

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F210149

PAMELA LOCKHART	CLAIMANT
ST. EDWARD MERCY MEDICAL CENTER	RESPONDENT
SISTERS OF MERCY HEATH SYSTEM INSURANCE CARRIER	RESPONDENT

OPINION FILED APRIL 2, 2004

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Fort Smith, Sebastian County, Arkansas.

Claimant represented by BRENT STERLING, Attorney, Fayetteville, Arkansas.

Respondents represented by RANDY MURPHY, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on January 29, 2004, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on September 30, 2003. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

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

2. On August 21, 2002, the relationship of employee-employer-carrier existed between the parties.

3. The claimant is entitled to a compensation rate based on an average weekly wage of \$346.00 entitling her to a temporary total

disability rate of \$230.00 and a permanent partial disability rate of \$173.00.

By agreement of the parties the issues to litigate are limited to the following:

1. Compensability of the claimant's spinal problems.
2. Related medical.
3. The claimant's entitlement to temporary total disability from August 21, 2002, to December 18, 2002.
4. Is the claimant entitled to a permanent impairment rating of 9 to 10 percent to the body as a whole as assessed by Dr. Hayes.
5. Attorney's fees.
6. Credit to the respondents for benefits paid.

In regard to the foregoing issues the claimant contends that she sustained a compensable injury and/or aggravation of a preexisting condition to her lumbar spine as a result of pushing an oversized patient food service cart while performing her employment for the respondent. The claimant underwent surgery on October 21, 2002, by Dr. Mark Hayes. Dr. Hayes subsequently released the claimant on December 18, 2002, with permanent restrictions of no lifting or carrying over 40 pounds, no pushing or pulling over 40 pounds, no repetitive activities and no excessive bending or twisting. Dr. Hayes indicated in his March 5, 2003, narrative report that the findings on the mylogram and CT scan are consistent with Ms. Lockhart's description of her injury and duties at St. Edward's Hospital; that within a reasonable degree of medical certainty Ms. Lockhart did sustain an injury as a result of her

work related activity; and that ms. Lockhart's work activities are the major cause (more than 50%) of the need for medical care and treatment. The claimant contends that she sustained a compensable injury and/or aggravation of her preexisting lumbar spinal condition as a result of her work for the respondent and that she is entitled to all pertinent workers' compensation benefits.

In regard to the foregoing issues the respondents contend that the claimant did not sustain an injury within the course and scope of her employment. Respondents will also assert a credit or offset for disability benefits paid to claimant through her policy with St. Edward.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted medical exhibits marked Claimant's Exhibit No. 1 and 2, additional documents respectively marked Claimant's Exhibit No. 3, 4, 5, 6, 7, 8 and 9. The respondents submitted the deposition of Dr. Mark Hays marked Respondents' Exhibit No. 1 and the personnel records of the claimant marked Respondents' Exhibit No. 2. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that she was fifty years old and was twelve hours away from a two-year degree from Carl Albert State College. The claimant testified that she did have a certificate in dietary management from Kiamichi Area Technology Center. The claimant testified that she went to work for the respondent as a

certified dietary manager and her responsibilities involved watching the tray line, quality control, making sure the diets match the claimant's diet and follow doctors' orders, getting the tray line ready so that food could be served and other various duties and assignments. The claimant testified that part of her job involved taking trays of food up to the patient floors on carts and delivering the trays to the patients. The claimant testified that she did not do this job all of the time but when the need arose she would perform these tasks. The claimant testified that about three months before August 24, 2002, she began having to deliver the carts more frequently. The claimant testified that in August 2002 she began to develop problems in her low back as well as muscle spasms and some numbness in her leg. The claimant testified that the activities she was involved in at that time was loading and unloading the food carts as well as pulling them to the various floors. The claimant testified that when these symptoms arose she began to self medicate using Ben Gay, B C Powder, Motrin, Aleve and other over the counter medications. The claimant agreed that these medications help relieve her symptoms and she continued to work. The claimant testified that she did miss one day of work explaining that when she got out of bed one morning she could not bear weight on her left leg so she called in and took off work for that day. The claimant testified that these symptoms went away and she reported to work on her next scheduled work day. The claimant testified that this event was approximately a week to a week and a half before August 21, 2002.

The claimant testified that on August 21, 2002, she was pulling or pushing a food cart when she felt excruciating pain that when down her left leg, her left leg would not bear her weight and there was pain across her lower back. The claimant remembered that it was approximately 9:45 a.m. in the morning having started her shift at 5:30 a.m. The claimant testified that earlier she was loading and unloading the carts as well as pulling the carts to the patient's floor. The claimant testified that these carts weigh approximately 350 to 500 pounds when loaded with the trays. The claimant testified that the carts were difficult to pull or push, some worse than others. The claimant testified that she would have to push or pull a cart approximately 100 feet down the hall. The claimant testified that she reported her problem to Martin Hoyt, her supervisor, and asked him for medical treatment since she was having difficulty walking at that time. The claimant testified that she said, "Martin, I have hurt my back. I need to go to the doctor." He said, "Ok." The claimant testified that no doctor's appointment was set up and she kept working stating that it was really difficult to get through the rest of her shift. The claimant remembers that her symptoms got worse as her shift continued and in the afternoon she asked her supervisor if he had called a doctor yet and he told her no. The claimant testified that Mr. Hoyt stated that he thought that she wanted to see her family doctor and she told him no that she meant the company doctor. The claimant testified that at the end of her shift she hobbled out to her car and drove herself home. The claimant

testified that she did not go to the ER for fear that they would give her some type of shot to relieve her pain and she would not be able to get home.

The claimant testified that when she reached her home she laid on the couch and took B C Powder as well as put a heating pad and Ben Gay on her back. The claimant testified that this was the treatment that she had been giving her back but this time it did not ease up her symptoms. The claimant testified that her husband went on to work since they both thought that her pain would eventually subside but when her pain continued to get worse she had to call her husband at work to come and take her to the Indian Hospital. The claimant explained that she knew that there would be no waiting at the Talihina Hospital and she was comfortable with the doctors there. The claimant testified that she described her job activities to the personnel in ER and that range of motions tests were given. The claimant testified that an MRI was ordered but could not be done there. The claimant testified that she was given an off work slip until she was seen by her family physician and a neurologist as well as had her MRI. The claimant testified that she was given medications for her pain as well as muscle relaxers. The claimant testified that when they left the ER she went straight home to bed and that her husband contacted her supervisor. The claimant testified that her husband telephoned Mr. Hoyt and got his voice mail but the next day her husband took her off work slip to Mr. Hoyt and she rode in the car with him. The claimant testified that her husband asked to fill out an accident

report but when he returned to the car he did not have an accident report for her to sign.

The claimant testified that she underwent an MRI on August 24, 2002, at the respondent's hospital. The claimant testified that when she went to have her MRI she reported to the respondent's personnel that it was a work related claim. The claimant remembered that this test was run on a Saturday and on the following Monday, August 26, she returned to the hospital to speak with her supervisor. The claimant testified that her husband went with her because she was still having difficulty walking and she was still having the same symptoms. The claimant testified that at this time she did fill out an injury report noting that her accident happened on August 21, 2002. The claimant testified that she again told her supervisor, Mr. Hoyt, that she hurt herself moving the carts explaining that she felt something in her back give way, felt pain and her leg went numb.

The claimant testified that on August 28, 2002, she was contacted by Steve May who took her recorded statement. This statement is marked Claimant's Exhibit No. 4 in the documentary evidence. The claimant testified that she reported to Mr. May that she had been having intermittent problems with her back for two to three weeks prior to August 21 but on August 21, 2002, her symptoms got noticeably worse. The claimant remembers that she told Mr. May that she reported this incident to her supervisor, Martin Hoyt. The claimant testified that she told Mr. May that she had been working with the carts more frequently for the past few weeks and

that her pain started while pulling a cart. The claimant testified that she received, through the mail, another workers' compensation form which she filled out indicating that she had hurt her back while pushing oversized patient food carts on August 21, 2002.

The claimant testified that even after filling out an accident report and giving a recorded statement and filling out additional workers' compensation forms she was not sent to the doctor by the respondent. The claimant testified that she did return to the Indian Clinic and was seen by Dr. Ferguson on August 29, 2002. The claimant testified that Dr. Ferguson, after examination, gave her a note setting forth that she was unable to work and needed to be evaluated and treated by a neurosurgeon. The claimant testified that she took this note to Dr. Capocelli, a neurosurgeon at the respondent's hospital, and was not able to get an appointment with him before six months.

The claimant testified that even with being off work her symptoms have not improved and in fact have progressively gotten worse. The claimant testified that on September 10, 2002, she received a letter from workers' compensation setting forth that they were denying her claim for benefits. The claimant testified that after receiving this letter she scheduled an appointment with a neurosurgeon on her own. The claimant testified that she was seen by Dr. Mark Hayes, a spine specialist in Tulsa, Oklahoma, on September 17, 2002. Again the claimant testified that she told Dr. Hayes that she was pushing and pulling food carts delivering food to patients when she felt excruciating pain in her back and down

her left leg on August 21, 2002, while working for the respondent. The claimant remembers that Dr. Hayes ordered diagnostic testing, released her from work and subsequently scheduled surgery for her. The claimant testified that she underwent surgery on October 21, 2002, for her L4-5 disc. The claimant testified that Dr. Hayes released her on December 18, 2002, to return to work with permanent restrictions of no lifting over forty pounds, no bending, twisting, stooping and no repetitive motion. The claimant testified that during the period of time she has been off work she stayed in contact with the respondent as to the progress of her condition. The claimant testified that after Dr. Hayes released her with restrictions, she returned to the respondent and offered to work within her limitations. The claimant testified that the respondent did not offer her any employment. The claimant testified that during the period of time she was off she had to take off on FMLA as well as personal leave and reported regularly to Kathie Phelps and Martin Hoyt.

The claimant testified that after she was released by Dr. Hayes she underwent a non-work related surgery in March 2003. The claimant remembers that she was released from this surgery on May 23, 2003, with restrictions of no lifting or pulling over fifty pounds. The claimant testified that she provided all of this information to the respondent as well and after all of this she sat down with the respondent to discuss returning to work but was not offered any employment.

The claimant testified that in 1976 she had a back injury when she was picked up into the center of a tornado and was hit by a board between her shoulder blades which resulted in a compression fracture at T11. The claimant testified that she recovered from this injury and this injury did not affect her ability to go back to work. The claimant agreed that she was treated by a chiropractor, Dr. Stone, between May 10, 1999, through December 6, 2000, but not for her low back.

The claimant testified that initially she had good relief from her symptoms following her low back surgery but at some point she began to develop recurrent low back pain. The claimant testified that she began to be seen by Dr. Hayes' partner, Dr. Allen Fielding, who is a neurologist. The claimant testified that she was still dragging her foot and could not stand for extended periods of time without her leg going out and dragging her toes. The claimant explained that Dr. Hayes, during this period of time, was away from his office due to illness. The claimant agreed that she is now being seen by Dr. Hayes and on December 4, 2003, he had her undergo a diskogram. The claimant testified that currently she is experiencing problems and her symptoms are limiting her activities. The claimant testified that she has applied for and has begun receiving long term disability benefits through the respondent's benefit package. The claimant stated that these benefits began on November 20, 2002, in the amount of \$1,058.00 per month. The claimant explained that as a part of the requirements of receiving long term disability, she had to apply for social

security disability or they would suspend her benefits. The claimant testified that she would like to be retrained in order to reenter the work force perhaps in the computer field or data entry.

On cross examination, the claimant agreed that she was still on long term disability stating that she was aware that if she returned to work her long term disability benefits would terminate and there would be no need for her to have to apply for social security. The claimant testified that currently she is waiting for a hearing on her social security claim. The claimant agreed that she has had several health issues which have been addressed and are continuing to require treatment. The claimant agreed that she has undergone surgery for an incontinence problem and she also is under active treatment for breast cancer. The claimant testified that she felt like she had good results as far as alleviation from pain as a result of her first back surgery but she did suffer some permanent nerve damage. The claimant agreed that it is her understanding from Dr. Hayes that her pain now is at the L5-S1 level which is different from where he did the original surgery. The claimant agreed that besides the permanent restrictions imposed by Dr. Hayes, the doctor who did her incontinence surgery also gave her a fifty-pound lifting restriction. The claimant agreed before August 21, 2002, she has had other instances while working for the respondent for which she went to the emergency room. The claimant agreed that all of her work related injuries which sent her to the ER while she was working for the respondent prior to August 21,

