BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F403302

KAREN GOFF — CLAIMANT

HERITAGE PARK NURSING CENTER — RESPONDENT

CROCKETT ADJUSTMENT
INSURANCE CARRIER — RESPONDENT

OPINION FILED MAY 6, 2005

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

Respondents represented by WILLIAM FRYE, Attorney, Little Rock, Arkansas.

## STATEMENT OF THE CASE

A hearing was held on March 8, 2005, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on November 8, 2004. 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 March 20, 2004, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her low back on March 20, 2004.

4. Medical expenses have been paid.

5. Temporary total disability has been paid to May 20, 2004.

6. The claimant is entitled to a workers' compensation rate of $300.00 per week for temporary total disability.

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

1. Additional temporary total disability benefits from May 21, 2004, to a date to be determined.

2. Additional medical from date of last payment.

3. Attorney's fees.

It was agreed by the parties that the claimant can return to see Dr. Knox for an appointment and that this appointment is authorized and will be paid for by the respondent.

In regard to the foregoing issues the claimant contends that she was injured on March 20, 2004, when she was transferring a resident to a wheelchair. Claimant has seen Dr. Knox, Dr. Stanford and Dr. Raben. She remains within her healing period. If not, when she has reached MMI and the doctors have indicated that she should get into another line of work. She maintains that she is physically unable to do the type of work that she was doing at the time of the injury and, therefore, she has incurred permanent impairment and in turn wage loss. Claimant was originally seen by Dr. Knox and has also been seen by Dr. Raben. She wishes to formally request a change to Dr. Tony Raben and would appreciate it if the respondent would state its official position in regard to this request.

In regard to the foregoing issues the respondents contend that the claimant was injured on March 20, 2004, when she reached over

to pick up an item from the floor. The claimant was treated by Dr. Arkin, who referred the claimant to Dr. Raben. The claimant was also seen by Dr. Knox. Dr. Knox did diagnostic studies and indicated that the claimant may need additional treatment and possibly a spinal fusion. Dr. Knox indicated that the claimant could return to light duty. The respondents send the claimant a certified letter indicating that light duty was available. However, the claimant refused to return to work. The claimant was then evaluated by Dr. Standefer for a second opinion on July 22. Dr. Standefer indicated that the claimant's neurological and sensory examinations were normal and that the claimant had no spasms and mild limited range of motion. He went on to state that he found no evidence of a ruptured disc, nerve root impingement or stenosis. He did not recommend any type of surgery. At this point, the respondents are unsure as to what medical treatment the claimant is asking for and, therefore, are unable to take a position on that issue.

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 information marked Claimant's Exhibit No. 1 and Claimant's Exhibit No. 2. The respondents submitted medical information marked Respondents' Exhibit No. 1 and documentary evidence marked Respondents' Exhibit No. 2. All these exhibits were admitted without objection.

## DISCUSSION

The claimant testified through an interpreter that she began to work for the respondent as a CNA in either November or December 2003. The claimant testified and it has been stipulated by the respondent that she sustained a compensable injury to her low back on March 20, 2004. The claimant testified that she received medical treatment immediately for her back problems where she was x-rayed and given medications. The claimant testified that she was initially seen by Dr. Holder and then was referred to Dr. Raben who recommended back surgery. The claimant testified that Dr. Raben took her off work and referred her to Dr. Knox.

The claimant testified that she did try to return to work for the respondent but was only able to work one day. The claimant testified that she was placed on the easiest wing and was asked to make up beds but could not preform this task without assistance. The claimant testified that she was also to help with the lunch trays and the water glasses but that the carts which were used to deliver the trays required her to have to squat down to get some of the trays out and that these activities really irritated her back. The claimant testified that she told her supervisor that she was in a lot of pain but she would try to finish out her shift. When asked, the claimant indicated that this attempt to return to work was prior to her being seen by Dr. Raben. The claimant testified that she did receive a letter from the respondent asking her to come back to work on light duty but she had already tried to work and knew that she could not do it.

On cross examination, the claimant agreed that she last saw Dr. Raben on August 10 at which time she was having pain in her back, legs, neck and arms. The claimant was asked about Dr. Raben's recommendation that she could sit for thirty minutes, stand for an hour and walk for two hours and the claimant responded that she could stand but it was very painful when she would sit. The claimant agreed that it was at this appointment with Dr. Raben that she made him aware that she might be pregnant. The claimant testified that she understood that the recommendations and treatment plan which Dr. Raben was formulating for her could not be done due to her pregnancy. The claimant was asked why the therapist sent a report saying that she had only gone to therapy one time and that being on August 12 and the claimant responded, "Because I didn't go." The claimant testified that because there was a mix up as to what she was to do she just did not go to therapy. The claimant agreed that when she is at home she does not have pain and she does not have a problem with walking and she can stand for long periods of time. The claimant testified that she is expecting her second child and that after her first child was born she was off work for one year. The claimant testified that she anticipated being off work for six months following the birth of her second child because it is to be cesarian and she plans to breast feed. The claimant testified that she has not looked into any other type work nor has she pursued her real estate licence at this time desiring only to resolve her back problems before she undertakes any new projects. The claimant testified that Dr. Knox

released her to return to work with restrictions of no lifting anything over five pounds, not to bend, not to sit, basically just to be standing up. The claimant testified that she did get a letter from the respondents dated May 25 where they offered her light duty. The claimant acknowledged that the respondents offered her light duty including nail care, paperwork and passing ice. The claimant testified that at the time she got the letter she could not do any of these things because, at that time, her back was really bothering her and she needed to go to the doctor. The claimant testified that Dr. Standefer did not recommend surgery for her but did recommend that she begin exercising. The claimant testified that she uses a treadmill approximately five minutes at a time. The claimant testified that the last prescription medication she has taken was prescribed by Dr. Holder. The claimant testified that she did not know what her status as far as employment was with the respondent. The claimant agreed that it was her decision not to return to work when she was offered light duty by the respondent.

On redirect examination, the claimant stated that she did not attend physical therapy because she was having a lot of pain. The claimant testified that the respondents have not contacted her concerning returning to work although she, the claimant, has contacted “Wendy” about what doctor she should go to see.

Ceree Somerville testified that she works for the respondent doing human resources and workers’ comp. Ms. Somerville testified that the respondent has a light duty program and that the

respondent basis light duty on what the doctor recommends for that particular patient. Ms. Somerville testified that light duty often time consists of doing paperwork, feeding patients, chart meal consumption, nail care, monitor bowel and bladder books and pass ice. This witness testified that on any of these particular jobs, if a claimant is unable to do part of the job they can arrange for someone else to help do the part that they are not able to do. This witness testified that she has seen the restrictions as set forth by Dr. Knox and, in her opinion, there were jobs available for the claimant within her restrictions. Ms. Somerville was asked if they heard back from the claimant after she was sent her letter and this witness responded, “No.” Ms. Somerville testified that the claimant is still an employee of the respondent even though they have not heard from her in over ten months.

On cross examination, Ms. Somerville was asked if when someone is doing the feeding job at the circular table, is it possible to stand and feed the patients and this witness testified that yes they could stand but agreed that they would have to bend over to feed the patient if they were standing.

The medical records set forth that the claimant was seen at St. Mary’s Hospital on March 20, 2004, with complaints of low back pain. Medications were prescribed and the claimant was taken off work for one day. On March 23, 2004, there is a physician’s report indicating that the claimant has lumbar strain and that physical therapy was recommended as well as medications. This report also takes the claimant off work until March 30, 2004. Dr. Holder

writes on March 30, 2004, that he has continued to treat the claimant for her low back problems. Dr. Holder notes that his treatment involves continuing her present medications, physical therapy for one more week and to continue to be off work since she does not have any light duty available at her work. On April 8, 2004, Dr. Holder writes that the claimant is making significant progress with her physical therapy although she is still a little stiff. After examination, the doctor diagnosed the claimant with having lumbosacral strain and recommended that she return to work on April 9, 2004, but to lift no more than twenty pounds for ten days and he prescribed medications. Dr. James Arkins writes on April 14, 2004, that he has seen the claimant for her back problems, noting that she continues to complain of pain in her low back with any type of bending forward or backward as well as squatting. Dr. Arkins notes that the claimant tried to work on Saturday but was unable to return to work on Sunday and Monday because of the work assigned to her. The doctor notes that she is no longer in physical therapy but she remains on muscle relaxers and pain pills. Upon examination, Dr. Arkins notes that the claimant has persistent muscle spasms in her lower lumbar area, noting that he has reviewed her lumbar spine series and it is normal. Dr. Arkins diagnosed the claimant with persistent myofacial strain of the lumbar spine and notes that she should not return to work until she is seen by Dr. Holder on April 19, 2004. Dr. Arkins prescribes medications and recommends that she use intermittent ice and heat on her lower back. The claimant was seen

by Dr. Holder on April 19, 2004, at which time an MRI was recommended as well as medications and to continue off work. On April 23, 2004, Dr. Holder sees the claimant and notes that she has a herniated disc at L4-5 and that she should remain off work until she is seen by a spine specialist.

Dr. Cyril Raben writes on May 4, 2004, that he has reviewed the claimant's MRI and that she has a central and right sided disc herniation at L4-5. Dr. Raben, after examination, assessed the claimant with having lumbar radicular syndrome with probable L5 radiculopathy, herniated nucleus pulposus at L4-5 and disc derangement at L3/4, L4/5 and L5/S1. Dr. Raben recommended that she have an epidural steroid injection and continue her physical therapy. Dr. Raben prescribed medications for the claimant for pain, spasm and inflamation. Dr. Luke Knox writes on May 20, 2004, that he has seen the claimant for her back and bilateral leg pain. Dr. Knox notes that the claimant's MRI scan and plan films were reviewed and she was found to have a mild central disc herniation at L4-L5 associated with degenerative changes at L5-S1. Dr. Knox notes that he feels that her pain most certainly is coming from the L4-L5 central disc herniation. Dr. Knox recommended that she give this condition a bit more time to resolve itself and he gave her the ok to return to work with a five pound weight restriction and to avoid bending, lifting, stooping and twisting as well as be given frequent breaks. Dr. Knox gave the claimant a shot of Depo-Medrol and continued her physical therapy. Dr. Knox writes on June 17, 2004, in response to the carrier's questions reporting that the

claimant's MRI revealed some element of degenerative disc changes at multiple levels of her lumbar spine. Dr. Knox notes that there were pre-existing factors involved at those levels but opines that the claimant's injury of March 26, 2004, contributes to a greater than 50 percent chance that this event is the culprit of her current complaints. Dr. Knox writes on a separate instrument but dated June 17, 2004, that the claimant continues to be without significant improvement despite a shot of Depo-Medrol and physical therapy and further notes that she is to undergo a mylograph for further work up. The claimant underwent a lumbar mylogram on July 2, 2004, which revealed moderate symmetric broad based disc protrusions at L4-5 and L5-S1 and a milder degree of symmetric disc protrusion at L3-4. This report notes that only the L4-5 appears likely to be associated with the root entrapment. Dr. Knox writes on July 7, 2004, that he has reviewed her mylogram and CT scan noting that she had a rather prominent instability at L4-L5 level with the associated central disc herniation as well as a central disc herniation at L4-S1. Dr. Knox recommended that she consider a surgical decompression, noting that he urged her to pursue other options if desired.

The claimant had a consultation/evaluation with Dr. Michael Standefer on July 22, 2004. Dr. Standefer sets forth a very detailed history of the claimant's medical problems and treatment by her various physicians. Dr. Standefer also discusses at length the claimant's radiographic studies and after reviewing all of this information as well as an examination of the claimant, he assesses

that she has lumbar strain versus symptomatic back pain from defused disc bulging at L4-5 and L5-S1. Dr. Standefer notes that the claimant has no evidence on clinic exam of overt radiculopathy and the dynamic flexation and extension views have not demonstrated any slippage. Dr. Standefer writes that he does not believe that surgical intervention would serve any useful purpose and that the likelihood of significant improvement with lumbar fusion would be extremely low. The doctor recommended continued conservative care to include medications, a walking program, exercise program as well as observe restrictions and to consider retraining. Dr. standefer notes that the claimant could return to work at the nursing home at light duty noting that her restrictions as listed earlier in the chart are quite reasonable. Dr. Raben writes on August 10, 2004, that he would suggest an EMG nerve conduction study on the claimant's legs. Dr. Raben writes that depending on the results of this test he would suggest a neuroforaminal block on the left at L3/4. Dr. Raben writes that if this is the problem area, they can simple decompress the nerve root on that side. In the alternative, Dr. Raben writes that he would suggest disc space injections at L4-5 and perhaps L5-S1 if she does not get good relief with the left sided block. Dr. Raben further writes that depending on the result of this last mentioned procedure, other alternatives could be approached. Dr. Raben notes at the end of his report that the patient mentions that she might be pregnant.

After a review of this entire record, I find that the claimant has failed to prove by a preponderance of the evidence that she is

temporarily totally disabled from May 21, 2004, to a date to be determined. The claimant has been released to light duty with listed restrictions which several of her doctors have indicated are reasonable in light of her problems. The respondents have testified that light duty of various types are available to the claimant and that she was approached to return to work at light duty. The claimant testified that she made the decision not to return to work feeling she was not able. Therefore, I find that the respondents made light duty available to this claimant within her restrictions which she made little to no effort to comply with. I further find that the claimant is entitled to additional medical treatment for her compensable injury. The various doctors which the claimant has continued to see have consistently recommended various types of treatment and all have included ongoing medical treatment as well as physical therapy. Therefore, I find that the claimant is entitled to additional medical treatment for her compensable injury. It is noted that the parties have agreed that the claimant can return to see Dr. Knox for an appointment and that this appointment is authorized and will be paid for by the respondents.

FINDINGS & CONCLUSIONS

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

2. On March 20, 2004, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her low back on March 20, 2004.

4. Medical expenses have been paid.

5. Temporary total disability has been paid to May 20, 2004.

6. The claimant is entitled to a workers' compensation rate of $300.00 per week for temporary total disability.

7. The claimant has proven by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable injury subsequent to May 20, 2004.

8. The parties have agreed that the claimant can return to Dr. Knox and that this appointment is authorized and will be paid by the respondents.

9. The claimant has failed to prove by a preponderance of the evidence that she is temporarily totally disabled subsequent to May 20, 2004. See discussion above.

ORDER

The claimant has proven by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable injury at the expenses of the respondents.

The claimant has failed to prove by a preponderance of the evidence that she is entitled to additional temporary total disability from May 21, 2004, to a date to be determined.

It is agreed by the parties that the claimant can return to Dr. Knox for an appointment and that this appointment is authorized and will be paid for by the respondents.

IT IS SO ORDERED.

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ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE