

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F504870**

<b>CHARLES BARNES, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>GREENHEAD FARMING CO., INC., EMPLOYER</b>	<b>RESPONDENT</b>
<b>COMMERCE &amp; INDUSTRY INS., CO., CARRIER</b>	<b>RESPONDENT</b>

**OPINION FILED SEPTEMBER 13, 2006**

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on June 16, 2006, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE JAMES A. MCLARTY, III, Attorney at Law, Newport, Arkansas.

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

**STATEMENT OF THE CASE**

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

On May 9, 2006, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order of the same date 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' contentions relative to same. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Charles Barnes, the claimant, and Shelley Evins, coupled with medical reports and other documents comprise the record in this claim.

## DISCUSSION

Charles Barnes, the claimant, with a date of birth of September 7, 1960, has a six grade education. Claimant has been employed by respondent for a period of 16 to 18 years as a heavy equipment operator and mechanic. Claimant operated excavators and bulldozers.

On May 11, 2005, while discharging employment duties for respondent claimant was involved in an accident which serves as the basis for he present claim. At the time of the accident the excavator was on a lowboy trailer and was being moved from one work site to another. The truck and trailer that was transporting the excavator got stuck in a ditch and the claimant was in the process of unloading the excavator when it began to slid off the trailer at which time he jumped through the open windshield off of it fearing that the excavator would roll over on him. Claimant noted that he had to jump far out and away in order to clear the trailer.

In describing the excavator claimant estimated it weight at ninety-seven thousand pounds. The excavator sits like a bulldozer on a frame that has metal tracks instead of wheels. The excavator is equipped with a bucket that when fully extended reaches 28 feet and has a capacity to hold two yards of material.

Claimant estimates that he was approximately six feet off the ground at the time he jumped out of the excavator. Claimant testified that he broke his left foot from the impact of jumping out of the excavator. Claimant explained that he instantly realized that he had sustained an injury in the accident when he experienced severe pain and was unable to stand or bear weight on his left foot.

Claimant received initial medical treatment relative to the injury growing out of the May 11, 2005, accident at the emergency room of Harris Hospital in Newport, where he was seen by

Dr. Pulisetty. Claimant was directed to refrain from all weight bearing for several day. Also due to the presence of swelling in the left foot a cast was not applied to the foot. Within a week of the accident through the assistance of crutches begin the partially put weight on the lower extremities. Claimant observed that when he started walking on crutches he noticed that he was experiencing physical problems elsewhere, other than his known fractured left foot. The problems were in his right hip and right leg, which claimant described as a burning in the hip that went down the right leg and a sensation of his right foot going to sleep or numbness. The burning in the right hip area was below the claimant's belt line. Claimant asserts that he continues to experience the afore symptoms.

Claimant acknowledged that he has had medical problems with his back in the past. Claimant's past medical problems include treatment for injuries sustained in a motor vehicle accident. Claimant denies that any of his past medical problems or injuries produced symptoms similar to those he experience once he begin to partially bear following the May 11, 2005, accident.

Claimant had access to a 1-800 telephone number whereby he contacted the claims representative and case manager of respondent-carrier, Ms. Linda Howell and Ms. Linda Grimes. Claimant relayed his additional complaints of right hip pain, burning/numbness/pain in his right leg and right foot, which he attributed to the May 11, 2005, work-related accident, and requested permission to have the same examined by a physician. Claimant was told by the carrier's representative that the complains were due to the fact that he was putting too much weight on the right leg and that the problems/complaints would resolve over time. Arrangements were not made to have the claimant's right sided complaints evaluated by a physician by the claims

representatives.

When the complaints did not resolve claimant continued to relay same to the claim representatives of respondents, however no effort was made by respondents to have the claimant's complaints medically evaluated. The credible testimony of the claimant reflects that he registered his complaints relative to his right hip, leg, and foot to the examining and treating physicians which had been selected by respondent, however neither medical treatment, examination, or evaluation was forthcoming by the physicians. Regarding his continuing request for authorization from the claims representative for medical treatment for his right hip-leg-foot complaints claimant testified:

After they told me to wait until I got off the crutches, wait until I put weight on both legs. And then it didn't get no better. And then when I called them back and told them it wasn't getting any better, that's when she said she - -

\* \* \*

I called them back and told them that the leg wasn't getting no better, and that I was going to have to see a doctor. She said she would call me back. I called her back. And she said they couldn't do nothing with it. It had been too long. (T. 19-20).

The claimant, who resides in Newport, was directed by respondents to an orthopedic physician in Mountain View, Ark., for care and treatment regarding his left lower extremity injury growing out of the May 11, 2005, accident. While the claimant asked Dr. Varela to check out his right hip, right leg, and right foot complaints, he declined to do so based on the fact that the claimant had been referred to him for the left lower extremity compensable complaint. The testimony of the claimant reflects that it was at the point that he had been directed to the Mountain View orthopedic physician and had been declined treatment/evaluation of his right-

sided complaints that he contacted the claims representative and was told that too much time had elapsed for treatment of the right hip/leg complaint. Claimant testified that it was his impression that when he was referred to the Mountain View physician that his right-sided complaints would be addressed.

Prior to his referral to Dr. Varela in Mountain View, claimant had been examined by Dr. Eichert in Jonesboro. Claimant's testimony reflects that he relayed his right-sided complaints, which he attributed to the May 11, 2005, work-related accident to Dr. Eichert, who declined to address same. Regarding his experience with Dr. Eichert, to whom he was referred by respondents, Claimant testified:

He came in there, he had me sit on the table. He took a little reflex above my knee, off the back of my leg, got his paperwork and walked out the door.

\* \* \*

No. He made me take a couple of steps across the floor, and he thumped my knee. That's about it. (T. 34).

Claimant's testimony reflects that the duration of his evaluation/examination by Dr. Eichert was about twenty (20) minutes. Regarding his request of Dr. Eichert to check out his right-sided complaints during the examination, Claimant testified:

I asked would he check it, if they tell him to get him to check it because it had to be okayed. He said no. (T. 37).

The testimony of the claimant reflects that within a week following the May 11, 2005, accident he was placed on crutches and on same for twelve (12) weeks. Claimant was released to return to part-time work approximately four (4) weeks following the May 11, 2005, accident. Claimant returned to the employment of respondent on a part-time basis upon his release. The

credible evidence in the record reflects that when the claimant was released to part-time work, he reported to respondent-employer and was assigned duties sitting in a chair in the shop. Since putting his crutches aside while the claimant has returned to a full duty status, he has not resumed his pre-injury job duties. Claimant now ride around in the truck most of the time and serve in a support role of other employees. Claimant has resumed some limited operation of the heavy equipment.

The testimony of the claimant reflects that the pain in his right hip, right leg, and foot has gotten worse since its first onset within a week of the May 11, 2005, accident. As a consequence of the afore and the lack of access to sanctioned medical treatment relative to same, claimant sought medical treatment under the care of Dr. Nicole Lawson in February 2006, as a result of a referral of his family physician. Following her evaluation Dr. Lawson recommended that the claimant undergo a MRI scan and arranged for same to be done in Searcy. Claimant paid for the cost of the MRI scan, which disclosed objective findings of injury to his lumbar spine. Claimant has steadfastly maintained that the injury/complaints relative to his right hip, right leg and foot grew out of the May 11, 2005, accident just as the left lower extremity injury which was accepted by respondents as compensable.

Claimant was released as having reached maximum medical improvement with a 21 % to the left lower extremity by Dr. Charles Varela on March 22, 2006. Claimant asserts that but for the fact that he has a supportive employer and a supportive supervisor he would not be able to be continually working for respondent presently. Claimant is unable to pull his full weight due to the residuals of his compensable injury and specifically his right-sided complaints and symptoms.

Claimant acknowledged being involved in several motor vehicle accidents in the past, however had no recollection of a November 15, 1992, four-wheeler accident wherein medical treatment was received at Harris Hospital in Newport. Likewise claimant concedes that he received medical treatment at Harris Hospital on May 26, 1994, for complaints of back pain after riding a four-wheeler. On September 5, 2002, claimant was involved in a motor vehicle accident when he ran off the road, hit a tree, and flipped his pickup over.

Claimant acknowledged that he had treated with Dr. William C. Kent, his primary care physician, in the past. Claimant explained that Dr. Kent has given him shots in his shoulder for bursitis as well as pain medication for pulled muscles. There is no evidence in the record to reflect that the claimant sought or obtained medical treatment for complaints similar to his present right-sided complaints prior to May 11, 2005.

Mr. Shelley Evins, general manager for respondent-employer, testified that he has known the claimant and been his supervisor since he became the general manager in 1990. Regarding his observation of the claimant prior and subsequent to the May 11, 2005, accident, Mr. Evins testified:

His ability to get around on equipment prior to his accident, most of the time we go to move equipment, I didn't have to send anybody with him. But as far as jumping up on lowboy, getting chains, it's hard for him to do it. He can do it but about 90% of the time, I'll send someone with him to, he overlooks putting the excavator up there. He may put it up there. Someone else booms it down, which is securing it for safe transportation. (T. 39).

Regarding the claimant's character, based on his dealing with him since 1990, Mr. Evins' testimony reflects:

He's one of the few employees that I've had working under me

that I've never caught lying. In fact, there's a lot of time, I'll sign him a check when he - - we don't know where we can buy the part. He may carry it for a few days. It's a signed corporate check to buy what he needs to buy. (T. 41).

Mr. Evins testified that he was not aware of the claimant having back problems prior to the May 11, 2005, accident, although he was aware of the claimant's September 5, 2002, pickup truck accident:

He was involved in one of, I know a pick up. He was involved in an accident two or three years ago. He came to work. He had some bruises and minor cuts. And I told him before he him to work, I was going to need him to go get that checked out. Even though that it wasn't job related. I wanted him checked out to see that he was - did not have any injuries. (T. 44).

Regarding any four-wheeler accidents that the claimant may have been involved in prior to May 11, 2005, Mr. Evins testified:

Not that I can remember. He may be involved in something I have no knowledge but as far as his ability to work, I don't think there was never anything happened to not let him do his duties. (T. 44).

Mr. Evins provided context regarding his contact with the claims representative relative to the claimant's injuries and the claimant's return to work from the injuries. Regarding his concern about having the claimant's leg and foot medically checked out, Mr. Evins testified:

I started doing this when they wanted him to come back part time. I didn't think he was ready to come back part time.

\* \* \*

I said, I don't think he's ready. I visit with him, and the man just can't do what he normally does. But I'll give him - - I said there's no office work. What I have for him to do, he's got to be up on his foot. But they gave me a letter signed by a doctor saying he could work maybe three to four hours a day for four days a week. I went along with that. But what he did actually was sit in a chair down at the shop. When people

would come in, he would show them how to do different things. (T. 42).

Mr. Evins noted that with reservations he allowed the claimant to return to work because of the insistence of the one of the case workers. Mr. Evins explained the afore:

That's right. I was concerned that maybe we would do further damage by him - - that's the reason I told him, I told everybody up there to give him a chair, make sure he's sitting in the chair. (T. 43).

The medical records reflect that the claimant was last seen at Harris Hospital in Newport on September 5, 2002, prior to his May 11, 2005, compensable injury. The September 5, 2002, hospital visit was the product of a motor vehicle accident the preceding day. Claimant complained of stiffness and soreness, as well as pain or hurting in his right shoulder, chest and right leg along with multiple bruises on his forehead, hands and chest. The claimant's motor vehicle injuries were diagnosed as contusions for which he was prescribed Lorcet Plus/Skelaxin. Claimant was also directed to return to the emergency room if he was not better. (RX. #1, p. 3). There is no evidence in the record to reflect that the claimant sought or required further medical treatment relative to the September 2002, motor vehicle accident. Nor is there evidence to reflect that the claimant suffered residuals from the September 2002, motor vehicle accident that restricted or impaired him in the discharge of his employment duties.

Prior to the above cited September 5, 2002, visit to Harris Hospital, the evidence in the record reflects that claimant had last received medical treatment on May 26, 1994, for complaints of back pain brought on by riding a 4-wheeler over rough ground. Claimant's complaint was diagnosed as an acute lumbar sprain, recurrent, for which he was prescribed pain medication and anti-inflammatories.(RX. #1, p. 2). Prior to the May 26, 1994, Harris Hospital visit, the records

reflect that claimant was last seen at that facility on November 15, 1992. (RX. #1,p. 1).

On May 11, 2005, the claimant was seen at Harris Hospital with a history of a left ankle injury “with a jumping and twist”. After initial emergency medical treatment claimant was directed to keep the leg elevated and to see Dr. Pulisetty the following day. (CX. #1, p. 1-4).

The May 12, 2005, consultation report of Dr. Diwakar Pulisetty, a Newport orthopedic surgeon, relative to the claimant reflects, in pertinent part:

. . . This is a 44-year-old white male who works as a laborer for Greenhead Farming Co., jumped off a truck, twisted the left foot and ankle, sustained injury. He was seen later in the Emergency Room, was given a short-leg brace with the diagnosis of calcaneous fracture. From the injury, his main complaint is confined to the foot and ankle only. He did not have any other musculoskeletal injury. He didn't have any other internal injury.

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#### MUSCULOSKELETAL SYSTEM EXAMINATION:

Spine: Straight.

Gait: Antalgic gait from left foot pain.

Examination of the left lower extremity: Hip and knee joints are unremarkable with normal with normal ROM and muscle strength and skin condition.

Left foot and ankle examination: Swelling of the heel, ankle and midfoot. There is severe tenderness in the calcaneous. There is no tenderness in the toes or the metatarsals. No definitive tenderness in the ankle joint itself. ROM in the ankle, hindfoot are restricted, secondary to pain. ROM in the digits also restricted secondary to pain in the heel. Contralateral lower extremity examination: Unremarkable.

X-rays of the foot and ankle available. There is a fracture of the body of the calcaneous seen. Bohler angle maintained. Overall, there is no significant displacement of the fracture.

DIAGNOSIS: Minimally displaced fracture, os calcis, left foot.

MDM: Since this is not a displaced or compressed fracture of the os calcis with intact subtalar joint, I would like to treat him non-operatively.

He should be able to get not only healing but also ROM in the hindfoot. Condition, prognosis, treatment options were discussed in detail, patient has readily agreed for non-operatively management. He will continue to have short-leg brace for his swollen heel and foot for now. He will keep the leg elevated to bring down the swelling. He will remain non-weightbearing. He will keep off work for sometime, to start with three (3) weeks. If he can modify the job to a sitting/desk work, I would let him start working very soon. He told me his job involves sitting, squatting, climbing, and walking. I'm afraid he cannot do this until the fracture heals. He will have Darvocet for pain medication, ice the foot whenever he experiences severe pain. (CX. #1, p. 4-5).

The claimant returned to the employment of respondent on a part-time basis pursuant to the above directions of Dr. Pulisetty. On July 8, 2005, claimant was seen at Harris Hospital relative to an injury to his finger which was sustained when he got the finger caught in a chain. It is undisputed that the claimant was continuing to experience residuals and to receive treatment for the acknowledged compensable left lower extremity injury, nevertheless no reference was made to the same in the records of the visit. (CX. #1, p. 12). The afore adds credence to the claimant's assertions that he complained about his right hip and leg pain to medical providers within a week of the May 11, 2005, accident and the failure of same to document the complaints in medical records.

Claimant was again seen by Dr. Pulisetty on September 9, 2005. The clinic note relative to the visit reflects, in pertinent part:

Mr. Barnes said that the heel does not hurt when he is walking and putting pressure on the affected extremity. His main symptoms are on the lateral aspect of the ankle, and the numbness in the small toe and weakness in the great toe. Clinically, there is no swelling. . . .

Work Status: He said he would like to increase the number of hours per week. He wanted to make it 30-35 hours per week, as he tolerates. I agreed with him. He also requested Lorcets for pain relief. I cautioned him about the addiction potential for the prescription pain medicine. He

said he understands this. He wanted pain medicine to be able to increase the loading on the heels. I also cautioned him not to take prescription pain medicine while at work, especially with instruments that may cause harm to himself, as well as others, he said he understands this. (CX. #1, p. 13).

On November 1, 2005, claimant was seen by Dr. Stephen J. Eichert, D.O., pursuant to arrangements by Ms. Linda Howell, R.N., a case manager with CompChoice. The Medical Treatment Report, which was completed by Dr. Eichert, recites the claimant's name, date of the appointment, date of injury and diagnosis of "chronic low back pain". The document also reflects that the claimant was released as having reached maximum medical improvement and was released to full duty with no restrictions. (CX. #1, p. 14).

Dr. Eichert's narrative report of November 1, 2005, to Ms. Howell relative to his examination of the claimant reflects, in pertinent part:

I examined Charles Barnes in the presence of his ex-wife today. He is a 45-year-old right-handed white male who jumped off of a vehicle and fractured his left foot on May 11, 2005. Since that time he has been treated by an orthopedic surgeon for a fracture. He has done well, but complains that he cannot flex his left great toe and he has a little bit of numbness.

He has had back pain for many years and is being treated by Dr. Coleman Kent for this currently. He tells me that his right leg goes to sleep at times and that on standing it seems to be more problematic. That is new. Current medicines are Valium, Soma, and Lortab. There are no allergies. Tobacco use is two packs of cigarettes per day for 20 years.

Physical exam is significant for brisk symmetric deep tendon reflexes, flexor plantar responses, and the absence of focal weakness. He can heel and toe walk without obvious difficulty. Straight leg raising is unremarkable.

Charles Barnes is recovering from a fracture of his left foot. He has chronic low back pain.

There is no evidence of a new neurologic injury and he is at MMI from my viewpoint. (CX. #1, p. 15).

Despite the severity of the claimant's acknowledged compensable left lower extremity injury, Dr. Eichert purports to release the claimant as having reached maximum medical improvement without any restrictions on his employment activities. On the one hand Dr. Eichert writes that the claimant "is recovering from a fracture of his left foot", while at the same time pronouncing him at maximum medical improvement. While Dr. Eichert asserts that the claimant "has had low back pain for many years", there are no medical reports in the record of Dr. Kent Coleman evidencing such treatment. Claimant is succinct and credible in describing the medical treatment he received under the care of Dr. Kent. Further, there is no evidence in the record to reflect that any complaints for which the claimant received medical treatment from Dr. Kent restricted, limited or impaired the claimant's ability to perform his employment duties for respondent prior to May 11, 2005.

On December 5, 2005, claimant was seen by Dr. Charles D. Varela, a Mountain View orthopedic physician, pursuant to arrangement by the case manager. The focus of the December 5, 2005, visit of the claimant to Dr. Varela was the claimant's left foot injury. Dr. Varela's assessment of the claimant's complaints, following his examination, were status post left calcaneal fracture and fracture proximal phalanx, second toe. In terms of a treatment plan, the December 5, 2005, clinic note of Dr. Varela reflects, regarding the claimant:

The patient is advised at this time that the fracture has healed about as well as it can be expected. The patient was advised that he needs to wear good supportive work boots and that he can engage in normal activity as tolerated without restriction or impairment. At this point, no further surgical/medical intervention is necessary. The patient can progress to normal activities without restriction or impairment. The

patient is advised that he still continues to have nonspecific pain and swelling of the heel that I would recommend another three months of care. The patient will return at that time, and I believe that the patient will have reached medical improvement at that time and impairment can be performed at that time. Since this is an intraarticular injury of the subtalar joint, the patient is at risk for degenerative arthritis in the future of the subtalar joint. The exact probability of this cannot be stated, however, it would only be a mild risk. (CX. #1, p. 16).

The December 5, 2005, clinic note of Dr. Varela made no mention of the claimant's complaints relative to his right hip, leg and foot, although the same was at the focus of November 1, 2005, visit to Dr. Eichert.

Claimant was again seen by Dr. Varela on February 22, 2006. The clinic note regarding the February 22, 2006, visit reflects, in pertinent part:

Mr. Barnes follows up for recheck calcaneus fracture. He states that he still has some limited range of motion of the great toe on that side with pain from the heel to the end of the foot as well as even more marked pain in the left lateral anterior ankle with weight bearing. He is noting that he has developing problems on the other lower extremity secondary to abnormal gait. (CX. #1, p. 17).

The physical examination conducted by Dr. Varela during the February 22, 2006, visit of the claimant was limited to the claimant's left lower extremity complaint/injury. Dr. Varela did provide treatment to the claimant during the February 22, 2006, visit in the form of an intraarticular injection of Depo-Medrol, lidocaine and Marcaine. Dr. Varela noted during the February 22, 2006, visit that the claimant was "reaching" maximum medical improvement. On March 22, 2006, Dr. Varela, following his examination of the claimant's left lower extremity compensable injury, concluded that the claimant had reached maximum medical improvement and assessed 21 % permanent physical impairment to the claimant's left foot. (CX. #1, p. 18).

A February 24, 2006, correspondence of Dr. Nicole M. Lawson, a Newport family physician, relative to the claimant reflects, in pertinent part:

I have been treating Mr. Barnes since January 25 of this year for severe back pain. According to Mr. Barnes he injured his back at work and pain has gotten increasingly worse with time. He has been trying to work which requires manual labor, therefore causing his symptoms to worsen. Because of the symptoms he continues to have and the history I have obtained, it is my medical opinion he needs an MRI of his lumbar and thoracic spine as soon as possible along with physical therapy. I previously ordered this but he was unable to get this done due to the cost. Please see if you can be of assistance in helping get authorization for this. If you have any questions or concerns or I may be of further assistance, please give me a call. (CX. #1, p. 22).

On February 24, 2006, claimant was seen at Searcy Open MRI, pursuant to referral of Dr. Lawson, and underwent the recommended MRI scan. The MRI scan report reflects, in pertinent part:

L2-3: Diffuse disk bulge is noted at this level superimposed on a broad based protrusion in the right extraforaminal region. This protrusion may impinge upon the right L2 nerve root although this is not definite. No significant central canal stenosis or neural foraminal narrowing is observed.

\* \* \*

L4-5: Diffuse disk bulge at this level results in minimal bilateral anteroinferior narrowing without nerve root impingement or central canal stenosis. There is a small central annular tear at this level.

L5-S1: A diffuse disk bulge at this level results in severe bilateral neural foraminal narrowing with impingement upon the bilateral exiting L5 nerve roots. Additionally there is a 8 mm right paracentral disk extrusion with superior migration. This disk extrusion impinges upon the thecal sac at the level where the right S1 nerve root leaves the thecal sac. No significant central canal stenosis is observed.

IMPRESSION:

1. RIGHT PARACENTRAL DISK PROTRUSION AT L5-S1 MEASURING 8 MM WITH SUPERIOR MIGRATION AND POSSIBLY IMPINGEMENT UPON THE RIGHT S1 NERVE ROOT. ADDITIONALLY DIFFUSE DISK BULGE AT L5-S1 APPEARS TO IMPINGE UPON THE EXITING BILATERAL L5 NERVE ROOTS AT THE NEURAL FORAMEN.
2. SLIGHT EXTRAFORAMINAL BROAD BASED DISK PROTRUSION AT L2-3. IMPINGEMENT ON THE RIGHT L2 NERVE ROOT CANNOT BE EXCLUDED AT THIS LEVEL.
3. NO OTHER EVIDENCE OF NERVE ROOT IMPINGEMENT OR CANAL STENOSIS IS OBSERVED. (CX.#1, p. 20-21).

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, 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 May 11, 2005, the relationship of employee-employer-carrier existed among the parties.
3. On May 11, 2005, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$305.00/\$229.00, for temporary total/permanent partial disability.
4. On May 11, 2005, the claimant sustained an injury to his back, as well as his left lower extremity, arising out of and in the course of his employment with respondents.
5. The attorney fee provision of the Arkansas Workers' Compensation Act, as codified in Ark. Code Ann. §11-9-715 (2)(B)(ii), is constitutional.
6. The medical treatment rendered to the claimant relative to his back, right hip, right leg/foot complaint under the care of Dr. Nicole Lawson, as well as referrals therefrom, to

include the February 24, 2006, MRI scan, is reasonable and necessary medical treatment in connection to the claimant's compensable injury. Respondents controverted the compensability of the claimant's low back, right hip/leg/foot injury.

7. The respondent shall pay all reasonable hospital and medical expenses arising out of the claimant's low back injury which grew out of the May 11, 2005, compensable accident.

8. The respondents have controverted the claimant's entitlement to all workers' compensation benefits relative to his compensable low back injury growing out of the May 11, 2005, compensable accident.

### **DISCUSSION**

On May 11, 2005, while discharging employment duties for respondent-employer, claimant was involved in a work-related accident. The injury to the claimant's left lower extremity was accepted as compensable and respondents paid appropriate corresponding medical and indemnity benefits. Claimant maintains that the May 11, 2005, accident also resulted in an injury to his low back, which was manifested by right hip and leg pain as well as numbness and a burning sensation in the right leg and foot. Claimant seeks corresponding workers' compensation benefits regarding his low back. Respondents content that the claimant did not suffer a compensable lower back injury on May 11, 2005.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation as a result of an injury having been sustained subsequent to the effective date of the afore provision. In order to prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, the claimant must establish by a preponderance of the evidence: an injury arising out

of and in the course of employment; that the injury caused internal or external harm to the body which required medical services or resulted in disability or death; medical evidence supported by objective findings, as defined by Ark. Code Ann. §11-9-102 (16), establishing the injury; and that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. §11-9-102 (4)(A) (i).

Claimant has been employed by respondent-employer for a period of between 16 and 18 years as an operator of heavy equipment. While the medical in the record does reflect that the in 1992, and 1994, claimant sought and obtained medical treatment at Harris Hospital in Newport for complaints of back pain associated with operating a 4-wheeler, there is no evidence that the same resulted in prolonged medical treatment, extensive diagnostic studies or restrictions or limitations on the claimant's employment activities.

In September 2002, claimant was involved in a non-worked motor vehicle. Claimant reported for work following the accident and only sought and obtained medical treatment at the insistence of his supervisor. The injuries sustained in the September 2002, motor vehicle accident did not prevent the claimant from performing his regular employment duties, nor is there evidence in the record to reflect that the injuries warranted extensive diagnostic studies or treatment.

The mechanics of the claimant's May 11, 2005, work-related accident is not disputed. Claimant jumped through the open windshield of the excavator and out far enough to clear the trailer on which the excavator was loaded. The excavator was approximately six (6) feet off the surface. The initial impact from the jump affected the claimant left lower extremity, and the lower extremity injury was immediately appreciated by the claimant. Because of the severity of

the left lower extremity injury, the initial complaint and medical treatment was focused on the extremity.

Once the claimant began using crutches and attempting to bear weight through the use of same, he correspondingly began experiencing symptoms on his right side, and more specifically in the right hip, right leg and foot. I find the claimant to be a credible witness. The veracity of the claimant is attested by his long-term supervisor. The credible evidence reflects that when the claimant relayed his complaints/symptoms regarding his right hip and leg to claims representatives of respondent-carrier he was informed that the same was probably due to the fact that he was not accustomed to use of the crutches and had just began bearing weight.

While the medical providers furnished medical treatment for the acknowledged compensable left lower extremity injury, respondent-carrier withheld authorization to address the claimant's symptoms relative to his right hip, leg and foot. While the November 1, 2005, report of Dr. Eichert recited the claimant's complaint regarding his right hip, leg, and foot, the report does not reflect the results of a physical examination or whether an examination was in fact conducted with respect to right-sided complaints. Dr. Eichert's conclusion that there was no evidence of "new neurologic injury" is completely contrary to the results of the objective findings of the February 24, 2006, MRI scan. The medical care the claimant received from Dr. Eichert was almost nonexistent as it related to his back complaint, which was primary reason for the examination. (CX. #1, p. 14). *Stephenson v. Tyson Foods, Inc.*, 70 Ark. App. 265, 19 S.W.3d 36 (2000).

The credible evidence preponderates that the claimant consistently complained of symptoms of pain in his right hip, right leg pain and burning sensation along with numbness, and

right numbness, within a week or shortly thereafter following his May 11, 2005, compensable accident. Respondent-carrier ultimately informed the claimant that it was not responsible for his right-sided complaints because he had waited too long. Nevertheless, the evidence preponderates that respondent-carrier or its representative consistently urged the claimant to “wait” and allow time for his symptoms to resolve.

After being informed that respondents would not be responsible for medical treatment regarding his right-sided complaints, claimant sought medical treatment for his complaint under the care of Dr. Nicole Lawson. At the time the claimant was seen by Dr. Lawson, respondents had denied the compensability of the back injury, which was producing the right hip, right leg and right foot symptoms. Respondents were fully aware that the claimant was relating the afore as the product of the May 11, 2005, work-related accident.

Ark. Code Ann. §11-9-508 (a) requires an employer to provide such medical services as may be reasonably necessary in connection with an employee’s injury. *Cox v. Klipsch & Associates*, 71 Ark. App. 433, 30 S.W.3d 764 (2000). What constituted reasonable and necessary medical treatment is a question of fact. In the instant claim, the evidence preponderates that prior to May 11, 2005, claimant discharged his assigned job duties in the employment of respondent-employer with physical limitation or restrictions relative to his low back. Subsequent to the May 11, 2005, work-related accident, claimant has consistently complained of right hip pain, right leg pain and burning sensation along with numbness, and right foot symptoms. Once the claimant’s complaints were adequately by a physician, Dr. Lawson, subsequent diagnostic studies [MRI scan] confirmed objective findings of evidencing the injury. There is no evidence in the record reflecting that the claimant has been engaged in heavy manual

labor or that he has suffered any other accidental injury to produce the back injury other than the May 11, 2005, work-related accident.

The claimant has sustained his burden of proof by a preponderance of the evidence that he suffered an injury to his low back within the course and scope of his employment with respondent during the May 11, 2005, work-related accident. Respondents have controverted the claimant's entitlement to all workers' compensation benefits relative to his low back growing out of the May 11, 2005, accident.

Medical treatment rendered to the claimant under the care of Dr. Nicole Lawson, to include referrals therefrom, is reasonable and necessary in connection with the claimant's May 11, 2005, compensable back injury. Respondents are liable for the cost of said medical treatment, to include the cost of the February 24, 2006, MRI scan.

#### **AWARD**

Respondents are herein ordered and directed to pay all reasonable, necessary and related medical, hospital, nursing, and other apparatus expenses, to include medical relate travel, growing out of the May 11, 2005, compensable injury to the claimant's low back.

Maximum attorney fees are herein awarded to 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.**

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