

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F309361

DEBBIE L. HALL, EMPLOYEE	CLAIMANT
PROFESSIONAL EDUCATORS, EMPLOYER	RESPONDENT
CUNNINGHAM LINDSEY, INSURANCE CARRIER/TPA	RESPONDENT

OPINION FILED SEPTEMBER 26, 2006

Hearing before Chief Administrative Law Judge David Greenbaum on August 21, 2006, at Little Rock, Pulaski County, Arkansas.

Claimant represented by Mr. Marvin "Chip" Leibovich, Jr., Attorney-at-Law, Bryant, Arkansas.

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

STATEMENT OF THE CASE

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

A prehearing telephone conference was conducted May 24, 2006, and a Prehearing Order was filed on said date. A hearing was scheduled for June 29, 2006. The hearing was rescheduled for August 21, 2006, at the request of respondents because of the unavailability of a critical witness, Richard Merritt, the claims adjustor. However, Mr. Merritt was not called as a witness. At the hearing, the parties announced that the stipulations, issues, as well as their respective contentions were properly set out in the May 24, 2006, Prehearing Order. A copy of the Order was introduced as "Commission's Exhibit 1" without objection.

It was stipulated that the employment relationship existed between the parties at all relevant times, including August 20, 2003; that the claimant sustained a compensable cervical injury on said date; that the applicable compensation rate was \$129.00 per week for both temporary total disability and permanent partial disability; that respondents paid temporary total disability, as well as various medical and related expenses through on or about September 21, 2005; and that respondents controverted claimant's entitlement to additional temporary total disability, as well as additional medical treatment by Dr. Adada beyond the treatment previously paid.

By agreement of the parties, the follow issues were presented for determination:

- 1) Whether the claimant's healing period had ended, and, if so, the date the healing period ended.
- 2) Whether the claimant was entitled to additional temporary total disability.
- 3) Whether respondents were responsible for outstanding medical expenses, including, but not limited to surgery performed by Dr. Adada on March 1, 2006.
- 4) Whether respondents were responsible for continued, additional medical treatment by Dr. Adada.
- 5) Whether the claimant was entitled to costs.

Claimant contended, in summary, that her healing period had not yet ended; that she was entitled to additional temporary total disability after benefits were terminated on September 21, 2005, and continuing through a date yet to be

determined; that respondents should be held responsible for all medical treatment, including, but not limited to surgery performed by Dr. Adada, on March 1, 2006, maintaining that the surgery was reasonably necessary, as well as related to the compensable injury; that respondents should remain responsible for continued, additional medical treatment by Dr. Adada; and that a controverted attorney's fee should attach to any additional benefits awarded. In addition, claimant contended that she should be awarded various costs pursuant to A.C.A. §11-9-714. When questioned at the hearing concerning what specific costs the claimant was requesting, claimant's attorney replied, "The cost of obtaining medical evidence, as well as postage."

The respondents contended that the claimant's healing period ended on or before September 25, 2005, and that the claimant was not entitled to additional or continued temporary total disability. Respondents maintained that the claimant failed and/or refused to cooperate with medical treatment proposed by the respondents, as well as refused to see additional providers concerning the necessity for additional medical treatment and that the additional treatment provided by Dr. Adada, including, but not limited to his surgery was not reasonably necessary, not pre-authorized as required by Commission Rule 099.30, and, therefore, should not be the responsibility of the respondents. Respondents further maintained that continued medical treatment was not reasonably necessary. Finally, respondents contended that costs were not appropriate in this claim.

In addition to the claimant, her mother, Morgia Futrell, was called as a corroborating witness. The record is composed solely of the transcript of the August 21, 2006, hearing containing a sixty-two (62) page packet of documentary evidence introduced as "Claimant's Exhibit A."

From a review of the record as a whole, to include medical reports, documents and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witnesses and to observe their demeanor, the following findings of fact and conclusions of law are made in accordance with Ark. Code Ann. §11-9-704:

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 are hereby accepted as fact.
3. The claimant's healing period had not ended as of the date of the within hearing.
4. The claimant has proven, by a preponderance of the evidence, that she remained within her healing period and totally disabled after September 21, 2005, and continuing until such time that she is released following a second cervical surgery performed on or about March 1, 2006, by Dr. Badia Adada.
5. The claimant has proven, by a preponderance of the credible evidence, that the surgery performed by Dr. Adada on March 1, 2006, was reasonably

necessary, as well as causally related to the August 20, 2003, admitted, compensable injury and should, therefore, remain the responsibility of the respondents. In addition, claimant has proven, by a preponderance of the evidence, that she is entitled to continued, reasonably necessary medical treatment by Dr. Adada.

