CLAIMANT**
CITY OF CONWAY, EMPLOYER	**RESPONDENT**
MUNICIPAL LEAGUE WORKERS' COMPENSATION PROGRAM, CARRIER	**RESPONDENT**

OPINION FILED SEPTEMBER 20, 2022

A hearing was held before ADMINISTRATIVE LAW JUDGE KATIE ANDERSON, in Little Rock, Pulaski County, Arkansas.

Claimant, Mr. Glenn Gregg, was represented by Mr. Aaron Martin, Attorney at Law, Fayetteville, Arkansas.

Respondents were represented by Ms. Mary Edwards, Attorney at Law, North Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held in the above-captioned claim on June 22, 2022, in Little Rock, Arkansas. A Prehearing Order was previously entered in this case on May 12, 2022. The Prehearing Order has been marked as Commission's Exhibit #1 and was made a part of the record without any objection from the parties.

Stipulations:

During the pre-hearing telephone conference, the parties agreed to the following stipulations. They read:

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

2. An employer-employee relationship existed on January 7, 2020, when the Claimant sustained a compensable injury to his right arm.

3. At the time of the injury, the Claimant was earning an average weekly wage that would entitle him to the maximum temporary total disability (TTD)/permanent partial disability (PPD) compensation rates of $711.00/$530.00.

4. All issues not litigated herein are reserved under the Arkansas Workers' Compensation Act.

Issues:

The parties agreed to litigate the following issues, which were also modified at the hearing:

1. Whether the Claimant is entitled to a permanent impairment rating of 12% and related permanent partial disability benefits, and if so, whether the rating is as to the body as a whole or as to the upper extremity.

2. Attorney's fee.

Contentions:

The following contentions were submitted by the parties:

The Claimant contends that he sustained a compensable injury to his right arm on January 7, 2020. The Claimant was assigned an anatomical impairment rating of 12% to the body as a whole and contends that he is entitled to 54 weeks of permanent partial disability benefits at the rate of $533.00, for a total of $28,782.00. Finally, the Claimant contends that Respondents have controverted the Claimant's entitlement to the indemnity benefits sought and is entitled to an additional attorney fee.

Respondents contend that the Claimant sustained a compensable aggravation of a preexisting injury on January 7, 2020. The Claimant has been treated appropriately for this aggravation by conservative medical treatment.

Specifically, Dr. O'Malley recommended surgery to repair the Claimant's torn bicep, and

that surgery was scheduled on January 22, 2020. While in the surgery, Dr. O'Malley opined that the injury was chronic and not acute in nature. He authored a report on December 3, 2020, stating that Claimant's problems were preexisting and assigned a 0% impairment rating. Claimant filed a change of physician to Dr. Tom Roberts. Following isokinetic testing, Dr. Roberts assigned Claimant an impairment rating of twenty percent (20%) to the upper extremity or twelve percent (12%) to the body as a whole.

Respondents contend that the Claimant is not entitled to any impairment rating. Specifically, Claimant cannot prove by a preponderance of the evidence that the impairment rating assigned by Dr. Roberts is the major cause of his disability or impairment. Respondents contend that the Claimant had a chronic injury and is therefore not entitled to an impairment rating. However, in the event an impairment rating is assigned, Respondents contend it should be to his upper extremity, not as to the body to the whole. Claimant injured his right distal bicep, and any impairment rating assigned would need to be as a scheduled injury according to Ark. Code Ann. § 11-9-521(a)(1).

Respondents reserve the right to file an Amended Response to the Prehearing Questionnaire or other appropriate pleading and to allege any further affirmative defense(s) that might be available upon further discovery.

Summary of Evidence:

The record consists of the hearing transcript of June 22, 2022, and the exhibits contained therein. Specifically, the following exhibits have been made a part of the record: Commission's Exhibit #1 included the Prehearing Order entered on January 7, 2022, and the parties' responsive filings; Joint Exhibit #1 consisted of one-hundred and twenty-two (122) pages of medical records;

Respondents' Exhibit #1 was seven (7) pages in length and consisted of medical records; and Respondents' Exhibit #2 was six (6) pages in length and consisted of the Commission's Change of Physician Order, Respondents' Medical Payment Log, and Respondents' Indemnity Log.

Post-hearing, the Commission requested that the parties submit briefs on the issues litigated. The parties' briefs have been blue-backed and are incorporated into the June 22, 2022, hearing transcript.

Witnesses:

During the hearing, Mr. Gregg (Claimant, used interchangeably herein) and Charles Prout, Claimant's supervisor, were the only witnesses to testify.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the evidence and other matters properly before the Commission, and after having had an opportunity to hear the testimony of the witnesses and observe their demeanor, I hereby make the following findings of fact and conclusions of law in accordance with Ark. Code Ann. § 11-9-704 (Repl. 2012):

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

2. I accept the above stipulations as fact.

3. The Claimant proved his entitlement to a 20% permanent physical impairment to the right upper extremity for his distal bicep rupture on January 7, 2020.

