BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E811362

DANIEL LEROUX, EMPLOYEE	**CLAIMANT**
L.A. DARLING CO., SELF-INSURED EMPLOYER	**RESPONDENT #1**
SECOND INJURY FUND,	**RESPONDENT #2**
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND,	**RESPONDENT #3**

OPINION FILED MARCH 24, 2006

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on January 20, 2006, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE JOHN BARTTELT, Attorney at Law, Jonesboro, Arkansas.

Respondent #1 represented by the HONORABLE RICHARD LUSBY, Attorney at Law, Jonesboro, Arkansas.

Respondent #2 represented by the HONORABLE DAVID L. PAKE, Attorney at Law, Little Rock, Arkansas.

Respondent #3 represented by the HONORABLE JUDY W. RUDD, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

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

On October 11, 2005, 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 the issues. The Pre-hearing Order is herein designated a part of this record as Commission Exhibit #1.

The testimony of Daniel Leroux, the claimant, Gary Gossett, Randy Dunlap, coupled with medical reports, photographs, and a DVD, and other documents comprise the record in this claim.

DISCUSSION

Daniel Alan Leroux, the claimant, with a date of birth of November 19, 1957, is a high school graduate. Claimant noted that he was in good health at the time he commenced his employment with respondent on January 8, 1988.

Claimant suffered an injury within the course and scope of his employment with respondent on August 18, 1998, the compensability of which was ligated before the Arkansas Workers' Compensation Commission in a February 23, 1999, hearing. At the time of the August 18, 1998, injury claimant was working in the paint room of respondent hanging parts. Claimant suffered his compensable back injury when he reached down and grabbed a falling beam before it hit the floor and felt something pop in his back. The Full Commission affirmed and adopted the findings of the March 31, 1999, ruling of the Administrative Law Judge regarding compensability of the claimant's August 18, 1998, low back injury.

At this juncture the issues before the Commission include the extent of the claimant's anatomical impairment growing out of the August 18, 1998, compensable injury; permanent total disability/wage loss; and second injury fund liability.

Regarding his employment history, the testimony of the claimant reflects that after high

school he worked at Waterloo Industries as a painter for approximately three (3) years commencing in either 1976 or 1977. Later, claimant worked at a service station for approximately one year with duties that included fixing flat tires. Claimant later worked on oil rigs in Texas for four (4) years. The testimony of the claimant reflects that he did sustain head and face injuries while working on the oil rigs, for which he received workers' compensation benefits and fully recovered. Thereafter claimant returned to Missouri and commenced his employment with respondent in 1988.

Respondent #1 is a manufacturer of store fixtures. The jobs performed at respondent #1 are in the plant and are production or assembly line type jobs. Claimant's testimony reflects that during his employment at respondent-employer between 1988 and 1998, he performed between 12 to 15 different jobs.

The testimony of the claimant reflects that following his August 18, 1998, compensable injury he received medical treatment for several years, and ultimately underwent surgery at the L4-L5 disc level under the care of Dr. Edward Cooper, a Jonesboro orthopedic surgeon. Claimant's testimony reflects that he was off work for a period of time following the surgery. The medical evidence in the record reflects that after undergoing the low back surgery claimant received substantial medical treatment off and on for the next four years.

Following his 2000 low back surgery claimant testified that he continued to experience low back pain to the point that he was referred to Dr. Calin A. Savu, a Jonesboro pain management specialist. Claimant estimated that he treated with Dr. Savu for about two (2) years, which included injections and medication. Claimant's testimony reflects that he did not realize any benefit from his treatment with Dr. Savu.

The testimony of the claimant reflects that immediately following his surgery he received relief from symptoms such that he was able to return to work. Claimant noted that he again begin having problems and sought and obtained medical treatment, with included the treatment under the care of Dr. Savu, for which Respondent #1continued to pay.

Claimant testified that while he worked full time for Respondent #1 during the years 2001 through 2003, there were periods when he was directed to remain off work by the doctor relative to his compensable injury. Claimant's testimony reflects that the afore periods could range from one to two week at a time, which he estimates occurred two times. Otherwise, claimant maintained that he tried to go to work every day. The testimony of the claimant reflects that during 2002 and 2003, respondent-employer made accommodations regarding his light duty status with such assignments as sitting in the office answering the telephone, running errands, and doing some painting.

The testimony of the claimant reflects that in November 2003, Dr. Savu wrote a letter to the third-party administrator of Respondent #1 which placed physical restrictions of his employment activities, to include no twisting, turning, bending over or lifting weights greater than thirty (30) pounds. Claimant testified that during the same period he was sent to another physician by the third-party administrator of Respondent #1 for a second opinion. Claimant also underwent a function capacity evaluation.

Claimant's testimony reflects that he attempted to go back to work at respondent-employer after seeing Dr. Savu in November 2003. While the claimant is uncertain when he was placed back in the plant on a production-type job, he does recall that the same was after seeing Dr. Savu in November 2003. Claimant testified that he was assigned the extensions job at that

time.

In describing the extension job, claimant testified handled two pieces of metal, approximately 12 to 14 inches in length. Claimant explained:

> I'd take the grates and put inside the extension and the machine crimped them together. (T. 25).

The testimony of the claimant reflects that the parts (extension blanks) come in a wire-bound hog trough. Claimant continued, regarding his movements in discharging the extension job:

> Take these (extension blanks), stack them on a table, and take these, stack them on a table, and put them together, put them in the machine and punch the buttons. (T. 28).

Claimant retrieved the extension blanks from the "hog trough", a big round tub setting on the floor, which entailed bending over waist high. Claimant testified that he picked up 10 to 12 extension blanks at a time and placed them on the table. The testimony of the claimant reflects that the extension blades were placed at his work station in the same manner as the extension blanks. Claimant would place the finished product in a container.

Claimant testified that he was having problems doing his assigned job. In describing his problems, claimant testified:

> Back hurting, it was swollen there. I'd get a lot of heat - like someone stuck a knife in your back. (T. 31).

Claimant attributed the bending and lifting as the basis for his increased symptoms. Claimant acknowledged that he could either stand or sit while performing the extension job. Claimant asserts that he told Randy Dunlap, the production supervisor, that he was having problems doing the extension job. The following day claimant's job was changed to running a hat former.

The testimony of the claimant reflects that he was moved to the job running the hat

former in early December 2003. In describing the job tasks involved in running the hat former, claimant noted that thin pieces of metal, referred to as blanks, come in large rolls or sheets; that the rolls go through a machine; and that his function was to take the finished product once it had come out of the machine and throw it into a "hog trough". Claimant performed the hat former job sitting. Claimant note that sometime the blanks would be on pallets. Claimant explained how he performed the job in such instances:

> And you laid them on the table and they'd cut the bands - pick the - and then bundle them up and set them over a magnet and would separate pieces and then I'd push it through the machine. (T.35).

The testimony of the claimant reflects that he continued to experience pain throughout the time he performed the hat former job. Claimant asserts that when working with blanks in large rolls, the prolonged sitting caused his pain, and when working with the blanks from the pallet it was the prolonged standing that produced his pain.

Claimant's testimony reflects that throughout 2001, 2002, and 2003, he was allowed to sit, stand, and walk around when he reached his maximum positional point while discharging employment duties. Specifically, claimant testified that after sitting for about 20 minutes he would have to get up and walk around and do something. Respondent-employer accommodated the claimant with respect to the afore.

Claimant's testimony reflects that his assigned job prior to seeing Dr. Savu on November 7, 2003, was running a shelf line. Claimant added that the physical demands or difficulty of the shelf line were comparable to extension job. Claimant's testimony reflects that in the shelf ling job he feed blanks into the machine. Other jobs performed by the claimant during the time he was assigned to light duty included running a band on the paint line, and hanging hooks, which

was also on the paint line. Claimant's testimony reflects that during the time he was assigned medical restrictions regarding his employment activities respondent-employer provided job duties within the restrictions and he received no complaints from supervisory personnel regarding his job performance.

Claimant's testimony reflects that after being assigned to the hat former job in December 2003, he worked every day during the month, although he was having the same or similar physical problems, relative to pain. Claimant testified that he also worked every day during the month of January 2004. Claimant worked second shift. On January 22, 2004, claimant returned to Dr. Savu due to increased pain, which had its onset during the first week of January 2004.

Claimant testified that he talked to Willie Williams of respondent-employer about returning to Dr. Savu for medical treatment in January 2004, however "nobody said nothing to me"in terms of providing authorization. Claimant's testimony reflects that he contacted his attorney who in terms contacted "workman's comp." and an appointment was set up. Claimant was already taking medicine, Oxycontin, at the time of the January 22, 2004, visit to Dr. Savu.

Following the January 22, 2004, visit to Dr. Savu claimant reported for work at his regular scheduled time. After furnishing the release slip which was authored by Dr. Savu to office personnel, claimant reported to his work station and commenced discharging his job duties. Claimant asserts that after two to three hours Calvin Busby, one of the supervisor, and told him he needed to go to the office with him. Upon arriving at the office claimant was informed by Gary Gossett, the human resources manager for respondent-employer, that there was no more light work , that respondent had no more work for him, and that he needed to go home.

Claimant's testimony reflects that he was told by Mr. Gossett to go home, and thereafter

walked out of the plant by Mr. Busby. Claimant testified that it was his understanding that his employment had been terminated by respondent as of January 22, 2004. Claimant's testimony reflects the he received four to five months of unemployment benefits during which time he applied for other jobs.

Claimant testimony reflects that he applied for jobs at Seark Parts, and Town & County grocery store. Claimant also applied for jobs at a couple of other tool and dye places. Claimant testified that he was never offered a job and ultimately applied for and was approve for social security disability benefits. As of the date of the hearing claimant had been receiving social security disability benefits for 10-11 months.

Claimant asserts that he current physical condition is worse than it was in late 2003 or early 2004. Claimant noted that the pain in the right side of his low back, as well as his right leg, and that he has difficulty sleeping as a result of same. Claimant also expressed concerns that his symptoms and sleep disturbance is affecting his nerves.

The testimony of the claimant reflects that his wife works and is away from home all day. Claimant testified that during a typical day he spends his time walking around and watching television. Claimant maintains that he tries to get some exercise:

> Legs exercise, stretch exercise, I lay on my back and I've got to push my stomach down, and then raise it up, walk. I've got a big ball that I've got work with - try to straighten my back up. (T. 47).

Claimant denies that the exercise is of any help, however continues to perform them pursuant to the recommendation of his therapist.

Claimant testified that since his termination by respondent-employer he has continue to take medication relative to his injury, however the same is now being furnished by his family

doctor. Claimant identified the medication being prescribed for him at this time to include aspirins, Hydrocodone, Xanax, three vitamins, and a water pill. Claimant noted that he also takes one pill for his leg and applies a lotion on his legs.

Regarding the job depicted in a video, which is contained in the record as Respondent #1, exhibit #5, claimant testified that the same has something to do with uprights, a job that he performed five to six years ago. Claimant denied that the job was offered to him by respondent-employer any time in the year before he was fired.

Claimant testified that he believes that he is disabled and he is not aware of any job that he is able to do. Claimant opined that but for the accommodations afforded by respondent-employer subsequent to his injury and surgery he would not have been able to continued working during the years that he did.

While the claimant testified that he did not have any problems with his back prior to he employment by respondent-employer in 1988 nor did he experience difficult with same prior to his August 18, 1998, compensable injury, he did have a problem with his leg. Clamant estimated that the problem with his right leg started in "about" 1995. In describing the problem with his leg, claimant testified he experienced numbness, swelling, and charley horses. The testimony of the claimant reflects that before his 1998 back injury his leg complaint was causing him problems walking, standing, and sitting. Claimant observed that the problems with his right leg has continued through the years.

Observation of the claimant's right leg during the hearing disclosed discoloration of black and purple with skin flaking and dryness. The area of the right leg involved commences just below the knee and continues down to his foot and toes. Claimant's right leg displayed

"varicose vein-like symptoms". Claimant testified that the problem with his right leg has progressively worsen since its onset in 1995.

During cross-examination claimant acknowledged that he underwent surgery relative to his August 18, 1998, compensable back injury under the care of Dr. Cooper in May 2000, and that following recuperation was released to light duty. Claimant returned to the employment of respondent-employer following his light duty release and was provided an appropriate light duty job. Further, claimant concedes that he continued to preform "those make-work, light-duty" jobs from 2000 until late 2003.

Claimant acknowledged that respondent-employer arranged for him to be evaluated by Dr. John Brophy, a Memphis neurosurgeon, in November 2003. Following the examination by Dr. Brophy, claimant underwent a functional capacity evaluation. Further, claimant acknowledge seeing the report generated by the FCE examiner reflecting "unreliable and inconsistent effort" during the test, however stated that he did not understand it. Finally, claimant denies that he saw any report changing his status from "light duty" to "regular duty" following the examination by Dr. Brophy and FCE in November 2003.

Claimant testified that he is aware the employees of respondent-employer have different job classifications. Claimant's testimony reflects that he was not aware of his job classification at the time he left the company in January 2004. Claimant concedes that it was after the examination by Dr. Brophy and FCE that he was placed in the metal forming jobs of working the extension cell and hat former.

Claimant testified that when he worked the extension cell, the length of the extension were 6". In terms of the mechanics of the job, the testimony reflects that there are two to three

employees that work together in creating the extension that includes both the extension blank and the extension blades. Claimant acknowledged that the only part of the extension creation process that he did was to take an extension blank that had already been slotted and notched, and the extension blades, and partially insert the blade into the blank and then put the two of them that were partially put together into a slot in the machine, and the machine forced the two into the proper alignment.

Claimant denies the he was provided the assistance of a "set-up man" at the extension job or that the "hog tough"/hopper was placed on the tilt table. Claimant maintains that the parts were placed in the aisle, and that he would take a hand-jack, pick it (the hopper) up and move it to his machine. Claimant denies that the hand-jack was motorized. Further, claimant asserts that the jack only lifted the hopper/wire-bound/"trough" four to five inches off the floor. Claimant concedes that there were other jack that lifted the containers higher off the floor, but not the one that he was using.

The testimony of the claimant reflects that when he reported to supervisory personnel that he was having trouble performing the extension job he was told to sit for the remainder of his shift. The next day when claimant reported for work he was assigned the hat former job. Claimant denies that the job depicted in the video was the last job that he performed in the employment of respondent-employer. (R1, X5).

Claimant maintains that he was working on the hat former job on January 22, 2004, after having seen Dr. Savu earlier, when he was directed to the office and told that respondent did not have light duty work available for him. Claimant worked second shift, and noted that Calvin Busby, as supervisor, over-lapped both first and second shift.

With respect the to termination of his employment on January 22, 2004, by Gary Gossett, claimant's testimony reflects:

> No, sir. He told me no work - no restrictions - no light duty.
>
> Get out of her - go home. (T. 74).

Claimant acknowledged that in December 2004, he received a $1,200.00 vacation check from respondent-employer. Claimant denies that he received twenty-six (25) weeks of short term disability from respondent-employer in 2004. Claimant acknowledged receiving short term disability for respondent-employer in 2002. Claimant asserts that after his employment was terminated by respondent-employer he only received the vacation check and unemployment benefits.

Claimant denies that he represented to personnel of the Employment Securities Division that he was "ready, willing, and able to work" when he sought unemployment benefits. Claimant's testimony reflects:

> I went in and told them I got fired because of light work, showed them the papers from the doctor - under restrictions, but you're able to work, with certain limits. (T. 77).

Claimant acknowledged that he did not seek vocational rehabilitation benefits relative to his workers' compensation claim against respondent. (T. 79).

Claimant's testimony reflects that he is now receiving social security disability benefits of $1,101.00, monthly. Claimant also acknowledged child support arrearage in Doniphan, Ripley County, Missouri.