6. The pre-authorization provisions of Commission Rule 099.30 do not apply to the within claim. Further, even if pre-authorization was required, which is not conceded herein, a preponderance of the credible evidence reflects that the surgery was medically necessary and is, therefore, respondents' responsibility within the medical cost containment guidelines established by Rule 099.30.
7. The claimant has failed to prove entitlement to costs pursuant to Ark. Code Ann. §11-9-714.

DISCUSSION

The claimant, Debbie L. Hall, testified in her own behalf. On August 20, 2003, the claimant was employed by Little Scholars Day Care, a/k/a Professional Educators. The claimant's duties included both administrative/clerical work, as well as watching the children at the school. The claimant sustained an admitted, compensable injury as the result of a specific incident identifiable in time and place of occurrence on August 20, 2003, when she fell down a flight of stairs. The record reflects that the claimant had undergone a prior low back fusion at the L5-S1 level

in 1990. Although the fall may have aggravated her pre-existing back condition, the primary injury sustained as a result of the August 20, 2003, fall involved the claimant's cervical spine. The claimant was initially taken by ambulance to the emergency room at the Baptist Hospital in Little Rock, Arkansas. Following the emergency room treatment, the treatment was transferred to UAMS. The claimant underwent emergency surgery performed by Dr. Mark Linskey on August 22, 2003, specifically, an anterior discectomy and cervical fusion at C6-7. Dr. Linskey subsequently moved to California at which time the claimant's care was assumed by Dr. Badia Adada who was part of Dr. Linskey's surgical team. Dr. Adada has since remained the claimant's primary treating physician. Respondents exercised good faith in meeting its obligations under our workers' compensation laws by paying for the claimant's medical care and treatment, as well as temporary total disability benefits through on or about September 21, 2005, at which point respondents controverted all medical treatment by Dr. Adada, as well as additional temporary total disability. The record reflects that the claimant was receiving temporary total disability, as well as related medical treatment during June, 2005, when she began having additional weakness on the left side. The claimant stated that she was sent to the emergency room by Dr. Adada for a repeat MRI on or about June 11, 2005. Following several consultations with Dr. Adada, as well as additional diagnostic studies, the claimant was scheduled for surgery. Prior to the surgery, the claimant was contacted by Dr. Adada's nurse and advised that surgery

had been cancelled because the case manager for the insurance company wanted a second opinion. The claimant cooperated and was evaluated by three (3) separate physicians at the instance of respondents, specifically, Dr. Bruce Safman, Dr. Wayne Bruffett, and Dr. Reginald Rutherford.

Following evaluations by the aforementioned physicians, respondents terminated claimant's temporary total disability, as well as continued treatment by Dr. Adada. The following letter was sent by Richard Merritt, respondents' claim adjustor, on September 26, 2005, to both the claimant and her attorney:

This letter will reiterate to you that we are not authorizing the cervical surgical procedure that was recommended by Dr. Adada. We have two (2) other physicians that have examined Ms. Futrell-Hall and reviewed the cervical MRI. Both conclude that there have not been any changes in the cervical and surgery was not warranted. We have again reviewed the entire file of Ms. Futrell-Hall. Please be advised that we will not authorize any medical treatment by any provider other than a provider referred to by Dr. Wayne Bruffett.