2002, were handled through workers' compensation. The claimant testified again that she reported to her supervisor that she hurt her back while she was upstairs pushing and pulling the breakfast carts and she has given this same information to her different medical providers. The claimant testified that for two to three weeks prior to August 21, 2002, she was having some muscle spasms in her back but was not having chronic back pain. The claimant agreed that on August 21, 2002, she had her husband take her to the Indian Hospital in Talihina which is approximately the same distance from her home as is the respondent's hospital in Fort Smith. The claimant agreed that her condition has deteriorated since she saw Dr. Hayes on November 19, 2002.

On redirect examination, the claimant testified that prior to August 21, 2002, she treated her back problems with Ben Gay and a heating pad with success. The claimant testified that after August 21, 2002, when she tried this type of treatment for her back, her symptoms did not go away.

The claimant's husband Michael Lockhart testified on her behalf. Mr. Lockhart testified that he can recall in August 2002 that his wife began experiencing minor aches and pains in her low back. Mr. Lockhart testified that on August 21, 2002, when his wife got home from work it was obvious that she was in quite a bit of pain and he asked if he needed to take her to the emergency room at which time she said no. Mr. Lockhart testified that the claimant told him that she was going to try to use her heating pad and some anti-inflammatories to try and see if that would ease her

discomfort. This witness testified that his wife told him that she had been pushing and pulling food carts twice that day and had hurt her back. Mr. Lockhart testified that he left for his job at 4:30 p.m. and that round 7:00 or 7:30 his wife called him and asked him to come get her to take her to the emergency room. Mr. Lockhart testified that after they got back from the Talihina Indian Hospital he contacted the respondent and got Mr. Martin Hoyt's voice mail at which time he left a message that the claimant would not be in the next day and he would bring in a doctor's note releasing her from work. Mr. Lockhart testified that the next day he and his wife went to the respondent's hospital to turn in her note and fill out an accident report. This witness testified that the lady who took the doctor's note told him that she did not know where the accident report forms were and even if she did she did not know how to fill them out that we would have to come back and talk with Mr. Hoyt. Mr. Lockhart testified that the following Monday he and the claimant went back to the respondent's hospital and went to the food service area, saw Martin Hoyt and filled out the accident reports. Mr. Lockhart testified that the accident reports were filled out in Mr. Hoyt's office in his presence.

On cross examination, Mr. Lockhart testified that he was present with his wife in the emergency room when the claimant completed the paperwork and gave information to the ER nurse. Mr. Lockhart remembered that his wife reported that she had hurt herself at work while pulling and pushing a cart. This witness testified that he did not remember the claimant reporting that she

had chronic back pain but he does remember that she reported that she had muscle spasms for the last few weeks.

Martin Hoyt testified that he had been working for the respondent for the past thirty years and is currently the section manager in nutritional services. Mr. Hoyt testified that he was the claimant's supervisor. Mr. Hoyt testified that on August 21, 2002, that around 9:30 a.m. the claimant asked him if she could take off early that day to go to the doctor and he told her that she could. Mr. Hoyt testified that the claimant did not mention to him at that time why she needed to go to the doctor and she did not report to him that she had injured herself at work. Mr. Hoyt testified that around 2:00, the end of the claimant's shift, she came up to him and asked him if he had the papers and he did not know what papers she was talking about. Mr. Hoyt testified that the claimant said, "Well, I am going to the doctor. I need to go to the doctor." Mr. Hoyt testified that the claimant told him that it was about her back and he did not know anything about it and he asked her, "Well when did you hurt your back?" And she couldn't tell me when she hurt it. Mr. Hoyt testified that the claimant said that she hurt it in the process of her work through the carts but she did not tell me when. Mr. Hoyt testified that he told the claimant that, "Well, I can't just let you go see the doctor. I need to call Debbie," This witness remembers that he went into the office to call Debbie and that she told him to go ahead and fill out the papers and when he came back to his office the claimant had gone. Mr. Hoyt testified that he did not know until the claimant

asked him about needing papers that she was talking about a work related problem. Mr. Hoyt was shown the employee injury report and he identified his signature on this document but testified that it was not his handwriting that filled out the document. This witness testified that he does not recall sitting down with the claimant while she filled out these papers.

