

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F411268

BOBBY A. CASH, EMPLOYEE	CLAIMANT
NUCOR YAMATO STEEL COMPANY, EMPLOYER	RESPONDENT
ACE AMERICAN INSURANCE COMPANY, INSURANCE CARRIER/TPA	RESPONDENT

OPINION FILED MAY 25, 2006

Hearing before Chief Administrative Law Judge David Greenbaum on April 21, 2006, at Luxora, Mississippi County, Arkansas.

Claimant appeared, *pro se*.

Respondents represented by Mr. Michael E. Ryburn, Attorney-at-Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted on April 21, 2006, to determine whether the claimant was entitled to additional workers' compensation benefits.

A prehearing conference was conducted in this claim on February 22, 2006, and a Prehearing Order was filed on said date. A copy of the Prehearing Order was marked "Commission's Exhibit 1" and made a part of the record without objection.

At the prehearing conference, the parties stipulated that the employment relationship existed at all relevant times, including April 17, 2003; that the claimant sustained a compensable crush injury to his left foot on said date; that he earned sufficient wages to entitle him to the maximum compensation rates of \$440.00 per week for temporary total disability and \$330.00 per week for permanent partial disability; that respondents paid related medical treatment through on or about

March 10, 2004; and that respondents had controverted all benefits beyond those previously paid.

At the prehearing conference, the parties agreed that the primary issue to be presented for determination concerned claimant's entitlement to additional medical care and treatment. In addition, respondents raised the statute of limitations as an affirmative defense.

Claimant contended, in summary, that he continued to experience significant physical problems involving his left foot and that respondents improperly terminated all medical treatment; that respondents should be directed and ordered to pay all outstanding medical treatment, together with continued, reasonably necessary medical treatment, including, but not limited to possible surgery suggested by his primary treating physician. Because the claimant was drawing long-term disability benefits, he reserved his entitlement to indemnity benefits, both temporary total disability, as well as permanent partial disability pending a determination on the agreed issues.

The respondents contended that the claimant was released to return to work without any permanent disability and was not entitled to any further benefits. Respondents further maintained that the statute of limitations had run on this claim. Specifically, respondents contended that the claimant did not file a claim for additional benefits within two (2) years of the date of accident or one year from the date of last payment. Finally, respondents claimed a credit for any long-term

disability benefits paid.

Prior to the start of the hearing, respondents dismissed its statute of limitations defense. It acknowledged that after the prehearing conference, discovery reflected that a claim for additional benefits was timely filed through a Commission Form AR-C. Accordingly, the sole issue concerned respondents' responsibility for outstanding medical treatment, together with remaining responsible for continued medical treatment.

Again, it is undisputed that the claimant sustained a crush injury to his left foot on April 17, 2003. At the hearing, the claimant alleged that as a result of the injury to the left foot, over time, he favored that foot so much that it caused severe inflammatory arthritis in his right foot and that respondents should be responsible for treatment for both the left foot, as well as the right foot. In response, respondents contended that claimant's injury had healed and that the injury was merely a temporary aggravation of a pre-existing condition and that any further treatment necessary to either foot was due to the claimant's inherent condition of arthritis and was unrelated to the April 17, 2003, admitted injury. Clearly, the Prehearing Order did not reflect any issue concerning the possible compensable consequence of claimant's right foot problems, although, admittedly, the medical evidence did note both complaints.

The claimant has, on numerous occasions, been advised of his right to legal representation; that under the workers' compensation laws, an attorney could not

charge him a fee for representing him in a workers' compensation claim without approval of this Commission; that fees are normally awarded out of any benefits that an attorney might secure in his behalf, and that a portion of the fee would be the responsibility of respondents. In addition, the claimant was advised that he had the burden of proving his entitlement to additional benefits and that if he failed to meet his burden, he could not request a second hearing, maintaining that his failure was due to his lack of knowledge of the workers' compensation law or lack of legal representation. The claimant elected to proceed, *pro se*.

A procedural history of this claim is necessary to address the limited issues. As will be set out further below, by necessity, the nature and extent of claimant's injury, as well as claimant's entitlement to further workers' compensation benefits requires further development of the medical evidence and must be specifically reserved. Although the claimant has the burden of proof relative to any issues, the claimant's attempts to obtain follow-up medical care was complicated in part because both the claimant and employer converted the claimant's medical care to health insurance and claimant's disability to long-term disability benefits. In fact, the record reflects that the claimant receives significantly more in disability than he would be entitled in workers' compensation benefits. Respondents have asserted a credit for any benefits paid pursuant to A.C.A. §11-9-411. Further, the record reflects that although the claimant petitioned for a change of treating physicians, he failed to follow through with his petition, and the Commission did not act on the

request because it erroneously believed compensability was being disputed. The record clearly reflects that the claimant has never exercised his absolute right to a one-time change of treating physicians. Further, his efforts at obtaining follow-up care were frustrated in part because respondents asserted a statute of limitations defense which was dismissed at the within hearing. The claimant has proven, by a preponderance of the credible evidence that he continues to experience significant problems with his left foot and is entitled to follow-up maintenance care. Despite the claimant's assertion at the prehearing conference, there is no credible evidence whatsoever that the claimant requires any type of surgical intervention. In fact, at the hearing, the claimant stated that the only follow-up care he was seeking was prescription medication to treat his injuries. He pointed out that all medical treatment was initially paid by the workers' compensation carrier, but that it was subsequently covered by his employer's group health insurance until recently when his health insurance was cancelled.

Subsequent to the hearing, the claimant, by two (2) separate letters, requested additional workers' compensation benefits. In the first, the claimant requested a change of treating physicians, which he pointed out was his second request. In a second letter, the claimant requested a hearing concerning the compensable consequence of his right foot condition. These additional issues will require further proceedings and are specifically reserved.

Again, a summary of the procedural history is warranted.

As reflected by the stipulations, the claimant sustained a compensable crush injury to his left foot on April 17, 2003. Respondents paid related medical through on or about March 10, 2004, at which time it terminated all benefits. On October 27, 2004, the claimant filed a Commission Form AR-C requesting both initial benefits, as well as additional benefits, including a request for change of physicians. This was also claimed in a cover letter attached to the Commission Form AR-C. The claim was then assigned to the Commission's Medical Cost Containment Division to address the change of physicians request. The change of physicians request was never acted upon because the respondent failed and/or refused to respond to the Commission Form AR-C filed by the claimant. Thereafter, the claim was assigned to the Legal Advisor Division for a legal advisor conference and/or a mediation conference. Attempts to resolve the claim through mediation or other amicable means were unsuccessful. The claim was then assigned to the Adjudication Division on December 2, 2005. A prehearing questionnaire was sent on December 2, 2005. Following receipt of prehearing information filings by both parties, a prehearing conference notice was sent January 3, 2006, scheduling a prehearing conference for February 22, 2006. The prehearing conference was conducted as scheduled and a Prehearing Order filed February 22, 2006, as reflected above which was introduced as "Commission's Exhibit 1."

The claimant was the only witness to testify. The record is composed solely of the transcript of the April 21, 2006, hearing containing the claimant's credible

testimony, together with medical reports submitted by both parties.

The claimant, Bobby Cash, is forty-one (41) years old. He completed the 11th grade. He subsequently received his G.E.D. The claimant worked for Nucor Yamato Steel Company for approximately five (5) years before sustaining his admitted injury. The claimant's description of the injury is set out below:

Q Okay. Now, tell us how your injury occurred on April 17th of '03?

A I work what is called the repair bed. What they do, if the inspector sees a flaw in the I-beam, they send it back to us at the repair bed and we either fix it or cut it to a new length. Okay. At the time of the injury we were getting a lot of bent flanges back on the I-beams, a bunch of them. I was up on the repair bed doing my job, as I was trained to do, and swinging a sledgehammer knocking the dents out of the flanges. The crane operator was getting really frustrated because he had to flip every bar so we could fix it. Well, he got in such a rush and aggravated, he grabbed one bar and he just – I don't know if he hit the wrong switch or what, but he rammed another I-beam into the I-beam that I was working on and crushed my foot between the I-beam that I was working on and the side guard of the repair bed.

Q So your foot was in between two I-beams, is that right?

A Actually, between the I-beam and the side guard –

Q Okay.

A – which is steel also. (Tr.14-15)

The claimant was initially taken to the emergency room for treatment. The claimant was then referred to Dr. Yao, an orthopedic surgeon in Blytheville, Arkansas. Dr. Yao did not treat the claimant's crush injury, but referred the claimant to Dr. John J. Lochemes, with the Memphis Orthopedic Group in Memphis, Tennessee. The claimant did not undergo any surgeries. Dr. Lochemes treated the claimant conservatively with medication and various foot casts and walking shoes.

The claimant was permitted to return to work and was provided a sit-down job for several months until the employer could no longer provide accommodations, at which time the claimant was placed on long-term disability benefits. The claimant maintained that he has never received any workers' compensation benefits; however, acknowledged that he had been drawing \$2,964.00 per month since disability benefits were initiated which he stated was guaranteed until age 65. (Tr.19)

Dr. Lochemes subsequently referred the claimant to the Memphis Rehab Center for a functional capacity evaluation which was performed on September 9, 2003. Following the functional capacity evaluation, Dr. Lochemes released the claimant on September 11, 2003, with permanent restrictions of medium work with a fifty (50) pound occasional lifting limit and standing tolerance in the one (1) to two (2) hour range with limited climbing. (Resp. Ex. A, pp.1-6)

Despite the aforementioned permanent restrictions, for some unexplained reason, on October 30, 2003, Dr. Lochemes issued a report indicating no restrictions from the work injury and to return to work pending fitness for duty and to return as needed. (Resp. Ex. A, p.7)

At the time of his release, Dr. Lochemes was treating the claimant with medications, specifically, Vioxx, Xanax, and Tylenol. The record does reflect that Dr. Lochemes referred the claimant to Dr. Randy Roberts, a rheumatologist who saw the claimant in consultation on September 16, 2003. Dr. Roberts diagnosed

inflammatory arthritis, with characteristics of reactive arthritis. Dr. Roberts started the claimant on additional medication, Indomethacin, while noting that the usual course would indicate significant improvement over a period of months or even resolution while noting possibly recurrent, periodically. (Resp. Ex. A, pp.9-10)

Again, Dr. Lochemes' reports are confusing at best. The claimant introduced a long-term disability benefit statement signed by Dr. Lochemes, reflecting the restrictions in work tolerance were permanent rather than temporary which renders Dr. Lochemes' October 30, 2003, employment report indicating no restrictions suspect, at best. (Cl. Ex. B)

The record reflects that the claimant subsequently saw a foot doctor, Dr. Bryan H. Glenn, on his own. As previously pointed out, although the claimant petitioned for a change of physicians, as of the date of the within hearing, the claimant had not followed through on his petition. Accordingly, because the claimant has failed to pursue or comply with the statutory requirements for change of physicians, Ark. Code Ann. §11-9-514, any such treatment would be considered unauthorized and not the responsibility of the respondent/insurance carrier. By necessity, this issue, as well as additional issues raised for the first time at the hearing, as well as subsequent to the hearing, must be reserved. The Commission cannot retroactively approve the change. *American Transportation Co. vs. Payne*, 10 Ark. App. 56, 661 S.W.2d 418 (1983).

Again, the change of physicians issue is not currently before the

Commission. The issue has never been developed. I assume it is even possible that the claimant selected Dr. Yao who referred the claimant to Dr. Lochemes. Further, it is possible that the change of physician rules do not apply if the employer failed to provide the claimant with a Commission Form AR-N concerning his rights. Again, said issue is not currently before the Commission and must be reserved.

Further, it is undisputed that the claimant has received significant benefits from the employer's group disability policy, as well as group accident and health insurance policy, and that the provisions of A.C.A. §11-9-411 set out below for the claimant's information only apply:

(a) Any benefits payable to an injured worker under this chapter shall be reduced in an amount equal to, dollar-for-dollar, the amount of benefits the injured worker has previously received for the same medical services or period of disability, whether those benefits were paid under a group health care service plan of whatever form or nature, a group disability policy, a group loss of income policy, a group accident, health, or accident and health policy, a self-insured employee health or welfare benefits plan, or a group hospital or medical service contract.

(b) The claimant shall be required to disclose in a manner to be determined by the Workers' Compensation Commission the identify, address, or phone number of any person or entity which has paid benefits described in this section in connection with any claim under this chapter.

(c)(1) Prior to any final award or approval of a joint petition, the claimant shall be required to furnish the respondent with releases of all subrogation claims for the benefits described in this section.

(2)(A) In the event that the claimant is unable to produce releases required by this section, then the Commission shall determine the amount of such potential subrogation claims and shall direct the carrier or self-insured employer to hold in reserve only said sums for a period of five (5) years.

(B) If, after the expiration of five (5) years, no release or final court order is presented otherwise directing the payment of said sums, then the carrier or self-

insured employer shall tender said sums to the Death and Permanent Total Disability Trust Fund.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The stipulations agreed to by the parties and contained in the February 22, 2006, Prehearing Order are hereby accepted as fact.
3. The claimant has proven, by a preponderance of the credible evidence, that he is entitled to continued, reasonably necessary medical treatment.
4. This claim is not barred by statute of limitations.
5. The nature and extent of claimant's injury, as well as claimant's entitlement to further benefits requires further development of the medical evidence and is, by necessity, specifically reserved.

DISCUSSION

The Workers' Compensation Act requires employers to provide such medical services as may be reasonably necessary in connection with an employee's injury. A.C.A. §11-9-508; *American Greeting Corp. vs. Garey*, 61 Ark. App. 18, 963 S.W.2d 613 (1998). What constitutes reasonably necessary medical treatment under A.C.A. §11-9-508 is a question of fact for the Commission. *Gansky vs. Hi-Tech Engineering*, 325 Ark. 163, 924 S.W.2d 790 (1996); *Geo Specialty Chem., Inc. vs. Clingan*, 69 Ark. App. 369, 13 S.W.3d 218 (2000). Medical treatment which is

required to stabilize and maintain an injured worker's status remains the responsibility of the employer. *Artex Hydroponics, Inc. vs. Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983).

The claimant's credible testimony reflects that he continues to experience physical problems involving his injured left foot and requires anti-inflammatory medication, as well as medication for pain. The claimant has proven that this medication is reasonably necessary, as well as related to the admitted injury, and should be paid by the respondent/insurance carrier. The problem in this claim is that the claimant has failed to prove that his outstanding medical expenses were by an authorized treating physician. Accordingly, the claimant is required to return to an authorized treating physician to either obtain the medications needed or obtain a valid referral to another physician to obtain the medications required. Alternatively, the claimant would be required to follow the statutory procedures in obtaining a change of treating physicians. In view of the foregoing, the parties are encouraged to communicate in an attempt to amicably resolve the claimant's medication needs. By necessity, all issues not addressed herein are specifically reserved.

IT IS SO ORDERED.

DAVID GREENBAUM
Chief Administrative Law Judge