4. The Claimant's attorney is entitled to a controverted attorney's fee on all indemnity benefits awarded herein, pursuant to Ark. Code Ann. § 11-9-715.

CASE IN CHIEF

Claimant's Testimony:

Claimant testified that he was born on December 18, 1969, and was fifty-two (52) years old at the time of the hearing. The Claimant testified that he currently worked as a Captain for the Respondent-Employer. He began working for the Respondent-Employer on June 5, 2000, as a firefighter. He was a driver for fourteen (14) years and then moved to the position of Captain, which was the title he currently held with Respondent-Employer. As for the events of January 7, 2020, the Claimant testified:

Q: Okay.
Mr. Gregg, January 7th of 2020, tell us what happened.

A: We were at a training exercise[,] and we were asked - - myself, along with some other firefighters were asked to move a generator in a trailer.

Myself, Todd Dorn, Dale Battles, Patrick Morgan and Jonathan Talley went into an enclosed cargo trailer, spun the generator about half of what it needed to go, and on the second spin I felt or heard a pop in my arm. I definitely felt it, but it sounded like I could hear it as well.

Q: Okay. And you say your arm and you're motioning for the record, but just to confirm, which arm was that?

A: My right arm.

Q: The generator, it took five people to move this?

A: It was a fairly large generator.

Q: Estimated weight?

A: Probably 500 pounds.

Q: Okay. And you already mentioned about the pop. Did you have any other immediate symptoms?

A: It hurt.

Q: Okay.

A: I said some pretty nasty words. Just instant pain, and my muscle balled up into the top of my arm.

Q: Okay. You mentioned the five people that were inside the trailer with you.

A: Yes.

Q: Ok. Were there any other witnesses that you recall?

A: There were other people around, but I don't know if there was anyone else in the trailer. Those are the people that I knew were helping me.

As far as the treatment he received, the Claimant testified that immediately after the incident he was taken to the Baptist Hospital Emergency Room in Conway where he saw Dr. Fontenette. He testified that his right arm was hurting and that the muscle was "balled up" in the upper arm. There, Claimant underwent an x-ray and an MRI of the right arm. Two weeks later, the Claimant saw Dr. O'Malley. The Claimant stated that by that time, the pain in his right arm was not as bad as it had been initially; however, the arm "still looked the same." Dr. O'Malley recommended surgery to attempt to reattach the bicep muscle, and the Claimant underwent the procedure. However, when he woke from surgery, it was his understanding that nothing had been done.

The Claimant then saw Dr. Roberts for a second opinion. As for his symptoms when he saw Dr. Roberts, the Claimant testified that his arm was not as painful as it was before but that the "muscle was still balled up in [his] arm." Dr. Roberts recommended that he undergo strength testing and physical therapy. However, the Claimant testified that he did not receive any benefit or relief from the physical therapy. He last saw Dr. Roberts in July of 2021, and is scheduled to see him again in July of 2022.

The Claimant testified that he was off work approximately three (3) months after the

January 7, 2020, work-related injury, and once he was released, he returned to work. He was working at the time of the hearing. He had returned to his previous work with no restrictions. However, he testified that he continued to have symptoms with his right arm. He stated, "If I overuse my right arm, it just feels like a spasm in my right arm, like, it just feels like [I've] been hit, like a frog in [my] arm - - I don't know how to explain it - - but with overuse, so I have to just watch what I do with it and compensate with my left arm as much as I can." The right arm symptoms have had some impact on his daily activities as he must use his left arm to compensate for the right arm. He stated that he was unable to lift as much with his right arm or do as much as he was accustomed to doing with his right arm. For example, he is no longer able to workout and do bicep curls with his right arm due to pain during exercise. The Claimant stated that he is right-hand dominant.

According to the Claimant, he had not experienced symptoms in his right arm prior to January 7, 2020. He had not heard the same popping sound in his right bicep prior to January 7, 2020. The Claimant testified that he had not had any restrictions or missed any work because of a condition in the right bicep prior to January 7, 2020. As for any workers' compensation history, the Claimant testified that he had a prior work injury when he worked for a previous employer (Arco, Incorporated) when he cut off his left index finger at the knuckle. In 2004, during his time with Respondent-Employer, he had a prior injury to his shoulders, which he described as follows:

> We were doing a training exercise where you were supposed to be stuck in an elevator shaft, and they put a rope around your hands and pulled you up out of the shaft. And my air pack got hung on the opening, and they kept yanking, trying to get me out, and finally broke the air pack, but they got me through, but I felt a pop in each shoulder and like instant pain.

The Claimant ultimately underwent shoulder surgery on his left shoulder. Although he had

symptoms in both the right and left shoulders after the 2004 injury, he had surgery only on the left shoulder, and he did not have any symptoms in his right bicep at that time. The Claimant returned to work after he had healed from the 2004 shoulder injuries and surgery without any restrictions and was able to do his job without difficulty. He was able to exercise after the 2004 injuries and could do arm curls with his right arm.

When asked about Dr. O'Malley's December 3, 2020, letter, wherein he opined that the Claimant had injured his right bicep six (6) months prior to the injury date of January 7, 2020, the Claimant disputed Dr. O'Malley's opinion and testified that he had not injured his right bicep prior to January 7, 2020. The Claimant stated that if he had injured his right bicep prior to January 7, 2020, he would have reported the incident and sought medical treatment due to the pain he experienced in his right bicep after the January 7, 2020, work injury. When asked if he agreed with Dr. O'Malley's statement that he had been "performing [his] full job as a firefighter with a torn distal bicep prior to his work injury of January 7th of 2020," the Claimant responded:

A: No.

Q: Why?

A: Because it's not true.

Q: Okay. But you're currently working with a torn bicep, is that right?

A: I'm currently working with a bicep that's been healed for two-and-a-half years.

Q: Is there any doubt in your mind that you did not rupture your bicep on January 7th of 2020?

A: No.

The Claimant testified that Charles Prout was his Battalion Chief from September of 2019,

until January 7, 2020, the date of the work injury. He stated that he saw Prout every three days at work due to their work schedule. He also was friends with Prout and would see him outside of work as well. The Claimant testified that Prout was present on January 7, 2020, when he injured his right bicep, but he was unsure if Prout actually witnessed the injury.

On cross-examination, the Claimant testified that Respondents had accepted his January 7, 2020, injury as compensable and paid some medical and temporary total disability benefits. With regard to his medical treatment, the Claimant stated that he developed an infection at the surgical site after Dr. O'Malley opened him up to repair the bicep rupture, for which he took medication (likely antibiotics). Thereafter, the Claimant participated in some physical therapy sessions, and ultimately requested a change of physician. Thereafter, when the Claimant saw Dr. Roberts, he recommended isokinetic testing, which was performed by a physical therapist. Afterward, Dr. Roberts recommended additional physical therapy. After a couple of physical therapy sessions, the Claimant returned to Dr. Roberts, and then participated in a second round of isokinetic testing. The Claimant confirmed that Dr. Roberts subsequently assigned an impairment rating. While the Claimant did not recall whether Dr. Roberts had done a range-of-motion evaluation, he did not dispute the medical records that showed that Dr. Roberts had performed such testing on February 20, 2020, May 4, 2020, and July 21, 2020. The Claimant also did not dispute medical records indicating that Dr. O'Malley performed range-of-motion testing on January 11, 2020, and that medical reports indicated that when Claimant saw Dr. O'Malley for the surgery, the Claimant had normal range-of-motion.

The Claimant also confirmed that Dr. O'Malley released him to return to work with a lifting restriction on January 31, 2020; however, the Claimant stated that he did not return to work until

March or April of 2020. During that time, the Claimant used some of his sick/vacation time. The Claimant stated that when he returned to work, he was able to work at full duty with the exception of experiencing muscle spasms and compensating with his left arm. After the January 7, 2020, work injury, when the Claimant tried to perform exercises with his right arm in the form of bicep curls, he experienced constant cramping, so he no longer performed these exercises with that arm. The Claimant reiterated that he had not had any prior injuries to his right arm, nor had he received any medical treatment to the right arm.

The Claimant was asked about a prior notation in his medical records from October 4, 2018, indicating a healing biopsy in his right forearm. However, the Claimant explained that the records where referencing an area that he had removed from his right forearm due to skin cancer concerns. The Claimant also explained that another medical record indicating that he was prescribed Norco, was referencing some arthritis he was experiencing in his knees. Lastly, the Claimant clarified that when he previously injured his shoulders at work, he did not file a workers' compensation claim for those injuries. While he did undergo surgery on the left shoulder, he decided against surgery on the right shoulder as the recovery time prevented him from timely returning to work.

When questioned by the Commission, the Claimant testified that his right arm bicep muscle remained "balled up" in the top portion of his arm near his shoulder. He experienced muscle spasms and pain if he overused that arm.

Charles Prout:

Mr. Prout testified that he was employed by Respondent-Employer for thirty-one (31) years and four (4) months and retired in July of 2021. His last position with Respondent-Employer was

Battalion Chief where he was responsible for any situation including emergency management, incident command, and personnel management. He and the Claimant had worked together on and off for more than twenty (20) years and had been on the same shift for the last fifteen (15) years. Mr. Prout testified that he was the Claimant's supervisor on January 7, 2020.

Mr. Prout testified that he was present on January 7, 2020, when the Claimant was injured at work. He testified that he had directed the Claimant and others to move a generator. He was speaking with the Captain when he heard "commotion" and "a little cussing and carrying on." The Claimant's co-workers stated, "Hey, Gregg's hurt." Mr. Prout stated that he went over to the Claimant and observed an obvious injury "where there should be a bicep there's [sic] nothing, and it's [sic] rolled up on his shoulder." Mr. Prout testified that over the years, he had probably seen four (4) or five (5) of such injuries at the fire department. He stated, "It's blatantly obvious when one detaches, where it goes and what it looks like." Thereafter, Mr. Prout began notifying the secretary, the Ops Chief, and the Major Chief, and when he could not reach the workers' compensation physician, he made the decision to send the Claimant to Baptist Hospital. Once he was able, Mr. Prout returned to the hospital to stay with the Claimant. At that time, he was able to speak with the nurse regarding some pain medication because the injury was very painful. He stated, "It has to be painful. It looks painful."