On cross examination, Mr. Hoyt testified that in the afternoon the claimant did tell him that she had hurt her back through the carts. Mr. Hoyt testified that he does not remember the claimant and her husband coming in and signing an employee injury report on Monday, August 26, stating that he cannot say whether he did or he did not he just does not remember it. Mr. Hoyt testified that on the day the claimant went to the doctor there was a message on his work answering machine that she had gone to see the doctor. Mr. Hoyt testified that a part of the claimant's job was for her to pull and push the carts on a daily basis. Mr. Hoyt testified that he would estimate that these carts would weigh around 800 pounds noting that they have big wheels and roll pretty easy although they are harder to roll on the carpet stating that, "They are big carts." Mr. Hoyt was asked if during the course of her employment with the respondent did any of her actions cause him to find her to be dishonest and Mr. Hoyt responded, "I never thought, you know, that---I always believe someone is honest until proven different." Mr. Hoyt then stated that he had never said anything about the claimant not being honest.

The medical records set forth that the claimant was seen at the emergency room of the Talihina Indian Hospital on August 21, 2002, with complaints of low back pain with radiation down her left leg. The ER notes indicate that she has been having problems for three weeks but they are getting worse and she does a lot of lifting, bending and pushing at work. The claimant was prescribed medications and referred to have an MRI. The claimant underwent an MRI on August 24, 2002, which revealed some old compression fractures at T11 and L2. This test also showed mild retropulsion of the L2 and L3, defused moderate disc bulge at L2-3 and an annular tear. This report sets forth that the claimant had mild spurring at the posterior superior corner at L2 indenting the subarachnoid space central to the left as well as defused moderate disc bulge at other levels. The claimant was seen by Dr. Mark Hayes on September 17, 2002, upon referral from Dr. Ferguson at the Indian Hospital in Talihina. The doctor's notes report that the claimant reports that she was injured on August 21, 2002, when she was pulling a dietary cart and she began having back and leg pain at that time. After a physical examination as well as a review of the claimant's MRI, Dr. Hayes diagnosed the claimant with having lumbar radiculopathy but recommended having a myelogram and a CT since her MRI was unclear. The claimant underwent a lumbar myelogram on September 26, 2002, which revealed a compression fracture involving the L1 vertebra and there is retrodisthesis of the L1 on L2 as well as severe disc space narrowing at the L4-L5 level with mild mass effect upon the anterior aspect of the thecal

sac. A CT scan of the claimant's lumbar spine done on September 26, 2002, also showed that there is a compression fracture involving the L1 vertebra with retolisthesis of L1 on L2 as well as degenerative changes involving the disc space at L4-5 with mild circumferential disc bulging at L4-L5, slightly greater on the left. Dr. Hayes writes on September 26, 2002, that the claimant's mylogram and CT scan show what appears to be a subtle disc protrusion at L4-5 on the left which is consistent with her clinical symptoms. Dr. Hayes recommended epidural steroid injections but it is noted that the claimant wanted to speak with her other physicians who were prescribing medications for her cancer treatment before she underwent the injection therapy. After visiting with her other treating physician the claimant returned to Dr. Hayes on October 10, 2002, stating that she was ready to proceed with the recommended surgery which he had also discussed with her earlier. The claimant underwent surgery on October 21, 2002, having a decompressive lumbar laminectomy on the left at L4 with foraminotomy and diskectomy. The claimant was discharged from the Southcrest Hospital on October 22 noting that post operatively she had done well, home care was discussed and she was told to call if any problem arose. Dr. Hayes writes on December 17, 2002, that the claimant is doing well although she is having a little bit of twinging in her leg. Dr. Hayes released her but assessed her with permanent restrictions of no lifting over forty pounds, no repetitive activities and no excessive bending or twisting as well as no pushing or pulling over forty pounds. Dr. Hayes writes on

March 5, 2003, concerning his treatment of the claimant. Dr. Hayes notes that the claimant's disc herniation and the severe stenosis the claimant had was consistent with her clinical symptoms and, in his opinion, within a reasonable degree of certainty that the findings on the mylogram and CT scan were consistent with the claimant's description of her injury and duties while working for the respondent. Dr. Hayes writes that it is also his opinion within a reasonable degree of medical certainty that the claimant did sustain an injury as a result of her work related activities. Dr. Hayes writes that within a reasonable degree of medical certainty the claimant's work activities are the major cause of her need for medical care and treatment. The claimant was seen by Dr. Allen Fielding, a partner with Dr. Hayes, on September 23, 2003, where it is noted that she reports never returning to her post operative level of activity noting that her severe pain is gone but she still is plagued with low back pain with activity and it is difficult for her to sit for any period of time. After examination and review of the claimant's test results, Dr. Fielding recommended a second mylogram and CT scan to compare with her original test. These recommended test were carried out on October 8, 2003, where it is noted that the claimant has a small post operative laminectomy at L4-L5 on the left with decreasing amount of soft tissue compression on the left at L4-5. It is also noted that there is disc osteophyte spurring and foraminal narrowing bilaterally. This test also sets forth that the claimant has a stable compression deformity at the L1 vertebra body with some

retrolisthesis unchanged from the prior study as well as pronouncedly transitional lumbar sacral segment with rudimentary L5 disc. Dr. Allen Fielding writes on October 9 that he has seen the claimant with her mylogram and CT scans showing the expected post operative change at L4-5 on the left noting that there is no evidence of nerve root compression, disc herniation or spinal stenosis. Dr. Fielding reported to the claimant that her mild residual complaints will take time to resolve although they might not totally resolve. Dr. Mark Hayes writes on December 4, 2003, that the claimant's symptoms have not resolved and he thinks her symptoms are consistent with a weak disc and recommended that she undergo a diskogram. Dr. Charles Eckman writes on January 12, 2004, that the claimant's diskogram reveals that her L5/S1 is primarily her back pain generator and the L4/5 disc does not appear to be symptomatic.

The 239 pages of medical exhibits submitted by the claimant as set forth in their Exhibit No. 2 set forth a long history of the claimant having a variety of physical problems very little to none of it mentioning problems with her back but primarily addressing her problems with cancer and other more minor health problems.

In Dr. Mark Hayes deposition when being questioned about the diagnosis of the claimant prior to her back surgery, Dr. Hayes stated that stenosis denotes narrowing around the nerve. Dr. Hayes further explained that stenosis does not signify a cause it just means narrowing around the nerve. Dr. Hayes testified that the claimant had a disc protrusion which he did not feel was clinically

chronic but was relatively acute. Dr. Hayes was asked if he knew when this occurred and he responded, "When she got hurt at work." Further explaining that he gathered this information from the history she gave him. Dr. Hayes stated that taking in account the claimant's history as well as his surgical findings, he would say that she had some preexisting issues on top of an acute herniated disc that caused nerve root compression resulting in her symptoms. Dr. Hayes was asked if he believed that the claimant was incapable of working from the date he initially saw her on September 17, 2002, until he released her on December 18, 2002, and Dr. Hayes responded, "Yes." Dr. Hayes testified that he believes the claimant is currently having some discomfort coming from her L5-S1 disc noting that the L4-5 operated disc is asymptomatic. Dr. Hayes testified that he was not going to attribute a cause to her problems at the L5-S1 level but he would just note that she has got some symptoms at that level. Dr. Hayes summed up his evaluation of the claimant stating that he thinks the claimant's problem with low back pain to a large extent was coming from the L5-S1 disc in retrospect, which had been chronic and long term. The doctor stated that there was probably some degree of back pain coming from the L4-5 but he believes that she did have a disc herniation that caused leg symptoms which became intolerable which he operated on at the L4-5 level. Dr. Hayes stated that based on the A.M.A. Guides, Forth Edition, he would assess the claimant with a 9 to 10 percent impairment rating explaining that he did not take into

consideration pain or range of motion when assessing this impairment.

