

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F104417**

<b>NORMAN BATTEN, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>FERRELL GAS LP, EMPLOYER</b>	<b>RESPONDENT</b>
<b>FIDELITY &amp; GUARANTY INS., CO., CARRIER</b>	<b>RESPONDENT</b>

**OPINION FILED MARCH 22, 2004**

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on March 19, 2004 at Jonesboro, Craighead County, Arkansas.

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

Respondents represented by THE HONORABLE MELISSA ROSS, Attorney-at-Law, Little Rock, Arkansas.

**STATEMENT OF THE CASE**

A hearing was conducted in the above-style claim to determine the claimant's entitlement to workers' compensation benefits.

On December 19, 2003, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order was filed. The Pre-hearing Order reflects stipulations entered by the parties, to include the fact that the Arkansas Workers' Compensation Commission has jurisdiction of this claim, the existence of the employment relationship on March 17, 2004, at which time the claimant earned wages sufficient to entitle him to weekly workers' compensation benefits at the rates of \$299.00/\$224.00, for temporary total/permanent partial disability benefits. The Pre-hearing order further reflects the issues to be addressed during the course of the hearing,

and the parties' contentions relative to the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

Both parties have made responsive filings to the pre-hearing questionnaire forwarded by the Commission, and the same is incorporated in the Pre-hearing Order. (Comm. Ex. #1). In expanding on the previously filed pre-hearing questionnaires, claimant asserts entitlement to temporary total disability benefits from July 17, 2001 through October 31, 2002, when he reached maximum medical improvement and was assessed with a 20% permanent physical impairment. Respondents assert that if the claim is found to be compensable they would not be responsible for the payment of workers' compensation benefits to and on behalf of the claimant until April 2, 2001, when notice of the injury alleged was received.

The testimony of Norman Batten, the claimant; Ms. Bonnie Spurlock, the claimant's sister; Ms. Billie Summers, a friend of the claimant; Mr. Eddie Wayne Golf, a co-worker of the claimant; and Mr. Dee Milam, the manager of respondent-employer and the claimant's immediate supervisor, along with medical reports and other documents comprise the record in this claim.

### **DISCUSSION**

Norman D. Batten, the claimant, with a date of birth of April 29, 1956, was employed by predecessor of respondent-employer, and continued in that employment with respondent on December 16, 1999. Claimant discharged duties as a driver/salesman. Claimant last discharged duties as a driver/salesman for respondent-employer on April 2, 2001, and any employment duties in November 2001.

Claimant acknowledged that he had previously received medical treatment relative to his

low back when he experienced an onset of low back pain in 1994 when getting out of the bath tub. Claimant was seen at the emergency room of St. Bernards Regional Medical Center for the 1994 low back complaint. Claimant's testimony reflects that he missed little, if any, time from work as a result of the 1994, back strain, and the following his recovery did not require medical treatment until 2001.

A review of the medical in the record reflects that claimant was seen at the emergency room of St. Bernards Regional Medical Center on August 9, 1994, with complaint of low back pain which had its onset the previous day while he was getting out of the tub. Claimant also complained of pain radiating to left leg during the afore visit. X-rays of the claimant's lumbar spine were obtained and disclosed narrowing at L5-S1 disc space and minimal spur formation. (RX 1, p. 1-2). There is no evidence in the record to reflect that the claimant sought or obtained medical treatment relative to his back between August 10, 1994, and March 17, 2001.

The testimony in the record reflects that claimant discharged his employment duties in the employment of respondent without restrictions or limitations on his physical activities prior to March 17, 2001. The testimony of Dee Milam, the manager of respondent-employer, reflects that he was responsible for hiring the claimant; that he had not known of the claimant to register complaints regarding his back prior to March 17, 2001; and that the claimant had always successfully discharged his assigned job duties. While Mr. Milam is uncertain of the date that claimant first reported having sustained the March 17, 2001, back injury, he is certain that the same was had prior to the April 2, 2001, emergency room visit.

The evidence in the record reflects that periodically the truck driver/salesmen in the employ of respondent were required to be "on call" during the weekend, which was outside

normal hours of operation. The on-call driver had a telephone listing of the other drivers. In the event that a customer ran out of LP gas during the weekend, when respondent-employer was closed, the on-call driver could be reached for gas delivery. The testimony in the record reflects that during the winter months, when a customer called for gas delivery, the same was handled as soon as possible. The on-call driver was furnished a L P gas delivery truck with which to service the customers.

The credible evidence in the record reflects that one of the trucks of respondent-employer was difficult to start. Claimant noted that on occasions two (2) individuals would be needed to start the truck. The testimony of Mr. Eddie Wayne Golf, a driver/salesman of respondent-employer and co-worker of the claimant, corroborative of that of the claimant with respect to the difficulty of starting the truck. Mr. Milam also acknowledged that one of the delivery trucks was difficult to start.

On March 17, 2001, claimant was the on-call driver for respondent-employer. Claimant estimates that the outside temperature twenty (20) degrees, and he decided to start the truck and get the engine warm in the event of a service call. Claimant's testimony reflects that as he exited the vehicle, he experienced a pop and excruciating pain in his low back such that it caused him to go to the ground. A friend of the claimant, Ms. Billie Summers, had worked the 7:00 P.M. to 7:00 A.M. shift at her job the preceding night, and arrangements had been made that she would come by and have coffee with the claimant on March 17, 2001, after work.

Ms. Summers, who had formerly lived with the claimant, testified that after sitting and visiting with the claimant for a period on March 17, 2001, claimant announced that he was going to go start the L P delivery truck to get the engine warm in case he received call for service. Ms.

Summers testified that after waiting long period of time for the claimant to return, she decided to go outside to check on him. As Ms. Summers was going out of the door, she heard the truck start and saw claimant as he was getting out of the truck. Ms. Summer's testimony reflects that as the claimant lowered his foot to the ground, he collapsed and went to his knees on the ground. Ms. Summers also observed from the claimant's facial expression that he was in severe pain. Ms. Summers went to the aid of the claimant, and after sitting with him for approximately ten (10) minutes assisted him into the residence.

While the claimant testified that the date of the occurrence was Sunday, March 17, 2001, a review of the 2001 calendar reflects that March 17, 2001, was a Saturday. The claimant's corroborating witnesses identified the injury sufficiently through time and date of occurrence. Specifically, Ms. Summers noted that she had concluded her work-day shift at 7:00 A.M. and proceeded to claimant's residence for coffee on the morning of the accident. The testimony of Mr. Eddie Wayne Golf, the claimant's co-worker, reflects that the Monday following the occurrence claimant relayed to other drivers sitting around before the beginning of the shift that he had hurt his back while starting the truck during his on-call tour.

The testimony of Ms. Bonnie Jean Spurlock, the claimant's sister, reflects that she sees the claimant 5-7 times per week. Ms. Spurlock testified that claimant, who seldom took medication, got some pain pills from her to address his low back pain between March 18, 2001, and April 1, 2001. Claimant relayed to Ms. Spurlock the injury to his back suffered while getting out of the truck after starting it while on-call as the basis for the need of the medication.

Claimant continued to discharge his regular employment duties as a truck driver/salesman for respondent-employer following his March 17, 2001, injury. The evidence discloses that

claimant relayed to co-workers the March 17, 2001, accident and injury to his back while on-call during that weekend on Monday morning, March 19, 2001. Claimant noted that his back pain and symptoms grew progressively worse as he discharged his regular duties until he could no longer endure them and he sought medical treatment. The credible evidence in the record reflects that prior to obtaining medical treatment, claimant informed his immediate supervisor, Mr. James D. Milam, of the injury and the need for medical treatment.

On April 2, 2001, claimant was seen at the emergency room of St. Bernards Regional Medical Center for his low back complaint. At the time of the emergency room visit, claimant provided a history of the work-related injury:

**HPI: 3 weeks ago was stepping out of large truck at work and stepped heavily onto footing causing immediate nonradiating back pain. . . .**

\* \* \*

**BACK: mild tenderness L2 to L4 reproduces pain.**

\* \* \*

**CT scan showed right sided HNP L5-S1 and left L4-L5 most likely (RX. #1, p. 3).**

The CT scan of April 2, 2001, relative to the claimant reflects:

CONCLUSION: 1. Moderate-sized right paracentral HNP at L5-S1 causing right-sided spinal canal stenosis behind the superior vertebral endplate of S1.

2. Mild left bony neuroforaminal stenosis at L4-L5 secondary to degenerative osteophytosis.

3. Mild degenerative disc bulging, L2 through L4, and degenerative vertebral endplate osteophytic hypertrophy L4 through L5. (CX #1, p.5).

The Patient Record of St. Bernards Medical Center relative to the April 2, 2001, emergency room visit of the claimant reflects that claimant registered complains of back pain for two (2) weeks after he stepped off a gas truck. Claimant was provided a light duty release by the attending emergency physician and a neurosurgical consultation arranged. (CX. #1, p.2).

Claimant provided the limited/light duty releases, authored by medical providers to supervisory personnel of respondent-employer. Corresponding limited/light duty work was made available to the claimant by respondent-employer through November 2001. In November 2001, claimant was informed by his supervisor, Mr. James D. Milam, that light duty work would no longer be available from him. Mr. Milam explained that the claimant presence in November 2001, was becoming disruptive from the standpoint of other employees who were performing regular job duties. It is undisputed that at the time respondent-employer ceased providing light/limited duty work for the claimant, claimant remained under care of medical provider relative to complaints growing out of the March 17, 2001, accident and on limited/light duty.

On April 25, 2001, claimant was seen by Dr. Jeffrey A. Kornblum, a Jonesboro neurosurgeon, pursuant to the referral of Dr. Karen Roe, the April 2, 2001, St. Bernards Medical Center attending emergency room physician. The April 25, 2001, consultation report of Dr. Kornblum, reflects a history of the claimant's injury consistent with the claimant's hearing testimony. The April 25, 2001, report of Dr. Kornblum further reflects:

**Back:** Gait is a little guarded, though otherwise normal. He is able to heel and toe walk. Range of motion of the lumbar spine reveals mild limitation. His spine appears to be near linear. He is not tender to palpation. He points to the mid lumbar region as the area of discomfort. FABER maneuver resulted in some increased back pain in the right, negative on the left.

\* \* \*

**Neurological:** Deep tendon reflexes are brisk in the upper and lower extremities, graded 2/4. Long tract signs were absent. Motor exam was 5/5 throughout the lower extremities, noted to include exam of psoas, anterior quad, hamstring, anterior tibialis, extensor hallucis longus, gastrosoleus and peroneal musculature. Sensory exam was intact to pin, vibration and position sense. Heel-to-knee testing was normal.

\* \* \*

**DIAGNOSTIC IMAGING:** CT exam available for review from March of this year, shows evidence of some degenerative facet changes at multiple levels, some disc bulging at L5 that is predominantly towards the right, and a broad-based disc protrusion to the left at L4. (RX. #1, p. 8)

In addition to medication, claimant's treatment under the care of Dr. Kornblum, relative to the March 17, 2001, included a physical therapy program. Claimant continued working for respondent-employer performing light/limited duty.

When next seen by Dr. Kornblum on May 17, 2001, due to his continued complaints, claimant was advised to consider a cord block for further symptomatic improvement. Dr. Kornblum also recommended an MR for further evaluation of claimant's spinal canal. On July 24, 2001, claimant underwent the afore studies at St. Bernards Medical Center which disclosed:

CONCLUSION: 1. There is degenerative disc disease as described as well as facet arthropathy at multiple levels. The most significant level appears to be L4-L5 with spinal canal stenosis and left lateral recess stenosis due to disc bulging and facet hypertrophy. This, dose not appear to significantly compromise the nerve root. (CX. #1, p.10).

After obtaining the results of the diagnostic studies claimant was referred by Dr. Kornblum to Dr. Calin A. Savu, a pain management specialist at the Center For Pain Management. Claimant was initially evaluated by Dr. Savu on August 2, 2001. The August 2,

2001, report of Dr. Savu reflects the results of the claimant's physical examination:

**MUSCULOSKELETAL:** Antalgic gait with good heel and toe walking. The lumbar region reveals a flattened lordosis with significant paraspinal spasm. Posterior extension is severely restricted to less than one-third of normal range and it reproduces the spontaneous pain. The SI joints are tender. Gaenslen and Patrick signs are negative and so is straight leg raising bilaterally. Exquisite tenderness is elicited on palpation of the lumbosacral facets.

Dr. Savu's August 2, 2001, report also reflects his diagnosis of the claimant's complaint and a treatment plan:

**B. DIAGNOSIS:**

1. Spinal stenosis with bilateral radiculopathy.
2. Lumbosacral spondylosis with facet arthropathy.
3. The differential diagnosis also includes discogenic pain syndrome.

**C. THERAPEUTIC PLAN:**

1. Medical therapy: Medical therapy will be continued as is.
2. Interventional therapy: interventional therapy will be guided according to the results of the patient's different provocative and diagnostic test that will include epidural steroid injections, medial branch blocks as well as, if these fail, provocative disc injections. The patient will also need to stop smoking and be referred for behavioral therapy in view of Dr. Dixon in view of his high levels of anxiety and somatization. (CX. #1, p. 12-13).

The claimant underwent treatment with Dr. Savu, to include multiple blocks, however did not achieve long-term relief of his low back pain. On October 31, 2001, Dr. Savu performed a discogram at L3, L4 and L5, which suggested concordant pain at L5-S1. Claimant was ultimately referred back to Dr. Kornblum by Dr. Savu. After noting the medical treatment received by the claimant since his May 2001, visit, the November 20, 2001, report of Dr. Kornblum reflects, in pertinent part:

. . . MR had been performed in July, showing multilevel degenerative changes throughout the lumbar spine with facet and disc changes. He notably has no lower extremity complaints of radicular pain, paresthesia or numbness. He has not had sphincter disturbance. He does note for the last week that he had been having right knee pain which is focally, minimally so on the left side. He indicates that he was told he had his problems emanating from L5 and would need surgery performed.

\* \* \*

**IMPRESSION:** Mr. Batten has a persistent problem with low-grade back pain, without neurological deficit and without neurogenic pain.

I have discussed with him that he has multilevel degenerative changes, though no overwhelming abnormality. I am hesitant to consider surgery in this setting, as I feel his ability to achieve a surgical success is low and no better than 50/50. I reviewed with him that the discogram is a controversial study and considering his multilevel degenerative disease, I would not accept it as a statement that L5 is his sole pain generator. I have advised he consider continuing along conservative management with exercise, good body mechanics, and use of non-steroidals. We reviewed that if he felt his pain was reaching higher levels such as 7-10 on a 0-10 scale, I would consider the L5 discectomy and fusion. If opting for surgery, cessation of smoking and an understanding of potential benefit versus risks in this setting. If the need arises, he is welcome to be referred for reevaluation. (CX. #1, p.14-15).

Following his November 20, 2001, visit with Dr. Kornblum, claimant was referred by Dr. Samuel Burchfield, his family physician, to Dr. W. Craig Clark, a Southaven, Mississippi neurosurgeon.(CX. #1, p. 18). Claimant was seen by Dr. Clark on December 19, 2001. Dr. Clark's report relative to the visit reflects the history of the claimant's injury, medical treatment received relative to same, the results of his physical evaluation, assessment of the claimant's complaint, and treatment recommendations. The report further reflects:

Review of the MRI scan reveals a disc bulge with some lateral

recess stenosis present at L4-5 left greater than the right.

Clinically there is no evidence of myelopathy or radiculopathy present. Clinically his symptoms seem to be more consistent with a left sacroiliitis superimposed on a chronic lumbar strain. As a result we have today performed a trigger point injection and continue him on oral medication. We will plan on rechecking his status in about 2 to 3 weeks with further recommendations based on his status at the follow up visit. (CX. #1, p. 17)

On January 25, 2002, pursuant to the directions of Dr. Clark, claimant underwent a lumbar myelogram and post myelogram CT of his lumbar spine. (CX. #1, p.19-20). Following the afore studies claimant was seen by Dr. Clark on January 30, 2002:

. . . The myelogram basically shows the disc rupture present at L3-4 on the right and a disc rupture present at L4-5 on the left. The large amount of compression would appear to be 3-4 on the right. Most of his complaints are on the left side at this point. He notes that he is taking medication mostly everyday and using pain pills on a daily basis. As a result I have explained to him that it is important to know how he is going to do without narcotic pain medicine since he has to make a decision regarding how he would like to proceed. As a result I have encouraged him to discontinue his pain medications. We will see him back in about 2 weeks. During that time period, the patient has to decide how he desires to proceed i.e. with continued conservative care or proceed with surgical decompression for the disc rupture as identified.

He was previously doing very heavy work and it is highly unlikely that he is going to be able to function in the 100 pound weight limit range that he was previously functioning in with his previous job either with or without the surgery as noted. . . (CX. #1, p. 21).

The medical in the record reflects that approximately six (6) weeks prior to March 28, 2002, claimant was admitted for surgery at Methodist Hospital, however due to uncontrolled hypertension the procedure was postponed. Claimant was readmitted on March 28, 2002, under the care of Dr. Clark for elective decompression of the neural elements for symptomatic relief.

(CX. #1, p.22-25). On March 29, 2002, claimant was discharged from Methodist Healthcare after having undergone a hemilaminectomy with microdiscectomy at L4-L5 on the left and a partial hemilaminectomy with microdiscectomy at L3-L4 on the right for the diagnosed herniated nucleus pulposus at L3-L4 on the right and herniated nucleus pulposus with lateral recess stenosis at L4-L5 on the left. (CX. #1, p.26-27).

Claimant was seen in followup by Dr. Clark on May 2, 2002, at which time the medical records reflect a “good recovery all in all so far”. The May 2, 2002, report of Dr. Clark reflects plans to refer the claimant for a Function Capacity Evaluation in an effort to set restrictions toward returning the claimant to regular duty. (CX. #1, p.28). The FCE was had at HealthSouth on June 13, 2002. (RX. #1, p. 13-17).

Claimant disputed the result of the examiner with respect to capability to perform heavy duty work. When again seen by Dr. Clark on July 10, 2002, following the FCE, claimant relayed that he was unable to complete the exam because he was in too much pain. The July 10, 2002, office note visit, further reflects:

. . . . He says that this morning he felt like he was being “stabbed with a knife in the low back.” He localizes his pain to the SI joints bilaterally and as a result we have performed bilateral SI joint trigger point injections today utilizing Marcaine and Depo Medrol. . . . We will proceed with a MRI of the lumbar spine with and without contrast in order to rule out any residual or recurrent neural compression. (CX. 1, p. 29).

Claimant underwent the above-mentioned MRI on July 14, 2002. (CX. #1, p. 30-31). The studies did not reflect a recurrent herniation. When next seen by Dr. Clark on August 19, 2002, claimant noted that he was still having “significant” pain in the left lower extremity. Claimant also reported to Dr. Clark during the August 19, 2002, visit that two (2) weeks earlier

“something happen”, resulting in much worse and unremitting pain. (RX. #1, p. 20). As a consequence of the afore, claimant underwent another MRI on August 21, 2002, which disclosed a HNP at L4-5 on the left. (RX. #1, p. 21-22).

Claimant was seen by Dr. Clark on September 5, 2002, following the August 21, 2002, MRI scan. The office note relative to the visit reflects:

This gentlemen returns for follow up today. The MRI scan performed in the interim shows a disc rupture now present at L4-5 on the left. Repeat examination also shows a partial foot drop on the left. He continues to have significant and severe pain in the left lower extremity. As a result of the neural compression present and his persistent left lower extremity complaints, we have today offered his a posterior microdisectomy directed towards decompression of the neural elements. He is aware of potential risks and complications of this planned procedure including but not limited to incomplete pain relief, increased numbness or weakness, bleeding, blood loss and infection and desires to proceed. As a result of the partial foot drop present, I have recommended proceeding as soon as possible. He wants to try to have surgery and as a result we will proceed with the necessary approvals and scheduling and notify him once this is complete. (CX. #1, p32.).

On September 20, 2002, claimant was admitted to Methodist Healthcare Hospital under the care of Dr. Clark, and underwent a partial hemilaminectomy with microdisectomy and removal of extensive epidural fibrosis at L4-L5 on the right for the diagnosed herniated nucleus pulposus at L4-L5 on the right. (CX. #1, p. 33-37). The September 21, 2002, Discharge Summary relative to the claimant reflects, in pertinent part:

#### SIGNIFICANT FINDINGS

This gentlemen underwent removal of a ruptured disk at L3-L4 on the right and decompression of the lateral recess stenosis at L4-L5 on the right in early March. He had good relief of the right-sided symptoms but continued to complain of left-sided pain. He then experienced dramatic worsening of his pain

and numbness of the foot manifested with partial foot drop. Magnetic resonance image scanning was repeated, and this showed a disk rupture with extensive scar present at L4-L5 on the right. Having failed maximum medical therapy, he was admitted for elective decompression of the neural elements for symptomatic relief. (CX. #1, p. 38).

Claimant asserts entitlement to temporary total disability benefits through October 31, 2002, the date he reached maximum medical improvement relative to his March 17, 2001, accident. The record reflects a office note of Dr. Clark relative to claimant's visit of October 31, 2002:

At this point in time he would be about at his point of maximal medical improvement. As a result based on the disc rupture at L3-4 treated surgically with the lateral recess stenosis at L4-5 left treated and subsequently the disc rupture at L4-5 left treated surgically, he would be entitled to a permanent partial impairment rating of 20% to the body as a whole. This is calculated as 10% for the disc rupture at L3-4 with 2% for additional level at 4-5. He then had a separate incident with disc rupture at L4-5 on the left treated surgically. With combination of these values per the Combined Rating Scale he would be entitled to a permanent partial impairment rating of 20% as noted above. (CX. #1,p.40).

Claimant did not return to the employment of respondent-employer following the October 31, 2002, visit to Dr. Clark. Claimant noted that he is not physically capable of returning to pre-injury job duties with respondent-employer. In November 2001, respondent-employer informed the claimant that light/limited duty work was no longer available for him.

Claimant did receive indemnity disability benefits through a group policy through his employment, \$1,167.14, per month from June 2002 through December 2003. Claimant also received short term disability benefit from January 17, 2002 through May 7, 2002. (RX. #2, 2-4)

After a thorough consideration of all the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documents, and application of appropriate statutory provisions and case law, I make the following:

### **FINDINGS**

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 17, 2001, the relationship of employee-employer-carrier existed among the parties.
3. On March 17, 2001, the claimant earned wages sufficient to entitle his to weekly compensation benefits of \$299.00/\$224.00 for temporary total/permanent partial disability benefits.
4. The claimant has sustained his burden of proof by a preponderance of the evidence that he was engaged in employment service on March 17, 2001, when he sustained an injury to his back arising out of and in the course of his employment. Further, the claimant has sustained his burden of proof by a preponderance of the evidence that the March 17, 2001, compensable injury was reported to appropriate supervisory personnel of respondent-employer prior to the time he received medical treatment for same on April 2, 2001.
5. The claimant was temporarily totally disabled as a result of his March 17, 2001, compensable injury, from the period in November 2001, when respondent-employer ceased to provide work within the limitations of his medical restriction imposed relative to the compensable injury, until October 31, 2002, when he reached maximum medical improvement.
6. Claimant reached the end of his healing period relative to his compensable

of March 17, 2001, injury on October 31, 2002, and has sustained a permanent physical impairment as a result of same in the amount of 20% to the body as a whole.

7. The respondents shall pay all reasonable and necessary hospital and medical expenses arising out of the claimant's March 17, 2001, compensable injury. Further, the respondents shall reimburse any other carrier or party for sums expended to and on behalf of the claimant for medical treatment relative to the March 17, 2001, compensable injury.

8. The respondents have controverted this claim in its entirety.

### **CONCLUSIONS**

Claimant asserts that while starting the engine of his assigned on-call LP gas truck on March 17, 2001, he suffered an injury to his back as he exited the vehicle. As a consequence of the accident, claimant maintains that he is entitled to temporary total disability benefits, medical benefits, permanent partial disability benefits and controverted attorney fees. Respondents deny that the claimant suffered an injury in the course and scope of his employment. The present claimant is one governed by the provisions of Act 796 of 1993, in that claimant asserts entitlement to workers' compensation benefits as a result of having sustained a compensable injury subsequent to the effective date of the afore provision.

Claimant asserts that he suffered a specific injury identifiable by time and place of occurrence, March 17, 2001. It is not disputed that claimant was the on-call LP gas delivery truck driver for respondent-employer on March 17, 2001. On-call drivers were required to deliver LP gas to customers of respondent-employer on the weekend when the office of respondent-employer was closed. During periods of cold weather, deliveries to customers were to be had as soon as possible, after receiving notice (telephone call).

On the morning of March 17, 2001, the outside temperature was in the 20's. The on-call truck assigned to the claimant was difficult to start. While starting the truck to warm the engine in the event of a call for gas delivery from a customer claimant injured his back as he was exiting the vehicle. Respondents' assertion that employment services were not being performed at the time of the accident is not persuasive.

To prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, claimant must establish by a preponderance of the evidence an injury arising out of and in the course of employment, that the injury caused internal or external harm to the body which required medical services or resulted in disability, medical evidence supported by objective findings, as defined in Ark. Code Ann. § 11-9-102 (16), establishing the injury, and that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. § 11-9-102 (4) (A) (i) (Repl. 2002).

Ark. Code Ann. § 11-9-102 (4) (A) (Supp. 2001) defines "compensable injury" as "an accidental injury causing internal or external physical harm to the body . . . arising out of and in the course of employment." Ark. Code Ann. § 11-9-102 (4) (B) (iii) notes that the term "compensable injury" does not include an injury that was inflicted upon the employee at a time when employment services were not being performed. The Arkansas Supreme Court has held that the same test used to determine whether an employee was "within" the course of employment" should be used to determine whether the employee was performing employment services. *Collins v. Excel Specialty Prods.*, 347 Ark. 811, 69 S. W. 3d 14 (2002). The test is whether the injury occurred within the time and space boundaries of employment, when the employee was carrying out the employer's purpose or advancing the employer's interest, directly or indirectly. *Id. See also*

*Pifer v. Single Source Transp.*, 347 Ark. 851, 69 S. W. 3d 1 (2002); *Ray v. Wayne Smith Trucking*, 68 Ark. App. 115 (1999) The claimant has sustained his burden of proof by a preponderance of the evidence that he was performing employment services at the time of the March 17, 2001, accident

While the claimant testified that the accidental injury to his back occurred on March 17, 2001, which he identified as a Sunday, the undisputed facts reflect that at the time of the accidental injury to his back, claimant was the on-call L P gas delivery truck driver for respondent-employer. The on-call driver was utilized by respondent-employer on the weekends or holidays when the office of respondent-employer was closed. Though he did not report the injury to his immediate supervisor until prior to April 2, 2001, initial visit for medical treatment for his injury, claimant did tell his co-workers of his accidental injury the Monday morning following the occurrence. March 17, 2001, occurred on a Saturday.

The Arkansas Supreme Court noted in *Edens v. Superior Marble & Glass*, 346 Ark. 487, 58 S. W. 3d 369 (2001), that it is not a prerequisite to compensability that the claimant identify the precise date upon which an accidental injury occurred. Rather, the claimant must only prove that the occurrence of the injury is capable of being identified. In the instant claim, the claimant has sustained his burden of proof by a preponderance of the evidence that he sustained an injury to his back on March 17, 2001, while exiting his assigned on-call L P gas delivery truck.

Claimant experienced difficulty with his lower back while getting out of a bathtub in 1994. After receiving emergency medical treatment relative to the afore, claimant resumed his regular employment duties. There is no evidence in the record to reflect that claimant sought or obtained medical treatment relative to his low back between the time of the August 9, 1994, emergency room visit and March 17, 2001. Claimant discharged his regular employment duties without

restrictions or limitations through March 17, 2001. Following the March 17, 2001, accidental low back injury claimant continued to discharge his regular job duties until his symptoms progressed to the point that he had to seek medical treatment, April 2, 2001.

The evidence reflects that prior to the April 2, 2001, emergency room visit to St. Bernards Medical Center, claimant reported the March 17, 2001, accidental injury to appropriate supervisory personnel of respondent-employer. Workers' compensation benefits to the claimant did not inure to the claimant until the April 2, 2001, emergency room visit. Thereafter, claimant was placed on restricted/light duty by his treating/examining physicians, and the same was provide by respondent-employer until November 2001.

A review of the medical in the record relative to the instant claim reflects that after the initial April 2, 2001, emergency room visit, claimant was seen by his family physician, Dr. Samuel S. Burchfield, on April 18, 2001, for complaints growing out of the March 17, 2001, accident. Claimant was later seen by Dr. Jeffrey Kornblum, an Jonesboro neurosurgeon, and Dr. Calin Savu, a pain management specialist. The medical is replete with objective findings evidencing injury. Dr. Savu noted muscle spasms in the affected area. Claimant underwent a battery studies to include CT scans, MRI scans, discogram, and mylegrams.

Claimant was provided limited/restricted duty by respondent-employer pursuant to the medical restrictions on his employment activities through November 2001. Claimant remained within his healing period with restrictions on his employment activities by his treating physicians at the time he was informed by his supervisor that limited/restricted duty would no longer be furnished by same.

Temporary total disability is that period within the healing period in which a claimant

suffers a total incapacity to earn wages. *Arkansas State Hwy. and Transp. Dep't v. Breshears*, 272 Ark. 244, 613 S. W. 2d 392 (1981). The healing period is that period for healing of an injury which continues until the claimant is as far restored as the permanent character of the injury will permit. A claimant is entitled to temporary total disability during his healing period if he shows by a preponderance of the evidence that he had a total incapacity to earn wages. *Carroll Gen. Hosp. v. Green*, 54 Ark. App. 102, 923 S. W. 2d 878 (1996); *Superior Industries v. Thomaston*, 72 Ark. App. 7, 32 S. W. 3d 52 (2000).

Respondents did not pay temporary total disability benefits to the claimant or furnish work within his medical restrictions by his treating physicians relative to the March 17, 2001, compensable injury subsequent to November 2001. Claimant did not reach the end of his healing period relative to his compensable injury until October 31, 2002. Ark. Code Ann. § 11-9-102 (12) defines the healing period “as that period for the healing of an injury resulting from an accident.” The healing period is that period for healing of an injury which continues until the employee is as far restored as the permanent character of the injury will permit. If the underlying condition causing the disability has become more stable and if nothing further in the way of treatment will improve that condition, the healing period has ended. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S. W. 2d 457 (1994).

The evidence in the record discloses that claimant did receive indemnity benefits through an insurance disability policy furnished through his employment. The afore benefits were not initiated until January 17, 2002, and continued until December 29, 2003. The weekly rate of the afore indemnity benefits was slightly less than claimant’s temporary total disability rate. Claimant is entitled to the payment of temporary total disability benefits from November 2001, when he last

discharged limited duty in the employment of respondent-employer, until October 31, 2002.

Respondents have controverted the claimant's entitlement to temporary total disability benefits.

Respondents shall pay to the claimant the difference between his temporary total disability compensation rate and the rate of the indemnity disability received from the health care carrier, for the period January 17, 2002 through October 31, 2002. Respondents shall also reimburse the disability carrier for sums paid to the claimant during the period January 17, 2002, through October 31, 2002.

As of October 31, 2002, claimant reached the end of his healing period and was no longer entitled to the payment of temporary total disability benefits. Claimant received two (2) additional months of disability benefits from the health care carrier subsequent to the end of his healing period. Respondents are directed to reimburse the health care carrier for indemnity benefits paid to the claimant subsequent to October 31, 2002.

On December 19, 2001, claimant came under the care and treatment of Dr. W. Craig Clark, a Southaven, Mississippi neurosurgeon, relative to his March 17, 2001, compensable injury pursuant to a referral of Dr. Samuel Burchfield, his family physician. Under Dr. Clark's care, claimant underwent additional diagnostic studies, and ultimately surgery on two (2) different occasions. The medical records of Dr. Clark, relative to the claimant have been previously referenced and thoroughly reviewed. As with his medical treatment under the care of his treating physician prior to Dr. Clark, claimant's medical treatment under the care of Dr. Clark was reasonable, necessary and related to the March 17, 2001, compensable injury.

It is undisputed, based on the objective medical in the record, that the claimant had pre-existing degenerative disc disease in his lumbar spine prior to his March 17, 2001, compensable

injury. There is no evidence in the record to reflect that claimant received active or ongoing medical treatment relative the degenerative disc disease in close proximity to his March 17, 2002, compensable injury. A pre-existing disease or infirmity does not disqualify a claim if the employment aggravated, accelerated, or combined with the disease or infirmity to produce the disability for which compensation is sought. *St. Vincent Medical Center v. Brown*, 53 Ark. App. 30, 917 S. W. 2d 550 (1996). In workers' compensation law, the employer takes the employee as he finds him, and employment circumstances that aggravate pre-existing conditions are compensable. *Nashville Livestock Commission v. Cox*, 302 Ark. 69, 787 S. W. 2d 64 (1990).

While the claimant has pre-existing degenerative disc disease in his lumbar spine, the evidence preponderates that he suffered a specific injury to his back on March 17, 2001, which resulted in two (2) different surgical procedures on separate occasions to address different herniated discs. Ark. Code Ann. § 11-9-508 (a) requires employers to provide such medical services as may be reasonably necessary in connection with the employee's injury. *Cox v. Klipsch & Associates*, 71 Ark. App. 433, 30 S. W. 3d 764 (2000). Whether a medical procedure or device is reasonable and necessary treatment is a question of fact.

The October 31, 2002, final report of Dr. Clark, setting forth the claimant's anatomical rating is base upon objective measurable finding, and comports with the requirement of the Arkansas Workers' Compensation Act. The evidence preponderates that the claimant has sustained a permanent physical impairment in the amount of 20% to the body as a whole as a result of his compensable March 17, 2001, injury and surgical treatment of same. Respondents have controverted this claim in its entirety.

## AWARD

Respondents are hereby ordered and directed to pay to the claimant temporary total disability benefits at the weekly compensation rate of \$299.00, for the period commencing November 2001, when limited duty work was no longer furnished , until October 31, 2002. Said sums accrued shall be paid in lump without discount. Respondents may claim credit for sums heretofore paid the claimant during the afore period.

Respondents are further ordered and directed to pay to the claimant permanent partial disability benefits at the weekly compensation benefits rate of \$224.00, to correspond to the claimant's permanent physical impairment of 20 % to the body as a whole, as a result of his compensable injury of March 17, 2001. Said sums accrued shall be paid in lump with discount. Respondents may claim credit for sums heretofore paid toward the afore obligation.

Respondents are further ordered and directed to pay to and on behalf of the claimant all reasonable related medical, hospital, nursing and other apparatus expenses, to include medical related travel, growing out of the March 17, 2001, compensable injury.

Respondents are herein ordered and directed to reimburse any other insurance carrier for sums expended to and on behalf of the claimant relative to the March 17, 2001, compensable injury.

Maximum attorney fees are herein awarded to the claimant's attorney, the Honorable Kristofer E. Richardson, on this award, pursuant to Ark. Code Ann. § 11-9-715.

This award shall bear interest at the maximum legal rate pursuant to Ark. Code Ann. § 11-9-809, until paid.

Matters not addressed herein are expressly reserved.

**IT IS SO ORDERED.**

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**Andrew L. Blood,  
Administrative Law Judge**

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