

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F303964

CHRISTINA BOST, EMPLOYEE

CLAIMANT

ST. BERNARD MED. CTR., SELF-INSURED EMPLOYER

RESPONDENT

RISK MANAGEMENT RESOURCES, TPA

RESPONDENT

OPINION FILED JANUARY 3, 2005

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on October 1, 2004, at Jonesboro, Craighead County, Arkansas.

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

Respondent represented by the HONORABLE BETTY J. DEMORY, 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 additional workers' compensation benefits.

On July 27, 2004, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order of the same date was file. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' respective contentions relative to the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Christina Holt Bost, the claimant, coupled with medical reports and

other documents comprise the record in this claim.

DISCUSSION

Christina Holt Bost, the claimant, with a date of birth of March 5, 1965, received her GED in 1987, and later attended Delta Tech for her LPN. Claimant is a long-term employee of respondent having suffered a prior work-related injury in March 1997. Claimant last discharged employment duties for respondent on or about April 13, 2003.

In March 1997, claimant suffered an injury to her upper back within the course and scope of her employment. On August 22, 1997, claimant underwent surgery for diagnosed herniated nucleus pulposus at T6-7 right, and T8-9 right, under the care of Dr. Gregory F. Ricca, a Jonesboro neurosurgeon. During the course of her recovery from the procedure claimant developed Reflex Sympathetic Dystrophy (RSD). Claimant returned to light duty in the employment of respondent in November 1997, and continued same until November 1998, when she was released to full duties.

Claimant acknowledged that she suffered flare-ups off and on for a period, however maintains that she eventually reached the point that she no longer suffered from same. Claimant also acknowledged that prior to April 2003, she had been diagnosed with fibromyalgia and that she has arthritis in her hands. Claimant's primary care physician is Dr. Corey Diamond, an internist. Claimant initially received treatment under the care of Dr. Randy D. Roberts for her fibromyalgia, however is currently treated by Dr. Beata Majewski for same.

The compensability of the claimant's April 2, 2003, thoracic spine injury is not disputed. In describing the mechanics of the accident, claimant's testimony reflects:

I was working on a different floor from my boss to cover

a few short hours. I had a patient who was a very large man, mentally - - some kind of mental retardation or slowness who was wanting everyone to move him. He was pretty much unwilling to try to help himself and we were, I and my co-workers, the techs, were trying to encourage him to move on his own. I stood beside his bed at dinnertime when his tray came and he was facing the wall with his back to me. I always sort of walk up to the bed and put my knees on it for support in order to help me not use my back. I asked Mr. Jones, who is now deceased, to, if he would turn over I would assist him in sitting on the side of the bed to eat his meal. And he turned over, and I had held my hand out and he turned over pretty quickly, grabbed me by my hands and pulled on me and I was hyper-extended and twisted across his bed. . . . and when I stood back up I though, I've pulled a muscle. That was at 5:30 in the evening and I was getting off at seven.

Instantly, the only thing that I was most aware of was the tightness that I, you know, I had believed that I had pulled a muscle. I didn't realize until somewhere between 6:45 and 7:00 p.m. when I was giving report to the nurse coming on that I probably really injured myself. (T. 9-10).

The injury was reported by the claimant to appropriate supervisory personnel of respondent. On April 3, 2003, claimant was seen by respondent's designated medical provider, Dr. Michael D. Lack, relative to her April 2, 2003, injury. Claimant's medical treatment under the care of Dr. Lack included a physical examination, medication, and direction to use heat. Claimant was also directed to remain off work until a MRI was performed. (RX.#2, p. 165). On April 5, 2003, claimant underwent the MRI scan of her thoracic spine. (RX #2, p. 167-175).

Claimant was seen in follow-up by Dr. Lack on April 7, 2003. Claimant relayed to Dr. Lack during the afore visit that she was still having spasms in her thoracic back all the way across, and that the right side was worse than the left. In addition to noting that the MRI was abnormal, the April 7, 2003, report reflects that claimant was provided medication by Dr. Lack, released to return to work with restrictions of no heavy manual labor, no stooping, crawling, or

bending, and no lifting/pushing or pulling greater than 5lbs. Claimant was also referred by Dr. Lack to Dr. Ricca, the neurosurgeon who performed claimant's 1997 surgery.

The testimony of the claimant reflects that she was assigned secretarial work on a different floor than her usual nursing floor. Claimant maintains that she was unable to perform the job due to residuals of her injury, though she tried as long as she could:

I tried from - - I don't remember the first date that they released me but April 13th was the last day that I tried to do that.

The secretary work on the floor that I was working on at that time is, you have four lines on the phone, you answer the phone, you answer call lights, you page nurses to patient's rooms, you put charts together. You have to bend over, twist, stoop, stand up, sit down. It's very, very fast paced. (T. 32).

Claimant returned to Dr. Lack on April 15, 2003, and relayed that she was not physically able to work. The April 15, 2003, report of Dr. Lack reflects that claimant was in physical therapy at the time of the visit. In addition to directing the claimant to continue with medications and physical therapy, the April 15, 2003, report of Dr. Lack reflects that claimant was released to return to work with the same restrictions as the prior visit, and that an appointment was scheduled for the claimant to be seen by Dr. Ricca on April 28, 2003. (RX.#2, p.180-181).

On April 17, 2003, claimant was seen in the emergency room of St. Barnard's Regional Medical Center. The emergency room report reflects a history of the claimant bending over dishwasher and feeling something pop in her lower thoracic back marked increase in pain. The report noted that claimant already had back pain prior to the incident.(RX #2, p. 182-185).

Claimant was not engaged in any prohibited, careless, or contraindicated activity at the time of the April 17, 2003, incident. Further, claimant underwent another MRI scan on April 18, 2003,

which did not disclose a change in the claimant's thoracic disc herniations from prior April 5, 2003, MRI scan. (RX. #2, p. 186-188). The medical in the record reflects that claimant was again seen at the emergency room of St .Bernard's Regional Medical Center on April 19, 2003, due to an exacerbation of her thoracic back pain. (RX. #2, p.189-192)

Subsequent to the visit claimant was furnished an off-work slip directing her to remain off work until seen by Dr. Ricca on April 28, 2003.(RX. #2, p. 193). The April 21, 2003, off-work slip was authorized pursuant to the direction of claimant's primary care physician, Dr. C. L. Diamond. Claimant's testimony reflects that she treated with Dr. Diamond for the compensable injury in an effort to get relief from her pain, which had not been achieved under the care of Dr. Lack.

On April 28, 2003, claimant was evaluated by Dr. Gregory F. Ricca, a Jonesboro neurosurgeon, relative to her April 2, 2003, compensable injury pursuant to the referral of Dr. Lack. The April 28, 2003, report of Dr. Ricca reflects that he recommended that claimant continue physical therapy, undergo a CT of her lumbar spine, and be evaluated by Dr. Savu for thoracic blocks. (RX. #2, p. 194-196). Dr. Ricca also directed that claimant remain off work pending the afore treatment measures. (RX. #2, p. 197).

On May 5, 2003, claimant was again seen at the emergency room of St. Barnard's Regional Medical Center due to an exacerbation of her thoracic back pain bought on by physical therapy.(RX. #2, p. 198-202). Claimant did undergo the lumbar spine CT as recommended by Dr. Ricca on May 13, 2003, which disclosed unremarkable results. (RX. #2, p. 203).

On May 9, 2003, claimant was admitted to St. Barnard's Regional Medical Center under the direction of Dr. Ricca, and underwent a thoracic myelogram and post myelogram

computerized tomography. The Discharge Summary of Dr. Ricca relative to the claimant's admission reflects, in pertinent part:

I talked with the patient again about her pain following her myelogram and she describes severe pain involving the right scapula region as well as diffusely in the right thoracic area from approximately T4 to T10 posteriorly. She states that she has lost weight because she can't eat and has to take a lot of pain medications for the pain.

The myelogram and post myelogram computerized tomography were of excellent quality and showed a small herniated nucleus pulposus at T6-T7 right with mild effacement of the spinal cord on the right. This sometimes can cause symptoms but I would not expect it to cause the symptoms that she reports to me.

* * *

I reviewed the options with Ms. Bost and I recommended against surgical intervention. I recommended that she proceed with thoracic injection by Dr. Savu. (RX. #2, p. 204).

On May 19, 2003, claimant was evaluated by Dr. Sunil Gera, a pain medicine specialist, pursuant to a request by Dr. Ricca. Following his evaluation of the claimant, Dr. Gera scheduled her for thoracic epidural steroid injection, which was had on May 22, 2003. (RX. #2, p. 221-223). Claimant was next seen by Dr. Gera on June 2, 2003. The June 2, 2003, report of Dr. Gera reflects that claimant received two to three relief of her pain before it gradually started to come back. Claimant's medication was shifted from narcotics to Bextra and Robaxin. While the June 2, 2003, report of Dr. Gera reflected plans to repeat the thoracic epidural in 10 days, he also released claimant to light duty:

I am going to send her to light duty, which includes not lifting more than 20 pounds and not pulling or pushing more than 20 pounds. The rest of the things she can do. It was explained to her that with this pain, I cannot keep

her off work. Gradually, gradually she has to go to work. (RX. #2, p. 224).

On June 12, 2003, claimant underwent the second epidural injection under the care of Dr. Gera. (RX. #2, p.231).

The testimony of the claimant reflects that at the time of the June 2003, light duty release she continued to experience disabling symptoms such that she was not physically capable of performing the previous light duty position. Claimant acknowledge that she spoke with appropriate supervisory personnel of respondent and elected to take leave of absence in June 2003. On June 2, 2003, claimant was again seen at the emergency room of St. Bernard's Regional Medical Center with complaints of severe cramping/spasming pain in the thoracic area. (RX. #2, p.227-230).

On June 26, 2003, claimant was evaluated by Dr. Reza Shahim, a Little Rock neurosurgeon, at the request of respondent relative to her April 2, 2003, compensable injury. The June 26, 2003, report of Dr. Shahim reflects, in pertinent part:

Ms. Bost has musculoskeletal shoulder and back pain. I do not believe she has thoracic myelopathy or radiculopathy. My review of her myelogram shows no clear evidence of nerve root or cord compression. There is disc disease at multiple levels in the thoracic spine, but myelography clearly does not show any significant stenosis or nerve root compression. I do not Believe Ms. Bost is a surgical candidate. I think she is best managed conservatively. She has already been treated with physical therapy and epidural steroid injections. She may choose to undergo further therapy or further epidural steroid injections. I doubt that repeat epidural steroid injections would be of much benefit to her. She has tenderness that is palpable along her shoulder blade and I think that explains the majority of her symptoms which is muscular in nature and this is best treated conservatively. I have recommended to her to be off work for the next month to recover from this injury. She should see her family physician prior to returning to work. I would

expect her to be able to return to work after one month. (RX. #2, p. 233).

Dr. Shahim issued a work release form directing the claimant to remain off work for one month following the June 26, 2003, visit. (RX #2, p.234).

On July 10, 2003, claimant was seen by Dr. Corey L. Diamond, her family doctor. Following his examination of her, and after noting a history of the April 2, 2003, compensable injury and medical treatment received relative to same, Dr. Diamond continued the claimant's medication, referred her to physical therapy, and directed a return visit in one month. (RX. #2, p. 235-237). On August 8, 2003, Dr. Diamond authored a off-work release relative to the claimant's April 2, 2003, compensable injury directing her to remain off work for thirty (30) days beginning July 24, 2003. (RX. #2, p.238). In correspondence date August 15, 2003, Dr. Diamond notified respondents that a second opinion was being scheduled for the claimant with a Memphis neurosurgeon, relative to the April 2, 2003, compensable injury. (RX. #2, p. 239).

Claimant was examined by Dr. Rodney G. Olinger, a Memphis neurosurgeon, on September 4, 2003, pursuant to request of Dr. Diamond. After reciting the history of the claimant's injury and medical treatment received relative to same, Dr. Olinger noted that claimant was present to see if there was anything further to do from a surgical standpoint. The September 4, 2003, report of Dr. Olinger reflects, in pertinent part:

NEUROLOGICAL EXAMINATION: She has a well-healed thoracic scar just off the midline to the right. She has some tenderness over the musculature. I do not detect any definite motor, sensory or reflex deficits in the lower extremities. She has 1+ reflexes, she had downgoing toes bilaterally. She does have a slight bit of numbness in the foot, but no radicular pain.

RADIOGRAPHIC STUDIES: I reviewed her MRI, myelogram and post-myelogram CT scan. She does appear to have a small disk

osteophyte protrusion at T6-7. At T8-9 there is a more central small disk protrusion.

IMPRESSION: I also reviewed the note from Dr. Rikka at the time of the myelogram he recommended against any kind of surgical intervention. I told Ms. Bost that I certainly would not recommend operating again on this area through the scar. I am not sure that would be of any benefit to her and certainly would carry a high risk. In thoracic approach through thoracotomy would probably produce more pain than what she already has. The indications for thoracic disc surgery in a situation like that would be myelopathy and not just radicular pain. From my standpoint of view I do not think surgery is indicated with conventional approaches. I do not know if she might benefit from evaluation for a minimally invasive approach, but that is certainly a possibility, although I am not sure that the indications for that would be different. That would be an option in her situation for her to be evaluated for a minimally invasive thoracic approach to see if she is a candidate, and if not, her only other option would be continued pain management. (RX. #2, p.241-242).

Respondents, as of August 19, 2003, discontinued claimant's temporary total disability benefits, and medical benefits, relative to the April 2, 2003, compensable injury.

On September 8, 2003, claimant was evaluated by Dr. A. Roy Tyrer, Jr., a Memphis neurosurgeon, at the request of respondent. The September 11, 2003, report of Dr. Tyrer, relative to his evaluation of the claimant, reflects that he had access to claimant's prior pertinent medical, to include the September 4, 2003, report of Dr. Olinger. The September 11, 2003, report further reflects:

IMPRESSION: Post operative status mid dorsal discectomy, right, remote, aggravated by current thoracic musculoskeletal strain, accentuated by functional factors.

Where as, this lady apparently has been taking pain medication pretty regularly since her April 2003 injury, I can't definitely establish the extent to which she may be pain medication dependent. I urged her to avoid the use of prescription narcotics and try and get by with over the counter medicines. I told the

patient I saw no indication suggesting need for further thoracic spine surgery, nor do I think further surgery per se, would improve her present symptoms, in fact I would be concerned that it might have an adverse effect. I encouraged the patient to increase her physical activities, but avoid excessive physical effort including heavy lifting. I also told her I saw no reason why she should not be able to get back to her former physical state and return to regular light duty nursing, but I feel she should always be protected of her back. At this time it has been only a little more than five months since her injury. I do not think she has yet reached maximum medical improvement, and I would give her at least another three months. I encouraged her to use local moist heat to the back when discomfort was present. A limited amount of additional physical therapy might be helpful, such as once weekly. I think she might also benefit by water aerobics on a regular basis at least twice weekly. I do not think she has had an Isotope bone scan since her present injury, and I think it would be desirable to have, but it was not ordered.

Also I would suggest obtaining a current sedimentation rate.
(RX. #2, p.251-252).

On September 12, 2003, Dr. Diamond authored a correspondence noting that claimant had been seen by a neurosurgeon and that surgical intervention did not appear to be an option. The correspondence further noted that treatment of the claimant's compensable injury consisted of physical therapy. The correspondence directed that claimant remain off work for an additional thirty (30) days. (RX. #2, p.253). Claimant continued to receive active medical treatment under the care of Dr. Diamond. (RX. #2, p. 254-257). In a September 30, 2003, correspondence relative to the claimant, Dr. Diamond noted his review of the reports of Drs. Tyrer, Gera, and Shahim. The correspondence concluded:

. . . . I am in agreement that there should be some improvement in Ms. Bost's back pain, but she continues to experience fairly severe pain, associated with the depression exacerbated by her pain; I am in hopes that with more time she will see some improvement in her back pain; I discussed with Ms. Bost on our last visit that I would not be able to keep requesting work leaves for her, as so far

she has shown little improvement in her pain syndrome and she will need to consider other options if her pain does not improve. (RX. #2, p.258).

Claimant noted that she had been seen by Dr. Olinger on two (2) separate occasions, and that she was referred by him to one of his associates. The record reflects that claimant was seen for the second time by Dr. Olinger on November 5, 2003. As a result of the examination and history relayed by the claimant during the visit, Dr. Olinger arranged for her to be evaluated by one of complex spine surgeons. (RX. #2, p.267).

Pursuant to the above, on November 12, 2003, claimant was evaluated by Dr. Kenan Arnautovic. The November 12, 2003, report of Dr. Arnautovic reflects, in pertinent part:

I have reviewed the studies from April. I do see a T6-7 and T8-9 right-sided small herniated thoracic disc. I don't see any significant indentation of the thecal sac on thoracic myelography.

I don't believe that surgery would be indicated in this particular situation. I don't believe that her pain symptoms would improve and I don't see any significant weakness in her lower extremities. I recommended she consider another neurosurgical opinion if that is what the patient would opt for. I will also talk to Dr. Olinger personally regarding my evaluation and opinion. (RX.#2, p. 269).

Claimant was seen by Dr. Diamond on December 3, 2003. The December 3, 2003, office note reflects that the Memphis physicians suggested that claimant seen Dr. F. Richard Jordan, a North Little Rock neurosurgeon, for further treatment relative the residuals of her compensable injury. (RX. #2, p. 275).

On January 27, 2004, claimant was evaluated by Dr. Terence P. Braden, III, D.O, at the request of respondent for the purpose of an impairment rating. The January 27, 2004, report of Dr. Braden reflects that he had access to the claimant's prior pertinent medical history. The

January 27, 2004, report reflects, in pertinent part regarding the claimant's then present health status:

She has continued to follow with Dr. Corey Diamond for her ongoing needs. She reports that she has thoracic pain on her right side which radiates around to the right lateral aspect of her ribcage at times. She says that sometimes it goes down her back and she feels that it does down into her right buttocks area and down into her right foot on the right side. She says that she also is now beginning to have some left-sided symptoms that occur intermittently in the left thoracic spine. None of these symptoms change with coughing or sneezing. She reports no bowel or bladder difficulties. She says she has weakness intermittently in the right lower extremity and sometimes she says she has loss of balance in the leg. She notices no jumping or tightness in the leg itself.(RX. #2. p.283).

Dr. Braden concluded that the claimant appeared to have reached maximum medical improvement relative to the April 2, 2003, injury, and that based on the lack of new objective findings, the same had resulted in no permanent physical impairment. (RX. #2, p. 282-285).

Claimant's testimony reflects that treatment for her fibromyalgia was had under the care of Dr. Beata Majewski after Dr. Randy D. Roberts was no longer a member of the physicians authorized by her health care provider carrier. Claimant was seen by Dr. Majewski on February 6, 2004. Following her evaluation of the claimant, the February 6, 2004, report of Dr. Majewski, reflects, in pertinent part:

IMPRESSION: I don't think that her fibromyalgia is a main issue right now. There is definitely soft tissue tenderness but that would not account for her other problems. There is definitely neurologic deficit on the right side which would require evaluation.

PLAN:

1.

* * *

4. I will plan to see Ms. Bost back in four weeks in follow-up.

I encouraged her to be seen by the neurosurgeon. (CX. #1, p.3).

On February 20, 2004, claimant was evaluated by Dr. F. Richard Jordan, a North Little Rock neurosurgeon, pursuant to a referral Dr. Diamond. While the February 20, 2004, report of Dr. Jordan reflects the history of the claimant's prior thoracic injury and treatment, as well as a history of the April 2, 2003, injury, it does not reflect evidence of the previous neurological evaluations relative to the most current injury. After noting the results of the physical examination of the claimant, the February 20, 2004, report reflects:

We reviewed her MRI which shows an HNP at T6/7 and T8/9 with cord compression.

We reviewed our evaluation and the films with the patient and have decided to proceed with a thoracic laminectomy at T6/7 and T8/9. We have scheduled this for March 25, 2004 at BHMC-NLR. In the interim we gave her Mepergan Fortis #30 to use sparingly for the pain.. . (CX. #1, p.5).

On March 25, 2004, claimant underwent the surgical procedural as reflected the above February 20, 2004, report. The March 27, 2004, Discharge Summary, relative to the claimant, reflects, in part:

HOSPITAL COURSE:

. . . . By March 27, she was doing remarkably well. She was ambulatory without assistance and taking a regular diet. Her wound was healing well and she was afebrile. (CX. #1, p. 8).

Claimant testified regarding her decision to proceed with surgery under the care of Dr. Jordan in light of the recommendations against surgery by the other physicians:

. . . The reason I wen through with Dr. Jordan is I had been living almost a year in chronic pain that is indescribable, unable to take care of myself or my children. And at that point in the physical shape that I was in, I didn't feel like I had anything to lose at that time. (T. 39).

The testimony of the claimant reflects, regarding the benefits realized from the surgery by Dr. Jordan:

I would say the largest benefit I've had from the laminectomies is the very sharp, intense, heavy pain that goes - - that was down my right leg has improved. Although the other results of the myelopathy are still there. I don't have that really intense, sharp, radiating pain pressure. (T. 15).

Prior to her follow-up examination with Dr. Jordan relative to the March 25, 2004, thoracic laminectomy, claimant was seen by Dr. Majewski on April 23, 2004. Dr. Majewski's examination of the claimant disclosed severe muscle spasm involving the trapezius muscles bilaterally and muscles along the spine. (CX. 1, p.9).

On May 18, 2004, claimant was seen in follow-up by Dr. Jordan. The May 18, 2004, report reflects, in pertinent part:

. . . . She reports several areas of improvement. She reports improvement in her gait and she is not having as much as pain in her right thigh. Unfortunately, she is still having some of the back and leg pain.

We know that she has RSD and discussed epidural stimulation in the past. She wants to try the stimulator so that she can one day be off so many medications. She is off the Oxycotin now but is still taking Tylox and Zanaflex.

She plans to obtain a psychological evaluation to preclude any reason why she would not be a good candidate for an implantable device. We will tentatively schedule a trial with stimulation with placement of the electrode on June 18, 2004 at BHMC-NLR.(CX. 1, p. 11).

In a handwritten slip of May 17, 2004, Dr. Jordan relayed that the March 25, 2004, surgery of the claimant was for treatment related to the injury of April 2, 2003. (CX. #1, p. 10).

On June 18, 2004, claimant underwent a thoracic laminotomy for the implantation of

epidural electrodes. (CX. #1, p.12-15). The testimony of the claimant reflects that she received relief from her pain with the trial stimulator. As a consequence of the afore, she was returned permanent placement.

The medical in the record reflects that on June 23, 2004, claimant underwent the second stage of the implantation of the spinal cord stimulator. The operative report relative to the afore reflects, in pertinent part:

This was a 39-year-old woman with pervious surgeries for ruptured disc. She remains with back and bilateral leg pain. She has undergone a pervious trial implantation of an epidural electrode and had good success and comes now for implantation of the spinal cord stimulation itself. (CX. #1, p.16).

On July 1, 2004, claimant returned to Dr. Jordan for removal of the suture from the June 23, 2004, procedural. The July 1, 2004, clinic note reflects that claimant was given instructions on wound care, activity restrictions, and direction to return on July 22, 2004, for reevaluation. (CX. #1, p. 18).

Claimant's testimony reflect that the stimulator was wired on the wrong side during the June 23, 2004, procedure, and, as a consequence, did not afford her relief of her right-sided symptoms. Claimant continues to take medication to address her symptoms due to the fact that she is not using the epidural spinal cord stimulator. At the time of the hearing claimant was scheduled to be seen by Dr. Jordan on October 4, 2004, to discuss whether to rewire the stimulator in order to address her right-sides symptoms or to remove it. (T. 15).

After a thorough consideration of all the evidence in this record, to include the testimony of the witnesses, review of the medical evidence, and application of the appropriate statutory

provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On April 2, 2003, the relationship of employee-employer existed between the parties.
3. On April 2, 2003, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$283.00/\$212.00, for temporary total/permanent partial disability.
4. On April 2, 2003, the claimant sustained an injury arising out of and in the course of her employment.
5. The claimant was temporarily totally disabled for the period April 13, 2003, continuing through the end of her healing period, a date to be determined.
6. The evidence preponderates that medical treatment rendered to the claimant subsequent to August 19, 2003, under the care and at the direction of Dr. Corey L. Diamond, to include referrals therefrom, was reasonably necessary and related to the treatment of claimant's April 2, 2003, compensable injury.
7. The respondent shall pay all reasonable hospital and medical expenses arising out of the compensable injury of April 2, 2003.
8. The respondent has controverted the claimant's entitlement to the payment of medical and temporary total disability benefits subsequent to August 18, 2003.

DISCUSSION

On April 2, 2003, claimant suffered a compensable injury to her thoracic spine in the employment of respondent. The claim was accepted as compensable with respondent providing

reasonably necessary medical benefits to the claimant through August 18, 2003. Respondent also paid temporary total disability benefits to the claimant for the period April 28, 2003, through August 18, 2003. Claimant asserts entitlement to additional workers' compensation benefits as a result of the compensable injury. Respondent that the claimant has been paid all appropriate benefits to which she is entitled. The present claim is one governed by the provisions of Act 796 of 1993, in that claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

Following her April 2, 2003, compensable injury claimant came under the care of respondent's designated medical provider, Dr. Michael Lack, on April 3, 2003. Although initially directed to remain off work pending further diagnostic studies, claimant was released to restricted duty by Dr. Lack on April 7, 2003. Claimant discharged the duties of a LPN at the time of her injury.

The April 7, 2003, light duty release authored by Dr. Lack imposed the following restrictions on the claimant's employment activities: no heavy manual labor; no stooping crawling or bending; and no lifting/pushing or pulling greater than 5 lbs. Claimant reported to work for respondent with the afore restrictions and was assigned duties as secretarial duties which entailed activities contrary to the restrictions issued by Dr. Lack. Claimant discharged the secretarial position until her symptoms progressed to the point that she was unable to continue, April 13, 2003. Prior to being seen by Dr. Gregory Ricca, a neurosurgeon, pursuant to the referral of Dr. Lack, claimant had been seen in the emergency room of St. Barnard's Regional Medical Center of two (2) occasions, in addition to a repeat visit to Dr. Lack on April 21, 2003.

Claimant was clearly within her healing period on April 13, 2003, at the time she was

unable to discharge the assigned “light duties” in her employment with respondent. Upon being seen by Dr. Ricca on April 28, 2003, she was directed to remain off work pending further diagnostic studies. Respondent initiated the payment of temporary total disability benefits on April 28, 2003, following the off-work directions of Dr. Ricca.

There is no evidence reflecting an improvement in the claimant’s condition between April 7, 2003, and April 28, 2003. If anything, the credible evidence reflects that claimant’s condition worsened during the afore as a consequence of attempting to perform the assigned secretary job. A claimant is entitled to temporary total disability during her healing period if she shows by a preponderance of the evidence that she had a total incapacity to earn wages. *Carroll General Hospital v. Green*, 54 Ark. App. 102, 923 S.W. 2d 878 (1996). The evidence preponderates that the claimant was totally incapacitated from engaging in gainful employment for the period commencing April 13, 2003, and continuing through April 28, 2003, and beyond, to include that period subsequent to August 18, 2003.

The evidence preponderates that claimant continued to receive active medical treatment relative to the April 2, 2003, compensable injury subsequent to August 18, 2003. Claimant suffered a prior injury to her thoracic spine in the employment of respondent in 1997, for which she underwent surgery under the care of Dr. Ricca. The medical reflects that claimant was diagnosed with and treated for fibromyalgia prior to her April 2, 2003, compensable injury. Claimant suffered from and was treated for RSD relative to the prior 1997 injury.

In workers’ compensation law, an employer takes the employee as he finds her, an employment circumstances that aggravate pre-existing conditions are compensable. *Heritage Baptist Temple v. Robison*, 82 Ark. App. 460, 120 S.W. 3d 150 (2003). A review of the evidence

in the record reflects that the only activity to occur in close proximity to the termination of the claimant's medical and temporary total disability benefits was receipt of the August 15, 2003, report of claimant's primary care physician, Dr. Corey L. Diamond. (RX. #1, p. 239).

Ark. Code Ann. § 11-9-102 (12), defines the healing period "as that period for healing of an injury resulting from an accident." Whether an employee's healing period has ended is a factual determination. *Ketcher Roofing Co. v. Johnson*, 50 Ark. App. 63, 901 S. W. 2d 25 (1995). The healing period continues until the claimant is as far restored as the permanent character of the compensable injury will permit. *Arkansas State Highway & Transportation Department v. Breshears*, 272 Ark. 244, 613 S.W. 2d 392 (1981); *Georgia-Pacific Corp. v. Carter*, 62 Ark. App. 162, 969 S.W. 2d 677 (1998).

In the instant claim, claimant continued to seek and obtain active medical treatment relative to her compensable injury subsequent to August 19, 2003. The evidence preponderates that claimant has been unable to engage in gainful employment due to residuals of her compensable injury. While it is undisputed that subsequent light duty releases were authored by Dr. Gera, the evidence preponderates that claimant could not physically discharge the light duty position of secretary in the employment of respondent. Further, the evidence reflects that off-work slips were authored by Dr. Diamond, Dr. Tyrer, and Dr. Jordan.

While Dr. Braden opined that the claimant "appears" to have reached maximum medical improvement in his January 27, 2004, report, the evidence clearly reflects that such was not the case. Claimant's condition was improved by the March 25, 2004, surgery by Dr. Jordan. Further treatment is being offered and provided relative to her compensable injury by Dr. Jordan. Claimant continues in her healing period and totally incapacitated from engaging in gainful

employment. Respondent has controverted claimant entitlement to temporary total disability benefits subsequent to August 18, 2003.

Ark. Code Ann. § 11-9-508 mandates that employers provide such medical service 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. In the instant claim, while claimant has been seen by several neurosurgeons relative to her compensable injury who had recommended against surgery, the evidence preponderates that she realized improvement relative to the injury as a result of the surgery performed by Dr. Jordan on March 25, 2004. Further, the evidence reflects that following the placement of the epidural stimulator electrode on June 18, 2004, claimant received such improvement in her symptom that continuance to the implantation of the spinal cord stimulation was deemed reasonable.

Claimant had experienced indescribable pain relative to the April 2, 2003, compensable injury from the date of its occurrence until the March 25, 2004, surgery by Dr. Jordan, shortly under a year. Subsequent to the procedure she experienced an appreciable relief of some of her symptoms. The evidence in the record preponderates that the medical treatment received by the claimant under the care of and at the direction of her primary care physician, Dr. Corey L. Diamond, to include the referral to Dr. Jordan, subsequent to August 19, 2003, was reasonably necessary and related to the treatment of the April 2, 2003, compensable injury. Respondent has controverted the claimant's entitlement to medical treatment subsequent to August 19, 2003.

AWARD

Respondent is hereby ordered and directed to pay to the claimant temporary total

disability benefits at the weekly compensation benefit rate of \$283.00, for the period beginning April 13, 2003, and continuing through the end of the claimant's healing period, a date to be determined, as a result to the April 2, 2003, compensable injury. Said sums accrued shall be paid in lump without discount. Respondent may claim credit for sums heretofore paid toward the afore obligation.

Respondent is further ordered and directed to pay all reasonable necessary and related medical, hospital, nursing, and other apparatus expenses growing out of the claimant's compensable injury of April 2, 2003, to include that treatment provided by and at the direction of Dr. Corey L. Diamond and referrals therefrom.

Claimant's attorney, the Honorable Kristofer E. Richardson, is herein awarded attorney fees at the maximum rate on the controverted portion of the indemnity benefits awarded herein, pursuant to Ark. Code Ann. § 11-9-715, § 11-9-801, and WCC Rule 10. The claimant's portion of the controverted attorney's fee shall be withheld from and paid out of, indemnity benefits and remitted by the respondent, directly to the claimant's attorney.

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

Matters not addressed herein are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, Administrative Law Judge