When asked how often he saw the Claimant at work, Mr. Prout testified that he saw him every shift. Also, Mr. Prout stated that:

> If we are stationed at the same station, you see them every shift all day, on and off. If he's at another station, probably once or twice a shift. Some of that depends on the call volume, what calls, where it's at, what training is that day or just what else is going on.

However, Mr. Prout testified that prior to the January 7, 2020, work injury, he had never seen the

Claimant's right bicep curled up at the top of his arm. Furthermore, Mr. Prout stated that he had not heard the Claimant complain of right-arm problems prior to the work injury; to his knowledge the Claimant had not missed any work due to a right arm injury prior to the injury at issue; and that the Claimant was an "honorable man."

On cross-examination, Mr. Prout stated that he saw the bicep after the injury and the "deformity was obvious." He said, "I mean, we're all EMT's and we're all paramedics. This is our field. It's, yes, ma'am, it was very obvious." Mr. Prout testified that he had been an EMT for thirty-one (31) years. Although he did not see the actual injury occur as he was standing outside the trailer at the time, he observed the bicep muscle pushed up into the Claimant's arm immediately thereafter. The Claimant and the other witnesses to the injury shared what had happened inside the trailer. Mr. Prout testified that it was required that the Claimant be released by the doctor to return to work. Once he returned, the Claimant was able to do the work.

Medical Exhibits:

Medical records showed that prior to the compensable injury to the Claimant's right arm, he was seen at Conway Family Practice Clinic between March 16, 2018, and December 31, 2019, for medication refills and general health care. During that time, the Claimant was treated for arthropathy, unspecified; insomnia; reflux; attention-deficit hyperactivity disorder (ADHD); a food allergy; an acute upper respiratory infection; an enlarged prostate; essential hypertension; and hypercholesterolemia.

On January 7, 2020, Claimant presented at the emergency room, where he saw Dr. Angelique Fontenette with complaints of a right arm injury at work. Claimant reported that while moving a heavy generator, he felt a pop in his right arm with immediate pain, the formation of a

knot, and slight numbness to the antecubital fossa area (elbow). The Claimant's physical examination revealed tenderness and swelling to the distal medial bicep. An x-ray of the Claimant's right elbow revealed some degenerative joint disease but no evidence of a fracture. An MRI of Claimant's right elbow revealed the following findings:

1. The biceps brachii tendon is completely torn and retracted approximately 12 cm to the level of the distal humerus.

2. The brachialis tendon appears indistinct distally but remains intact. Findings may represent underlying sprain.

3. Fraying of the common extensor tendon at the level of the humeral attachment but no associated marrow edema.

4. Calcification within the distal triceps tendon with overlying inflammation. Findings may represent acute enthesopathic changes.

The Claimant was diagnosed with bicep rupture, distal, right. He was given prescription medication and released. Emergency room records stated that there was a knot forming; that Claimant's pain was a seven (7) out of ten (10); and that Claimant was able to move his arm, but it was painful.

On January 17, 2020, the Claimant saw Dr. Lawrence Kevin O'Malley, an orthopedist, where Claimant reported that he was seen in the emergency room the week before after picking up a generator while at work and feeling a pop in his right elbow. Because of severe right elbow pain, Claimant underwent an x-ray and an MRI of the right elbow, which revealed a distal bicep rupture. Dr. O'Malley noted severe pain associated with supination and flexion of his elbow and a deformity "about his bicep." A physical examination of Claimant's right elbow showed the following:

Range of Motion
Extension 0

Flexion 130
Pronation normal Right elbow pronation 90
Supination normal Right elbow supination 90

Muscle Strength
Pronation 5/5
Supination 4/5

Tests
Varus negative
Valgus negative
Tinel's sign (cubital tunnel) negative

Other
Erythema absent
Sensation normal
Pulse present

Comments: Negative resistive tennis elbow test. Negative milking. Unable to hook the bicep. Bicep deformity is appreciated.

Dr. O'Malley discussed surgery and the postoperative rehabilitation protocol, and the Claimant elected to proceed with surgery.

On January 22, 2020, Claimant underwent surgery on his right arm for a preoperative diagnosis of acute distal bicep rupture. Dr. O'Malley performed the procedure, and his surgical notes indicated the following:

> Incision was made, dissected down, lateral antebrachial cutaneous nerve was then protected, dissected down tuberosity. Then, worked our way up proximally. [I]dentified the tendon, but noticed a severe amount of scarring. Thus, we made a proximal incision directly over the tendon, dissected down, identified the tendon, which was scarred and also rounded off consistent with a chronic injury. There was extensive scarring and essentially no ability to mobilize the muscle or tendon beyond its current position. There was less than 3 cm of tendon left. Due to the fact that this was a chronic injury, the patient described an acute injury. We felt it most prudent to not perform a reconstruction as this was not discussed preoperatively with the patient and recovery is drastically different. The patient had been doing fine with this previous injury as this work injury was only last 2 weeks, but this distal biceps [sic] rupture was greater than 2 weeks in age. Wounds were copiously irrigated. There were closed in a layered fashion. Sterile dressing

applied.

Dr. O'Malley's surgical notes closed with instructions for the Claimant to return to his office in two weeks, when he would order formal physical therapy to work on range of motion and strengthening. Claimant's post-operative diagnosis was noted as right chronic bicep tendon rupture.

On January 29, 2020, the Claimant returned to Dr. O'Malley with complaints of redness, swelling, and purulent discharge from the forearm incision. He also complained of increased pain and feeling "feverish." He was given antibiotics and diagnosed with superficial incisional infection of surgical site.

On January 31, 2020, Dr. O'Malley's notes indicated that the Claimant's infection at the surgical site had improved with antibiotics with some slight erythema that was resolving. He noted there was some slight swelling but otherwise neurovascularly intact. Dr. O'Malley ordered physical therapy for elbow range of motion and strengthening and gave the Claimant a ten (10) pound lifting restriction for the right upper extremity for the chronic distal bicep rupture.

On February 17, 2020, the Claimant visited Conway Regional Health System with concerns about the long-term prospects with his right arm. Dr. Tom Roberts' clinic records provide a description of the work event when the Claimant was picking up a generator at work and felt a pop in his right bicep; state that the Claimant was in pain and his bicep was rolled up in his arm; and note the surgical procedure on the Claimant's right arm. Clinic notes indicate that the Claimant was informed that the injury was an old injury and that it was unable to be repaired. The Claimant denied any prior injury to his arm before January 7, 2020. In his assessment, Dr. Roberts stated:

> By history this is an acute rupture. I have reviewed his MRI and clinic notes and operative note. The patient describes bruising and swelling of his arm after the injury. Dr. O'Malley was unable to do the repair and suggested a possible graft. Patient [and] I have discussed things in detail. He has reasonable function of his arm today but wonders if he will be able to continue to do his job without reconstructing this. After lengthy discussion of [sic] recommended an isokinetic test to evaluate his strength for comparison with his opposite arm. We will see him back after this is done. Pros and cons of operative and nonoperative treatment were discussed in detail with him today as well. I have reviewed all of his previous medical records. Follow-up after his test is done.

On February 18, 2020, the Claimant underwent an initial physical/occupational therapy evaluation. The evaluation form indicated that the Claimant's primary complaint was weakness in his right arm as a result of carrying a heavy generator at work on January 7, 2020. Evaluation notes stated the following:

> Patient presents 5 weeks s/p failed distal bicep tendon repair sx in dominant RUE. He is a firefighter and requires sufficient strength in UE to perform heavy lifting, carrying, pulling, and dragging tasks. He has no pain. PT performed an isokinetic test last week and this revealed strength discrepancy compared to LUE in elbow flexion, elbow extension, and shoulder extension. MMT reveals decreased scapular stability and decreased strength in supination. Patient will benefit from strengthening to build compensatory strength for loss of distal biceps attachment in order to return to full duty work tasks.

Therapy was recommended two (2) times per week for four (4) weeks. Claimant should be able to then perform his job at full duty after four (4) weeks.

A physical therapy note from February 18, 2020, also indicated that Claimant had performed isokinetic testing with no issues.

On February 20, 2020, the Claimant returned to Dr. Tom Roberts for his isokinetic testing. Upon examination, Dr. Roberts noted:

> **Exam**
>
> He has full motion of his right elbow. His scars are well-healed. He does have some tenderness over the biceps stump. He has reasonable elbow flexion and

> supination strength but not equal to the opposite side. There is no swelling or ecchymosis.
>
> **Assessment & Plan**
>
> His isokinetic test shows a 15.7% deficit in his triceps and 29.6% in his biceps at 60 degrees/s at 60 degrees/s his shoulder has 0% deficit in flexion but 13.9% deficit in extension. He has 18.3% deficit in flexion and 5.7% in extension at 180 degrees/s. [W]e discussed his findings[,] and if he can have enough strength to do his job[,] he would prefer not to have surgery. I think this is reasonable as at this point we would have to use a graft. A prescription for therapy is written. I will see him back in a month. If he cannot get to the point where he feels he can do his job[,] then we will probably go ahead with the surgery.

Between February 18, 2020, and February 28, 2020, the Claimant attended two physical therapy sessions. Also in that time, he had one cancellation and one missed appointment. He was discharged on February 28, 2020.

