BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G900538

ELDRIDGE HOWARD, III, EMPLOYEE	CLAIMANT
CITY OF FAITH PRISON MINISTRIES, EMPLOYER	RESPONDENT
TECHNOLOGY INSURANCE CO., CARRIER AMTRUST NORTH AMERICA, TPA	RESPONDENT

OPINION FILED MAY 26, 2023

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

Claimant represented by the HONORABLE DARRELL F. BROWN, JR., Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE WILLIAM C. FRYE, Attorney at Law, North Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The claimant appeals an administrative law judge's opinion filed September 20, 2022. The administrative law judge found that the claimant did not prove he sustained a compensable injury. After reviewing the entire record *de novo*, the Full Commission reverses the administrative law judge's opinion. The Full Commission finds that the claimant proved he sustained a compensable injury to his left elbow.

I. HISTORY

Eldridge Charles Howard, III, now age 40, testified that he was diagnosed as having epileptic seizures beginning in 2005. Dr. David M.

Rhodes treated Mr. Howard, and corresponded with Dr. Robin Jeffers-Perry on May 26, 2005:

> The patient is a 22 year old right hand dominant male, student, who on 5/7/05 was involved in a motor vehicle accident. He sustained an open left elbow dislocation with brachial artery injury and open left distal radius and ulnar fracture. He complains of pain in the arm that is exacerbated with range of motion and alleviated with rest.…
> There is an ex/fix across the elbow and across the left distal radius with decreased sensation to light touch in the radial and ulnar nerve distribution.…
> **X-RAYS:** 2 views of the left elbow were ordered, performed and interpreted by me with the following findings: Show subluxation of the radial head. 2 views of the left wrist show segmental bone deformity of the distal radius.

Dr. Rhodes assessed "1. Status post left elbow and distal radius open fracture ex/fix with brachial artery graft….Schedule left elbow ex/fix removal."

Dr. Rhodes reported on May 27, 2005, "Mr. Eldridge Howard was taken to the operating room today for removal of external fixator across his left elbow under anesthesia….He was given a follow-up appointment that day with therapy to get placed in a hinged elbow brace."

Dr. Rhodes informed Dr. Jeffers-Perry on June 17, 2005, "Mr. Eldridge Howard was taken to the operating room today for removal of his ex/fix of his left distal radius."

Dr. Rhodes' assessment on July 18, 2005 was "1. Left distal radius fracture and brachial plexus injury and elbow fracture dislocation."

Dr. Rhodes reported on July 22, 2005, "Mr. Eldridge Howard was taken to the operating room today for treatment of his left distal radius non-union."

Dr. David N. Collins evaluated the claimant on August 31, 2005:

> Mr. Howard is a 22-year old patient seen in consultation for his right shoulder at the request of David Rhodes, M.D. His chief complaint is pain and dysfunction. His primary care physician is Dr. Perry.
> Mr. Howard was involved in severe accident on 5/07/05. He apparently was treated in Memphis for an open, left elbow dislocation with brachial artery injury and a left open distal radius and ulna fracture. He came to the care of Dr. Rhodes on 5/26/05. At that time, he had an ex-fix in place. He had some concerns regarding the injury relative to infection. Over the course of time, he was treated for nonunion and went on to have additional surgery with bone grafting. It was determined at some point that he had a brachial plexus injury. He continues under Dr. Rhodes' care for the upper extremity with concerns regarding the elbow, forearm, and shoulder.

Dr. Collins gave the following impression: "It appears that Mr. Howard sustained an injury of significant magnitude to the left upper extremity….There are no specific problems related to the shoulder, other than weakness which should hopefully improve over time….The greatest concern, I would think at this point, is his elbow….There are no specific indications for additional imaging studies or diagnostic tests regarding the left shoulder. I will follow him as needed."

Dr. Michael M. Moore corresponded with Dr. Rhodes on September 13, 2005:

> Thank you very much for referring Eldridge Howard for consultation. He was seen at the ***Arkansas Hand Center*** on 09/13/05 for *Second Opinion Evaluation*. He is a pleasant, 22-year-old, right-hand dominant student who was involved in a motor vehicle accident on 05/07/05. He sustained severe injuries to the left wrist and elbow….Apparently, external fixation devices were placed on the wrist and elbow. Mr. Howard required repair of the brachial artery. In addition, skin grafting was required to cover a wound over the anteromedial aspect of the elbow….
> It is my opinion Mr. Howard has sustained a complex injury to the left upper extremity….If Mr. Howard were my patient, it would be my recommendation that a Zoom CT scan of the left distal radius be performed. If there appeared to be healing of the distal radius, I would recommend removing the plate and debriding the fracture site.