On cross examination, Dr. Hayes was asked that assuming that the claimant had an intermittent history of low back going down into her left leg and it had gotten significant worse on August 21, 2002, would that in any way change his opinion that he stated in his March 5, 2003, narrative report, Dr. Hayes responded, "It tends to confirm that." Dr. Hayes agreed that in his medical opinion the claimant did have a herniated disc present and he observed it at the time of his surgery. Dr. Hayes indicated in his testimony that he thinks a lot of her back symptoms were really coming from the L5-S1 level. Dr. Hayes stated that the L4-5 level which he operated on was primarily causing her leg symptoms and in his opinion this was related to her work activities and her injury on August 21, 2002. Dr. Hayes again stated that in his opinion the claimant was temporarily totally disabled from the time he saw her on September 17, 2002, until he released her on December 17, 2002, with her permanent restrictions.

After a review of this entire record, I find that the claimant has proven by a preponderance of the evidence that she sustained a compensable low back injury while working for the respondent. The claimant has testified that due to her work of having to push and pull heavy carts of food trays throughout the month of August 2002, she began to experience some aches and pains in her low back for which she self medicated with Ben Gay, over the counter pain relievers and a heating pad. The claimant has testified that this

conservative home treatment caused her discomfort to resolve and she was able to return to her work for the respondent. The claimant has testified that on August 21, 2002, while pulling and pushing these carts of food trays she felt extreme pain in her low back which ran down into her left leg. The claimant testified that she reported this problem to her supervisor. Mr. Hoyt has testified that the claimant reported to him that she needed to be seen by a doctor and that when he talked with her in the afternoon she reported having back pain but since she could not tell him the exact time and location when she felt this pain, he did not consider it to be work related. The claimant, in her medical reports, has consistently noted that her pain was as a result of her pushing and pulling while at work and there are objective medical findings to establish that she had a herniated disc. Dr. Hayes, in his narrative report as well as in his deposition, has clearly set forth that in his opinion her back injury was her need for medical treatment and that in his opinion, based on the history which the claimant gave, her work activities caused her injury. The claimant has also proven by a preponderance of the evidence that she is entitled to temporary total disability beginning August 22, 2002, until she was released by Dr. Hayes on December 18, 2002. Dr. Hayes, in his deposition, clearly set forth that the claimant was totally disabled from the time he began to see her up until he released her on December 18, 2002. Dr. Ferguson, on August 29, 2002, released the claimant from work until she was evaluated and treated by a neurosurgeon. The claimant and her husband both have

testified that when she was seen at the Talihina Indian Hospital she was given a release from work which they took to the respondent and this testimony has not been refuted by the claimant's supervisor, Mr. Martin Hoyt. Dr. Mark Hayes, in his deposition, assessed the claimant with a 9 to 10 percent impairment to her back as a result of her work related injury setting forth that his evaluation was in line with the A.M.A. Guides, Forth Edition, and he did not take into consideration pain or range of motion with his assessment. The claimant, therefore, is entitled to a 10 percent whole body impairment rating for her compensable injury for which the respondents should pay her permanent partial disability benefits.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On August 21, 2002, the relationship of employee-employer-carrier existed between the parties.
3. The claimant is entitled to a compensation rate based on an average weekly wage of \$346.00 entitling her to a temporary total disability rate of \$230.00 and a permanent partial disability rate of \$173.00.
4. The claimant has proven by a preponderance of the evidence that she sustained a work related injury while working for the respondent on August 21, 2002. See discussion above.

5. The respondents should pay for all reasonable and necessary medical treatment for this claimant's compensable injury from August 21, 2002, to a date to be determined.

6. The claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability beginning August 22, 2002, to December 18, 2002. See discussion above.

7. The claimant is entitled to an impairment rating in the amount of 10 percent for her work related back injury which the respondents should pay. See discussion above.

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

9. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back while working for the respondent on August 21, 2002.

The respondents should pay for the cost of this claimant's medical treatment for her compensable back injury.

The respondents should pay temporary total disability to the claimant beginning August 22, 2002, to December 18, 2002.

The respondents should pay permanent partial impairment to this claimant in the amount of 10 percent to the body as a whole.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the

respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE