

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM. NO. F209546

MARGARET CLARK, EMPLOYEE

CLAIMANT

ARKANSAS CHILDREN'S HOSPITAL, SELF-INSURED EMPLOYER **RESPONDENT**

RISK MANAGEMENT RESOURCES, TPA

RESPONDENT

OPINION FILED JANUARY 10, 2005

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on November 16, 2004, at Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE KENNETH E. BUCKNER, Attorney at Law, Pine Bluff, 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 October 5, 2004, 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, 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 Margaret Clark, the claimant, coupled with medical reports and other

documents comprise the record in this claim. Claimant was provided an opportunity to secured an additional exhibit, medial report from Dr. Stan Kellar, for inclusion in the record subsequent to the hearing. The November 24, 2004, report of Dr. Kellar is herein designated a part of the record as Claimant Supplemental Exhibit #1.

DISCUSSION

Margaret Clark, the claimant, with a date of birth of October 14, 1954, commenced her employment with respondent as a registered nurse on January 15, 2001. On August 13, 2002, claimant suffered the injuries which serve as the basis for the present claim for continued temporary total and medical benefits.

Claimant, who worked in All care to patients in the infant and toddler unit, arrived for work at 6:15 a.m. on August 13, 2002. A fire had occurred in the conference room which adjoins the patient's room. Claimant not that the area was stuffy, and that while there was no longer any smoke present, fumes remained. Claimant worked 13 hours, her usual shift, on August 13, 2002, and observed that she could still smell the odor/fumes burning.

Claimant's testimony reflects, with respect to her efforts to protect the children in her charge:

The children in the regular south hallways were moved to another floor. They had already moved the ventilator babies that adjoined, that immediately adjoined the room that burned and already moved them to just around the corner there through the two double doors and put them in there. I was in charge, me and another registered nurse were in charge of the south ventilator room babies and we stayed there most of the morning until we could get them moved to that room also.(T. 16).

The testimony of the claimant reflects that she was in and out of the area where the fumes were

located the whole time of the 13-hour shift. Claimant noted that the afore entailed going back and getting things that belonged to the babies in the rooms as well as things they needed to take to the other room where the babies were now located.

Claimant acknowledged that she had pre-existing asthma, which was diagnosed as mild adult onset in 1984/85. At the time treatment measures utilized included allergy injections and an Albuterol inhaler to use pm. Claimant's testimony reflects, with respect to the difference in her condition after exposure to the fumes on August 13, 2002:

Before I had some maybe two bronchial infections, three, somewhere in that amount, a year. I was only taking Singulair, which is a asthma medication at night. And then had the pm Albuterol inhaler. Now, it's like I have a terrible bronchial infection. I can't breathe very well. I'm on multiple meds that I have to use in order to be able to breathe.

I'm on Spiriva inhaler, I'm on Serevent inhaler, I'm on Qvar inhaler, I'm on Albuterol inhaler and on the Singulair and those are at least two days, I mean twice a day and then the Albuterol I use, you know, in addition to that as needed. (T. 18-19).

Claimant observed that the medications that she used prior to the exposure are now utilizes in increased doses.

In terms of medical treatment, claimant was seen by her primary care physician, Dr. Clyde Paulk, on August 15, 2002, for complaints attributable to the August 13, 2002, exposure. Claimant was referred by Dr. Paulk to Dr. Nancy Rector, a pulmonologist. After a period of treatment with Dr. Rector. On March 21, 2003, claimant was evaluated by Dr. Stan L. Kellar, a Little Rock pulmonologist, at the request of respondent for a second opinion, and thereafter, per apparent agreement of the parties, assumed treatment of her respiratory complaints. Dr. Kellar ultimately referred the claimant to the National Jewish Hospital in Denver, Colorado.

The testimony in the record reflects that claimant was treated with massive doses of steroid early on relative to her compensable respiratory complaints in an effort to help her respond quicker. Claimant treated with Dr. Mike Moore for a biceps tendon rupture. Dr. Moore attributed the rupture to the high doses of steroids. Dr. Kellar concurred in the assessment. Respondent, who had contested the compensability of the biceps tendon complaint, thereafter accepted compensability.

Claimant was seen by a number of medical specialist relative to complaints growing out of the August 13, 2002, exposure, to include Dr. Thomas Smith, an ear, nose and throat specialist; Dr. David C. Bauman, a cardiologist; and Dr. Charles Pearce and Dr. Scott Bowman, orthopedist. Dr. Bowen performed acromioplasties on both of claimant's shoulders.

A dispute developed regarding Dr. Bowen's treatment. Specifically, Dr. Bowen's records reflect that the treatment he rendered on behalf of claimant was due to injuries she sustained while pushing herself up in bed. (RX. #1, p. 245-246). Claimant's testimony reflects, regarding the afore:

Dr. Michael Moore had don my left biceps tendon repair and after I came home from the hospital I was getting in my bed scooting over when I got a little sharp stabbing pain like something tore in my right arm. (T. 22).

Claimant was still under the care of Dr. Moore relative to the biceps tendon surgery at the time of the incident involving her shoulder. Claimant wore a cast on the left upper extremity for months following the procedure by Dr. Moore. The cast was above and below claimant's elbow.

While under the care and treatment of Dr. Rector claimant was permitted to return to work 8-hours shifts in October 2002. Claimant worked the 8-hour shift from October 2002,

through April 17, 2003, when respondent declined to further provide the modified shift work. Claimant was informed that until she could return to her regular shift without restrictions on her employment activities she could not return to work.

Claimant was paid temporary total disability benefits from August 2002 until October 2002, when she returned to work. After respondent ceased to provide work for claimant on April 17, 2003, she was without indemnity workers' compensation benefits until an Agreed Order was entered bring her benefits current. (CM. #2). Thereafter claimant received temporary total disability benefits through January 14, 2004, at which time respondent initiated the payment of indemnity benefits to correspond with the anatomical impairment assessed by Dr. Moore. Claimant last received an indemnity check relative to the impairment rating on August 3, 2004.

Claimant asserts, with respect to her respiratory complaints attributable to the August 13, 2002, exposure, that her pattern had been such that at time she would get better and at other times it would get worse. Claimant acknowledged that during a July 3, 2003, visit with Dr. Kellar he indicated that her condition had significantly improved, and she was released to full time work. At the time she was seen by Dr. Kellar in January 2004, claimant's testified that her respiratory condition was worse that it was in July 2003. At the time in July 2003, Dr. Kellar authored a report reflecting that claimant has reached maximum medical improvement, claimant remained under the care of Dr. Moore relative to her left biceps tendon. Claimant's testimony reflect hat she continued to treat with Dr. Kellar subsequent to July 2003.

Claimant was aware of the recommendation of Dr. Kellar regarding the evaluation at the National Jewish Hospital prior to August 17, 2004. At the time of the recommendation claimant had been accompanied to her appointment with Dr. Kellar by a nurse case manager retained by

respondent. Claimant testified regarding her understanding of the work at the National Jewish Hospital:

My understanding is that it deals in the special field of hard to treat respiratory problems and immune system deficiencies. (T. 27).

Claimant asserts the Ms. Revere, the nurse case manager, was familiar with the facility:

She told me that it was a very fine establishment. That they had helped a lot of people. She also has a daughter that has some asthma problems and said that she had know of the place. (T. 27-28).

Claimant desires to be seen at the National Jewish Hospital, and has expressed plans to be seen regardless of the cost being covered under the workers' compensation claim against respondent.

Claimant noted that her insurance ceases on November 30, 2004, and that she plans to pursue the treatment at the National Jewish Hospital before the expiration of coverage.

Claimant is currently unemployed due to residuals for her injury. Claimant's testimony reflects:

I have not been able to work due to being so sick. When I went back to work at Children's I went back and was working and doing my best to work to fulfill my responsibilities as a nurse. I was even taking my updrafts at the hospital, doing those treatments on myself so that I could be there to work to make money to live on.

Becky Kirsten is now the manager there. Todd Harness evidently is not there anymore. But she sent me a letter last week, if I recall right. I'd have to look at the letter but a week to 10 days ago stating that I no longer was employed at Children's Hospital because my medical leave was up. And, therefore, they were terminating my position at Children's. (T. 28-29)

Claimant testified that in her present physical condition she is unable to return the respondent working a 12-hour shift.

The testimony of the claimant reflects that the medications that she is currently taking

produce side-effects:

I'm real shaky with these medications. I stay very, very tired. I have like, I get up and try to do anything and I'm just exhausted. I can't be up and working because I can't breathe very well. And I cough all the time and stay hoarse all the time. . . . (T. 29-30).

Claimant noted that 95% of the time the more she talk or cough, the more difficulty she has.

Claimant testified that while she coughs regularly and has had the hoarse voice since the August 13, 2002, exposure, some days are worse than others, in that she seemingly cough non-stop.

Claimant observed that her throat gets very sore the more she talk and cough. Further, claimant noted that the cough is deep in her bronchial area and hurts in her chest.

On October 18, 2004, claimant underwent an evaluation by Dr. Christopher L. John, a pulmonologist, at the request of respondent. Claimant testified that Dr. John recommended diagnostic test, suggested that she stop taking certain of her medications, and a possible biopsy of her lungs. Claimant's testimony reflects that aside from the afore, Dr. John did not suggest any treatment options. Regarding the amount of time she spent with Dr. John, claimant testified:

My initial visit was about 10 to 15 minutes. And then when I came back for the results of the histamine challenge test he came in and sit worn and spoke with Ms. Revere and I about 15 minutes. (T. 32).

No further appointment was scheduled with Dr. John.

In February 2004, claimant underwent surgery on her right thumb, which was paid by her group insurance carrier. The testimony of the claimant reflects that the surgery she had on her right arm was the product of a dog attacking her. Claimant acknowledge treatment for IGG, a problem when the immune system is decreased such that infections can't be fought off. Claimant has also been diagnosed with some allergies.

The testimony of the claimant reflects that the treatment she had for her left and right shoulders was paid by her group health insurance. Claimant recently underwent additional surgery relative to a hernia which was also paid by her group health insurance.

Claimant acknowledge receiving short term disability benefits through a disability policy that respondent had in effect. Claimant received the afore from July 2003, through October 2003, six (6) weeks at \$445.00 per week. Claimant applied for Social Security disability, however was denied.

The testimony of the claimant reflects that at the time of her September 2003, deposition she was able to visit her ex-mother-in-law and her children as well as attend church three time per week. Claimant has two children and three grandchildren, all of whom live within driving distance of her residence. Claimant was also able to keep up with her housework. Claimant noted that presently she is unable to keep up with her housework or attend church with her former frequency due to residuals of her injury.

The medical in the record reflects that claimant was initially evaluated by Dr. Stan L. Kellar, a pulmonologist, on March 21, 2003, at the request of respondent. The March 21, 2003, report reflects, in pertinent part:

History: Ms. Clark is a 48 female who I was asked to see for a second opinion on a persistent cough and shortness of breath. Prior to August of 2002 Ms. Clark had mild asthma. She had been diagnosed in approximately 1984. She usually had trouble in spring and fall. . . . On August 13th she wen to work at Children's Hospital. There was a fire in a conference room on her floor. She was exposed to fumes and some smoke. She developed an increasing cough and increasing shortness of breath while at work.. . . . She was subsequently referred to Dr. Nancy Rector on Sept. 3rd. . . She continues to have a frequent cough. Her cough is usually productive of clear sputum although she again has green sputum. She continues to have a hurting sensation in the substernal area. She has

had low grade fever for the last two nights. She continues to have sinus congestion and some drainage. She continues to have increased weakness and shortness of breath with exertion. she can walk without difficulty but she has not been able to run and play with her grandchildren and cannot exercise. She has not been able to return to full-time work. . . .

* * *

Impression: 1. Cough, persistent. I feel her cough is a marker of the ongoing chronic inflammatory pattern. I cannot exclude other causes for cough such as occult acid reflux or cardiac disease.

2. Dyspnea, slowly improving.

3. Hoarseness of unknown cause. . . . She has a significant ongoing cough that can cause hoarseness. . .

4. Asthmatic pattern, exacerbated by fume and smoke exposure. . . This does raise concern for contributing problems such as occult reflux, cardiac disease, (RX. #1, p.178-179).

In a March 21, 2003, narrative report relative to the evaluation of the claimant, and responsive to inquiries from the nurse case manager, Dr. Kellar relayed that claimant would continue to require medical treatment and that she had not reached maximum medical improvement.(RX. #1, p. 181-182). Claimant continued to treat with Dr. Kellar following the initial evaluation.

Following a July 3, 2003, visit, after noting the improvement in claimant's respiratory complaints, Dr. Kellar released claimant from a pulmonary standpoint to return to work on July 14, 2003. Claimant was continued on medication by Dr. Kellar during the July 3, 2003, visit, and directed to return for reevaluation in three months. (RX. #1, p. 225). Claimant continued to treat with Dr. Michael Moore, an orthopedic physician, relative to her left rupture biceps tendon subsequent to the July 3, 2003, visit with Dr. Kellar. On January 15, 2004, Dr. Moore opined that claimant had reached maximum medical improvement relative to the biceps tendon injury. (RX. #1, p. 248).

In a December 17, 2003, correspondence Dr. Kellar recited the claimant's medical regime

and continued need for such medication. (RX. #1, p. 247). In his January 23, 2004, correspondence to respondent, Dr. Kellar addressed the claimant status with respect to her pulmonary complaint attributable to the August 13, 2002, exposure:

Ms. Clark continues to have a great deal of difficulty with a worsened asthma pattern following her smoke inhalation. We have not been able to establish long-term control. She has responded to steroids in the past but our pattern has never stabilized long enough to completely eliminate steroids. Her current problem is still related to worsening following her smoke inhalation.

She is being evaluated for other treatment modalities. I am looking for any other means to improve her worsened problem. Any allergy treatment would not be considered to be related to her smoke inhalation. However her worsened condition is still related to her smoke inhalation. (RX. #1, p. 250).

In an August 30, 2004, correspondence to respondent, after noting the claimant's continued difficulties, Dr. Kellar recommended that a second opinion be had at the National Jewish Center in Denver. (RX. #1, p. 267).

In response to an October 6, 2004, inquiry from respondent regarding the nexus of the claimant's continued need for medical treatment with the August 13, 2002, exposure, Dr. Kellar relayed in an October 7, 2004, correspondence:

Ms. Clark's asthma has been much more difficult to control following her smoke inhalation than it was historically prior to the exposure. She does gain some benefit from prednisone but prednisone carries severe potential long-term consequences. I have tried every other method I have available to control her asthma with less than ideal results. I have referred Ms. Clark to National Jewish Hospital in Denver to see if there is anything else they have to offer other than long-term steroids.

To a reasonable degree of medical certainty Ms. Clark's exacerbation Of asthma is related to the smoke inhalation and not hypogammaglobulinemia. (RX. #1, p. 285).

On October 18, 2004, claimant was evaluated by Dr. Christopher Leigh John, a Little Rock pulmonologist, at the request of respondent. The October 18, 2004, report of Dr. John reflects, in pertinent part:

IMPRESSION:

Persistent respiratory symptoms suggestive of a possible combination of chronic bronchitis and reactive airways disease possibly aggravated by exposure to fumes from a hospital based fire in 2002. Presently the symptoms appear to be persistent but on today's evaluation there was no evidence of obstructive airways disease either clinically or spirometrically. In view of this, and the fact that it is presumed by previous investigators that these symptoms are asthmatic in origin and as other investigations have been by and large negative I have suggested that we arrange for a Histamine Challenge Test. Once this is done we will have an idea of whether she does or does not have reactive airways disease.

In the interim, I will review the voluminous data provided and determine whether in deed she does or does not have evidence of hypogammaglobulinemia which is not likely to be related to the patient's steroid therapy as she is concerned. (RX. #1, p. 288).

Claimant was again seen by Dr. John on November 8, 2004, pursuant to October 18, 2004, the evaluation. The November 8, 2004, report, generated as a result of the visit reflect:

. . . . I have gone through the results of our information and have explained that her Histamine Challenge was weakly positive. . . . Typically, one would expect a patient with asthma to react at a much lower concentration than this. With her spirometry also being normal it would appear unlikely that she has significant asthma based on these results.

I have explained, however, that asthma being a variable disease certainly could show variability in the degree of reactivity and may well have improved on the patient's current therapy.

I have explained that it would appear that there is a temporal relationship between the patient's exposure at her place of work and the development of the symptoms and that the symptoms presently the patient complains of do appear to be associated with an increase in airways reactivity. What

I cannot do however is predict whether there was a similar degree of airways reactivity prior to the exposure.

I doubt that the National Jewish Hospital would significant differ in their diagnostic work up from the physician's work up that she has already received and I think that the likelihood of there being substantial change in her diagnosis in treatment is slim.

My overall impression is therefore that this young lady that was told having presented with seasonal symptoms as far back as 1958 that she had adult onset asthma does show evidence of increased airways reactivity which typically would not been considered at this level significant evidence of asthma. Whether the exposure to the fumes in 2002 increased the degree of reactivity at that time cannot be determined as there was no evidence of testing for increased airways reactivity at that time. There is however evidence at this point in time that she does have an increase in airways reactivity which should predispose her to develop respiratory symptoms more easily that a person with normal airways reactivity but given the severity of her claimed symptoms it is difficult to postulate that the present degree of reactivity is compatible with that.

I have explained to her that the preferred treatment for increased reactivity would be inhale steroid therapy, however, the patient claims that she has tried most of these with adverse affects causing there cessation. At this point in time therefore I would suggest that she continue with Serevent one activation BID, Albuterol 2 puffs PRN, and the Singular 10 mg once a day. (RX. #2).

Dr. Kellar had an opportunity to review the reports of Dr. John. In his November 24, 2004, correspondence, Dr. Kellar relayed:

. . . . He states that her histamine challenge was weakly positive. A positive test is a positive test. You can have asthma with a negative histamine challenge.

Ms. Clark has certainly demonstrated a great deal of difficulty with asthma during the time I have provided care. She had pulmonary function testing on March 21, 2003 showing a FEV1 of 2.12, 88% predicted. She has shown a change in her PFTs with a fall in her FEV1 to a value of 1.82, 76% predicted on June, 2004, representing a significant decline, despite treatment for asthma. She has taken oral steroids for prolonged time periods to control her symptoms.

I have exhausted all of my treatment options and investigation in trying to provide better control for her asthma. I am unwilling to subject her to long-term oral steroids therapy without further evaluation. I disagree with Dr. John. She is not well-controlled. I recommended the referral to National Jewish in Denver to make certain I am not overlooking some other treatment option or disease process.

What is very difficult to show in an objective test is the misery I have seen in Mrs. Clark since March 21, 2003. She has been willing to undergo any test ordered and to take any medicine prescribed in an attempt to get better. As she has expressed to me many times, she simply wants to be well enough to go back to work and take care of herself. I have not been able to accomplish that goal. She deserves further evaluation to see if there is anything else to offer. (Claimant Supplemental Exhibit #1).

Claimant desires to pursue the evaluation as recommended by Dr. Kellar relative to her respiratory complaints attributable to the August 13, 2002, exposure. While they differ on course of treatment, both Dr. John and Dr. Kellar recommend further treatment of claimant's respiratory complaints. Claimant also asserts entitlement to temporary total disability benefits from the date of suspension or last payment until she reaches maximum medical improvement.

After a thorough consideration of all the evidence in this record, to include the testimony of the witness, review of the medical and documentary 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 August 13, 2002, the relationship of employee-employer existed between the parties.
3. On August 13, 2002, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$425.00/\$319.00, for temporary total/permanent partial disability.

4. On August 13, 2002, the claimant sustained an injury arising out of and in the course of her employment, pursuant to Ark. Code Ann. §11-9-114.

5. In addition to prior periods of temporary total disability, claimant was temporarily totally disabled for the period January 23, 2004, and continuing through the end of her healing period, a date to be determined.

6. The referral to the claimant to the National Jewish Hospital by Dr. Stan L. Kellar, is reasonably necessary medical treatment in connection to the August 13, 2002, compensable injury of the claimant.

7. The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of August 13, 2002.

8. The respondent has controverted the claimant's entitlement to temporary total disability benefits subsequent to June 2004, and further medical benefits as recommended by Dr. Kellar, to include a referral to the National Jewish Hospital.

CONCLUSIONS

Claimant is a registered nurse who commenced her employment with respondent on January 15, 2001. Claimant last discharged employment duties for respondent on or about April 17, 2003, performing a reduced 8-hour shift pursuant to the directions of her treating physician. On August 13, 2002, claimant suffered a compensable injury in her employment with respondent when she was exposed to fumes and smoke which aggravated a pre-existing asthmatic condition. Claimant asserts entitlement to additional workers' compensation benefits, both medical and indemnity, as a result of the compensable August 13, 2002, injury. Respondent takes the position that claimant has been provided all appropriated 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 additional workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

Claimant suffered from adult onset asthma prior to her employment with respondent. There is no evidence in the record to reflect that her asthma interfered with, limited or restricted claimant's employment prior to August 13, 2002. Claimant typically worked a 12-13 hour shift in her employment with respondent. On August 13, 2002, claimant was exposed to fumes from an extinguished fire.

Claimant was referred by her primary care physician, Dr. Clyde Paulk, to a pulmonologist, Dr. Nancy Rector, for treatment relative to her asthma which was aggravated after the smoke inhalation exposure. Claimant treated with Dr. Rector from September 3, 2002, until she came under the care and treatment of Dr. Stan L. Kellar, another pulmonologist, on March 21, 2003, pursuant to the directions of respondent. On or about September 30, 2002, claimant was released by Dr. Rector to return to work with a reduced 8-hour shift. On July 3, 2003, claimant was released to full-time work by Dr. Kellar.

Claimant has been symptomatic and continuously in need of medical treatment relative to her respiratory complaints since the August 13, 2002, exposure. Respondent accommodated the claimant's restricted release with respect to the reduced shift until April 16 or 17, 2003, at which time she was informed that until she could work a full regular shift, there was no further work available for her. In March 2003, claimant came under the care of Dr. Kellar.

As a compensable of the medical treatment received relative to the respiratory complaints claimant suffered a left biceps tendon rupture. Claimant underwent surgery under the care of Dr.

Michael Moore, a Little Rock orthopedic surgeon, relative to the afore. On or about October 30, 2003, an agreement was reached whereby respondent paid the claimant temporary total and temporary partial disability benefits from August 14, 2002, through July 13, 2003. (CM. #2).

Claimant continued to receive temporary total disability benefits through January 14, 2004. On January 15, 2004, Dr. Moore authored a report reflecting that claimant had reached maximum medical improvement relative to the left biceps tendon tear and assessed her permanent physical impairment at 10% to the arm. (RX. #1, p. 248). Respondent initiated the payment of corresponding permanent partial disability benefits. Claimant last received indemnity benefits relative to her compensable injury on August 3, 2004, which represented the last of the permanent partial disability benefits relative to left arm impairment.

The evidence preponderates that claimant's respiratory complaints worsen between July 3, 2003, and January 23, 2004. The credible testimony of the claimant reflects that she has been unable to work since last discharging duties for respondent in April 2003. While it is undisputed that claimant suffers from other health concerns, and has undergone surgery relative to both shoulders and her thumb, which has not been deemed to be related to the August 13, 2002, compensable exposure, the evidence preponderates that claimant's inability to work is due in major part to the compensable respiratory complaints. Respondent terminated claimant's employment approximately ten (10) days prior to the November 16, 2004, hearing in this claim.

A specific course of treatment has been recommended by the claimant's treating physician relative to her respiratory complaint. Dr. Kellar has been the claimant's treating physician since March 2003, and is well versed in progress and setbacks. Claimant has been seen on two occasions by Dr. John for a total of approximately 30 minutes. While Dr. John has not

rendered any treatment of behalf of the claimant relative to her respiratory complaints, his report recognize that further medical treatment is warranted.

A pre-existing disease or infirmity does not disqualify a claim if the employment aggravates, accelerates, or combine 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. *Arkansas Power & Light Co. v. Scroggins*, 230 Ark. 936, 328 S.W. 2d 97 (1959).

Pursuant to Ark. Code Ann. § 11-9-508 (a), employers are required 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. In the instant claim, Dr. Kellar, the claimant's authorized treating, has set forth the basis for his recommendation that the claimant be evaluated at the National Jewish Hospital. Dr. Kellar has had extensive contact with the claimant since assuming her care and treatment in March 2003. Dr. Kellar is familiar with the claimant's response to the various treatment modalities instituted while she has been under his care. Claimant has sustained her burden of proof by a preponderance of the evidence that the referral as recommended by Dr. Kellar is reasonably necessary in relation to the injury received. Respondent has controverted the afore.

In April 2003, respondent failed to make available to the claimant work within her medical restriction of a 8-hour shift. Claimant has not been released by Kellar to return to regular work duties relative to her respiratory complaints since the January 23, 2004, visit.

Claimant was monitored by Dr. Kellar between the July 3, 2003, and January 23, 2004, visits. At the time claimant was seen by Dr. Kellar on January 23, 2004, he observed that she “continues to have a great deal of difficulty with a worsened asthma pattern” growing out of the August 13, 2002, exposure.

The healing period is that period of healing of an injury which continues until the claimant 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 the condition, the healing period has ended. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S.W. 2d 457 (1994). Conversely, if further treatment will improve the condition, and the underlying condition causing the disability has not become stable, than the healing period has not ended. In the instant claim, claimant remains within her healing period. The evidence preponderates that claimant is totally incapacitated from engaging in gainful employment, and has been so since January 23, 2004, as a result of her compensable aggravation of her pre-existing condition. Respondent has controverted the afore benefits.

AWARD

Respondent is hereby ordered to pay to the claimant temporary total disability benefits at the weekly compensation rate of \$425.00, for the period commencing January 23, 2004, and continuing until such time as the claimant has reached maximum medical improvement relative to her August 13, 2002, compensable injury or is released to return to appropriate work, a date to be determined. Said sums accrued shall be paid in lump without discount.

Respondent is further ordered and directed to pay all reasonable related medical, hospital, nursing, and other apparatus expenses, to include the recommended evaluation of the claimant at

the National Jewish Hospital, growing out of the August 13, 2002, compensable injury.

Maximum attorney fees are herein awarded to the claimant's attorney of the controverted portion of this award, pursuant to Ark. Code Ann. § 11-9-715.

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