Dr. Rhodes performed a "debridement of dorsal complex of left distal radius for osteomyelitis" on October 4, 2005. The post-operative diagnosis was "Retained hardware, left distal radius fracture, with chronic distal radius osteomyelitis, with extensor carpi radialis brevis and tongus tendon adhesions and adhesions of the flexor carpi radialis."

Dr. Rhodes' assessment on October 10, 2005 was "1. Left distal radius hardware removal with osteomyelitis."

The claimant testified, "After the '05 injury I was placed on disability probably in about 2007." An MRI of the claimant's left knee on January 21, 2008 showed, among other things, a "nondisplaced intra-articular fracture." The assessment of Dr. Robert C. Matthias on December 3, 2008 was "Severe left elbow degenerative disease following a severe traumatic injury."

Dr. Jeanine Andersson evaluated the claimant on July 15, 2013: "The patient is a 30-year-old right-hand dominant male who has a debilitating seizure disorder. He has no use of his left arm secondary to an MVA while having a seizure. He comes in today for evaluation of masses over his right hand which have progressively enlarged and are severely painful. Since this is his only useful hand, he wishes to have these surgically excised….I discussed with the patient today both nonsurgical and surgical treatment options. The patient would like to proceed with surgical excision of multiple hand masses."

Dr. Andersson assessed "#1 right hand multiple soft tissue masses – worsening of progressively enlarging. #2) left hand paralysis following MVA. #3 seizure disorder."

Dr. Andersson performed a procedure on July 30, 2013 which included "Right hand mass excision." The post-operative diagnosis was "Right hand multiple masses, including three masses of right thumb, two masses of right index finger and one mass in palm of hand."

Dr. Willis Courtney saw the claimant at Arkansas Neurology & Epilepsy Center on April 16, 2014:

> The patient is a 31 year old male who presents with seizure disorder. The patient's typical seizures are complex partial….The patient was referred by Dr. Robin Perry. The patient was last evaluated by me on November 19, 2013. At that time, the patient reported recurrent episodes of seizures as well as paroxysmal episodes of involuntary nystagmus and

> gait ataxia. The patient was scheduled for an EEG to assist in determining if additional or alternative anticonvulsant medication were required. The EEG study was unrevealing….

Dr. Courtney's impression included "1. Intractable partial complex epilepsy with and without secondary generalization, currently stable on phenobarbital, generic Trileptal, and generic Lamictal. 2. Status post MVA with fracture of the left forearm, requiring surgery. 3. Left foot surgery." Dr. Courtney recommended continued medication and "2. Seizure precautions."

The claimant sustained a "left distal ulnar fracture" on September 6, 2014 following a fall. The claimant was treated conservatively.

Dr. Courtney's impression on October 15, 2014 was "1. Intractable partial complex epilepsy with secondary generalization, currently stable." Dr. Courtney's impression on May 11, 2015 was "1. Intractable partial complex epilepsy with and without secondary generalization. 2. Reports of recurrent seizure described as nocturnal generalized tonic-clonic events as well as intermittent staring episodes/loss of time during wakefulness."

An RN noted on July 8, 2015, "Pt was walking down stairs last night and fell. Unsure if he had seizure or what. Hx seizure….Pt with small superficial lac to left side of forehead in scalp."

Dr. Casey M. Smolarz assessed the following on October 23, 2015: "1. Closed head injury, initial encounter. 2. Lip swelling. 3. Forehead

abrasion, initial encounter. 4. Motor vehicle accident. 5. History of seizure."

Dr. Zachary B. Lewis reported on October 23, 2015:

> Motor Vehicle Crash w/history of seizure disorder presenting to the ED after 4 block city speed MVC w/his vehicle striking multiple poles, one house, and one vehicle. Pt notes that he woke up around 1:30 AM, took his phenobarbital, and went to the strip club. Pt denies drug or EtOH use tonight. He left the club because his phenobarbital "kicked in" because it "messes with him sometimes." Pt notes remembering losing control and hitting the first few objects w/airbags being deployed….Pt unsure if he was knocked out. Ambulatory on the scene…. Pt was examined after traumatic event w/possible injury….Patient wishes to leave against medical advice.

Dr. Lewis diagnosed "1. Motor vehicle accident. 2. Lip swelling. 3. Forehead abrasion, initial encounter. 4. History of seizure."

Dr. Neil K. Masangkay noted on September 21, 2016, "Mr. Howard is a patient with a history of epilepsy for several years. He is on 3 AEDs including PHB. He was taking 120mg/day but reduced this to 60mg per day. He had been having good seizure control until earlier this week and has had at least two seizures since then leading to a fracture and a hematoma affecting his left shoulder and arm. On examination, his left arm had some scarring and limited range of motion because of the injuries noted above. The rest of his examination was unremarkable."

Dr. Shahryar Ahmadi performed a "left shoulder hemiarthroplasty" on September 21, 2016. The pre- and post-operative diagnosis was "Left

proximal humerus fracture dislocation." The claimant was provided follow-up treatment after surgery.

Dr. Robin Perry noted on January 8, 2018, "Patient is here for his Medicare physical. He does see neurology at UAMS every 6 months. He is on 3 medications for his seizure disorder. Seizures have been controlled. He was seeing ortho for shoulder injury and did have surgery. He has been released by ortho. He is not seeing any other physicians." Dr. Perry's assessment included "2. Epilepsy, unspecified, not intractable, without status epilepticus."

Dr. Humaira M. Khan provided an assessment and plan on March 12, 2018: "35 yo M w/seizures first dx in 2005 after a seizure caused a MVA. He was last seen in Nov 2016 and has not had seizures since. Prior MRI brain and EEG normal. He is on stable doses of Phenobarb 120 mg qhs, Lamictal 200 mg and Trileptal 1200 mg bid. No side effects reported. No doses missed….Seizure precautions discussed. RTC 9 months."

Dr. Ethan Schock evaluated the claimant on March 29, 2018: "Howard is here today for consideration of bilateral knee pain, left greater than right. He has a long history of seizure disorder and has had multiple motor vehicle accidents over the years. He has had no fractures about the knees but has had these injured with dashboard type injury several times….Examination today shows bilateral knee effusions."

Dr. Schock reported on April 19, 2018, "Left knee MRI is reviewed today and this confirms a large intra-articular loose body likely from a trochlear donor site….I think a knee arthroscopy with anticipated loose body removal and possible microfracture could be helpful for him."

Dr. Schock performed surgery on May 8, 2018: "Left knee arthroscopy with multicompartment chondroplasty and removal of multiple intra-articular loose bodies measuring greater than 5 mm." The post-operative diagnosis was "Degenerative arthritis with intra-articular loose bodies."

The claimant testified that he became employed with the respondents, City of Faith Prison Ministries, in approximately September 2018. The claimant testified on direct examination:

> Q. When you were employed by City of Faith, did you go through the application process?
> A. Yes, sir.
> Q. You advised them of all your injuries?
> A. Yes.
> Q. Did you advise them of all, any kind of work status that you had?
> A. I had to.
> Q. They knew about social security at that time?
> A. Yes.
> Q. And they approved you to do the work that you described earlier?
> A. Yes.
> Q. Working in the building and also driving the vehicle to and from the hospital with the food trays.
> A. Yes….
> Q. At the time in 2018, how long had it been since your last seizure?

> A. 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.

The parties stipulated that the claimant "would provide services for the respondent, and the services included operation of a vehicle."

The claimant testified on direct examination:

> Q. What was the primary purpose of City of Faith?
> A. Basically security, checking people in and out in the computers, sometimes searching them, making sure they didn't have certain items, picking up their meals from Baptist Hospital, taking the trays back to Baptist Hospital, sometimes walking around just checking the facility, making sure everything is going like it's supposed to.
> Q. And City of Faith has a number of residents that stay there at the facility, right?
> A. Yes, men and women….
> Q. I think you said you had to go and pick up the meal trays and bring them back?
> A. Yes, from the Baptist Hospital.
> Q. So explain to me what that would entail. What would you do?
> A. Well, sometimes it would be one or two of the residents with me in the van, and we would go, go to Baptist, we would pick up the trays, load up the trays, and we would go directly back to City of Faith, unload the trays. We would serve the trays, make sure everybody ate, clean up everything, put the trays back in the van, and I would take them back and unload them, come back, clock out, and that's it.

The parties stipulated, "The employer/employee/carrier relationship existed on December 2, 2018, when the claimant was operating a vehicle

owned by the respondent, City of Faith, and was involved in a motor vehicle accident, where he sustained a physical injury."

The claimant testified on direct examination:

> Q. On December 2, 2018, which is the day you had your accident in this case, what occurred on that day?
> A. Well, I came in and I got the trays, brought them back, everybody ate, everything was fine. This particular night nobody rode back with me to drop the trays back off.
> Q. At Baptist? Is that where you're dropping them back off?
> A. At Baptist. 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 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. From there, if I'm not mistaken, I called the police, and then I went to my supervisor, basically Mr. Seales, and he let me know basically what I needed to do. At that time I was in shock. I really didn't want to go to the emergency room, but he made sure that I did….Mr. Seales, he told me he wanted me to go to the emergency room, and that's when he let me know I could use the workers' comp….

According to the record, an RN entered an ED Triage Note at 11:55 p.m. on December 2, 2018: "Patient states he was involved in an MVC where his car was struck causing him to run into a building. Patient c/o left arm pain and right knee pain."

The claimant treated at Baptist Health on December 3, 2018:

> 35 yo AAM presents to the ED with c/o L elbow pain and swelling that onset tonight due to a MVC. Pt states he was a restrained driver who was hit by another vehicle on the L front side of his vehicle and had positive airbag deployment. Pt also reports having upper lip pain due to the airbags. Pt denies having any neck pain. Pt states he had a previous injury to his L arm before from another accident and he has had several procedures performed on his L arm, but he has noticed that he has some new swelling since the incident. Pt states his PCP is Dr. Robin Perry and his orthopedist is Dr. Moore….
> **Mouth: Pt has swelling to his upper lip**….
> Left elbow: He exhibits swelling (to medial aspect) and deformity (chronic)….

An x-ray of the claimant's left elbow showed "Chronic deformity, STS, nothing acute." An emergency physician diagnosed "Strain of left elbow, initial encounter….I see nothing acute on his x-ray. He did request a sling. We will treat with Toradol and encouraged him to follow-up with his orthopedist."

An RN reported on December 3, 2018, "Called patient, who states that he was having 'warning symptoms' last night, that may lead to a seizure. Reminded patient that he has an appointment for 12/12/18." An RN further noted on December 3, 2018, "Mrs. Tonya Kelley [patient's] mother called to requesting (sic) an urgent appointment and a call back from the nurse. Mrs. Kelley called to schedule patient for a follow up appointment to see Dr. Shihabuddin stating patient was seen in the ER last night after having a really bad seizure."

Dr. Perry examined the claimant on December 4, 2018:

> Patient is here for follow up after MVA. He was on the restrained driver of a van that was hit and he lost control and hit a storage building. Building and van both burned. Airbag deployed when he hit the curb. He injured his left knee. Also injured his chronically deformed left elbow. He had to wear knee braces. He did have drivers license. Has been seizure free for years. He is seeing neurologist at UAMS and just completed arthroscopic left [knee] surgery with Ortho specialist.

Dr. Perry assessed "1. Bursitis of left elbow, unspecified bursa. 2. Brachial plexus injury, left sequela." The record indicates that Dr. Perry took the claimant off work beginning December 4, 2018. The parties stipulated that the claim "was initially accepted as compensable."

An x-ray of the claimant's left upper extremity was taken on December 11, 2018 with the following findings and impression:

> Malunited distal radius and ulna fractures are seen. A nonunited ulnar styloid fracture is noted. Limited view of the elbow demonstrates significant heterotopic ossification. Elbow joint is grossly aligned. There is mild osteopenia. No significant soft tissue abnormality.

Dr. Ahmadi took the claimant off work on December 11, 2018.

Dr. Michael M. Hussey provided an Independent Medical Exam on February 20, 2019:

> Eldridge Howard is a 36-year-old African-American right-hand dominant male who presents to my clinic today for an independent medical examination regarding an injury that the claimant states occurred on 12/2/2018. Mr. Howard states that he was driving the company van of his employer City of Faith performing a food delivery when he states another vehicle struck his vehicle and caused him to hit a building. Mr. Howard states he had been working for City of Faith as a

security personnel for about 1-2 months prior to his motor vehicle collision. According to the fire department report presented to me, the van caught on fire. The fire department report also documents that he questioned Mr. Howard if he was injured, and Mr. Howard told him he was "fine" and that the MEMS unit had already checked him out and released him. Patient denies seeing the other vehicle that struck his van. He states that he did not have any significant immediate onset of pain after the collision but later noticed increased pain in the shoulder and elbow region. He states he does not remember having a seizure during the accident. He states he was taking seizure medication daily before and after his motor vehicle collision. He states his last seizure occurred around 2015….

Assessment: 36-year-old right-hand dominant male with seizure disorder, status post occupation related injury on 12/2/2018 due to motor vehicle collision with post-injury complaint of left shoulder/elbow pain that appears secondary to shoulder and elbow joint sprain.

In regards to the left shoulder, it is my opinion that the majority of Mr. Howard's pain and dysfunction is related to his pre-existing traumatic injury he sustained to the shoulder in 2016 that was related to a seizure. At that time Mr. Howard had a severe comminuted proximal humerus fracture that required a partial shoulder replacement by Dr. Ahmadi, which I believe was a reasonable treatment for his injury….There is no documentation in the medical record that he ever achieved significant improvement in his shoulder function or pain level. After his occupation related injury on 12/2/2018, the Fire Department report states that Mr. Howard did not complain of any pain in his left shoulder or elbow. It is my opinion, if Mr. Howard had that severe of new injury to his left arm that he would have complained of some arm pain at that time….

Specific questions to address presented by William C. Frye:

Question 1: I did find objective findings during my examination of the claimant's left shoulder which showed diffuse mild muscle atrophy compared to the contralateral uninjured right shoulder. There was no further objective findings found, as I was unable to obtain a reliable exam due to his extreme pain behavior exhibited during the left shoulder exam. In my opinion, the findings of diffuse muscle atrophy in

the left shoulder are not related to the claimant's December 2, 2018 motor vehicle accident, and are more likely related to his pre-existing left shoulder injury and surgery.
Question 2: In my opinion, there has been no significant change in the claimant's left shoulder x-rays before and after the 12/2/2018 accident. In my opinion, and in the documented opinion of Dr. Ahmadi, the x-rays show a stable hemiarthroplasty prosthesis with no sign of failure.
Question 3: Not applicable.
Question 4: Based on the objective evidence available to me, it is my opinion that the claimant does not need a reverse total shoulder replacement.
Question 5: In regards to future treatment for Mr. Howard's left shoulder occupation related injury, I would recommend conservative treatment. The objective clinical, physical exam, and imaging evidence available to me at most, points to a simple strain of the left shoulder. In my opinion, I do not see any significant objective derangement sustained on the 12/2/2018 accident to Mr. Howard's left shoulder that would warrant further surgical intervention.
Question 6: During my examination of Mr. Howard's left elbow, I did find objective findings. These findings included limited passive and active range of motion of the elbow joint as well as a soft tissue contracture of the skin and connective tissue in the area of the previously placed skin graft. There was noted to be significant soft tissue and skin deformity in the area of his prior injury that occurred in 2005. There were old well-healed skin incisions from previous surgery and external fixator placement, with no new soft tissue wounds present. There are multiple reports in his previous past medical history from multiple orthopedic surgeons prior to his 12/2/2018 accident, that document significant derangement of the left elbow with loss of motion and function. Therefore, it is my opinion that all of the objective findings that were noted on his left elbow were pre-existing prior to his 12/2/2018 motor vehicle accident.
Question 7: Based on imaging available to me, it is my opinion that the claimant's left elbow x-rays show no new significant changes from the time period before the 12/2/2018 accident, to after the accident. The x-rays and CT scan performed after the 12/2/2018 accident, are in my opinion of similar appearance to the x-rays that were taken prior to his

> 12/2/2018 accident. It is my opinion that all of the objective findings that were noted on his left elbow were pre-existing prior to his 12/2/2018 motor vehicle accident.
> Question 8: In my opinion, I do not believe the claimant requires a debridement of the left elbow based on the injury he sustained on 12/2/2018. It is obvious in his prior medical history that other upper extremity orthopedic surgeons had recommended either a debridement procedure or a total elbow arthroplasty of his left elbow many years [preceding] the 12/2/2018 accident.
> Question 9: In regards to future treatment for Mr. Howard's left elbow occupation related injury, I would recommend conservative treatment. The objective clinical, physical exam, and imaging evidence available to me at most, points to a simple strain of the left elbow. In my opinion, I do not see any significant objective derangement sustained on the 12/2/2018 accident to Mr. Howard's left elbow that would warrant further surgical intervention. The conservative treatment I would recommend if Mr. Howard were my patient would include rest, ice, topical analgesia creams, anti-inflammatory medication, and physical therapy to decrease pain and inflammation related to the joint sprains. The duration of treatment and recovery period for an injury of this nature in my experience with a joint sprain is typically 2-3 months with resumption of full duties at the end of 3 months.
> Question 10: The opinions that I have presented are based on a reasonable degree of medical certainty.

The parties stipulated that the respondents paid temporary total disability benefits through May 19, 2019. The claimant testified that he never returned to work for the respondent-employer.

Dr. Ahmadi performed surgery on August 16, 2019: "Revision of the left failed shoulder arthroplasty to reverse shoulder arthroplasty[.]" The pre- and post-operative diagnosis was "Failed left shoulder arthroplasty." Dr. Ahmadi performed left elbow surgery on January 23, 2020: "Radical

resection of the capsule, soft tissue, and heterotopic bone of the left elbow with contracture release." The pre- and post-operative diagnosis was "Left elbow stiffness."

Dr. William Bowen performed a right knee arthroscopy on May 13, 2020. The post-operative diagnosis was "1. Pigmented villonodular synovitis. 2. Grade 3 chondromalacia, patellofemoral joint and trochlea." Dr. Bowen performed a left knee arthroscopy on October 2, 2020. The post-operative diagnosis was "1. Pigmented villonodular synovitis, left knee. 2. Extensive grade 3 chondromalacia medial femoral condyle and patellofemoral joint."

A pre-hearing order was filed on June 7, 2022. The claimant contended, "Mr. Howard contends that he sustained injuries to his shoulder, elbow and knees as a result of the automobile accident which occurred on December 2, 2018 and further that though he had sustained injuries to his shoulder, elbow and knees previously, the injuries sustained in the present accident and surgeries and other medical issues were not exacerbated by the previous injuries as contended by the Respondent, as a result the Respondent should pay for the Claimant (sic) entire healing period in Temporary Disability payments and pay appropriately for any surgeries, medical bills and the appropriate sum for any disability that exist (sic) now due to that accident."

The parties stipulated that the claim "has now been controverted in its entirety." The respondents contended, "The Claimant in this matter has been on Social Security for years due to seizures, and shoulder and elbow problems. He did not divulge the seizure problem to his insured causing them to put him behind the wheel of a van when he should not have been driving. HE (sic) was involved in a motor vehicle accident in 2005 and sustained an injury to his elbow. He had a subluxation and underwent surgery with Dr. Rhoades (sic). He was then seen by Dr. David Collins for his left shoulder. It was noted that he had a non-union of the elbow and shoulder problems. He also had problems with his left knee popping and was seen by Dr. Ethan Schock. In 2008 he underwent shoulder surgery. He was also seen for severe elbow contracture and severe degenerative changes. He had another motor vehicle accident in 2013 due to a seizure. In 2014, he again injured his left arm in a fall. In 2015, he had another seizure and fell down 12 stairs and his history was seizures 5 times a week. He then had a motor vehicle accident taking out numerous poles due to another seizure. In 2016, he had another seizure and broke his shoulder. The Claimant thought he had a seizure in the night. Dr. Ahmadi did a total shoulder on the Claimant on September 21, 2016. He continued to have problems with the shoulder. He was then seen on March 29, 2017 with a history of numerous accidents hitting the dash and was having pain and

swelling of the knees. He was found to have a large loss of cartilage. He underwent surgery on his knee with Dr. Schock on May 8, 2018. The Claimant was involved in a motor vehicle accidents (sic) in which he drove his van into a building. His X-ray of the elbow showed the same severe degenerative changes. The X-ray showed no new fractures or failure of the total shoulder. The X-ray of the elbow showed an old injury and nothing new. The history he gave to OrthoArkansas was that the seizure was part of the accident. The Claimant then saw Dr. Hussey on February 20, 2019. He noted that the Claimant reported continued shoulder pain after his shoulder surgery. He opined that the problems in the shoulder was (sic) related to the 2016 injury since he did not have significant improvement from the surgery. The PT noted (sic) indicated that the Claimant had dismal function in the shoulder and could not raise his arm above his shoulder. He also said that there was no failure of the total shoulder so no reason to do another surgery. He also notes extreme pain behavior. On the elbow, he noted that the Claimant had already been told he needed the debridement before the December accident. He also said there was no new objective finding due to the accident. Dr. Schock in May of 2019 felt the Claimant did not need surgery and had a long history of recurrent effusions of both knees. He did undergo a revision of the shoulder and surgery of the elbow. In October of 2019, he was six weeks out from the surgery. The surgery for

the shoulder was performed on August 16 and the elbow surgery on January 23, 2020. He was then seen by Dr. Bowen on April 14, 2020 with a history of gradual onset of knee problems. He underwent right knee surgery and the pathology report said he had a diffuse-type tenosynovial giant cell tumor. He underwent surgery for left knee on October 2, 2020. The Respondents have no further medical treatment."

The respondents contended, "A. The Respondents contend that the accident was caused by the Claimant's failure to disclose his seizure and accident history which resulted in him being allowed to drive the company van that he wrecked due to a seizure. B. The Claimant's shoulder, knee, and elbow problems are not related to the accident but to continued preexisting conditions."

The parties agreed to litigate the following issues:

1. Compensability.
2. Temporary total disability.
3. Permanent partial disability.
4. Medical treatment.
5. Attorney's fees.

A hearing was held on August 16, 2022. At that time, the parties reserved the issue of permanent partial disability. An administrative law judge filed an opinion on September 20, 2022 and found that the claimant failed to prove he sustained a compensable injury. The claimant appeals to the Full Commission.

II. ADJUDICATION

Act 796 of 1993, as codified at Ark. Code Ann. §11-9-102(4)(Repl. 2012) provides, in pertinent part:

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

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4)(D)(Repl. 2012). "Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16)(A)(i)(Repl. 2012).

The employee has the burden of proving by a preponderance of the evidence that he sustained a compensable injury. Ark. Code Ann. §11-9-102(4)(E)(i)(Repl. 2012). Preponderance of the evidence means the evidence having greater weight or convincing force. *Metropolitan Nat'l Bank v. La Sher Oil Co.*, 81 Ark. App. 269, 101 S.W.3d 252 (2003).

An administrative law judge found in the present matter, "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." The Full Commission does not affirm this finding.

