BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G900538

ELDRIDGE HOWARD, III, EMPLOYEE **CLAIMANT**

VS.

CITY OF FAITH PRISON MINISTRIES, EMPLOYER **RESPONDENT**

TECHNOLOGY INSURANCE COMPANY, CARRIER/
AMTRUST NORTH AMERICA, TPA **RESPONDENT**

OPINION FILED SEPTEMBER 20, 2022

Hearing before Administrative Law Judge, James D. Kennedy, on the 16TH day of August, 2022, in Little Rock, Pulaski County, Arkansas.

Claimant is represented by Mr. Darrell F. Brown, Jr., Attorney-at-Law, Little Rock, Arkansas.

Respondent is represented by Mr. William C. Frye, Attorney-at-Law, North Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted on the 16th day of August, 2022, to determine the issues of compensability for a work-related injury; medical in regard to the work-related injury; temporary total disability from the date of May 19, 2019, to a date to be determined; and attorney fees, with all other issues reserved. A copy of the Prehearing Order was marked "Commission Exhibit 1" and made part of the record without objection. The Order provided the parties stipulated that the Arkansas Workers' Compensation Commission has jurisdiction of the within claim and that an employer/employee/carrier relationship existed on December 2, 2018, the date of the claimed injury, when the claimant was operating a vehicle owned by the respondent/employer and was involved in a motor vehicle accident where he contended he sustained a physical injury. The parties further

stipulated that the claimant's compensation rate was sufficient for a temporary total disability/permanent partial disability rate of $405.00 and $304.00, respectively. At the time of the hearing, the parties further agreed the claim was initially accepted as compensable and temporary total disability was paid until the date of May 19, 2019, and the matter has now been controverted in its entirety. There was no objection to these stipulations and the Prehearing Order was admitted into the record.

The claimant's and respondent's contentions are all set out in their respective responses to the Prehearing Questionnaire and made a part of the record without objection. The witnesses consisted of Eldridge Howard, the claimant, and Phillip Seales, his supervisor. From a review of the record as a whole, to include medical reports and other matters properly before the Commission, and having had an opportunity to observe the testimony and demeanor of the witnesses, the following findings of fact and conclusions of law are made in accordance with Arkansas Code Annotated §11-9-704.

FINDINGS OF FACT AND CONCLUSSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.

2. That an employer/employee relationship existed on December 2, 2018, the date of the claimed injury. At the time, the claimant earned an average weekly wage sufficient for temporary total disability/permanent partial disability rates of $405.00/$304.00, respectively, per week.

3. That the claimant was paid temporary total disability from the date of the claimed injury until May 19, 2019.

4. That there is no alternative but to find that the preponderance of the evidence shows that the claimant suffered a non-compensable, idiopathic injury on December 2, 2018, and consequently the claimant has failed to satisfy the required burden of proof that the claim is compensable.

5. Consequently, the remaining issues are moot.

6. If not already paid, the respondents are ordered to pay for the cost of the transcript forthwith.

REVIEW OF TESTIMONY AND EVIDENCE

The Prehearing Order along with the Prehearing Questionnaires of the parties were admitted into the record without objection. The parties submitted one joint exhibit of records including medical and an abstract that was in excess of five hundred (500) pages.

The claimant was the first witness to testify. He testified he worked for the City of Faith which was located on Twelfth Street in Little Rock and his job was basically security. He would pick up meals from Baptist Hospital and later return the trays, due to the fact a number of residents stayed at the facility. (Tr.8) He would go to Baptist Health, sometimes with one or two of the residents, where he would load trays of food into the van and drive directly back to City of Faith where he would deliver them. The trays would be served, then placed back into the van and returned. On the date of the incident, the claimant testified that after everybody ate, he loaded the trays and was in the process of returning the trays to Baptist. On his way back to Baptist he testified as follows:

> "So when I left the City of Faith to drop the trays off, nobody was with me. It was probably like a stop sign, probably like not even a minute away from City of Faith. It's like by the Penick Boys Club. It's Penick Boys Club. But if you're familiar with that area, it's like a short distance. It's a stop sign right there.
>
> As I was coming there, a car came around, hit me. I lost control. It was like, kind of like a sidewalk. So I hit really hard there, and after that it was just straight on into the building, which the car caught fire.
>
> I wasn't able to get out of the car, and I had to get out of the van by the sliding door on the side. That was the way I was able to get out."

The claimant went on to state that if he was not mistaken, he called the police and then went to his supervisor, Mr. Seales. "At that time I was in shock." His supervisor required him go to the emergency room. When he walked back to the City of Faith, he was given a Breathalyzer test and he also provided a urine sample. (Tr.10-11) City of Faith was a five (5) minute walk from the accident scene. He also stated that he drove himself to the emergency room that night and his arm was really swollen at the elbow. He also was experiencing shoulder and knee pain. (Tr.13)

The pain was in the left elbow and left shoulder. The visit to the emergency room was "like a follow-up" because he recently had shoulder surgery performed by Doctor Ahmadi, "probably like 2015 or 16", and had been released as of the December 2, 2018, date. (Tr.14) He never returned to work, and admitted he received $405.00 a week until May 19, 2019. (Tr.15) The claimant stated he returned to Doctor Ahmadi who basically ran all the tests like he did on the first surgery, and came to the decision to perform surgery on the elbow and re-do the shoulder replacement. (Tr.16) The surgeries were successful. The claimant also admitted he suffered a serious accident back in 2005 where he injured his elbow severely. The original surgery was performed at St. Jude's in Memphis and his elbow had never been the same. (Tr.17) The claimant denied he injured his shoulder back in 2005. However, later in 2016, he did injure the shoulder and surgery was performed by Doctor Ahmadi in regard to his rotator cuff. After the surgery, the shoulder was okay and the motion was better than now. (Tr.18) The claimant stated that after the 2005 injury, he was placed on disability and was never cleared to return to work. He also stated he provided the City of Faith with all of his injuries in the application process and advised them of his work status and his social security. The claimant was questioned about his

seizures and stated he was diagnosed with seizures back in 2005, when he had his first one at the time of the wreck.

In regard to 2018, and when he had his last seizure, he stated as follows:

> "2018. What I came to learn about seizures through the years, there's several different types of seizures, you know. You can have a seizure where you fall out, when you shake on the ground, or you can have a staring seizure, just me sitting here looking at you. So I really couldn't tell you how many seizures I've had since then as far as like where I had to go into the hospital or somebody around me noticing, I hadn't had a seizure"

He denied that it was determined he had a seizure at the time of the 2018 accident. In regard to the 2018 accident, he testified the other vehicle kept going. (Tr.19-21)

The claimant testified that he saw Doctor Schock about his knees and used his health insurance. (Tr.22) He eventually saw Doctor Bowen in regard to his knees. Doctor Schock performed arthroscopic surgery on the left knee back in 2018, which was successful. He was not restricted in doing anything and even passed the police department physical. He also stated he obtained a "workers pass" from social security. He went to Doctor Schock first, because he had performed the surgery on his left knee earlier in the year. Doctor Schock basically stated there was nothing different and the claimant ended up going back to his primary care doctor, Robin Perry. (Tr.23-24)

He went to Doctor Perry, because he did not agree with Doctor Schock's analysis, due to the fact his knees felt totally different. Doctor Perry told the claimant to see Doctor Bowen, who prescribed surgery for the right knee. The claimant admitted Doctor Schock looked at the right knee and did not see anything. (Tr.25-26) After the surgery, the claimant stated he suffered the worst pain he had ever seen, but it eventually subsided. (Tr.27) The claimant also admitted he talked to Doctor Bowen about his left knee and surgery was performed on the left knee in November of 2020. (Tr.28)

The claimant stated he still needed crutches and is still on and off with surgery. They are still having to drain fluid from his knee. He suspected he would start back on therapy after the hearing. He felt he injured his knees at the time of the accident. He was able to perform all of his duties at City of Faith prior to the accident, but was unable to after the accident because he could not stand as long, and had a difficult time with steps. He went on to ask that the Commission require his workers' compensation to pay for his surgeries and he receive payments until he reached the end of his healing period. (Tr.29-32)

Under cross-examination, the claimant testified he was no longer taking three (3) medications for seizures, but admitted he was on those medications from 2005 until July 4th of last year, when he started seeing a new neurologist that took him off the medications and placed him on a new one. He stated he was now taking Keppra. (Tr.32-33) He admitted that sometimes when he doesn't take his medication, as a seizure patient he gets an acid reflux like taste as a warning sign. The claimant admitted a seizure just happens or you just stare off into space and don't know where you are. (Tr.33) The claimant only admitted to the one seizure. He also admitted his doctor instructed him not to drive initially back in 2005, but it was okay now, as long as he was taking his medications. (Tr.34) The following questioning then occurred:

> Q. The reason I ask, I'm looking on page 118. It says "Remain on seizure precautions. He does not drive, no heights, showers, instead bathe. So as of 2015, ten years after you had the blackout and the big accident, you were told not to drive, is that correct?
>
> A. No, it wasn't demanded.
>
> Q. So this medical record that I'm reading from is incorrect?

A. He didn't demand me not to drive. He said I should be aware, but it was never demanded, like my license wasn't never taken away.

Q. No, I didn't say your license, I'm telling you your neurologist said remain on seizure precautions.

A. Precautions. That's it.

Q. And one of those was not to drive, wasn't it?

A. No, he never demanded me not to drive. (Tr. 35)

In further cross-examination, the claimant did not deny he previously had a seizure and a motor vehicle accident. He also agreed it was accurate that the doctor had him down as having a debilitating seizure disorder and admitted telling his doctor that the medications made him sleepy. The claimant was then questioned about another seizure in 2014, where he fell and fractured his elbow. The claimant denied fracturing his elbow, stating he did not recall it. He did state that he did not disagree with his medical records. (Tr.36-38)

Claimant was also questioned about a wreck in 2016 when he hit some poles and a building. The claimant thought that it was poles, a stop sign, and a fire hydrant. He denied it was caused by a seizure. He was then questioned about emergency room records which provided he did not take his phenobarbital and he responded "That was from me taking my phenobarbital." The claimant also admitted he woke up in September on the floor after a seizure, and that's when he broke his shoulder which resulted in a surgery by Doctor Ahmadi. He also admitted that in March of 2018, a few months prior to the automobile accident involving the City of Faith van, he indicated to his neurologist he had staring spells, one or two times a month. He also admitted that in March of 2018, his shoulder was still so bad that he was having people come and assist or aid him.

(Tr.39-40) He went on to state he had been needing assistance due to his shoulder since 2005. (Tr.41)

The claimant was then questioned about the accident on December 2, 2018. He stated that he traveled thirty (30) to forty (40) yards after his vehicle was hit. He responded he was going maybe five (5) miles an hour at the time of impact. He also stated he was coming to a stop sign. "A car turned to come on the street towards me where I was at. He hit me. I lost control of the vehicle, hit the sidewalk. That's where the most damage was done, where I hit my head and everything. And I proceeded to lose control and hit the building." (Tr.41-42)

The claimant was questioned about page 229 of the medical records, where on December 3, a nurse stated he was having warning symptoms last night that might lead to a seizure. The claimant responded you may get a taste or a smell if you don't take the medicine properly. He did not remember having a seizure on December the 2nd or the 3rd. He was also questioned about Tonya Kelley, the claimant's mom, who had contacted UAMS, requesting an urgent appointment for a follow up with Doctor Chad Wooten. The records provided she had stated the claimant was seen in the ER the night before after having a really bad seizure. The claimant responded that's my mom and she just wants to backtrack to make sure it wasn't a seizure. She was just taking precautions.