Claimant acknowledged that when he completed his employment application for respondent-employer he responded that he did not have any physical conditions which would

limit his ability to perform any of the jobs listed on the document. While the parties were unable to obtain medical reports regarding the claimant's past health problems, claimant acknowledged providing a history during his 2003 evaluation by Dr. Brophy of a July 1995 evaluation for deep vein thrombosis in his right lower extremity, and to a course of treatment with Coumadin from July 1995 to August 1995.

There is no evidence of the claimant receiving medical treatment relative to his right leg complaint between August 1995, and his August 18, 1998, compensable injury. Claimant's testimony reflects that the discoloration of his right leg has been present for approximately ten (10) years. Claimant testified that Dr. Musser has been his family doctor for 15 to 18 years. A December 28, 2004, progress note of Dr. Musser reflects with respect to a 3:00 p.m. office visit by the claimant, ". . . about four years ago the right lower leg started turning dark", and, " had a heart attack about the same time". (R2,X1,p.7). Claimant acknowledged relaying the afore history to Dr. Musser, as well as suffering a heart attack in 2000, which was treated with medication.

Pursuant to his doctors' directions, claimant testified that he is no longer taking the heart medication. Claimant testified that he was directed exercise by his treating physician relative to the heart attack. Further, claimant's testimony reflects that he did not feel as well after the heart attack as before. In explaining his symptoms/complaints since the heart attack, claimant noted that he experiences frequent dizziness and light-headed as well as shortness of breath and chest pains. Claimant concedes that he activity level was cut down by the heart attack. Claimant agreed that if his heart couldn't pump blood as well after the heart attack it could have caused some of the problems with his lower leg.

Claimant acknowledge that when he was seen by Dr. Savu on November 26, 2001, the physical examination disclosed that as far as his veins were concern, his pulses were equally brisk, with no trophic changes, edema or pitting in the leg. The testimony of the claimant reflects that he has undergone a couple of venous doppler tests, one have been performed on October 7, 2003, by Dr. McCray which showed no evidence of a deep vein thrombolis in the right leg. Claimant underwent another venous doppler test on February 25, 2005, in St. Louis by Dr. Balani, which disclosed no evidence of deep vein thrombosis or peripheral vascular disease.

Claimant underwent surgery relative to the August 18, 1998, low back injury on May 9, 2000. In 2001, claimant was rated by Dr. Edward Cooper with a 8% physical impairment relative to his back injury and surgery. Claimant acknowledged being evaluated by Dr. Brophy on October 1, 2003, and being assessed with a 10% rating for the back. The testimony of the claimant reflects that he has not received an impairment rating from any other doctor regarding any other condition that he has.

Claimant testified that he applied for social security disability benefits on February 3, 2004. Claimant last worked for respondent-employer on or about January 25, 2004, and received unemployment compensation benefits for four or five months.

Claimant testified that he was aware that Dr. Savu had recommended on January 22, 2004, part-time work and part-time work hardening for a couple of months before being returned to full-time employment. Claimant maintains that portion of Dr. Savu's recommendation that he disagreed had to do with losing weight.

Claimant acknowledged that on one occasion in 2004, he went to respondent-employer and delivered an off work slip from his personal physician related to his personal health problem

regarding his leg. Claimant denies that the afore occurred after his employment was terminated on January 22, 2004.

The testimony of Mr. Gary Gossett, Human Resource Manager-Gondola Division, reflects that he was responsible for overall workers' compensation issues for respondent-employer. Mr. Gossett testified that it is the policy of respondent-employer to provide various forms of light-duty with respect to injured workers. Mr. Grossett's testimony reflects that every effort is made to provide work, even make-work type jobs, of an injured employee still recuperating from injuries. Mr. Grossett maintains that the afore was done in the claimant's case from 2000 until November 2003.

Mr. Gossett testified that respondent-employer arranged for the claimant to be evaluated by Dr. John Brophy, and thereafter arranged for a functional capacity evaluation. Following the afore, Mr. Gossett testified that the claimant's job classification changed to Metal Former in Department 275, Plan B, which is a regular job classification. Prior to the November 2003, change in job classification, Mr. Gossett's testimony reflects regarding the claimant:

> His official job classification was Product Material Handler, okay? However, he was assigned to the paint line, doing paperwork, working on the computer for a period of time. Then there was a period of time we put him in the Maintenance office, doing paperwork, and orders and things like that. (T. 105).

Mr. Gossett denies that he terminated the claimant's employment. Mr. Gossett testified that when he learned that the claimant was complaining of problems, he observed claimant performing the job running the T5012. (R1,X3). Regarding how he learned that the clamant was having problems, Mr. Gossett testified:

> I don't recall the exact circumstances. It would have probably

> been either Randy Dunlap or Danny Reid, okay, because they were both involved with the situation that afternoon.
>
> I went out with Danny and Randy and looked at the job that he was running. (T. 107).

Mr. Gossett testified that the claimant was allowed to go home, however his employment was not terminated. Mr. Gossett's testimony reflects that the claimant's employment termination occurred in January 2005, a year following the start of the claimant's medical leave. Mr. Gossett maintains that the claimant was placed on medical leave after January 22, 2004. Mr. Gossett noted that respondent-employer does not place employee on medical leave for work-related problems, but rather for personal health problems. Mr. Gossett maintains that respondent-employer had a job available for the claimant within the restrictions related to his compensable back injury, the job working with the T5012 parts.

The testimony of Mr. Gossett reflects the he caused the CD-ROM to be made, which videoed the job that the claimant was observed performing on January 22, 2004, the night he complained that he could not continue working. Mr. Gossett testified that had the claimant not complained that he could not continued working he would still be working for respondent-employer.

Mr. Gossett testified that the claimant would have received the acknowledged $1,200.00, vacation check from respondent at the time his employment was terminated in January 2005. Mr. Gossett's testimony reflects that during the time the claimant was off work on medical leave claimant had to bring in slips from his personal family physician:

> They have t be presented. There was two slips to my knowledge that were presented - one in April, one in September - that kept him off work due to his right leg - whatever that particular . . . (T. 110).

While Mr. Gossett testified that the claimant was put back on regular duty in November 2003, he was unable to testify which doctor authorized the regular duty release of the claimant. Mr. Gossett disputes no doctor released the clamant to regular duty:

> No. There was documentation that was submitted to the company and we reviewed and within the restrictions that he was given, we felt, and we -it was our opinion that he could perform a metal former classification - the duties of a metal former classification successfully. (T. 113).

Dr. Savu was the claimant's authorized treating physician relative to the compensable August 18, 1998, back injury during the period 2002 and 2003. Mr. Gossett acknowledged that a November 7, 2003, letter from Dr. Savu to Ms. Lela Taskey of Management Claims Solution, the third-party administrator of the workers' compensation program of respondent-employer, restricts the claimant to light-duty work. Mr. Gossett testified that the decision to return the claimant to regular duty in November 2003, was a decision he made during a telephone conversation with Ms. Taskey.

Mr. Gossett acknowledged having a conversation with the claimant on January 22, 2004:

> I don't recall the exact conversation, but we did - after we went out and looked at the job he was performing - we told Danny that he could go home if he couldn't do it.(T. 116).

Mr. Gossett testified that he heard that the claimant had applied for unemployment benefits in February 2004. While the testimony of Mr. Gossett reflects that is the policy of respondent-employer to object to somebody applying for unemployment benefits if they quit or just walk off the job, however he was unable to testify if respondent-employer objected in the instance of the claimant receiving unemployment benefits. Later Mr. Gossett testified regarding the claimant's application for unemployment benefits:

Sir, I did not know he applied for unemployment benefits until we were preparing for this case. (T. 119).

Regarding the claimant's employment status and his receipt of unemployment benefits, Mr. Gossett's testimony reflects:

> Like I said, in February, I became aware of the fact that there was some confusion with what Danny's status was.
>
> Of 2004. There was communication between Brenda Cross, who's an HR staff member, Cassie Gilmore, who's an HR staff member, and myself. The were going back and forth on e-mails, as far as what Danny should be - should he be filing unemployment - should he be receiving TTD because of a workers' comp. claim, or should he be off on short-term disability?

Mr. Gossett acknowledged that the claimant did not fill out Family Medical Leave Act documents. While Mr. Gossett testified that to his knowledge the claimant did receive short-term disability benefits, he acknowledged the absence of any documents evidencing same. Regarding the claimant's employment status after January 22, 2004, Mr. Gossett testified:

> There was a period of time, immediately following the 22nd , we weren't sure exactly what Danny's status was.
>
> * * *
>
> Well, ultimately, we received documentation from his personal physician taking him off work.
>
> * * *
>
> I'm not saying he brought in - it was presented to the company.
>
> It came from his personal physician - it was either faxed in or Danny brought it in himself. (T. 117-118).

Mr. Gossett denies that the documentation was requested by respondent-employer, noting that

respondent-employer is not allowed to contact the claimant's personal physician.

Regarding the basis for the evaluation of the claimant by Dr. Brophy to ascertain the clamant's physical status, Mr. Gossett testified:

> Sir, it had nothing to do with Dr. Savu's records. It has to do with the fact that management of the company, when the question a person that's been in a position for three years, drawing full pay, and light-duty, not performing regular work, we have a responsibility to find out what's going on. (T. 120).

Mr. Gossett testified that the claimant was returned to regular duty classification following a functional capacity evaluation and a report by Dr. Brophy reflecting that there was no objective reason why the claimant could not return to full duty. Further, Mr. Gossett's testimony reflect that the jobs that the claimant was assigned were some of the lightest jobs in the facility.

Randy Dunlap testified that his job position with respondent in the latter part of 2003 and early 2004 was that of Production Supervisor on the second shift. One of the areas under Mr. Dunlap's supervision is the extension cell. Mr. Dunlap provided testimony regarding how material is delivered to the employees on the production line as well as the employees' access to equipment.

Regarding the last time that the claimant was physically working in the plant in January 2004, Mr. Dunlap testified that the claimant was in the miscellaneous press area on T5012 operation.. Further, Mr. Dunlap testified that the claimant complained to him that he was not able to do that job. The claimant's complaint was forwarded up the chain of command to other supervisory personnel.

The medical in the record reflects that after undergoing conservative management of his diagnosed HNP right L4-L5 with right L5 radiculopathy growing out of the August 18, 1998,

accident claimant elected to undergo surgery in the form of a right L4-5 hemilaminectomy and diskectomy under the care of Dr. R. Edward Cooper, a Jonesboro orthopedic surgeon on May 9, 2000. (CX #1, p. 1-8). During a May 22, 2000, follow-up visit to Dr. Cooper, the medical reflects that claimant relayed having spasms in the right thigh and calf. Dr. Cooper's impression of the claimant's complaint during the afore visit reflects:

> l. Status post right L4-L5 hemilaminectomy diskectomy with some residual right thigh and calf cramping uncertain etiology. There may be some residual nerve root irritation. (CX. #1, p. 10).

During a July 26, 2000, follow-up visit to Dr. Cooper claimant was released to light duty work which included no heavy lifting, bending or twisting greater than 5lbs. (CX. #1, p.12). The claimant was seen in follow-up by Dr. Cooper on January 15, 2001, the physical examination of which reflects:

> Today on physical examination his incision is well healed. There are no other changes in his exam. I discussed his case with him at length including the possibility of restrictions, what he felt that he was capable of doing at work. Given his surgery and residual back symptoms which are likely coming from some facet joint arthritis and continued degenerative disk changes, that a 30 lb. weight limit on him would be reasonable and also I think he should avoid trying to do tasks which require repetitive lifting and twisting. (CX. #1, p. 14).

In a January 17, 2001, chart note Dr. Cooper outlined that pursuant to the AMA Guidelines to the Evaluation of Permanent Impairment, 4th edition, page 113, for a single level surgically treated disc lesion the claimant had a 8% whole person impairment relative to the August 18, 1998, compensable injury. (CX. #1, p. 15).

The medical evidence reflects that when the claimant was seen by Dr. Cooper on July 11, 2001, claimant relayed that he was doing well until he was taken off light duty and placed back

on his normal job. As a consequence of the afore, claimant relayed that he began having recurrent back pain with radiation down the right posterolateral thigh, calf and into the sole of the right foot. Although the claimant had been placed back at desk duty/light duty, he continued to have "considerable pain". (CX. #1, p. 16).

Claimant underwent additional diagnostic studies pursuant to the directions of Dr. Cooper, to include an October 3, 2001, MRI of his lumbar spine. During the October 11, 2001, office visit, in addition to relaying complaints of symptoms in his back and down his right lower extremity, claimant also complained of his "right leg being blue". Dr. Cooper reported, during the physical examination, that it appeared that the claimant's circulation was intact. The report reflects:

> . . . . He does have some venous stasis changes which I think are responsible for the bluish discoloration of his lower extremity. The MRI is unavailable for my direct review. However, the radiologist report with the Gadolinium study saw enhancing scar around the nerve root, but no significant true disc material was noted. (CX. #1, p. 19).

Claimant was also referred by Dr. Cooper to the Chronic Pain Clinic relative to the residuals of his August 18, 1998, injury during the October 11, 2001, office visit.

On November 26, 2001, claimant was initially seen by Dr. Calin A. Savu at the Center for Pain Management of St. Bernards Medical Center pursuant to the referral of Dr. Cooper. In addition to the history of his August 18, 1998, low back injury and medical treatment relative to same, claimant also relayed a history of deep venous thrombosis of the right lower extremity without a clear cause which was treated as an inpatient with Heparin to Dr. Savu during the November 26, 2001, evaluation. The November 26, 2001, report of Dr. Savu concluded regarding the claimant:

DIAGNOSIS:
1. Lumbosacral spondylosis with facet disease.
2. Possible discogenic pain syndrome.
3. The differential also includes failed back surgery syndrome secondary to epidural scar formation and subsequent right lower extremity neuropathic pain.

THERAPY/PLAN:
1. Medical therapy will be initiated with long-acting narcoticis for now.
2. Interventional therapy - the patient will undergo a series of diagnostic injections which will include medical branch and intra-discal provocative injections. Depending on their result we will decide if he is a good candidate for either radiofrequency or fusion. If none of the above applies, the patient may need to undergo a trial of spinal cord stimulation if medication alone will not offer consistent relief. (CX. #1, p. 22).

On December 12, 2001, claimant underwent right medial branch blocks at the L3-4, L4-5 and L5-S1 facet joints under the direction of Dr. Savu. In December 20, 2001, report Dr. Savu noted that the claimant did not improve with the afore procedure, and outlined further treatment options, to include a provocative disc injection. (CX. #1, p. 24).

Claimant presented for the afore procedure on January 30, 2002, however due to a recent onset of chest pains, and in light of his risk factors for cardiac involvement the procedure was postponed, and Dr. Savu referred him back to Dr. Mercer for a cardiac evaluation. While the claimant testified that he had a heart attack and there is reference to same in December 28, 2004, progress notes, of the claimant's primary care physician, there are no medical reports of the claimant's treating cardiologist or hospital course of treatment as it relates to a heart attack or cardiac diagnostic procedures.

The medical in the record reflects that the claimant was evaluated by Dr. Ron D. Schechter, a Paragould orthopedic physician, on October 1, 2002, at the request of respondent-

employer, relative to his low back and right leg pain. After detailing the course of the claimant's medical treatment relative to the August 18, 1998, compensable injury through the December 12, 2001, visit to Dr. Savu, Dr. Schecther noted that there were no further medical records available after that time. Thereafter October 1, 2002, report reflects:

> . . . The patient reports that he's continued to have the same type of pain since that time with no improvement. He describes pain primarily in his buttocks regarding down the posterior aspect of the leg to the foot. His pain is about 80% back and buttocks pain and 20% leg pain. He has associated numbness and tingling in his posterior leg and calf. No bowel or bladder changes. (CX. #1, p. 26).

Following his evaluation Dr. Schechter assessed the claimant's complaints as "Degeneration, Lumbar/lmbsac Dic; neuritis, Lumbosacral Nos; and Lumbago". The October 1, 2002, report of Dr. Schechter concludes:

> I had a long discussion with Mr. LeRoux and reviewed his records in detail. I did not have any radiographics images to review today. Nonetheless, based on the records I received from his other physicians I can say the following. I believe that Mr. LeRoux has received a very appropriated thorough work up by his physicians to date. I do not think that it can be said that he's reached maximum medical improvement. By the records from the previous physicians, it seems clear that he could potentially have some degenerative disc disease, resulting in some discogenic pain. At this point I would recommend that the patient see a surgical spine specialist for further work up and I agree with Dr. Savu's thinking, that I would anticipate that a spine surgeon would next need to consider selective disc injections to see how it affects his pain with the idea that he might be a candidate for a possible complete discectomy, decompression and fusion. (CX. #1, p. 28).

On February 14, 2003, claimant was again seen by Dr. Savu, and underwent a provocative discogram at L3-L4, L4-L5, and L5-S1, as well as a post discogram CT study. The February 14, 2003, Clinic visit note of Dr. Savu relative to the claimant concludes:

> **MEDICAL DECISION MAKING:** Concordant pain at all levels

> investigated without control study. The patient does not appear to be a good candidate in view of the multiple sources of pain. It is very likely he will need to undergo prolonged physical therapy program which, if successful, would require a serious consideration for chronic narcotic treatment either p.o. or with an intrathecal system. (CX. #1, p. 30).

On February 23, 2003, Dr. Savu authored a release allowing the claimant to resume light work.(CX. #1, p. 36).

Dr. Savu reported that the claimant was doing quite well and had make gradual improvements in his ability to maintain consistent levels of activity throughout the day at the time of the claimant's April 24, 2003, clinic visit. Dr. Savu observed that the claimant did appear to have developed side effects from the OxyContin, and as a consequence was switched to MS Contin. (CX. #1, p. 38). Following a September 4, 2003, clinic visit, Dr. Savu noted, in part regarding the claimant:

> . . . . In conclusion, I am comfortable with his diagnosis of diskogenic pain which I think is accompanied by progressive deconditioning syndrome. The recommendation for him at this time will consist of continuous medical therapy and work hardening for at least six weeks. That should be done on a part-time basis in combination with part-time employment. At the end of those six weeks, I would recommend a full evaluation of his capacity by a specialized physical therapist. Based on that assessment, we will be able to decide in what capacity Mr. Leroux can continue his employment and clearly define his restrictions if any would be needed. (CX. #1, p. 39).

On October 1, 2003, claimant was evaluated by Dr. John D. Brophy, a Memphis neurosurgeon, relative to his residual back and leg pain status post lumbar diskectomy pursuant to the directions of respondent-employer. After reciting the history of the claimant's injury and medical treatment, a relayed by the claimant, the October 1, 2003, chart note of Dr. Brophy reflects:

> . . . . In early 2003, he developed swelling of his distal right lower

> extremity. Mr. Leroux is a poor historian but he indicates that he did undergo a comprehensive evaluation; however, a definite etiology was never determined. He is currently being treated with OxyContin 10 approximately three times a week. He has discontinued treatment with anti-inflammatories. Based on the severity of his back pain, he does not feel he is able to return to work at full duty. The pain is worse with sitting.(R1,X1, p. 1).

In terms of the medical record reviewed as a part of his evaluation of the claimant, Dr. Brophy's October 1, 2003, report does recite the history of the clamant's right leg pain of July 1995, with symptoms thought to be consistent with thrombophlebitis of the right lower extremity, as well as the treatment regimen instituted. The report further reflects that in April 2002, claimant required a cardiac catheterization procedure and he was diagnosed with stable angina, COPD, sleep apnea, shortness of breath, mitral valve prolapse and an anterior myocardial infraction. The October 1, 2003, report of Dr. Brophy concludes:

> RECOMMENDATIONS: In my opinion, Mr. Leroux has undergone an appropriate evaluation for his residual postoperative pain status post right L4-5 diskectomy. In my opinion, there is no indication for surgical intervention. From the standpoint of his lumbar radiculopathy and lumbar disc surgery, I would suggest initiation of a serious weight loss program as well as beginning an endurance exercise program. Based on his radiographic studies and physical examination, there is no objective reason why he could not return to work at full duty if he desired to do so. If his physicians feel that work restrictions are indicated, he should undergo a formal Functional Capacity Evaluation. I would suggest tapering and discontinuation of his narcotic requirement and initiation of a trail of anti-inflammatories. The standard rating for lumbar radiculopathy status post diskectomy is 10% whole body.
>
> Mr. Leroux has a history of thrombophlebitis and based on his medical records, he has intermittent swelling of the distal right lower extremity. Based on his evaluation today, I suggested follow-up evaluation through his primary care physician or possible vascular specialist to determine if further treatment is indicated. His right lower extremity swelling and cutaneous changes are unrelated to his lumbar herniated disc and lumbar diskectomy procedure, and maybe the source of some of his leg pain. It is

> also possible that work restrictions are indicated for his vascular problems. (R1,Xl, p. 4).

On November 3, 2003, claimant underwent a functional capacity evaluation at Functional Testing Centers, Inc., which was arranged by respondent-employer. The report reflects that the results suggested that the claimant gave an unreliable effort. The report concludes:

> Overall, Mr. Leroux demonstrates very inconsistent effort. He demonstrates the ability to work at least at the Light work category over the course of an 8 hour day. Until Mr. Leroux puts forth consistent effort of a maximal basis, no further recommendations were appropriate. Please refer below for the definition of Light work. (R1,X1, p. 6).

Light work is defined as the occasional lifting of 11-20 lbs, frequent lifting of 1-10 lbs.

A November 7, 2003, letter of Dr. Savu to Ms. Lela Taskey, the claim manger for the third party administrator of the workers' compensation program of respondent-employer, reflects that the evaluations of the claimant performed by Dr. Brophy and Functional Testing Centers, Inc., were received and reviewed. The November 7, 2003, correspondence of Dr. Savu further reflects, in pertinent part:

> They confirm my thesis that Mr. Leroux may return to work immediately at least while restricting him to light duties. A work hardening program would be very beneficial and I am convinced that he may make significant progress.
>
> His diskogenic pain is very unlikely to progress rapidly although some slight long-term worsening is possible. On the other hand, an active lifestyle with a consistent exercise program has been very beneficial for patients with severe diskogenic pain who refuse to undergo fusion surgery. I would like to meet Mr. Leroux and share that information with him while encouraging him to enroll in a work hardening program and hopefully progress from a light to moderate or even a full duty job description. No significant changes occurred in my approach to this patient compared to the 09/04/2003, evaluation.
>
> Recent studies have showed no significant impairment in fine motor or visual acuity-related skills in patients with chronic long-acting opioids. If

> his physical status improves as a result of increasing his exercise range, we could slowly taper down his medication over time. (R1,X1, p. 20).

The medical reflects that the claimant was seen by Dr. Savu on January 22, 2004, which was the last day that he discharged employment duties for respondent-employer. The January 22, 2004, report of Dr. Savu reflects, in pertinent part:

> . . . I was able to review the assessment of Mr. Leroux by functional testing centers. It revealed an unreliable effort with inconsistent range of motion and positive non objective signs. In my opinion, this is a reflection of fear avoidance behavior.
>
> His light work category ability will enable him to enroll in a part-time job which, in my opinion, should be supplemented by half-time work hardening for at least two months. I encouraged Mr. Leroux to continue his exercises aggressively and fully cooperate with the work hardening effort. I also tried to explain to him that no perfect solution can be achieved for his situation and I would strongly encourage him not to pursue any form of long-term disability as I think it would be overall detrimental, to his overall well being. The perfect solution part-time job combined with part-time work hardening for two months then followed by a full-time employment would offer him the best balance of self-reliance, financial independence, and physical ability which are very important factors in the long term success of chronic pain patients. I am not convinced Mr. Leroux is very willing to follow my advice but at least for now that's the best we can offer him. We will be available to offer advice on an as needed basis. (R1,X1, p. 22).

On April 19, 2004, claimant underwent a MRI scan of his lumbar spine at Samuel Medical Clinic pursuant to the direction of Dr. Musser. The impressions generated as a result of the diagnostic study reflects postoperative changes with scar formation more to right at the L4-5 level; mild bulging disc at L3-4 level; no definite recurrent herniated disc; and degenerative disc disease of L3-4, L4-5, and L5-S1 levels, along with mild degenerative arthritis. (CX.#1, p. 42).

On March 3, 2005, claimant underwent a CT scan of his right lower extremity at Poplar Bluff Medical Partners. The summary of the afore study disclosed increased number of venous

structures in the right lower tibial region and ankle suggesting venous stasis. (CX. #1, p.43).

Finally, the medical reflects that the claimant underwent a MRI of his lumbar spine on July 8, 2005, at Samuel Medical Clinic pursuant to the directions of Dr. Musser. The impressions generated as a result of the MRI scan reflects:

(1) Postoperative changes on the right with associated scar formation at the L5-S1 level.
(2) Small soft tissue density which does not enhance on the right at the L5-S1 level appearing new since previous study probably representing a new mild bulging disc. Early recurrent herniated disc cannot be ruled out however no pressure on the adjacent structures is noted.
(3) Mild posterior bulging disc at L3-4 and L4-5 levels
(4) Degenerative disc disease of the L3-4, L4-5, and L5-S1 discs.
(5) Mild degenerative arthritis. (CX. #1, p. 44-45).

While the hearing transcript reflects that a videotape was retained in the Commission's file, a videotape was not introduced or made a part of the record in these proceedings. Rather the afore refers to the CD-Rom, which is attached to the hearing transcript as an Respondent #1, exhibit #5. Respondent #1 was allowed to substitute photographs of exhibits 2 - 4 for inclusion in the hearing transcript. The actual exhibits were pieces of metal as described by counsel for respondent #1 in the hearing transcript.

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports, other documentary evidence, the CD-Rom, photographs and application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

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

2. On August 18, 1998, the relationship of employee-employer existed between the claimant and respondent #1, when the claimant sustained an injury to his low back arising out of and in the course of his employment. The claimant earned wages sufficient to entitle him to weekly compensation benefits of $276.00/$207.00, for total/permanent partial disability.

3. On January 17, 2001, the claimant reached the end of his healing period relative to the August 18, 1998, compensable low back injury.

4. The record fails to establish competent evidence that the claimant received short-term disability benefits subsequent to January 22, 2004, to entitle either respondent to credit based upon Ark. Code Ann. §11-9-411.

5. The claimant has a permanent physical impairment in the amount of 10% to the whole body, pursuant to the AMA Guidelines to the Evaluation of Permanent Impairment, 4th Edition, page 113, for lumbar radiculopathy post lumbar diskectomy.

6. When the claimant's age, education, permanent restrictions and limitations are considered, the evidence preponderates that he has suffered a loss of earning capacity or wage loss disability in the amount of 55% in excess of his anatomical impairment as a result of the August 18, 1998, compensable injury.

7. Respondent #2, the Second Injury Fund, has no liability in this claim, in that the pre-existing right lower extremity complaint does not combine with the August 18, 1998, compensable injury to produce the claimant's current disability status.

8. Respondent #1 shall pay all reasonable hospital and medical expenses arising out of the injury of August 18, 1998.

9. Respondent #1 has controverted the payment of permanent partial disability

benefits to the claimant in excess of the claimant's 8% anatomical impairment.

CONCLUSIONS

The claimant's August 18, 1998, low back injury was ruled compensable following a February 23, 1999, hearing before the Arkansas Workers' Compensation Commission. Although he later underwent surgery relative to the compensable injury, claimant continued in the employment of respondent-employer, having last discharged employment duties on January 22, 2004. Claimant asserts that he is entitled to additional workers' compensation benefits as a result of his compensable August 18, 1998, injury, to include indemnity benefits to correspond to a 10% whole body rating, as opposed to the 8% paid by respondent-employer, as well as permanent total disability benefits or, in the alternative, wage loss benefits in excess of the anatomical impairment, along with controverted attorney fees.

Respondent #1 maintains that the claimant sustained a 8% permanent physical impairment, which has been accepted and paid, as a result of the August 18, 1998, compensable injury. Respondent #1 denies that the claimant has been rendered permanently and totally disabled as a result of the compensable injury or that he is entitled to permanent partial disability benefits in excess of his 8% anatomical impairment. Respondent #1 asserts that if the claimant is found to have suffered wage loss or permanent disability in excess of the anatomical impairment respondent #2, the Second Injury Fund, is liable for the payment of same.

Respondent #2 denies that it has any liability in this claim. Respondent #3, the Death and Permanent Total Disability Trust Fund, maintains that pursuant to Ark. Code Ann. §11-9-525 (b)(1), the liability of respondent #2 must be determined prior to consideration of its liability.

The present claim is one governed by the provisions of Act 796 of 1993, in that the

claimant asserts entitlement to additional workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

PERMANENT PHYSICAL IMPAIRMENT

On May 9, 2000, the claimant underwent surgery relative to his August 18, 1998, compensable injury under the care of Dr. R. Edward Cooper, a Jonesboro orthopedic surgeon. Specifically, Dr. Cooper performed a right L4-5 hemilaminectomy and diskectomy in the treatment of the claimant's diagnosed right L4-5 herniated disc. The operative report regarding the claimant's May 9, 2000, surgery reflects that the claimant was found to have clinical findings consistent with right L4-5 HNP with right L5 radiculopathy, which had failed conservative treatment. When seen in follow-up on May 22, 2000, the medical records reflect that the claimant was having spasms in the right thigh and calf, and that when he coughed or strained he had shooting pain down the right leg to the toes.

During a January 15, 2001, office vice, Dr. Cooper recorded that the claimant continued to have back pain off and on, mainly while doing a lot of walking or with activities. Dr. Cooper reported that while the claimant did not have any leg pain he did have some numbness in the bottom of this foot, occasionally got a charley horse in the bottom of his right foot and right thigh. Claimant was released to work activities with a 30 pound lifting restriction and directions to avoid repetitive lifting and twisting. In a January 17, 2001, clinic note, Dr. Cooper assessed the claimant's impairment at 8% to body as a whole. Dr. Cooper recited that the AMA Guidelines to the Evaluation of Permanent Impairment, 4th edition, provided the afore rating for a single level surgically treated disc lesion. Respondent #1 paid accepted and paid permanent partial disability to the claimant in accordance with the rating.

A July 11, 2001, office note of Dr. Cooper reflects that clamant relayed that once he was taken off light duty and placed back on his normal job by respondent #1 he begin having recurrent back pain with radiation down the right posterolateral thigh, calf and into the sole of the right foot. Thereafter, the medical in the record reflects that the claimant has consistently relayed complaints of low back and right leg pain. Claimant was ultimately referred by Dr. Cooper to Dr. Calin A. Savu, a pain management specialist, for further treatment. Indeed, the evidence preponderates that the claimant's authorized treating physician relative to the August 18, 1998, compensable injury has remained Dr. Savu.

On October 1, 2003, claimant was evaluated by Dr. John D. Brophy, a Memphis neurosurgeon, pursuant to request of respondent #1. The October 1, 2003, report of Dr. Brophy reflects that in his opinion the clamant has undergone an appropriate evaluation for his residual postoperative pain status post right L4-5 diskectomy; and that there was no indication for surgical intervention. Further, Dr. Brophy recommended that from the standpoint of the claimant's lumbar radiculopathy and lumbar disc surgery, that the claimant initiate a serious weight loss program as well as begin an endurance exercise program. Dr. Brophy noted that the standard rating for lumbar radiculopathy status post lumbar diskectomy is 10% whole body.

Ark. Code Ann. §11-9-704 (c)(1) provides that the determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental finding. Objective findings are those finding which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102 (16). The claimant has the burden of proving by a preponderance of the evidence that he is entitled to an award for a permanent physical impairment.

While respondent #1 accepted and paid indemnity benefits to correspond with the 8% impairment rating assessed by Dr. Cooper on January 17, 2001, and deny that the extent of the claimant's anatomical impairment is 10%, the evidence on this question does not conflict, and, in fact, is consistent and in harmony. At the time of the January 17, 2001, rating by Dr. Cooper claimant did not have radiculopathy. Upon being returned to regular duties claimant experience recurrent back pain and pain radiating down into his right leg. The afore symptoms have remained in place since July 11, 2001. The claimant's symptoms have persisted and been medically documented since July 11, 2001, to include that point in time that he was evaluated by Dr. Brophy on October 1, 2003. The evidence preponderated that the extent of the claimant's anatomical impairment as a result of the August 18, 1998, compensable injury and surgery is 10% to the body as a whole pursuant to the AMA Guidelines to the Evaluation of Permanent Impairment, 4th edition, page 113, for a single level surgically treated disc lesion with radiculopathy. Respondent #1 has controverted the claimant's entitlement to permanent disability benefits in excess of a 8% permanent physical impairment.

WAGE LOSS BENEFITS

Claimant commenced his employment with respondent #1 on January 8, 1988, and continued in the employment of same through January 22, 2004. While the claimant had suffered a prior work related injury to his mouth and teeth while employed in the Texas oil industry, he fully recovered, and later returned to Missouri to commence his employment history with respondent #1. The claimant was in good health when he commenced his employment with respondent #1.

As noted above, there is an entry in the medical records to reflect that the claimant

commenced having problems with his right lower extremity in July 1995, and was treated for deep vein thrombosis with a course of Coumadin, a blood thinner, until August 1995. Claimant concedes that he did not receive any medical treatment regarding his right leg between August 1995, and his August 18, 1998, compensable low back injury. There are no medical reports in the record of the claimant's medical treatment regarding his right leg complaint prior to August 18, 1998.

Claimant underwent surgery relative to his August 18, 1998, compensable low back injury on May 9, 2000. The evidence in the record reflects that respondent #1 accommodated the claimant in consistently providing work within his restriction subsequent to July 11, 2001, when the claimant experienced recurrent back pain and radiation in the right leg after he was returned to his normal job. Claimant asserts that but for the accommodations afforded by respondent #1 with respect to light/restricted job duties he would not have been able to continue working as long as he did.

The claimant's authorized treating physician regarding his compensable August 18, 1998, injury remained Dr. Savu following claimant's referral to same by Dr. Cooper on October 11, 2001. At the time of the afore referral to the Chronic Pain Clinic Dr. Cooper noted that he saw nothing surgically that needed to be done. On October 1, 2002, the claimant was evaluated by Dr. Ron D. Schechter, a Paragould orthopedic surgeon, at the directions of respondent #1. Dr. Schechter recommended that the claimant see a surgical spine specialist for further work-up, and agreed with Dr. Savu's thinking.

Claimant was seen by Dr. Savu on September 4, 2003, at which time he recommended continuous medical therapy, and work hardening for at least six (6) weeks, which would be done

on a part-time basis in combination with part-time employment. Six-weeks post the September 4, 2003, visit would place the claimant's return visit in mid- to-late October 2003. Dr. Savu recommended a full evaluation of the claimant's capacity at the end of the six-week period by a specialized physical therapist. Dr. Savu offered that based on the afore assessment he would be able to decide in what capacity the claimant could continue his employment and clearly define any restrictions.

As noted above, on October 1, 2003, the claimant was evaluated by Dr. John D. Brophy, a Memphis neurosurgeon, at the request of respondent #1. Dr. Brophy observed, following his evaluation (physical examination and radiographic studies) of the claimant, that there was no objective reason why the claimant could not return to work at full duty. Further, Dr. Brophy noted that if the claimant's treating physician, Dr. Savu, felt that work restrictions were indicated the claimant should undergo a formal functional capacity evaluation.

On November 3, 2003, claimant underwent a functional capacity evaluation. While noting that the results reflected that the claimant did not demonstrate maximal or consistent effort, and as such his true functional limitations remained unknown, the claimant did demonstrate the ability to work at least at the light work category over the course of an 8 hour day. After obtaining the results of the functional capacity evaluation claimant was returned to regular job duties by respondent #1.

Dr. Savu, the claimant's authorized treating physician, was provided copies of the evaluation by Dr. Brophy and the FCE. In his November 7, 2003, correspondence to respondent #1 Dr. Savu opined that the claimant could return to work immediately restricted to light duties. Dr. Savu also recommended a work hardening program. Dr. Savu indicated that he would

encourage the claimant to enroll in a work hardening program which would him to progress from light to moderate or even a full duty job description.

Claimant worked light duty jobs in his employment with respondent #1 from 2000 until November 2003. In November 2003, following his evaluation by Dr. Brophy and the functional capacity evaluation, the claimant's job classification was changed to Metal Former in Dept. 275, plan B, which was his regular job classification. Claimant was placed on the extension cell job. After complaining that he was having problems on the extension, claimant was changed to the hat former job. At the time the claimant last discharged employment duties for respondent #1, he was assigned to the miscellaneous press area on T5012 operation. Claimant complained to supervisory personnel that he was unable to perform the job.

The testimony presented by respondent #1 reflects that the job to which the claimant was assigned following the evaluation by Dr. Brophy and the FCE were the "lightest" jobs in the facility. The claimant had not been released by his authorized treating physician, Dr. Savu, to return to unrestricted full regular duty. Claimant attributes his inability to continue working the assigned jobs after his return to regular job duties to having to bend over repetitively and frequently to retrieve parts out of the container ans well as prolonged standing, despite the fact that he was allowed take his time or work at his own pace.

The credible evidence in the record does not reflect that the claimant quit his job with respondent #1 on January 22, 2004. Prior to commencing his shift on January 22, 2004, claimant was seen by Dr. Savu regarding his residual symptoms and complaints attributed to the compensable August 18, 1998, injury. Claimant presented the release/documentation from Dr. Savue regarding the visit to office personnel of respondent # 1 as he usually did, and thereafter

proceeded to his work station. Claimant worked for several hours on January 22, 2004, before being directed to the office by supervisory personnel. Claimant was informed that respondent #1 had no further light duty work for him and that he needed to go home.

While respondent #1 asserts that the claimant's employment did not cease until January 2005, one (1) year after he had been placed on medical leave. The record does not contain documents evidencing that the claimant signed/applied for FMLA or medical leave, nor has respondent furnished "off-work slips" authored by the claimant's personal physician directing him to remain off work due to complaints associated with his right leg symptoms. The evidence does reflect that the claimant received unemployment compensation benefits.

The evidence preponderates that the claimant incurred limitations and physical restrictions on his employment activities as residuals of his compensable August 18, 1998, low back injury. During the time respondent #1 accommodated the claimant he was able to continued earning wages in the employment of same. While respondent #1 ceased providing work to the claimant within the restrictions/recommendations of the claimant's treating physician on or about November 7, 2003, claimant nevertheless continued performing his assigned job duties. Even after being returned to unrestricted regular job duties the credible evidence reflects that respondent #1 changed the claimant's job assignment on one occasion when claimant relayed that he was having trouble doing a job.

The evidence is clear that after the claimant was seen by his treating physician on January 22, 2004, and recommendations/restrictions outlined regarding his employment activities, respondent #1 directed the claimant to leave the plant, and effectively terminated his employment. Claimant had been doing his assigned job for several hours on January 22, 2004,

when he was directed to leave the plant. Claimant was not offered work by respondent #1 within the confines of the January 22, 2004, recommendations of Dr. Savu, nor was he allowed to continue performing his then assigned job.

Ark. Code Ann. §11-9-519(e)(1) (Repl. 2002), defines permanent total disability as "inability, because of compensable injury or occupational disease, to earn any meaningful wages in the same or other employment". Claimant acknowledged that had he not been directed to leave work by supervisory personnel of respondent #1 on January 22, 2004, he would have continued in the employment of same. Indeed, as noted above, despite the fact that the claimant had been seen by his treating physician on January 22, 2004, due to continuing complaints relative to residuals of his compensable injury, he nevertheless reported for work at the designated time and had worked three (3) hours before being summoned to the office and effectively terminated of his employment. Claimant has failed sustain his burden of proof by a preponderance of the evidence that he has been rendered permanently and totally disabled as a result of his August 18, 1998, compensable injury.

Ark. Code Ann. §11-9-522, Compensation for disability – Unscheduled permanent partial disability, provides, in pertinent part:

> (b) (1) In considering claims for permanent partial disability benefits in excess of the employee's percentage of permanent physical impairment, the Workers' Compensation Commission may take into account, in addition to the percentage of permanent physical impairment, such factors as the employee's age, education, work experience, and other matters reasonably expected to affect his or her future earning capacity.
>
> * * *
>
> (c) (2) Included in the stated intent of this section is to enable an employer to reduce or diminish payments of benefits for a functional disability,

> disability in excess of permanent physical impairment, which, in fact, no longer exists, or exists because of discharge for misconduct in connection with the work, or because the employee left his or her work voluntarily and without good cause connected with the work.

In the instant claim, the evidence preponderates that the claimant did not leave his work voluntarily but was directed to do so by respondent #1. There is no documentary evidence in the record to reflect that the claimant requested medical leave on or after January 22, 2004. Respondent #1 declined to further furnish employment for the claimant within physical restrictions relative to the August 18, 1998, compensable injury, subsequent to January 22, 2004.

Claimant sustained a 10% permanent physical impairment as a result of the August 18, 1998, compensable low back injury and surgery. As a consequence of the afore, claimant is limited in the amount of weights that he can lift, unable to do repetitive bending and twisting, or prolonged standing or sitting. Claimant's employment history is one of heavy manual labor jobs. Claimant is unable to return to employment requiring heavy physical demands. Claimant was employed by respondent #1 from 1988 until January 22, 2004, and was earning in excess of $16.00, per hour at the time his employment was terminated. There is evidence in the record to reflect that the claimant can perform jobs in the light category.

The wage loss factor is the extent to which a compensable injury has affected a claimant's ability to earn a livelihood. *Wal-Mart Stores, Inc. v. Connell,* 340 Ark. 475, 10 S.W.3d 882 (2000). As a consequence of the residuals of his compensable injury, claimant has been removed for jobs requiring repetitive bending, lifting or twisting. Claimant is unable to stand or sit fro prolonged periods of time as a consequence of his compensable injury. Claimant is a high school graduate whose work experience/history has been limited to manual labor jobs. The evidence

preponderates that when the wage loss considerations reasonably expected to affect his future earning capacity are applied to the claimant he has suffered a permanent partial wage loss in the amount of 55% in excess of his anatomical impairment. Respondent #1has controverted claimant's entitlement to wage loss disability benefits.

SECOND INJURY FUND LIABILITY

Ark. Code Ann. §11-9-525, Compensation for disability – Second injuries, provides, in pertinent part:

> (a)(1) The Second Injury Trust Fund established in this chapter is a special fund designed to ensure that an employer employing a handicapped worker will not, in the event that the workers suffers an injury on the job, be held liable for a greater disability or impairment than actually occurred while the worker was in his or her employment.
> (2) The employee is to be fully protected in that the fund pays the worker the difference between the employer's liability and the balance of his or her disability or impairment which results from all disabilities or impairments combined.
> (3) It is intended that latent conditions which are not known to the employee or employer not be considered previous disabilities or impairments which would give rise to a claim against the fund.

Liability to the Second Injury Fund, respondent #2, comes into question only after three hurdles have been overcome: the employee must have suffered a compensable injury at his present place of employment; prior to that injury the employee must have had a permanent partial disability or impairment; and the disability or impairment must have combined with the recent compensable injury to produce the current disability status. *Mid-State Construction Co. v. Second Injury Fund,* 295 Ark. 1, 746 S.W.2d 539 (1988).

The compensability of the claimant's August 18,1998, low back injury in the employment of respondent #1, which serves as the basis for the present claim is not disputed. Further, the

evidence preponderates that the claimant sustained a permanent physical impairment as a result of the August 18,1998, compensable injury. The evidence further reflects that while employed in the oil industry in Texas claimant suffered a compensable injury to his mouth, however there is no evidence that the claimant incurred a disability or impairment as a result of the same.

Claimant commenced his employment with respondent #1 on January 8, 1988. There is no evidence in the record to reflect that the claimant experienced any physical limitations or restrictions in the discharge of his employment with respondent #1 prior to his August 18, 1998, compensable low back injury. While there is testimony in the record to reflect that the claimant received medical treatment for a vascular condition in his right leg in July 1995 and August 1995, there are no medical reports in the record evidencing contemporaneous treatment. Subsequent to the August 18, 1998, compensable injury, the medical reports do document observations regarding the claimant's right lower extremity. Despite the various diagnostic studies performed regarding the claimant's right lower leg, a concise diagnosis has not been rendered.

The claimant dose not attribute his difficulty, restrictions or limitations, in performing his assigned jobs in the employment of respondent #1 to the vascular condition in his right leg. Indeed the only mention of possible impact of the claimant's leg condition on his work restrictions is found in the October 1, 2003, report of Dr. John D. Brophy, an examining neurosurgeon, who indicated that "it is possible that work restrictions are indicated for his vascular problems". None were imposed and the claimant does not attribute employment difficulties to the leg. Claimant also underwent a procedure for angina in 2002, a cardiac catheterization, and was diagnosed with stable angina, C.O.P.D., sleep apnea, shortness of breath,

mitral valve prolapse and an anterior myocardial infraction.

The preponderance of the evidence does not show that a prior disability or impairment combined with the August 18, 1998, compensable injury to produce the claimant's current disability status. Accordingly, respondent #2 has no liability in the present claim.

CREDIT PURSUANT TO ARK. CODE ANN. §11-9-411

Ark Code Ann. §11-9-411, Effect of payment by other insurers, provides, in pertinent part:

> (a) Any benefits payable to an insured 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 benefit plan, or a group hospital or medical service contract.

In the instant claim, claimant acknowledged receiving unemployment compensation benefits after his employment by respondent #1 was terminated on January 22, 2004, however denies receiving short-term disability benefits. The record is devoid of documentary exhibits evidencing claimant's receipt of short-term disability benefits, either before or after January 22, 2004. Accordingly, the evidence fails to preponderate that respondent #1 is entitled to credit pursuant to Ark. Code Ann. §11-9-411.

AWARD

Respondent #1 is herein ordered and directed to pay to the claimant permanent partial disability benefits at the weekly compensation benefit rate of $207.00, to correspond with the claimant's 10% permanent physical impairment growing out of his compensable injury of August

18, 1998. Said sums accrued shall be paid in lump without discount. Respondent #1 may claim credit for sums heretofore paid toward the afore mention obligation.

Respondent #1 is further ordered and directed to pay to the claimant permanent partial disability benefits at the weekly compensation benefit rate of $207.00, to correspond with the claimant's 55%permanent partial wage loss in excess of his anatomical impairment growing out of the August 18, 1998, compensable injury. Said sums accrued shall be paid in lump without discount.

Respondent #1 is further ordered and directed to pay all reasonable related medical, nursing, hospital, and other apparatus expenses growing out of the claimant's compensable injury of August 18, 1998, to include medical related travel.

Maximum attorney fees are herein awarded to the claimant's attorney, the Honorable John Barttelt, on 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.

IT IS SO ORDERED.

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Andrew L. Blood, Administrative Law Judge