On May 4, 2020, the Claimant had a follow-up appointment with Dr. Roberts, where Claimant reported that the physical therapy had not helped much with his normal daily activities. While Claimant reported not having any trouble doing his job, he did report that when using the right arm, he had issues with right arm fatigue. Claimant also reported that he did not want to be off work for six (6) months for surgery. Upon examination, Claimant had full range of motion of the right elbow; well-healed scars; and no signal in point tenderness about his biceps; and no instability of the elbow. The Claimant had prominent biceps on the right when compared to the left; his tendon was not intact; and he had mild weakness with supination and elbow flexion when compared to the left. As the Claimant was approximately four (4) months post-injury and had no complaints other than his right arm becoming fatigued at a faster rate that the left, the Claimant could resume normal duties. He was to return in July for repeat isokinetic testing and a final examination.

On July 16, 2020, the Claimant performed isokinetic testing with no issues. As the Claimant's goals were met, he was discharged from outpatient physical therapy services. Thereafter, on July 21, 2020, the Claimant saw Dr. Roberts and reported that his bicep was weaker than before. He reported that his bicep would begin "cramping" when he overused it. However, he also reported that he was able to do his job and most other things without significant problems. Upon examination, Dr. Roberts noted the following:

> He has full motion of his right elbow. He has some mild weakness with resisted supination and resisted elbow flexion. He also has some mild weakness on the right with extension of the elbow when compared with the left elbow. He has good forward flexion abduction strength of his shoulder. No significant swelling is noted. He does have a proximal position to his biceps tendon and muscle in his upper arm.

Dr. Roberts' notes reflect that the Claimant's "isokinetic test showed a 40.5% deficit at 60 degrees/s when testing elbow flexion and 38.2% at 120 degrees/s." His extension showed a "37% deficit at 60 degrees/s and 28% at 120 degrees/s." Dr. Roberts opined that based on the AMA Guidelines to the Evaluation of Permanent Impairment, Fourth Edition, Table 34, page 65, the Claimant "has between 31 and 60% strength loss in his biceps which is a 20% upper extremity impairment." Roberts further opined, "This corresponds to a 12% impairment of his body as a whole based upon Table 3, page 20."

On December 3, 2020, Dr. O'Malley authored a letter stating that he began treating the Claimant after his work injury on January 7, 2020, when he was lifting a heavy generator and felt a pop in his right arm. Dr. O'Malley noted that the Claimant was a firefighter and was performing full duty work prior to the injury on January 7, 2020. Dr. O'Malley noted that he saw the Claimant after he received emergency treatment. An MRI showed a rupture of the distal bicep with

retraction approximately twelve (12) cm above the joint line. During a January 22, 2020, surgery to repair the bicep rupture, the Claimant had "chronic scarring and no tendon intact." Dr. O'Malley stated that the residual tendon was noted to be approximately 2-3 cm in length from the end of the tendon to the myotendinous junction. There was no fluid identified around the bicep tendon, which was normally present after an acute rupture. The findings of the surgery were consistent with a chronic distal bicep rupture that occurred at least six (6) months prior to the work injury. Claimant then underwent physical therapy to work on strengthening since the bicep tendon was found to be chronically torn. Dr. O'Malley opined that the Claimant should be able to return to full duty without issue due to the chronic nature of his bicipital injury. Based on the surgical findings, Dr. O'Malley opined that he did not believe that "greater than 51% of the patient's findings of distal bicep rupture is related to his work injury. The tendon was found to be chronically torn." Because, in Dr. O'Malley's opinion, the Claimant had been performing his full job as a firefighter with a torn distal bicep prior to his work injury, based on the AMA Guides, fourth edition, the Claimant had a zero percent (0%) impairment rating.

Documentary Evidence:

The Form AR-N, dated January 7, 2020, indicates that the Claimant described his injury to his right bicep as follows, "I was helping move a generator and I felt a pop in my right bicep."

The Municipal Employee Report of Accident form dated January 8, 2020, states that the Claimant felt a pop in his right bicep when moving a generator. The incident was reported immediately to Chad Upton. He also listed Todd Thorn and Patrick Morgan as witnesses. His supervisor's name was Charles Prout. The form indicated that Claimant was receiving medical treatment and that it was anticipated that he would be released to light duty on January 11, 2020.

The First Report of Injury states that the Claimant sustained a "separation/avulsion" to his upper right arm on January 7, 2020, at approximately 2:30 p.m. while moving a generator at the Training House South Donaghey, in Conway, Arkansas. The Claimant received treatment at the Baptist Health Emergency Room. The preparer of the First Report of Injury was Lisa Mabry-Williams, HR Director for Respondent-Employer.

On February 7, 2020, a Change of Physician Order was entered by the Commission approving the Claimant's request to change from Dr. Lawrence O'Malley to Dr. Tom Roberts.

A Medical Payment Log generated on May 17, 2022, indicates that the Respondents paid a total of $7,618.20 in medical expenses for the Claimant (including doctor/medical care, hospital fees, physical therapy, and radiology).

An Indemnity Log generated on May 17, 2022, demonstrates that the Respondents paid the Claimant a total of $711.00 in temporary total disability benefits.