Ms. Futrell-Hall has had the benefit of choosing the medical providers of her choice since the date of accident but we will now direct medical attention to Dr. Bruffett as the primary medical provider. We expect Ms. Futrell-Hall to attend and comply with the appointments arranged for her. Failure to comply will jeopardize any further workers' compensation benefits. Please feel free to contact me should you have any questions. (Cl. Ex. A, p.27)

First, as will be set out further below, Mr. Merritt's statements concerning the medical providers' conclusions that there had not been any changes in the claimant's condition and that surgery was not warranted is simply inconsistent with the record as a whole. Further, Mr. Merritt's unilateral decision to change the claimant's authorized medical providers is not supported by either the facts or the law. In addition, his statement that the claimant had the benefit of selecting medical

providers of her own choosing is highly questionable, and, further, is neither relevant nor binding on the claimant's right to reasonably necessary medical treatment. The claimant's undisputed testimony concerning her course of medical treatment was brought out on cross-examination as follows:

Q Now, wasn't it you who initially chose UAMS yourself?

A I called the employer and told him who I had seen. They had taken me to Baptist by ambulance. I had gone home that night. At 2:00 I got up, had problems with my right side, had urinated on myself. So the next morning I got up and called my employer. He knew that I had been taken to Baptist. He knew what Baptist had told me and the lack of what they had done, and he knew things were not right. I told him, "Sir, I don't know what to do," and he said, "You need to go see somebody." I said, "Well, do you think I need to go over to UAMS? Would that be okay with you?" And he said, "That would be fine. You need to get this checked out, dear," is what he said.

Q Had you been treated at UAMS for some previous condition?

A No.

Q So that's the first time you had ever gone to UAMS?

A I went to UAMS many, many, many years ago, about 20 years ago.

Q What was wrong with Baptist Hospital? What was the problem?

MR. LEIBOVICH: Objection, relevance.

JUDGE GREENBAUM: I'll allow her to answer.

THE CLAIMANT: I went to Baptist and they were more concerned with an outstanding bill that I had than with me laying there urinating on the bed.

BY MR. RYBURN:

Q You had a bill with them for some previous treatment?

A For my son, yes.

Q Okay, and it had not been paid, and that's what you're –

A Yes.

Q So that was your decision to go to UAMS after that?

A No. It was partially. I got up the next morning. I discussed it with Mr. Sitz, the employer. He was aware that they were more concerned with what I owed than what was going on with me, and he agreed to let me go to UAMS.

Q Now, a doctor at UAMS did a surgery in August of 2003, and that doctor is no longer at UAMS, is that right?

A He's at Irvine now, yes, that's correct.

Q And this Dr. Adada is the one that took his place?

A Dr. Adada was on the surgical team, yes.

Q What kind of doctor is Dr. Adada?

A He's a neurosurgeon.

Q And what kind was the other doctor?

A Neurosurgeon.

Q Now, you were on temporary disability for a little over two years, is that right?

A From the date of injury until September 21st of '05. (Tr.28-30)

I found the claimant to be a most credible witness. Her testimony concerning her increased symptoms and need for additional medical treatment, including surgery, is supported by a preponderance of the credible evidence. The claimant's testimony was corroborated by her mother. For some unexplained reason, Dr. Adada's medical reports following the claimant's initial cervical fusion and post-surgery treatment were not introduced. Again, it is undisputed that respondents

paid for Dr. Adada's treatment through on or about September 21, 2005. Likewise, for some unexplained reason, the recommendations of respondents' initial medical examiner, Dr. Bruce Safman, were not introduced. Nevertheless, it is undisputed that the claimant began having increased weakness and numbness in both her upper and lower extremities, primarily on the left side, beginning in June, 2005. In addition, the claimant's incontinence increased. The claimant saw her authorized treating physician, Dr. Adada, on several occasions because of these increased symptoms. Dr. Adada ordered two (2) repeat MRIs. Following physical examinations and diagnostic studies, surgery was recommended and, in fact, scheduled. The surgery was cancelled at respondents' request in order to obtain a second opinion.

MEDICAL HISTORY

As previously noted, the claimant's primary, authorized medical provider since August 21, 2003, has been the Neurosurgical Department at UAMS. Following the claimant's compensable injury, she underwent an anterior discectomy and fusion at C6-7. All of the claimant's follow-up treatment has been provided at UAMS. The claimant's initial treating surgeon was Dr. Mark Linskey. Following Dr. Linskey's move to Irvine, California, Dr. Badia Adada, one of Dr. Linskey's associates and part of the surgical team, became the claimant's primary treating physician. Dr. Adada has continued to follow the claimant through the present. It is undisputed that the claimant had not reached maximum medical improvement

when additional surgery was recommended during June, 2005. The record reflects that the claimant was receiving active medical treatment during that time when she began developing increased physical problems, specifically, numbness and weakness on the left side, as well as increasing problems with incontinence. The claimant returned to Dr. Adada. Dr. Adada ordered an MRI of the cervical spine which was conducted on June 11, 2005. The findings indicated that the anterior fusion of C6-7 with screws was causing paramagnetic artifact especially at C6 and C7 levels, as well as slight kyphosis in the cervical spine at C5-6. In addition, a moderate central disc protrusion at C5-6 and osteophyte complex was found to be causing effacement of the ventral thecal sac and impingement upon the spinal cord. The study also noted straightening of the normal lordotic curve. (Cl. Ex. A, pp.10-13)

Dr. Adada elected to initially treat the claimant with physical and occupational therapy. He ordered additional diagnostic studies and discharged the claimant on June 15, 2005. He prescribed a cervical collar and pain medication. Dr. Adada re-evaluated the claimant on June 22, 2005. His physical examination revealed that the claimant had undergone a deterioration of her myelopathy. He concluded that the results of the findings were compatible with a transitional syndrome caused by the fusion at C6-7 and that if her symptoms did not improve, she would require surgery. (Cl. Ex. A, pp.15-17)

The claimant underwent a repeat MRI on July 15, 2005. Again, at C5-6 level,

immediately above the fusion, a broad based central disc osteophyte complex was identified, causing moderate central canal stenosis. In addition, there was a mild anterior contour flattening of the cervical cord and moderate to severe stenosis of the left C5-6 neural foramen. (Cl. Ex. A, pp.20-21)

The date the claimant was scheduled for surgery is unclear. However, it appears that respondents scheduled the claimant for an independent medical examination by Dr. Bruce Safman prior to the recommendation and scheduling of surgery as reflected by a letter from a medical case consultant dated June 12, 2005, scheduling the appointment with Dr. Safman for June 23, 2005. (Cl. Ex. A, p.13)

As previously noted, no report from Dr. Safman was submitted by either party. The record does reflect that the claimant was next referred to Dr. Wayne L. Bruffett. Dr. Bruffett's specialty is not clear. Dr. Bruffett examined the claimant on July 29, 2005, for a second opinion concerning the claimant's need for surgery. Dr. Bruffett performed a physical examination and reviewed the MRI on a computer which he stated was of limited quality because of the inability to pull up the images and to adjust the contrast. He requested the actual MRI films. Dr. Bruffett did observe a transitional syndrome with disc herniation at C5-6. He offered the following plan:

I reviewed things with Ms. Hall. I would like to obtain her actual MRI films and let me review these. I am going to try to see her back in the office next week. We might consider a neurology evaluation just to get another look at her situation and where she is neurologically. I have talked to her briefly about further treatment. It is difficult for me to know how much of what she is having now is new and how much is related to her previous disc herniation and permanent spinal cord injury.

It does not appear, by the current imaging, that the disc herniation at C5-6 is nearly as severe as the one she had at C6-7. Surgery is certainly a possibility, but I want to look at the MRI scan to give her some education as to what she can expect. If she has dense residual deficits from her previous injury, I do not know that further surgery is going to make a huge significant clinical change for her. There is always the risk of worsening symptoms down the road, but this is always difficult to predict. I will look at the MRI scan and then I will see her back next week. I have told her that I really do not think she needs to wear this cervical collar. (Cl. Ex. A, p.23)

The claimant returned to Dr. Bruffett on August 5, 2005, at which time Dr. Bruffett had obtained the actual MRI films from UAMS. His report of said date is set out, in part, below:

I am not sure what is causing Ms. Hall's new or worsening symptoms on the left side of her body. I certainly cannot say with certainty that it is related to her C5-6 level. Certainly this may be, but I am just not sure. I think an opinion from a neurologist with maybe some EMG's, certainly a neurologic exam, and maybe a myelogram CT might shed some more light on this. It is difficult to know how much of what she is experiencing now is from her old injury with just residual spinal cord problems or how much of this is a new, more acutely, recent process.

I do not see anything alarming with regards to her MRI. There is no signal change within her cord at the C5-6 level or evidence of acute disc herniation.

I have told her basically that I do not think further surgery is particularly necessary on her neck. Certainly, it could be done to help relieve her stenosis. If it is done to prevent problems down the road then that is always a possibility, but I do not intend to do surgery in that light. No one can predict the future. She may have further changes at C5-6 down the road that would cause her further problems and having surgery now might prevent those. However, she may never have a serious problem at C5-6. There is also a risk of problems with the surgery itself.

I just wanted her to have appropriate expectations if she does elect to have surgery. I just do not see an obvious problem that would require such. However, whether she has surgery or not is probably something that needs to be left up to her in my opinion. I am going to see her back if needed. Overall, I think it would be helpful for her to see a neurologist, such as Dr. Rutherford, just to get a look at this from a neurologic standpoint to see what he thinks. I just hate for her to go through an operation if a straightforward benefit cannot be expected. In my opinion, her stenosis at C5-6 is nonspecific at this point. I cannot really tie this into her

subjective complaints or objective findings. Maybe Dr. Rutherford can do a better job of that. (Cl. Ex. A, p.24) (Emphasis supplied)

The claimant was next seen in consultation by Dr. Reginald J. Rutherford, a neurologist at the Arkansas Specialty Care Center. His August 16, 2005, report concluded that there was no evidence on clinical grounds that the claimant suffered from progressive cervical myelopathy which is totally inconsistent with the other medical opinion of record. Dr. Rutherford recommended the claimant undergo an MRI study of the brain with contrast to insure that there was no evidence of co-morbid process such as multiple sclerosis or stroke.

An MRI study of the brain was found to be normal. Dr. Rutherford offered an opinion dated August 29, 2005, that there was no strong clinical indication for further cervical spinal surgery.

Based upon the conclusions of Dr. Bruffett and Dr. Rutherford, the claims adjustor, Richard Merritt, advised the claimant that respondents would not authorize the cervical surgical procedure recommended by Dr. Adada. However, Mr. Merritt further advised that respondents would not authorize any medical treatment by any provider other than a provider referred to by Dr. Wayne Bruffett. Mr. Merritt did not have the legal authority to unilaterally terminate the claimant's medical treatment by a previously authorized provider and then select a different medical provider without either the consent of the claimant or the approval of this Commission.

The consequences of Mr. Merritt's actions effectively terminated the claimant's medical treatment. Dr. Bruffett did not offer the claimant any treatment.

Dr. Bruffett's conclusion that the claimant's subjective complaints were not supported by objective findings is inherently inconsistent with his own diagnosis and the weight of credible medical evidence.

The claimant testified that respondents terminated all treatment, including the physical therapy previously prescribed by Dr. Adada. Respondents also cut off her pain management treatment. She conceded that respondents continued to pay for prescription coverage until on or about March 1, 2006, at which time it also cut off all of her prescription medications. After termination of medical treatment, the claimant continued to see Dr. Adada. She maintained that her physical condition had progressively deteriorated beginning in June, 2005. Dr. Adada performed cervical surgery on March 1, 2006. The claimant stated that the surgery performed by Dr. Adada improved her condition. In a report dated May 23, 2006, Dr. Adada opined that the claimant's surgery, performed on March 1, 2006, was reasonably, medically necessary, and causally related to her workers' compensation injury. Dr. Adada further stated that the claimant's surgery was to correct a herniated cervical disc with myelopathy, and that further delay of the surgery would have negative consequences on the claimant's physical condition. Dr. Adada further opined that the surgery corrected a spinal cord compression which was causing gradual paralysis and loss of neurologic function. Dr. Adada's opinion was stated within a reasonable degree of medical certainty. (Cl. Ex. A, pp.61-62)

TEMPORARY TOTAL DISABILITY

Temporary total disability is that period within the healing period in which an employee suffers a total incapacity to earn wages. *K II Construction Company v. Crabtree*, 78 Ark. App. 222, 79 S.W.3d 414 (2002). When an injured employee is totally incapacitated from earning wages and remains in his healing period, he is entitled to temporary total disability. *Id.* The healing period is statutorily defined as that period for healing of an injury resulting from an accident. *Dallas County Hospital v. Daniels*, 74 Ark. App. 177, 47 S.W.3d 283 (2001). The healing period ends when the employee is as far restored as the permanent nature of his injury will permit, and if the underlying condition causing the disability has become stable, and if nothing in the way of treatment will improve that condition, the healing period has ended. *Crabtree, supra*. The question of when the healing period has ended is a factual determination for the Commission.

The healing period is defined as that period for healing of the injury that continues until the employee is as far restored as the permanent character of the injury will permit. *Arkansas Highway & Transportation Department v. McWilliams*, 41 Ark. App. 1, 846 S.W.2d 670 (1993). If the underlying condition causing the disability has become more stable and if nothing further in the way of treatment will improve that condition, the healing period has ended. The persistence of pain may not in and of itself prevent a finding that the healing period is over, provided that the underlying condition has stabilized. *Id.*; *Mad Butcher, Inc. v. Parker*, 4 Ark. App.

124, 628 S.W.2d 582 (1982). Conversely, the healing period has not ended so long as treatment is administered for the healing and alleviation of the condition. *McWilliams, supra*; *J.A. Riggs Tractor v. Etkorn*, 30 Ark. App. 200, 785 S.W.2d 51 (1990). The determination of when the healing period ends is a factual determination to be made by the Commission. *McWilliams; Parker; supra*. In *Pallazollo v. Nelms Chevrolet*, 46 Ark. App. 130, 877 S.W.2d 938 (1994), the Court of Appeals stated that in order to be entitled to temporary total disability compensation for an unscheduled injury, a claimant must prove that he remained within his healing period and that he suffered a total incapacity to earn wages. *Arkansas State Highway & Transportation Department v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981).

A review of the evidence demonstrates that the claimant remained within her healing period and suffered a total incapacity to earn meaningful wages at the time respondents terminated her weekly indemnity benefits, as well as any medical treatment by any provider other than selected by Dr. Wayne Bruffett. In my opinion, the claims adjustor's decision as stated in his September 26, 2005, letter, set out above, contains erroneous conclusions concerning any changes in the claimant's physical condition and the diagnostic studies. Admittedly, two (2) physicians selected by the respondents concluded that they would not recommend surgery. The MRI contained objective findings to support a need for additional treatment, including surgery. The credible testimony of the claimant and her mother

confirmed that additional medical treatment was necessary. Further, the insurance carrier's unilateral decision to change medical providers after more than two (2) years of treatment is not supported by either the facts or the law. The claimant's entitlement to additional temporary total disability is inextricably linked to her entitlement to continued medical treatment. The respondents effectively terminated all medical treatment. The claimant had a long established doctor/patient relationship with Dr. Adada. Respondents changed the claimant's authorized medical provider without her consent. The Commission did not authorize the change.

Although Mr. Merritt correctly stated that the two (2) physicians selected by the respondents did not recommend surgery, he was incorrect in his conclusion that there had not been any changes in the claimant's cervical spine. Even Dr. Bruffett diagnosed a disc herniation at C5-6 with stenosis. Dr. Bruffett conceded that surgery could prevent additional problems in the future, but would not recommend surgery in that light. Dr. Bruffett further acknowledged that having surgery might prevent further physical problems, but was concerned about the problems with the surgery itself. In my opinion, Dr. Bruffett failed and/or refused to recognize the deterioration of the claimant's physical condition. The claimant was experiencing progressive numbness and weakness in both extremities. The record reflects that she was having increasing difficulties with incontinence. I find these problems to be serious and surgery to be appropriate. The claimant had an established

doctor/patient relationship with Dr. Adada. I find the medical opinion of Dr. Adada to be more persuasive than the opinion of Dr. Bruffett. Dr. Bruffett's recommendations concerning the claimant's need for surgery were inconsistent and appeared to reach a result desired by the respondent. He appeared to ignore the claimant's complaints and the objective findings in the MRI. Dr. Adada's opinions concerning the need for surgery were clear and unambiguous. The surgery performed by Dr. Adada improved the claimant's condition. The surgery was reasonably necessary.

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. v. 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 v. Hi-Tech Engineering*, 325 Ark. 163, 924 S.W.2d 790 (1996); *Geo Specialty Chem., Inc. v. 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. v. Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983).

When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, the Commission just analyze both the proposed procedure and the condition it is sought to remedy. *Deborah Jones v. Seba, Inc.*,

AWCC #D511255, Full Workers' Compensation Commission Opinion filed December 13, 1989. Also, the respondent is only responsible for medical services which are causally related to the compensable injury.

The purpose of claimant's cervical surgery was to correct a spinal cord compression which was causing gradual paralysis and loss of neurologic function. The claimant stated that the surgery improved her condition. A preponderance of the credible evidence reflects that the surgery was directly and causally related to the admitted injury. The surgery was reasonably necessary. Its cost should be borne by the respondents.

Two (2) corollary issues raised by the respondents need to be addressed. The first concerns respondents' unilateral decision to change the claimant's authorized medical provider. Ark. Code Ann. §11-9-514(a)(3)(A)(i) gives the employer the right to select the initial, primary care physician. The right to change physicians is a right given to the employee/claimant. Although an argument can be made that the claimant never selected the initial, primary care physician, it is undisputed that respondents agreed to the primary care physician, and, in fact, paid related medical treatment for more than two (2) years. It was without authority to unilaterally change the claimant's treating physician. Accordingly, the sole issue is whether the treatment is reasonably necessary, as well as causally related to the admitted injury. I find that it is.

Respondents further contend that the additional medical treatment provided

by Dr. Adada, including his surgery, was not pre-authorized as required by Commission Rule 099.30, and, therefore, should not be the responsibility of the respondents.

I feel compelled to point out that a decision to deny payment of any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury, can only be made by an Arkansas certified private review agent. See, Commission Rule 099.30(S).

Respondents failed to comply with the Commission rules. In addition, it did not seek any determination from the Workers' Compensation Commission, Medical Cost Containment Division on the proposed surgery. Rather, respondents elected to obtain medical evaluations from physicians of its own choosing for the purpose of justifying its decision to cancel the scheduled surgery. The medical evidence previously discussed justifies the claimant's need for additional treatment, including surgery.

The only remaining issue concerns claimant's request for costs pursuant to A.C.A. §11-9-714. The provision of this section is set out in its entirety below:

If the Court having jurisdiction of proceedings in respect of any claim or compensation order determines that the proceeding in respect to the claim or order have been instituted or continued without reasonable grounds, the cost of the proceedings shall be assessed against the party who has instituted or continued the proceedings.

Respondents are responsible for the costs in taking and transcribing the

within claim. This section is limited to the cost of the proceeding. Its purpose is to avoid frivolous actions rather than to assess costs incidental to the prosecution of a claim. Accordingly, the claimant's request that respondents be responsible for costs in obtaining medical evidence, as well as postage is respectfully denied and dismissed.

AWARD

_____ Respondent, Cunningham Lindsey, is hereby directed and ordered to pay, to the claimant, temporary total disability benefits at the rate of \$129.00 per week beginning September 22, 2005, and continuing through at least August 21, 2006, and until such time as claimant's healing period for her March 1, 2006, surgery is determined to have ended.

All accrued benefits shall be paid in lump sum and without discount.

Respondents are further directed and ordered to pay all outstanding hospital, medical, and related expenses as the result of claimant's compensable injury, including, but not limited to surgery performed by Dr. Adada on March 1, 2006, and respondents remain responsible for continued, reasonably necessary medical treatment by Dr. Adada.

Additionally, claimant's attorney, Mr. Marvin "Chip" Leibovich, Jr., is hereby awarded the maximum statutory attorney's fee on this entire Award, to be paid in accordance with Ark. Code Ann. §11-9-715, §11-9-801, and Commission Rule 099.10. Pursuant to the Full Commission's decision in *Coleman v. Holiday Inn*,

AWCC #D708577 (November 21, 1990) and *Chamness v. Superior Industries*, AWCC #E019760 (March 5, 1992), the claimant's portion of the controverted attorney's fee is to be withheld from, and paid out of, indemnity benefits and remitted by respondent directly to claimant's attorney. As a reminder, Ark. Code Ann. §11-9-715 as amended by Act 1281 of 2002 limits attorney's fees on medical benefits and services for injuries after July 1, 2001.

This Award shall bear interest at the legal rate until paid.

_____IT IS SO ORDERED.

DAVID GREENBAUM
Chief Administrative Law Judge

/jg