In regard to the elbow, the claimant admitted he had suffered an open fracture back in 2005. He was questioned about loose bodies and severe arthritis in the elbow and the discussion of extensive surgery of the elbow, referring to page 40 of the medical exhibit, and he responded, "Maybe, yeah." (Tr.44-46)

The claimant was also questioned about falling down twelve (12) stairs on July of 2015, which resulted in pain to his head, shoulder, and hip on the left side. He responded "It's kind of right, but it's, no not 12 stairs. That's a little much. If I remember, I was in bed, and I fell out of bed and that's when the shoulder injury happened." (Tr.46-47)

When the claimant was questioned whether they could agree about complications from seizures back in 2015, when his vehicle struck multiple poles, a house, and a car, the claimant denied suffering from seizure complications. (Tr.48)

The claimant was then cross-examined about the time he had a seizure and fell and fractured his shoulder. He was also questioned about taking hydrocodone and whether it was for his elbow. He responded that he had no idea but that it could have been for his hand, shoulder, elbow, or knee. He had no idea. He was also questioned about the medical records providing he had two (2) seizures and the claimant responded that he did not disagree with that. (Tr.49-50) The claimant also admitted he called in for pain medication in November, referring to page 182 of the medical records, and was told he had nerve damage in his arm. (Tr.51) He also admitted he had testified in his deposition that there was never a time when he could use his left arm for anything other than minor activities and was never able to extend the arm after the wreck in 2005. (Tr.53)

He agreed that an MRI of the left knee had been ordered by Doctor Schock in January of 2008. He also agreed that it was true that on his visit to Doctor Schock on March 29, 2018, he complained of bilateral knee pain and had problems bending, squatting, standing, twisting, doing stairs, and walking. He denied these problems were "pretty much" the ones he suffered now. He stated the problems were now worse, way worse. He also agreed Doctor Schock was the only doctor that saw his knee both before

December 2, 2018, and after, and if the medical records provided Doctor Schock had not recommended any restrictions or limitations and did not see any evidence of a new injury from the December 2018 accident, that was what Doctor Schock had indicated. (Tr.53-54) The claimant was also questioned about the medical records providing that the claimant apparently had a seizure as part of motor vehicle accident, and he responded "Okay." (Tr.55)

Cross-examination continued with questioning about the claimant's visit to Doctor Hussey, for an IME in February in 2019. The report indicated the claimant told MEMs he was fine and they released him and the claimant responded that was "right." The report further provided that the claimant stated he had more surgeries on his left elbow than he could count and had never had full motion of the left elbow. The report also provided the claimant was suffering shoulder discomfort and restrictions prior to the motor vehicle accident and the claimant responded that was correct. (Tr.56) Additionally, the report provided the claimant had complaints of left shoulder pain since his surgery in September and he agreed it was referring to September of 2016. (Tr.57)

Back to the knees, the claimant admitted there was a year gap in the medical treatment for his knees after Doctor Schock stated he could see nothing wrong with the claimant's knees in March of 2019 and that the next record involving his knees was not until April 14, 2020. (Tr.60) He was also questioned about page 407 of the medical records which provided his chief complaint was of pain of the right knee, but that it did not mention the left knee. The claimant responded it was his understanding there was going to be "microscopic surgery on both knees." He also agreed that the left knee was scoped nine months prior to the accident. (Tr.61) Additionally, he admitted that the first time he

mentioned his left knee was in September of 2020, which was almost two (2) years after the accident. When the claimant was asked why he did not mention his left knee for two years, he responded he mentioned the knee to Doctor Schock when he performed the microscopic surgery on his knee. (Tr.62)

The claimant was also questioned about his work on windmills. He stated he was doing one-handed duty, spraying the blades calling it "labor work." "There's enough physical work that I was able to make it happen just with one hand." (Tr.63) When questioned about why he was not performing that type of work now since his right side was not injured, he stated that it was because he was doing therapy after surgery on his foot. Under further questioning, he agreed his foot was not injured in the wreck. (Tr.64)

On redirect, the claimant agreed he was mainly air brushing paint in regard to the windmill blades. He also agreed he was terminated from the job due to obtaining enough points for being late to work and "stuff like that." (Tr.67) The claimant also agreed the medical records at page 253 provided that "apparently he had a seizure as a part of this accident." The claimant stated that when he was having signs of a seizure, in regard to tasting, that was after the accident. Then the following questioning occurred.:

Q. So this was before. It said "the night before" you were having these symptoms.

A. Right.

Q. And your mother had called I think that next day?

A. Right.

Q. So those were simply signs you were having a seizure the day of, or before the accident or during the accident?

A. No.

Q. In fact, you told them it wasn't because of a seizure?

A. Right

Q. And at the hospital you also show on the records that you knew what happened, right?

A. Yes.

Q. You told them what happened, correct?

A. Yes.

The claimant further testified he told Mr. Seales about the accident and that he had memory of the accident. (Tr.68-70) The claimant was also questioned about a photo showing the area of the accident. He stated that the other car came from the direction to the right of the picture and he hit the curb with a substantial impact where he lost control. The airbags deployed when he hit the curb. He also stated he actually did not know that he was hitting the structure before he hit it, and that he was out of it due to the big bang, but admitted traveling thirty (30) to forty (40) yards before hitting the structure. The claimant denied having any seizures since December 2, 2018. Prior to that date, the claimant admitted having seizures and stated it was the result of him failing to take his medications. At the time of the accident, he had been taking his medications in a timely manner and had no issues prior to the accident or two weeks before. (Tr.73–76)

At this point, the claimant rested, and the respondents called Mr. Phillip Seales, the Chief of Security for the respondent and the claimant's supervisor. He testified the respondent employer operated as a re-entry service for people coming from the Bureau of Prisons in a work release program. He was not aware of the claimant's history of seizures. Security officers hired for the 1:00 to 9:00 shift were the ones who ran errands away from the building, "so any kind of seizures would have been an indication that he could not be hired for that position, so it would have been very important." He went on to

state we would not have placed him on the 1:00 to 9:00 shift and would have used him in a different position. The insurance would not have covered him if they were aware of his seizure medication.