An idiopathic injury is one whose cause is personal in nature, or peculiar to the individual. *Crawford v. Single Source Transp.*, 87 Ark. App. 216, 189 S.W.3d 507 (2004), citing *Kuhn v. Majestic Hotel*, 324 Ark. 21, 918 S.W.2d 158 (1996). Injuries sustained due to an unexplained cause are different from injuries where the cause is idiopathic. *ERC Contractor Yard & Sales v. Robertson*, 335 Ark. 63, 977 S.W.2d 212 (1998). Where a claimant suffers an unexplained injury at work, it is generally compensable. *Little Rock Convention & Visitors Bur. v. Pack*, 60 Ark. App. 82, 959 S.W.2d 415 (1997). Because an idiopathic injury is not related to employment, it is generally not compensable unless conditions related to the employment contribute to the risk. *Id*. Employment conditions can contribute to the risk or aggravate the injury by, for example, placing the employee in a position which increases the dangerous effect of a fall, such as on a height, near machinery or sharp corners, or in a moving vehicle. *Id*. *See also Delaplaine Farm Center v. Crafton*, 2011 Ark. App. 202, 382 S.W.2d 689.

In the present matter, the claimant testified that he has suffered from seizures since 2005. The evidence shows that the claimant was involved in a motor vehicle accident in 2005, and that the accident was caused by the claimant having a seizure. As a result of the motor vehicle accident on or

about May 7, 2005, the claimant sustained a traumatic injury to his left upper extremity. The injury required several surgical procedures to the claimant's left upper extremity. The claimant testified that he began receiving Social Security disability benefits in about 2007, which benefits were related to his epileptic condition. Dr. Andersson stated in July 2013 that the claimant suffered from "a debilitating seizure disorder." Dr. Courtney treated the claimant in April 2014 for a "seizure disorder." The claimant was involved in a motor vehicle accident in October 2015, at which time Dr. Lewis noted in part "4. History of seizure." Dr. Perry, Dr. Khan, and Dr. Schock all noted in 2018, prior to the claimant's employment with the respondents, that the claimant was prescribed several anti-convulsant medications and had "a long history" of a seizure disorder.

As we have noted, the claimant testified that he became employed with the respondents in approximately September 2018. The claimant testified that one of his employment duties for the respondents was driving a vehicle in which he picked up meals and returned them to Baptist Hospital. The parties stipulated that the claimant "would provide services for the respondent, and the services included operation of a vehicle." The parties also stipulated that on December 2, 2018 the claimant "was operating a vehicle owned by the respondent, City of Faith, and was involved in a motor vehicle accident, where he sustained a physical injury."

The claimant testified that he was driving the company vehicle to Baptist Hospital on December 2, 2018 in order to drop off trays. The claimant testified, "As I was coming there, a car came around, hit me. I lost control….So I hit really hard there, and after that it was just straight on into the building, which the car caught fire." In workers' compensation cases, the Commission functions as the trier of fact. *Blevins v. Safeway Stores*, 25 Ark. App. 297, 757 S.W.2d 569 (1988). The determination of the credibility and weight to be given a witness's testimony is within the sole province of the Commission. *Murphy v. Forsgren, Inc.*, 99 Ark. App. 223, 258 S.W.3d 794 (2007). The Commission is not required to believe the testimony of the claimant or any other witness but may accept and translate into findings of fact only those portions of the testimony it deems worthy of belief. *Farmers Co-op v. Biles*, 77 Ark. App. 1, 69 S.W.3d 899 (2002).

In the present matter, the Full Commission finds that the claimant was not a credible witness with regard to the circumstances of the December 2, 2018 motor vehicle accident. There is no evidence of record corroborating the claimant's assertion that the vehicle in which he was driving was struck by another vehicle. The evidence instead demonstrates that the claimant suffered from a seizure on December 2, 2018, which condition was idiopathic to the claimant. An RN plainly noted on December 3, 2018 that the claimant reported having "warning symptoms last night,

that may lead to a seizure." An RN also noted on December 3, 2018, "Mrs. Tonya Kelley [patient's] mother called to [request] an urgent appointment and a call back from the nurse. Mrs. Kelley called to schedule patient for a follow up appointment to see Dr. Shihabuddin stating patient was seen in the ER last night *after having a really bad seizure* [emphasis supplied]."

The probative evidence before the Commission does not reflect that the vehicle in which the claimant was driving on December 2, 2018 was struck by another vehicle. Instead, the evidence demonstrates that the claimant suffered from a seizure on December 2, 2018, which idiopathic condition led to the motor vehicle accident. The evidence therefore shows that the claimant suffered from an idiopathic injury on December 2, 2018. Because an idiopathic injury is not related to employment, it is generally not compensable unless conditions related to the employment contribute to the risk. *Little Rock Convention & Visitors Bur., supra*. Employment conditions can contribute to the risk or aggravate the injury by, for example, placing the employee in dangerous position which increases the dangerous effect of the injury, such as "in a moving vehicle." *Id*. *See also Crawford, supra*.

The parties stipulated that the claimant in the present matter "was operating a vehicle owned by the respondent, City of Faith," at the time of the December 2, 2018 motor vehicle accident. The evidence demonstrates that the claimant sustained injuries as the result of an idiopathic condition,

but that the employment circumstances contributed to the injury, that is, the claimant was in a moving vehicle, performing employment services, at the time of the idiopathic event. The claimant's injuries on December 2, 2018 were therefore compensable.

The respondents argue on appeal that the claimant is barred from receiving benefits in accordance with cited provisions of "Larson's Workers' Compensation Law." Indeed, in accordance with "Larson's," an employee may be precluded from benefits under the Workers' Compensation Act for an otherwise compensable injury if it is shown that the employee knowingly and willfully made a false representation as to his physical condition; the employer relied upon the false representation, which reliance was a substantial factor in the employment; and there was a causal connection between the false representation and the injury. *Johnson v. PAM Transport, Inc.*, 2017 Ark. App. 514, 529 S.W.3d 678, citing *Shippers Transport of Georgia v. Stepp*, 265 Ark. 365, 578 S.W.2d 232 (1979).

In the present matter, the evidence does not demonstrate that the claimant knowingly and willfully made a false representation as to his physical condition. The claimant testified that, when he applied for employment with the respondents, he advised them of his pre-existing injuries, and that he informed the respondents that he was receiving Social Security disability benefits. The Full Commission recognizes the credible

testimony of Philip Seales, a security officer with the respondents. Philip Seales testified that he was unaware of the claimant's prior history of seizures. Mr. Seales testified that the claimant would not have been allowed to drive a vehicle for the respondents if they had known of the claimant's pre-existing condition.

However, Philip Seales agreed on cross-examination that he was not the individual who hired the claimant. Philip Seales testified that the claimant was interviewed and hired by a Mr. Pettus. Philip Seales testified, "Mr. Pettus was very thorough." Mr. Pettus was deceased as of the time of the August 16, 2022 hearing and of course did not testify. There is simply no probative evidence demonstrating that the claimant knowingly and willingly made a false representation to the respondents at the time of his hiring. The Full Commission notes that there are no documents in the record such as an employment application or pre-employment physical examination. The claimant testified with regard to Philip Seales, "he let me know I could use the workers' comp" following the accidental injury. We therefore find that the respondents did not prove the claim should be barred in accordance with *Johnson* and *Shippers, supra*. Because the evidence does not demonstrate that the claimant knowingly and willfully made a false representation at the time of his hiring, we need not adjudicate whether the

employer relied upon a "false representation" or whether there was a causal connection between the alleged false representation and the injury.

The Full Commission finds that the claimant proved by a preponderance of the evidence that he sustained a compensable injury. The claimant proved that he sustained an accidental injury causing physical harm to the body. The claimant proved that the injury arose out of and in the course of employment, required medical services, and resulted in disability. The injury was caused by a specific incident and was identifiable by time and place of occurrence on December 2, 2018. The claimant also established a compensable injury by medical evidence supported by objective findings. Namely, the objective findings established a compensable injury to the claimant's upper lip (swelling) and a compensable injury to the claimant's left elbow (swelling). The claimant does not contend that he is entitled to benefits related to the swelling in his upper lip. The evidence otherwise demonstrates that the claimant sustained a compensable "strain of left elbow" as assessed on December 3, 2018. The evidence does not demonstrate that the claimant proved he sustained a compensable injury to any other anatomic region or body part as a result of the specific incident occurring December 2, 2018.

After reviewing the entire record *de novo*, the Full Commission finds that the claimant proved by a preponderance of the evidence that he

sustained a compensable injury on December 2, 2018. The evidence demonstrates that the claimant sustained an idiopathic seizure, but that employment conditions aggravated the injury. The respondents did not prove that the claimant made a false representation as to his physical condition at the time of the claimant's hiring. The claimant proved that the medical treatment of record was reasonably necessary until the time of Dr. Hussey's Independent Medical Exam on February 20, 2019. The claimant did not prove that medical treatment beyond that time was reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a)(Repl. 2012). Nor did the claimant prove that he continued within a healing period for his compensable left elbow strain at any time beyond February 20, 2019. *See Ketcher Roofing Co. v. Johnson*, 50 Ark. App. 63, 901 S.W.2d 25 (1995). For prevailing in part on appeal to the Full Commission, the claimant's attorney is entitled to a fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b)(2)(Repl. 2012).

IT IS SO ORDERED.

SCOTTY DALE DOUTHIT, Chairman

M. SCOTT WILLHITE, Commissioner

MICHAEL R. MAYTON, Commissioner