ADJUDICATION

A. Extent of Claimant's Permanent Physical Impairment:

An injured worker must prove by a preponderance of the evidence that he or she is entitled to an award for a permanent physical impairment. Weber v. Best Western of Arkadelphia, Workers' Compensation Commission F100472 (Nov. 20, 2003). Any determination of the existence or extent of physical impairment shall be supported by objective and measurable findings. Ark. Code Ann. § 11-9-704(c)(1)(B) (Repl. 2012). "Objective findings" are defined as those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16)(A)(i) (Repl. 2012).

Pursuant to Ark. Code Ann. § 11-9-522(g) (Repl. 2012) and our Rule 099.34, the Commission has adopted the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993), to be used to assess anatomical impairment. Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment. Ark. Code Ann. § 11-9-102(4)(F)(ii)(a).

Here, the Claimant sustained an admitted compensable injury on January 7, 2020, to his right upper arm. Immediately after the injury, the Claimant was taken to the emergency room where the Claimant reported an incident at work when he was lifting a heavy generator and felt a pop with immediate pain and knot formation in his right upper arm. Emergency room records noted tenderness and swelling to the distal medial bicep. Despite his complaints of pain, the Claimant was able to extend the elbow slowly. Imaging revealed a distal bicep rupture. Thereafter, the Claimant saw Dr. O'Malley, an orthopedist, who noted the Claimant's severe pain and pain associated with supination and flexion of the elbow, and the deformity of the bicep. As a result, Dr. O'Malley placed the Claimant on a one (1) pound lifting restriction and recommended surgery with follow-up care.

The Claimant underwent a surgical procedure to repair the distal bicep rupture, which was performed more than two weeks after the January 7, 2020, compensable injury event. Dr. O'Malley's operative report reflects that he observed scarring and a rounded-off appearance of the tendon, which were indicative of a chronic injury, rather than an acute injury, that was greater than two weeks old. Dr. O'Malley did not repair the tendon, closed the incision, and recommended conservative treatment (physical therapy) to work on range of motion and strengthening.

The Claimant saw Dr. Tom Roberts, an orthopedist at Conway Regional, for a second opinion. Thereafter, he began treating with Dr. Roberts who recommended physical therapy and isokinetic testing for the Claimant's right distal bicep rupture. At a follow-up appointment with Dr. Roberts, Dr. Roberts recommended additional physical therapy and a second isokinetic test. As a result of the second round of isokinetic testing and physical therapy, Dr. Roberts noted that while the Claimant had full motion of the right elbow, he had mild weakness with resisted supination and resisted elbow flexion, and he had mild weakness on the right with extension of the elbow when compared with the left elbow. Dr. Roberts noted the proximal position of the Claimant's bicep tendon and muscle near the upper arm and shoulder area, and therefore, he made the following determination: "His isokinetic test today shows a 40.5 % deficit at 60 degrees/s when testing elbow flexion and 38.2% at 120 degrees/s. His extension shows a 37% deficit at 60 degrees/s and 28% at 120 degrees/s." As a result, based upon the AMA Guides, fourth edition, Table 34 page 65, Dr. Roberts opined that the Claimant has between 31 and 60% strength loss in his biceps and assigned him a 20% upper extremity impairment, which he also notes corresponds to a 12% permanent impairment of the body as a whole. Dr. Roberts' notation of the proximal location of the Claimant's right bicep tendon/muscle comports with what I was able to observe at the hearing in the matter. Given that the bicep muscle appeared enlarged and displaced more than two (2) years after the compensable work injury on January 7, 2020, it is reasonable that as a result of the distal bicep rupture, the Claimant would experience a loss of strength and mobility in his right arm. As such, I give Dr. Roberts' opinion great weight as it is based on objective findings and is supported by the evidence of record.

In addition, the parties also presented arguments as to whether the Claimant is entitled to an impairment rating to the right upper extremity or to the body as a whole. The Claimant asserts that the impairment rating should be as to the body as a whole; however, the Respondents, on the other hand, assert that any impairment rating should be assigned to the right upper extremity.

Pursuant to Arkansas Code Annotated section 11-9-521(a)(1) (Repl. 2012), an "[a]rm amputated at the elbow, or between the elbow and the shoulder" is classified as a scheduled injury, and the employee is entitled to a maximum of two hundred forty-four (244) weeks of benefits. However, a shoulder injury is an unscheduled injury. An unscheduled injury is entitled to a maximum of four hundred fifty (450) weeks pursuant to Arkansas Code Annotated section 11-9-522(a) (Repl. 2012).

Here, the Claimant's assertion that he is entitled to a permanent impairment rating as to the body as a whole for his right bicep rupture is not supported by the evidence of record. Initially, the Claimant's emergency room records demonstrated that he presented with a right arm injury. During examination, hospital records showed that the Claimant had tenderness and swelling to the distal medial bicep and that he could extend the forearm slowly. Imaging was taken of his right arm at the elbow, as requested by Dr. O'Malley. The MRI confirmed a right distal bicep rupture. There were no shoulder studies completed, nor were there any findings or observations that appear to be related to the shoulder. When the Claimant saw Dr. O'Malley, he presented with complaints of severe elbow pain and reported feeling a pop in his right elbow on January 7, 2020, when he was lifting a generator at work. The Claimant also reported pain with supination and flexion of the elbow. Dr. O'Malley noted the deformity of the bicep. Dr. O'Malley's notes indicated that he did a full examination of the Claimant's right and left elbows and recommended a right distal bicep

repair surgery. Again, there was no mention of the Claimant's right shoulder. Moreover, Dr. O'Malley's surgery records indicated that the Claimant's right elbow was "marked prior to procedure." When the Claimant had a post-operative visit for redness and swelling of the surgical site, the medical record indicated that the incision was on the Claimant's forearm.

Dr. Roberts' clinic notes also indicated that the Claimant had injured his right arm and presented with swelling and bruising to the elbow. When Dr. Roberts made his determination as to the permanent impairment rating, he relied on Claimant's deficit in flexion and extension of the elbow and the loss of strength in the Claimant's bicep. Dr. Roberts' records also noted the proximal position of the bicep. Dr. Roberts did not mention the Claimant's shoulder in his permanent impairment determination. Furthermore, the Claimant consistently referred to his right arm and bicep when describing his injury. An injury to his right distal bicep tendon and muscle is supported by the medical evidence of record. Any reference to a shoulder injury was a prior injury sustained by the Claimant and was unrelated to the claim at issue in this matter. Therefore, a preponderance of the evidence shows that the Claimant's injury was to his right elbow and bicep (and not to his shoulder), which was a scheduled injury.

I acknowledge Dr. O'Malley's medical opinion that the Claimant's right distal bicep rupture was a chronic injury and at the time of the surgery was more than two (2) weeks of age. However, I give Dr. O'Malley's opinion little weight as it is not supported by a preponderance of the evidence. The Claimant credibly testified that he had not previously injured his bicep, and this testimony is corroborated by the medical evidence. The testimony and medical records show that prior to the January 7, 2020, compensable work injury, the Claimant had not complained of any symptoms of pain, swelling, or tenderness in the right bicep or elbow area. Medical records prior

to the January 7, 2020, work injury make no mention of any complaints or treatment related to the Claimant's right elbow or bicep area. Claimant and his supervisor, Mr. Prout, both credibly testified that the Claimant had not missed any work prior to the January 7, 2020, work injury for issues with his right bicep, nor had he made any complaints to his supervisor regarding his right elbow or bicep prior to January 7, 2020, work injury. Claimant credibly testified that given the physical nature of his job as a firefighter, he would not have initially been able to do his job at full capacity with a torn bicep, as he missed almost three months of work after the January 7, 2020, compensable bicep injury.

Lastly, I note that the Claimant in this matter has been employed by the Respondent-Employer as a firefighter for more than twenty (20) years. His Battalion Chief, who was also present on the day of the compensable January 7, 2020, injury, testified that he was an "honorable man." The Claimant had one prior incident at work, when he lost the end of his index finger, for which he filed a workers' compensation claim. However, he also had a previous work injury during a training activity as a firefighter to both of his shoulders, requiring surgery on the left shoulder, for which he did not file a workers' compensation claim. As previously noted, I find the Claimant, as well as Mr. Prout, to be credible witnesses.

Based on my review of the evidence of record and the AMA Guides, I find Dr. Roberts' assignment of an upper extremity impairment rating to be valid and explained with convincing force. Therefore, I find that the Claimant proved he is entitled to this 20% upper extremity anatomical impairment rating. I find that this rating was based on objective and measurable physical findings and that the compensable injury was the major cause of the Claimant's 20% upper extremity anatomical impairment. Ark. Code Ann. § 11-9-102(4)(F)(ii)(a).

As such, I find that based on a preponderance of the evidence, the Claimant sustained a permanent physical impairment of 20% to the upper extremity as a result of his January 7, 2020, compensable right bicep injury. Respondents are therefore liable for payment of this rating.

C. Attorney's fee:

Here, the Respondents have controverted the Claimant's entitlement to a permanent impairment rating. As such, I therefore find that the Claimant's attorney is entitled to a controverted attorney's fee pursuant to Ark. Code Ann. § 11-9-715, on the indemnity benefits awarded herein to the Claimant.

ORDER

The Respondents are directed to pay benefits in accordance with the findings of fact set forth herein this Opinion.

All accrued sums shall be paid in lump sum without discount, and this award shall earn interest at the legal rate until paid, pursuant to Ark. Code Ann. § 11-9-809.

Pursuant to Ark. Code Ann. § 11-9-715, the Claimant's attorney is entitled to a 25% attorney's fee on the indemnity benefits awarded herein. This fee is to be paid one-half by the carrier and one-half by the claimant.

IT IS SO ORDERED.

KATIE ANDERSON
Administrative Law Judge