Mr. Seales testified he examined the vehicle after the accident when it was still inside the building. (Tr.77–79) Both the building and van were on fire. He was told by the claimant that a vehicle struck him from behind or from the side. He went out to the intersection and there was no sign of an impact. There were no lights off the vehicle, nor any kind of paint, or any particles or skid marks from either vehicle there. (Tr.80) The claimant would have been turning right at the intersection to travel to Baptist, and there was a stop sign there. In regard to the distance between the building where the van came to rest and the stop sign, Mr. Seales stated "If I were to compare it to a football field, it was less than 50 yards." (Tr.81) He also stated the claimant was complaining of his arm and was holding it close to his body and not moving it much. He never complained of his shoulder. (Tr.82)

Under cross-examination, Mr. Seales stated that Mr. Pettus, the assistant chief, who was no longer with us (it was later clarified that he had passed away) and was the one who actually interviewed the claimant at the time of hiring. He testified that Mr. Pettus would have been very thorough in regard to interviewing the claimant. He also agreed he did not see the accident occur and his knowledge of the accident was based on what the claimant told him. He also admitted that he was not an accident reconstructionist and it was possible that there were no broken lights or skid marks at the scene. In regard to viewing the van that was driven by the claimant, Mr. Seales stated, "The front of the vehicle was on fire, the back of the vehicle was still kind of viewable. I didn't see any

indications of impact on that part, but I couldn't get close to the front." (Tr.84–86) Mr. Pettus performed the drug and alcohol tests after the accident and there were no findings. (Tr.88)

The parties jointly submitted documents which consisting of 507 pages, which included the abstract of the documents. The traffic violation report from the State of Arkansas provided that the claimant was involved in an accident in August of 2011, and also provided there were multiple traffic violations with two separate requirements for an interlock device from the dates of October 4, 2016, through January 14, 2019.

In regard to medical exhibits, the claimant presented to Doctor Rhodes for left arm pain on May 26, 2005, after the claimant was involved in a motor vehicle accident on May 7, 2005, and sustained an open left elbow dislocation and a brachial artery injury, with an open left distal radius and ulnar fracture. The wound was dressed, and surgery was explained. (P.1) A report dated May 27, 2005, provided the claimant's left external fixator across his left elbow was removed. (P.2) The claimant returned to Doctor Rhodes on June 2 and 9, 2005, with continued left arm pain, and a CAT scan was ordered. (P.3-4) On June 17, 2005, Doctor Rhodes removed the external fixator of the left distal radius. (P.5) The claimant continued to return to Doctor Roads for treatment and post-surgical follow-up, with an office visit on July 25, 2005, and the report provided the claimant had the same range of motion in his hand as pre-operatively. (P.10) The claimant continued to present to Doctor Rhodes for post- surgical follow-up on July 28, 29, 2005 and August 2, 8, 23, of 2005. (P.11-15)

On August 31, 2005, the claimant presented to Doctor David Collins for an initial evaluation of left shoulder pain following the accident of May 7, 2005. The examination

provided for diminished active range, diminished hand movement, healing nerve injury, and shoulder weakness which should improve with time. (P.16-18)

The claimant then returned to Doctor Rhodes on September 6 and 8, 2005, for a follow-up involving the aspiration of an abscess of the left forearm. (P.19-20) On September 13, 2005, the claimant presented to Doctor Michael Moore for a second opinion of the left elbow and wrist. Doctor Moore opined his primary concern at the time was treating the osteomyelitis of the left distal radius and recommended a Zoom CT. He also thought a repeat nerve conduction EMG study of the left extremity was indicated and the onset of the pain in the neck and shoulder was most likely related to a brachial plexus injury. (P.21-25) The records provided that Doctor Moore referred the claimant to the Arkansas Specialty Hand Therapy Center on September 13, 2005, and that the claimant had significantly limited range of motion in all joints of the left wrist, forearm, and especially the elbow. (P.26-27)

The claimant then returned to Doctor Rhodes on September 19 and October 3, 2005, for a follow-up due to a continued discharge from his left wrist. On the October visit, there was an improved range of motion. (P.28-29) The claimant continued to present to Doctor Rhodes on October 4, 10, and 18, as well as November 3 of 2005, for continued debridement, hardware removal, and no drainage was noted on the November 3, 2005 visit. (P.28–34)

The claimant's return to Doctor Moore on November 3, 2005, provided that he concurred with Doctor Rhodes' referral to Doctor Hansen for the claimant's left elbow following the May 7, 2005, motor vehicle accident. (P.35) A CT scan on April 6, 2006, provided for old-healed trauma with no bone destruction and with no acute fracture. (P.36)

On January 21, 2008, the claimant presented for an MRI of the left knee which indicated extensive bone marrow edema of the proximal tibia, and a non-displaced intra-articular fracture in the anterior aspect of the lateral tibial plateau, along with a synovial cyst at the myotendinous junction of the popliteus. (P.37)

A report dated January 24, 2008, provided that the claimant presented to Doctor Ethan Schock for a six week follow-up after right rotator cuff repair and with lifting restrictions in place. (P.38) The next report dated December 2, 2008, provided that a diagnostic CT of the left upper extremity and elbow was ordered by Doctor Mathias. (P.39) The review by Doctor Mathias provided the CT scan noted degenerative changes over the radial capitella and ulnar humeral joints, with multiple loose bodies and enlargement of osteophytosis and gross changes involving the articular surfaces. The diagnosis provided for left elbow degenerative disease following a severe traumatic injury. The report went on to state that surgery might improve the range of motion but that it likely would be minimal, that the claimant had become functional with limited motion, and that he does not wish to proceed with additional treatment at this time. (P.40)

Five years later, the records provided the claimant presented to Doctor Jeanine Andersson on July 15, 2013, for an initial evaluation for surgical removal of multiple right-hand masses and left arm paralysis after a motor vehicle accident. The report further mentioned a seizure disorder and that the right hand was normal. (P.41-50) The operative report of Doctor Andersson dated July 30, 2013, provided that multiple masses were excised. (P.51-52) A follow-up report by Doctor Andersson, dated August 12, 2013, provided the claimant was doing well and healing. (P.53)

On November 20, 2013, a toxicology report in regard to seizure control was provided by St. Vincent Infirmary. (P.54) Approximately a month later on December 23, 2013, a left wrist MRI report provided there was no evidence of osteomyelitis and it further showed an old healing of the fracture of the distal radius with postop granulation tissue. (P.55-58) A second toxicology report in regard to seizure control and dated January 13, 2014, was provided. (P.59)

On April 16, 2014, the claimant presented to Doctor Willis Courtney and the office note provided the claimant had last been evaluated on November 19, 2013, for a seizure disorder. The report mentioned recurrent episodes of seizures, paroxysmal episodes of involuntary nystagmus and gait ataxia. The report also provided the claimant denied any further seizures or ataxic episodes since starting phenobarbital. (P.60-62) A third toxicology report of record for seizures was performed at St. Vincent Infirmary on May 29, 2014. (P.63)

On September 6, 2014, the claimant presented to the UAMS emergency department after a fall from a standing position, with a left wrist injury and an ulnar fracture. The report also mentioned bony remodeling and changes consistent with chronic osteomyelitis. The report also mentioned seizures under past medical history. (P.64-77) The claimant later returned to the UAMS emergency room on September 11, 2014, with a complaint of increased pain to his left elbow and wrist after the September 6, 2014, fall. (P.78-83)

On September 30, 2014, the claimant presented to Doctor Brian Norton for an initial evaluation for left arm pain after tripping and falling on his left arm and being diagnosed at UAMS. X-Rays provided for a fracture of the distal ulna and the claimant

was placed in a cast. (P.84-87) The claimant returned to Doctor Norton on October 1, 2014, and the report provided the claimant tripped and fell, landing on his left arm on September 6, 2014, when he was immediate pain and with swelling of the arm. The report further provided that the claimant had been seen at the UAMS emergency room. (P.88-92)

On October 15, 2014, the claimant presented to Doctor Willis Courtney in regard to a seizure disorder. He was last seen by Doctor Courtney on April 16, 2014, and denied any recent seizures and reported compliance with his anticonvulsant meds. The report provided that the claimant had intractable partial complex epilepsy with secondary generalization that is currently stable, and recommended seizure precautions with current treatment. (P.96-98) The fourth toxicology report for seizures was performed on April 7, 2015. (P.99) The claimant then returned to Doctor Courtney on May 11, 2015, in regard to his seizure disorder, where he provided that he awoke from his sleep on March 26, 2015, with aching muscles and weakness with an episode of shaking activity during his sleep. He also reported he had been witnessed by his counselor experiencing intermittent staring episodes. The report provided the claimant suffered from intractable partial complex epilepsy with or without secondary generalization. (P.100-102)

On July 8, 2015, the claimant reported to the UAMS emergency room after a fall due to a possible seizure, where he fell down some stairs and received a laceration to his left forehead, and with complaints of left knee and hip pain. (P.103-104) He again returned to the UAMS emergency room on October 23, 2015, after a motor vehicle accident with a closed head injury, a forehead abrasion, and with a history of seizure. The report provided that the claimant's vehicle struck multiple poles, a house, and a

vehicle, after apparently traveling four blocks. The claimant remembered losing control but was unsure if he was knocked out. (P.105-118)

The claimant presented to Doctor Bashir Shhabuddin on January 28, 2016, in regard to seizures, denying any seizures since his last visit. He reported no convulsions in the last ten (10) years but admitted staring episodes several times a week. The report provided the claimant didn't drive or work and recommended continued seizure precautions. (P.119-121) There was a reported slow impact with a pole and no signs of injury.

The claimant returned to the UAMS emergency room on February 9, 2016, for a third motor vehicle accident that is of record in this matter. The claimant denied being intoxicated and blamed the accident on his failing to take his phenobarbital since October. (P.122-128)

On March 25, 2016, the claimant received an EEG that was normal. (P.129-130) Then on September 19, 2016, the claimant was taken to the St. Vincent Infirmary emergency room after a transfer from the Arkansas Heart Hospital with left shoulder pain and swelling in his arm after awakening. (P.131-141) On September 21, 2016, the claimant presented for a neurological consult following a reported seizure earlier in the week, which resulted in a fracture of the left humerus and a hematoma. A left shoulder arthroplasty was performed. (P.142-166) On September 27, 2016, the claimant returned for a follow-up from the surgery and presented to Doctor John Williams for complaints of pain and being unable to use his sling. (P.167-170) The claimant returned to Doctor Shihabuddin in regard to a follow-up for seizures on November 10, 2016. The claimant reported staring spells for one to two months and provided his last convulsion was on

September 19, 2016. (P.181-184) During this time period, the claimant made numerous requests for additional pain medications and also for stronger pain medications on January 4, 2017. (P.197)

On March 12, 2018, the claimant presented to Doctor Humaira Khan for a follow-up in regard to seizures and complaints of left shoulder pain, since his September surgery. He stated he had no recent staring spells. The claimant was instructed to observe seizure precautions. (P.206-209)

On March 29, 2018, the claimant first presented to Doctor Ethan Schock for an initial evaluation of bilateral knee pain. (P.210-218) Doctor Schock recommended a left knee arthroscopy on April 19, 2018. The MRI of the left knee showed a large area of cartilage loss at the medial trochlea and high grade partial thickness cartilage. (P.219-220) He performed an arthroscopic surgery of the left knee on May 8, 2018, with a multicompartment chondroplasty and with removal of multiple intra-articular loose bodies. (P.222-224) A post operative office visit occurred on May 17, 2018, and a home exercise program was reviewed with a return to normal activities over the next few weeks. (P.225-227)

MEDICAL AFTER THE DECEMBER 2, 2018, MOTOR VEHICLE ACCIDENT

The claimant returned to Doctor Schock for a follow-up in regard to his bilateral knees on December 20, 2018. This was following another vehicle accident where the claimant may have had a seizure. The claimant provided that he does not recall the incident entirely, but may have struck his knee. (P.256–257) An MRI of the left upper extremity was obtained on December 26, 2018, which provided for a nondisplaced coronoid process of the ulna and a hairline nondisplaced transverse fracture of the

posterior distal humorous. (P.258–263) Later on January 2, 2019, the claimant received a normal CT of his head. (P.265–266)

Claimant then presented to Doctor Shahryar Ahmadi on January 16, 2019, for continued complaints of left shoulder and elbow pain following the motor vehicle accidents. Doctor Ahmadi recommended a reverse total shoulder arthroplasty and later a left elbow debridement. (P.268–272) On February 11, 2019, Doctor Michael Hussey made a referral for right shoulder physical therapy due to an impingement syndrome. (P.273) On February 20, 2019, Doctor Hussey provided an Independent Medical Exam for the left shoulder and elbow of the claimant, and opined the claimants present problems were pre-existing and conservative treatment was recommended. (P.274–288)

The claimant again returned to Doctor Ahmadi for an office visit for left shoulder pain which continued after an automobile accident, making a referral for an ultrasound to access tendons of the rotator cuff. (P.289–292) The claimant then returned to Doctor Schock on March 28, 2019, for a bilateral knee follow up. Doctor Schock issued a referral for physical therapy. (P.293–295) An ultrasound of the left upper extremity on April 5, 2019, showed no definite rotator cuff tear, but a marked thinning and atrophy of the supraspinatus was noted which was likely due to prior injury and surgery. (P.296) The claimant returned to Doctor Ahmadi for an office visit on April 16, 2019, and continued to complain of pain in his left shoulder and elbow. Doctor Ahmadi recommended treating the shoulder with physical therapy and treating the elbow surgically. (P.297-301)

On May 7, 2019, Doctor Schock referred the claimant to physical therapy for his right knee. (P.302) On May 9, 2019, the claimant presented to Doctor Schock for a bilateral knee follow up. Doctor Schock opined that no additional surgery was indicated

and that it had been noted the claimant had generalized degenerative changes with wear and degradation of the articular cartilage in all three compartments. He further noted there was no instability and no malalignment and stated, “I do not see any evidence for new injury from his December 2018 event and suspect that this was ongoing and preexistent arthritis of the claimant’s knees.” (P.303-306)

The claimant returned to Doctor Ahmadi on June 18, 2019, for an office visit and EMG nerve conduction study which showed a brachial plexopathy. The claimant was then referred to Doctor Bracey for an assessment. (P.311–314) The claimant was seen by Doctor Bracey on June 26, 2019, and opined that his impression was left acute chronic median nerve injury, but he did not feel the brachial plexus injury was the cause of the shoulder pain and felt that the shoulder pain was intra-articular and likely related to the shoulder replacement. He further stated the finger and thumb extension should continue to recover, that the median nerve injury was chronic and unlikely to recover further, and that surgery would consist of tendon transfers which the claimant was not interested in. The claimant was then referred back to Doctor Ahmadi for shoulder treatment. (P.315-318) Doctor Ahmadi saw the claimant on July 16, 2019, for a follow up for the left shoulder pain and a failed left shoulder hemiarthroplasty. (P.319-322) On July 24, 2019, the claimant was seen by Doctor Justin Treas for a pre-op evaluation of his seizure disorder and he provided that surgery could proceed. (P.329-334) On August 16, 2019, a left shoulder revision for a failed shoulder arthroplasty was performed by Doctor Ahmadi. (P.329-334) The claimant returned to Doctor Ahmadi for a post-operative follow-up on September 11, 2019, and physical therapy was initiated and the sling the claimant was using was discontinued. (P.335-339)

On August 27, 2019, the claimant presented to the UAMS emergency room for acute pain of his left shoulder. (P.340-352) A few days later on October 1, 2019, the claimant returned to Doctor Ahmadi with complaints of pain over the shoulder, neck, and arm area, and he opined that the pain appeared to neuropathic to brachial plexopathy, and referred the claimant to a pain specialist. (P.353-358) The claimant then made numerous visits to occupational therapy from October 7, 2019 to December 19, 2019. (P.369-378)

He then returned to UAMS on January 7, 2020, for a left shoulder X-Ray which indicated an intact left reversal shoulder arthroplasty. (P.379-380) The claimant was then seen by Doctor Ahmadi on the same date, and he stated they would proceed with a left shoulder open osteo capsular release. (P.381-384) On January 23, 2020, the claimant returned to Doctor Ahmadi for a six (6) month follow-up from his left shoulder reverse shoulder arthroplasty. He stated the claimant was satisfied with the operation but was complaining of significant elbow pain and wanted to proceed with a left shoulder open osteo capsular release. The claimant was also seen by Doctor Majors during at the time. (P.385-391) An office visit note to Doctor Ahmadi and Doctor Holt on February 5, 2020, provided the claimant was doing well and was being referred to physical therapy. (P.392-398) The claimant received multiple treatments of physical therapy from February 27, 2020, through March 26, 2020. (P.399-406)

The claimant was then seen at Bowen Hefley Orthopedics by Christian Perry, PA-C, on April 14, 2020, who evaluated the right knee and stated no swelling, tenderness, or effusion was noted, and the knee was aspirated, a cortisone injection was given, and a MRI referral was made. (P.407-409) The MRI provided the right knee

showed a large suprapatellar joint effusion, prominent synovitis, and probable debris anterior to the anterior horns of the medial and lateral menisci with prominent synovitis throughout the knee joint. (P.410) The claimant was then seen by Doctor Scott Bowen on April 28, 2020, who recommended right knee arthroscopy. (P.413-418) Right knee surgery was performed by Doctor Bowen on May 13, 2020. The history and physical notes provided the MRI findings of the right knee were similar to the left knee findings a year prior, and the operative report provided for right knee synovitis, and a patellofemoral chondroplasty was performed satisfactorily. (P.413-418) The claimant returned for a post-office follow-up on May 19, 2020, and the report by Doctor Bowen provided the claimant was in extreme pain, that an effusion was noted and aspirated, and the claimant was encouraged to exercise and to follow a healthy lifestyle. (P.419-420) The claimant again returned to Doctor Bowen on May 26, 2020, and effusion of the knee was again noted and aspirated and the claimant was referred to physical therapy. (P.421–422) The claimant proceeded with physical therapy from May 28, 2020, through June 29, 2020. (P.423–442)

The claimant again returned to Doctor Bowen on August 4, 2020, who provided the right knee was improving, but continued swelling of the left knee was noted, and the claimant was referred for a left knee MRI. (P.443–444) The MRI of the left knee dated September 3, 2020, indicated a large joint effusion with intra-articular loose body in the medial joint and with tricompartmental chondromalacia. (P.445) On a September 10, 2020, office visit, Doctor Bowen recommended arthroscopy of the left knee with physical therapy. (P.446-447) Later, a Therapy Dailey Note on September 16, 2020, provided

there was decreased painful right knee range of motion and strength and a home exercise program was created. (P.448–450)

The claimant returned to Doctor Bowen on October 2, 2020, for a review of left knee MRI findings and he recommended a left knee arthroscopy. The operative report in regard to the left knee provided for a subtotal synovectomy and a medial femoral condyle chondroplasty and also a patellofemoral compartment chondroplasty. (P.451–454) A follow-up with Doctor Bowen on October 8, 2020, provided that the claimant's left knee was improving and the knee was aspirated. (P.455–457) The claimant then received physical therapy from October 14, 2020, to October 11, 2020, and improvement was noted with some swelling and with no complaints in regard to his exercises. (P.458–466) The claimant returned to Doctor Bowen on November 3, 2020, and right knee swelling was noted with the pain worsening, but the left knee was doing well. The claimant was referred to pain management and for a right knee MRI. (P.468–470) The right knee MRI of December 1, 2020, provided for small suprapatellar joint effusion and grade 1 chondromalacia of the lateral femorotibial and patellofemoral compartments. (P.471-472) The claimant returned again to the office of Doctor Bowen on December 21, 2020, for a follow-up of the right knee MRI. The report provided the left knee was doing great but there was some recurrent swelling in the right knee. There was some thickening of the synovium consistent with PVNS and post-surgical changes with no evidence of significant avascular necrosis. (P.473–474) The claimant was seen again by Christian Perry, PA-C, of Bowen and Hefley on January 5, 2021 for a bilateral knee follow up and the report provided the left knee was doing well and there was only a trace of effusion of the right knee. (P.475–476)

The final medical report dated April 15, 2022, provided the claimant obtained a x-ray of the left shoulder which provided the wires were well placed and fixed and there was no acute fracture or dislocation. The x-ray of the left elbow provided for moderate to severe joint space narrowing with moderate periarticular heterotopic ossification around the joint. (P.477–479)

DISCUSSION AND ADJUDICATION OF ISSUES

In regard to the primary issue of compensability, the claimant has the burden of proving, by a preponderance of the evidence, that he is entitled to compensation benefits for his injuries under the Arkansas Workers' Compensation Law. In determining whether the claimant has sustained his burden of proof, the Commission shall weigh the evidence impartially, without giving the benefit of the doubt to either party. Ark. Code Ann. §11-9-704. *Wade v. Mr. Cavananugh's,* 298 Ark. 364, 768 S.W. 2d 521 (1989). Further, the Commission has the duty to translate evidence on all issues before it into findings of fact. *Weldon v. Pierce Brothers Construction Co*., 54 Ark. App. 344, 925 S.W.2d 179 (1996).

Here, it is clear that the claimant suffered a catastrophic automobile accident back on May 7, 2005, many years prior to the accident at issue here. The claimant admitted that he was diagnosed with seizures back in 2005, when he had the initial one of multiple motor vehicle accidents. The claimant admitted he was on three (3) medications for seizures from 2005 until July 4th of last year, when he started seeing a new neurologist, who removed him from the three (3) medications and placed him on one new one. He also admitted he was instructed not to drive back in 2005, but contended that it was now

okay as long as he was taking his medications. He also admitted a doctor told him he had a debilitating seizure disorder.

In regard to an automobile accident on October 23, 2015, the claimant denied he suffered a seizure. The claimant testified he thought he hit some poles, a stop sign, and a fire hydrant. However, the medical UAMS ER reports in regard to the accident was the claimant was taken after the accident provided that the claimant struck multiple poles, a house, and a vehicle, after traveling four blocks. It also provided that the claimant remembered losing control but did not know if he was knocked out and mentioned a history of seizures. The facts of the 2015 accident appear to be strikingly similar to the December 2, 2018, motor vehicle accident, currently at issue. In the 2018 motor vehicle accident, the claimant testified he was coming up to a stop sign at only five (5) miles per hour or less, when his vehicle was hit from the side or rear. He continued thirty (30) to forty (40) yards, per his testimony, and less than fifty (50) yards per the testimony of his supervisor, where he managed to somehow ram into a building with enough force for his vehicle to enter entirely into the building, catching both the vehicle and the building on fire. The claimant testified that he then walked the short distance back to his employer, the location where the journey started. The claimant's supervisor was only a short distance from the accident scene and when he went to see what had occurred, he did not observe any vehicle damage to the side or rear of the vehicle the claimant was driving. He admitted he could not see the front of the vehicle due to the fire and the vehicle resting in the building. He further testified that he looked at the intersection were the collision supposedly occurred and he did not see any skid marks, broken lights, or paint scuff marks.

The claimant also admitted to his neurologist that he was having “staring spells” one or two times a month for a few months prior to the 2018 motor vehicle accident. The claimant was also cross-examined about his mother contacting the UAMS ER and requesting an appointment with Doctor Wooten, because he had suffered a bad seizure the night before, and he basically passed it off as just a mom taking precautions.

The claimant was also questioned about an incident in July of 2015, when he fell down twelve (12) stairs and was injured. He denied he fell down twelve (12) stairs and stated he thought he had fallen out of bed at that time and injured his shoulder.

In regard to the medical introduced into the record, the records provided that the claimant received his first Toxicology Report in regard to seizures on November 20, 2013, with a second one on January 13, 2014, and a third Toxicology Report in regard to seizures on May 29, 2014, and later a fourth Toxicology Report in regard to seizures on April 7, 2014. A report by Doctor Courtney opined the claimant suffered from recurrent seizures, paroxysmal episodes of involuntary nystagmus, and gait ataxia in a report dated April 16, 2014. The medical reports also provided the claimant presented to the UAMS emergency room on September 6, 2014, after a fall from a standing position.

Another report from Doctor Courtney dated May 11, 2015, provided the claimant had admitted to having intermittent staring episodes and shaking activity during sleep. This report provided the claimant suffered from intractable partial complex epilepsy. The claimant saw Doctor Shhabuddin in regard to seizures on January 28, 2016, where the claimant admitted staring episodes several times a week. Doctor Shhabuddin recommended seizure precautions. On February 9, 2016, the claimant again presented to the ER of UAMS due to another motor vehicle accident. Later towards the end of

September 2016, the claimant received a neurological consult following a reported seizure which resulted in a fracture of the claimant's left humorous. The Claimant returned to Doctor Shhabuddin for a seizure follow up on September 19, 2016, and then presented to Doctor Kahn for another follow up in regard to seizures on March 12, 2018.

From the joint medical reports submitted by the parties, it is clear that the claimant had a history of seizure issues long before the motor vehicle accident of December 2, 2018. It also appears there are multiple discrepancies in the testimony of the claimant in regard to the seizures when comparing the testimony to the available medical records. "Compensable injury" means, among other things, an injury arising out of and in the course of employment. Ark. Code Ann. §11-9-102(4) (A). The phrase "arising out of the employment" refers to the origin or cause of the accident and the phrase "in the course of the employment" refers to the time, place, and circumstances under which the injury occurred. In order for an injury to arise out of the employment, it must be a natural and a probable consequence or incident of the employment and a natural result of one of its risks. *J. & G. Cabinets v. Hennington*, 269 Ark. 789, 600 S.W. 2d 916. (Ct. App. 1980) When an employee sustains an "unexplained" injury at work, the injury is generally compensable. However, when an employee sustains an injury classified as an "idiopathic" injury, at work, the injury is generally not compensable, because the injury is personal in nature and does not arise out of and in the course of employment. *Crawford v. Single Source Transportation*, Workers' Compensation Commission, F201868 (August 7, 2003) See also, *Kuhn v. Majestic Hotel*, 324 Ark. 21, 918 S.W.2d 158 (1996).

In the present matter, the claimant suffered from a history of falls and motor vehicle accidents, had been diagnosed with intractable partial complex epilepsy, and had been

known to suffer from neurologic symptoms since a catastrophic motor vehicle accident on May 7, 2005. He admitted to his doctors that he suffered from “staring episodes.” His medical records frequently mention “seizures.”

In addition, there is no alternative but to reach the conclusion that there was insufficient evidence to show another vehicle was present at the accident scene and of a second vehicle actually hitting the vehicle driven by the claimant, due to the fact that there were no skid marks or automobile parts left in the intersection. It is also completely implausible that a vehicle that was traveling five (5) miles per hour or less, would travel after the alleged accident at or near the stop sign thirty (30) to fifty (50) yards and strike a building with enough force to drive completely into the building and catch both the building and the vehicle on fire. In addition, it is noted that the facts of this accident are at least somewhat similar to one of claimant’s previous motor vehicle accidents a few years prior where the medical records provided he hit some poles, a house, and another vehicle, after traveling four blocks before finally coming to rest.

After weighing the evidence impartially, without giving the benefit of the doubt to either party, and based upon the available evidence, there is no alternative but to find that the preponderance of the evidence shows that the claimant sustained a non-compensable, idiopathic injury on December 2, 2018, and consequently, the claimant has failed to satisfy the required burden of proof that the claim is compensable. This finding makes the additional issues moot.

If not already paid, the respondents are ordered to pay the cost of the transcript forthwith.

IT IS SO ORDERED.

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JAMES D. KENNEDY
Administrative Law Judge