**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F203703**

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| **LOUCINDA PRINGLE, EMPLOYEE** | **CLAIMANT** |
| **L.A. DARLING CO., SELF-INSURED EMPLOYER** | **RESPONDENT** |
| **MANAGEMENT CLAIMS SOLUTIONS, TPA** | **RESPONDENT** |

**OPINION FILED JANUARY 5, 2006**

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on November 4, 2005, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE SCOTT A. ROBBINS, Attorney at Law, Popular Bluff, Missouri.

Respondent represented by the HONORABLE GAIL O. MATTHEWS, Attorney at Law, Little Rock, Arkansas.

## STATEMENT OF THE CASE

A hearing was conducted in the above-style claim to determine the claimant's entitlement to additional workers' compensation benefits growing out of her compensable injury of March 20, 2002.

On August 30, 2005, a pre-hearing 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 regarding the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. The parties further stipulated that during the period of disputed

temporary total disability, September 7, 2003 through January 4, 2004, claimant received short-term benefits. Further, the parties stipulated that the claimant's medical that was not covered through its workers' compensation program was paid under the respondent's group medical, which is also self-insured. Respondent asserts entitlement to credit for anything paid under short-term disability, $2,695.35. Claimant is only asking for medical expenses that she actually incurred herself.

The testimony of Loucinda Pringle, the claimant, coupled with medical reports and other documents comprise the record in this claim.

## DISCUSSION

Loucinda Pringle, the claimant, with a date of birth of November 17, 1963, has a 12th grade education. Claimant commenced her employment with respondent on August 4, 1988. Prior to her employment by respondent, claimant was employed as a QC Supervisor at Tome Ridge Farms in Georgia. Claimant was also employed as a courier at Corning for two years. Claimant presently discharge the job duties of a metal former, which entails operating different machines. Claimant explained the mechanics of her job duties:

> You pick up a part and put it in a machine and you take it out and lay it on a roller to go to the next operation or stack it in the rack. (T.9).

Claimant denies that she experienced limitations or restrictions relative to her back prior to the March 20, 2002, compensable accident.

Regarding her March 20, 2002, compensable injury, the testimony of the claimant reflects:

> I was standing at my machine, running my machine, and a

> lift driver had picked up a load of brackets, which was right behind my machine, and I had to stand on a platform and he swung around because he was taking the brackets to another platform. He swung around and hit the stand that I was standing in and knocked me into the machine and twisted and . . . (T. 10).

Following the accident claimant got down off of the platform. Claimant noted that she begin experiencing pain in her lower back below her waistline, which was worse in her left leg. The injury was reported by the claimant to her supervisor, Danny Byars, who was present at the time of the accident.

The testimony of the claimant reflects that she was taken to the first-aid station by Mr. Byars and the injury was logged down. Claimant declined Mr. Byars' offer of medical treatment. Claimant explained that at the time she want to wait and see if her complaint would resolve on its own. Claimant was unable to perform her regular job duties. Claimant's testimony reflects:

> No, and I think I went to the first-aid for a little while, and then after that, he had someone run my machine and I just more or less just walked around. (T. 11).

Claimant was furnish some pain medication from the first-aid station and was directed by supervisory personnel of respondent to let them know if she got worse and they would send her to the doctor.

Claimant noted that when the pain from the accident got worse she asked to be sent to a doctor. Regarding the medical treatment rendered to her following her request, the testimony of the claimant reflects:

> I went to the company doctor and then I went to physical therapy. I went through the shots in the back - the injections in the back, and then I went to physical therapy again, and I think that was all. (T. 12).

Claimant described her symptoms following the March 20, 2002, accident, as pain, burning and tingling that would radiate to her ankle and toes. Claimant testified that she did not get any relief from the pain as a result of the injections or physical therapy. Claimant explained:

> I had to keep going to the doctor, back and forth, and do pain pills, and it was like they didn't want to do anything but keep giving me pain pills, so I just had to do pain pills and go back and forth to the doctor and I was off work for a time, but then they took me back to work and put me on in light duty and I was still going back and forth to the doctor until August, when they said they weren't going to send me to the doctor no more - I would have to go to my own doctor. (T. 13).

The testimony of the claimant reflects that eventually she ended up seeing Dr. Dewayne Eubanks, a Jonesboro neurosurgeon, who recommended and scheduled surgery, however respondent refused to authorize it under its workers' compensation program.

The testimony of the claimant reflects that after the surgery with Dr. Eubanks was cancelled, she was seen by a doctor in Memphis, who referred her to another physician who performed a discogram, which disclosed bulging disc at L4-5. Once respondent refused to authorize surgery, claimant's testimony reflects that she was seen by Dr. Lewis in Jackson, Mississippi, who performed the surgery at the L4-5 level on September 24, 2003. Claimant testified regarding the improvement in her symptoms following the surgery:

> Actually, I felt like I could run, but my husband was like, no, don't you run. But it just - it really felt good that my leg didn't hurt through my hip like it had been. (T. 14).

Claimant added that the relief following the surgery was the first relief from her symptoms that she had experienced since the March 20, 2002, accident. Claimant's testimony reflects, regarding her physical capability since the surgery:

> I do everything that I can. When I get up on a morning, I'm stiff and it takes a little bit longer to get around, and I have trouble twisting and turning. It bothers me a little bit to stand or sit for a long period of time, but, other than that, I just go on with a normal life and try to take some Tylenol or Advil. (T. 16).

Claimant noted that the September 24, 2003, surgery relieved her symptoms of pain, burning and tingling which radiated to her ankle and toes. Claimant attributes her need for the September 24, 2003, surgery to the March 20, 2002, injury to her back at work.

In addition to a 10% permanent physical impairment based on the AMA Guidelines, claimant's testimony reflects that Dr. Lewis also imposed restrictions on her physical activities which included no heavy lifting, or repetitive bending and stooping. Claimant testified that she has been able to follow the restrictions and to continue to function. The testimony of the claimant reflects that as a consequence of her injury and surgery, she no longer bowl in a league or ride horses. Claimant noted that while she does not twist and turn as she formerly did and that while different jobs at respondent require some twisting and turning, she is able to perform her current job with respondent without any problems.

The claimant testified that once respondent declined to pay the cost of her medical treatment under its workers' compensation program she filed the claim with her health insurance carrier through her work. Claimant also took leave from work pursuant to a FMLA filing. While the health care provider paid a portion of the medical bills there is a total of $9,600.00, remaining in unpaid bills. Claimant has made some out-of-pocket payments toward the unpaid bills. The testimony of the claimant reflects that she was off work for three to four months following the September 24, 2003, surgery. Claimant received some short-term disability benefits during the afore period, but no workers' compensation indemnity benefits.

The claimant denies that she was told that she had degenerative disc disease by her treating physicians immediately following her accident. The testimony of the claimant reflects that she bowled in a league for two years prior to her accident. While the claimant rode horses prior to her accident, she did not own one.

The testimony of the claimant reflects that the company doctor, Dr. Monroe, referred her for diagnostic studies, to include a MRI scan. Claimant underwent an EMG pursuant to the directions of Dr. Spanos. As a result of the diagnostic studies claimant was informed that she had a bulging disc. Claimant was referred to Dr. Gera who provided epidural steroid injections. The testimony of the claimant reflects that after she did not receive any benefits from the therapy or epidurals she was referred by respondent to Dr. Eubanks.

Later, claimant underwent a discogram by a physician in Memphis. The testimony of the claimant reflects that she was seen by Dr. John Brophy, a neurosurgeon, and Dr. Riley Jones. Claimant denies that she was told by either of her physicians that her need for surgery was due to degenerative disc disease and not as a result of the March 20, 2002, accident.

The medical in the record reflects that the claimant received initial medical treatment for her complaints growing out of the March 20, 2002, accident under the care of respondent's designated medical provider, Dr. Lance E. Monroe on March 25, 2002. In his March 27, 2002, clinic note, Dr. Monroe recited the history of the claimant's work-related accident as well as the results of the claimant's physical examination which included "mod spasm paralumbar areas". (RX. #1, p. 3). Claimant underwent diagnostic studies pursuant to the directions of Dr. Monroe, to include x-rays and a MRI of her lumbar spine. (RX. #1, p. 1-2). Claimant's injury was assessed by Dr. Monroe as a sprain/strain of the lumbar region for which she was prescribed

Dexamethason Pak, Flextra DS and Skelaxin. (RX. #1, p. 4).

On April 4, 2002, claimant was again seen by Dr. Monroe relative to her complaints growing out of the March 20, 2002, accident. The April 4, 2002, clinic note reflects an additional problem registered by the claimant of radiculopathy to the left lower extremity. Darvocet-N was added to the claimant's treatment regiment by Dr. Monroe. (RX. #1, p. 10).

Claimant underwent physical therapy at Three Rivers Healthcare from April 15, 2002, May 8, 2002, and from March 3, 2003, through March 20, 2003, pursuant to a referral of Dr. Monroe for complaints attributable to the March 20, 2002, accident. (CX. #1, p. 3-15). Claimant also underwent physical therapy at Pendergrass Therapy Services, Inc. from September 24, 2002, through October 22, 2002. (CX. #1, p. 16-25).

Following a April 26, 2002, visit, claimant was referred by Dr. Monroe to additional diagnostic studies, to include an NCV and a neurological consultation. (RX. #1, p.17-19). During a May 10, 2002, visit, Dr. Monroe noted the presence of paralumbar spasm on the left as well as the results of a bone scan and MRI scan being negative. (RX. #1, p. 20-21).

On July 12, 2002, claimant was evaluated by Dr. Demetrius S. Spanos, at Neurology Associates of Northeast Arkansas, pursuant to a referral of Dr. Monroe. (RX. #1, p. 40-42). The July 12, 2002, report of Dr. Spanos reflects, in pertinent part:

> **Discussion:** The patient seems to be suffering from musculo-skeletal pain related to her work injury. She has already tried conservative treatment including physical therapy, which has not been helpful. I have recommended that she undergo nerve conduction studies of both lower extremities to ensure there is no nerve damage and have outlined a plan tor pain control including Effexor followed by Neurontin. If these are not helpful then I have already discussed with her the possibility of proceeding to chronic pain management and will do so on her return trip. (RX. #1, p. 41-42).

On July 16, 2002, claimant underwent the NCV studies pursuant to the directions of Dr. Spanos. The results of the studies were normal. (RX. #1, p. 43-45). A July 18, 2002, report of Dr. Spanos reflects that the results of the NCV studies were shared with the claimant. In terms of treatment recommendations, the July 18, 2002, report of Dr. Spanos reflects that an increase in the dosage of Neurontin would be tried and if the same failed a referral to Dr. Gera for pain management would follow. (RX. #1, p. 46).

On July 22, 2002, claimant was seen for an initial consultation by Dr. Sunil Gera, at Pain Management, pursuant to the referral of Dr. Spanos. The July 22, 2002, report of Dr. Gera reflects, in pertinent part:

> **HPI:** This is a 38-year-old white female who is standing and appears to be in some distress. According to her, she has been having this pain for the last four months after she was hit by a stand at her workplace and was knocked down. According to her, ever since then she has been having pain. She had been seen by Dr. Monroe and had some physical therapy also. Finally, she was seen by Dr. Spanos, who has done nerve conduction studies that are normal. MRI has shown some disc bulging. She is taking Neurontin, naproxen and Zanaflex. (RX. #1, p. 49).

Following his examination, Dr. Gera assessed the claimant's complaints as left sacroiliitis, gluteal bursitis, trochanteric bursitis, possibility of lumbar radiculopathy, and possiblity of facet arthropathy. Dr. Gera took the claimant off of the Zanaflex and Neurontin, which was not giving her any relief and making her drowsy, and started her on Skelexin. Claimant was also started on Arthrotec "for anti-inflammatory and analgesic effect", by Dr. Gera. The July 22, 2002, report of Dr. Gera also reflects in terms of treatment measures:

> I will inject her SI, trochanteric and gluteal bursa in one sitting and see how much response she gets. If she does not respond to the radiculopathic nature, though the nerve conduction studies were normal, I am going to go ahead and give a trial of LESIs.

* * *

> Once she gets some pain relief, I am going to send her back to physical therapy for strengthening her back muscles. (RX. #1, p. 52).

The medical in the record reflects that the claimant treated with Dr. Gera through September 3, 2002. On August 1, 2002, claimant has a LESI done by Dr. Gera. Claimant was seen in follow-up by Dr. Gera on August 23, 2002. The August 23, 2002, report concluded, in terms of treatment:

> I am going to inject her above described facet joints. If she gets temporary relief with those things and most of the pain is gone, then maybe down the road we will do radiofrequency of those nerves also. Everything was explained to her and she left happily. I did explain to her that with the way she has been improving, then possibly within four weeks I will put her in full duty.. . .(CX. #1, p. 2).

On September 3, 2002, claimant underwent facet injection under the care of Dr. Gera. The Procedure Note of the afore visit concludes:

> **ASSESSMENT/PLAN:** The patient had a very good relief n the back. Still she had some pain in the hip area. I will review her in my clinic. If the relief is short-lived, then we will do a radio-frequency ablation of the medial branch nerve. It was explained to the patient and she was happy. She was discharged in a satisfactory condition. (RX. #1, p. 59).

The medical in the record reflects that the claimant was initially evaluated by Dr. K. Dewayne Eubanks, a Jonesboro neurosurgeon, on November 5, 2002, pursuant to a request of Dr. Gera. The November 5, 2002, report of Dr. Eubanks reflects, in pertinent part:

> Ms. Pringle is a 38-year-old lady who was standing on her platform at work, running a machine, when a forklift rand into the platform and jerked her about. She really cannot recall if she fell or not, but she says as soon as the “adrenaline settled down”, she felt pain in her back. She currently complains of pain in her low back as well as running down her left lower extremity laterally down the thigh into the lateral leg. It is about 6-7/10 pain as a baseline with exacerbations up to “11-12". She

> has some right hip pain in addition. Her back pain never lets up, although it is certainly worsened by standing up for a while or by walking around. It is also during these times that her leg pain flares up. She has tried aggressive nonsurgical management all summer with Dr. Monroe, Dr. Spanos and Dr. Gera, including an injection of LESI (three in a series) and nothing has helped.
>
> Her exam is significant, as documented below, for a straight leg raise on the left, for an antalgic gait, stance and posture, and for pain with flexion/extension of the lumbar spine and some numbness that is a little bit patchy, but I have a vague sensation that it is L5ish in distribution. She definitely has extensor hallucis longus weakness on the left compared to the right.
>
> Her MRI scan shows a marked degenerated disc at L4-5 with central broad-based protrusion. She has modic endplate changes at that level.
>
> I had a long discussion with her about discongenic pain, her degenerated discs, her central disc herniation and the surgical therapy that would be necessary to alleviate this or as lease improve it, assuming that this is the source of her pain. We discussed discograms to try to figure out if this is indeed the source of her pain. She desires that we proceed with the testing and with surgery, if we think it can help.
>
> The plan is for discograms of L4-5 with a control at L3-4. If it is positive at L4-5, then we will do a discetomy at L4-5 with interbody fusion and pedicle screw augmentation. (RX. #1, p. 63).

On November 8, 2002, claimant was admitted to Regional Medical Center of NEA under the directions of Dr. Eubanks and underwent the above recommended discograms.(RX. #1, p. 67-68).

Claimant was seen in follow-up by Dr. Eubanks on November 14, 2002, regarding the results of the discograms. The afore report reflects, in pertinent part:

> Ms. Pringle came in for a discussion of options. I explained that with her discogram being positive at L4-5, she stood a reasonable chance of improving with surgical treatment, being an ALIF or PLIF at L4-5, with pedicle screw augmentation either via percutaneous pedicle screws (for an ALIF) or open pedicle screws if we were doing an open PLIF.

> I had a long discussion with her. She told me the other day that she had fallen onto her buttocks recently while at work and this is when she started getting the left leg pain more. Based on that, I am afraid that it is possible she has a free fragment that has herniated out more. This would definitely be important to know before planning for an anterior approach and even with a posterior approach, it would be helpful to know if I need to go after a free fragment somewhere. I am going to order an MRI scan to look at that and then based upon that, we will either proceed with PLIF or an ALIF. Because there is some confusion about the numbering system, where she has a sacralized or lumbarized vertebra, I am going to get an AP and lateral T-spine x-ray to count the number of rib-bearing vertebrae. (RX. #1, p. 69).

The November 14, 2002, report of Dr. Eubanks reflects plans to admit the claimant for surgery on November 27, 2002, at Regional Medical Center. On November 19, 2002, claimant did undergo the recommended MRI of her lumbar spine. (RX. #1, p. 74-76). Claimant was not again seen by Dr. Eubanks until September 11, 2003. (RX. #1, p. 61).

Following the claimant's November 2002, treatment by Dr. Eubanks, the medical reflects that she was next seen on December 17, 2002, at Memphis Orthopaedic Group by Dr. Riley Jones. After identifying the prior pertinent medical records of the claimant and conducting a physical examination, the December 17, 2002, report of Dr. Jones concludes:

> At the present time there apparently is a recommendation for a diskectomy and a posterior interbody fusion. Fusions bascially are done for instability and not for degenerative disc disease. It is my feeling there are multiple inconsistencies in this lady's examination and I think a better indicator of what kind of pathology she has would be a myelogram with a post metrizamide CT. I also think she should have a MMPI or MPI by someone like Dr. Greg Cates in Memphis, TN for evaluation of the non physiologic aspects of this. At the present time based on doing the fusion for pain and doing a diskectomy for a disc that really does not show up according to the radiologist, I think would probably leave us with a lady who has more of a pain syndrome than anything else. I would suggest that she have the above studies and then re-visit and see if there is anything there to be operated on and if there is, then we would suggest to proceed. (RX. #1, p. 78-79).

On January 7, 2003, claimant underwent a lumar myelogram and post pyelogram lumbar computed tomography pursuant to the recommendation of Dr. Jones. The results of the afore studies were interpreted by Dr. Louis S. Parvey. Among the opinions reflected by Dr. Parvey is the following:

> Degenerative disc disease and bulging of the anulus fibrosus at L4-5 with likely encroachment of the bulging anulus on the left L4 intervertebral foramen. This might be better evaluated by MRI. (RX. #1, p. 82).

Claimant was seen in follow-up by Dr. Jones on January 14, 2003. After noting the results of the above diagnostic studies, as well as a physical examination, the January 14, 2003, report of Dr. Jones concluded:

> Again, there are multiple inconsistencies on this lady. I have reviewed the myelogram and post Metrizamide CT myself and I really am not impressed with what I find. I'm not sure that surgery is going to help this lady. I suggest that they do get her to see Dr. Greg Cates for an MMPI and also that they get her to see one of the neurosurgeons, let him review this and see if he finds anything that requires an operative procedure. NO EMPLOYMENT REPORT. (RX. #1, p. 80).

The medical in the record reflects that claimant was next seen by a physician in connection with her complaints growing out of the March 20, 2002, accident, on January 20, 2003, by Dr. John D. Brophy, a Memphis neurosurgeon, in accordance with the recommendation of Dr. Jones. After reciting a history of the claimant's injury and medical treatment received relative to same, Dr. Brophy reviewed the prior diagnostic studies and conducted a physical examination of the claimant. The January 20, 2003, report of Dr. Brophy reflects his impression of the claimant's complaint and recommendations:

> IMPRESSION: Myofasical pain syndrome associated with mild lumbar spondylosis with evidence of exaggeration on physical examination. There

> is no clinical evidence of radiculopathy or radiographic evidence of nerve root compression.
>
> RECOMMENDATIONS: In my opinion, Ms. Pringle's pain will not improve with the lumbar fusion procedure suggested by Dr. Eubanks. In fact, I believe that there is a good chance her pain will be significantly worse after this procedure. Based on the lack of clinical evidence of radiculopathy on physical examination as well as the multiple radiographic studies which do not demonstrate evidence of nerve root compression, I would not consider further evaluation with myelography useful. Given her inappropriate sedentary status over the past nine months, I would offer her a two week work conditioning program followed by return to work at full duty without restriction. If she is unable to tolerate her previous job, she should consider alternative employment. I would suggest immediate initiation of a walking endurance exercise program as well as an additional trial of anti-inflammatories like Bextra. I would agree with Dr. Riley Jones that her failure to improve is more related to exaggeration of her symptoms than organic disease of the spine. Certainly, the injury she sustained at work did not cause the degenerative changes noted on MRI which Dr. Eubanks considers the source of her pain. (RX. #1, p. 86).

Following the January 20, 2003, evaluation by Dr. Brophy, claimant was next seen for medical treatment on January 31, 2003, by Dr. Monroe. The office note of Dr. Monroe reflects that the claimant's back pain and radiculopathy of the lower left extremity were unchanged. Claimant was prescribed Toradol UT and Vistaril. (RX. #1, p. 25-27). Claimant was again seen by Dr. Monroe on March 26, 2003. While the office note of Dr. Monroe relative to the March 26, 2003, visit of the claimant reflects that the claimant's back pain was unchanged, it also noted, "no objective findings to prevent return to work—work trial". (RX. #1, p. 28-30).

The claimant was again seen at the Rector Medical Clinic by Dr. Monroe on April 11, 2003, relative to her low back pain. While the office note reflects the entry "pain in different anatomic area and tender in different area than original", there is no evidence in the medical record to reflect that the claimant had suffered another incident/accident relative to her back at

the time of the April 11, 2003, visit. (RX. #1, p. 87). On April 14, 2003, claimant underwent a MRI scan of her lumbar spine at Arkansas Methodist Medical Center pursuant to the directions of Dr. Monroe. The MRI disclosed a "central disc bulge at L4-5, no spinal stenosis or disc herniation was identified, and non-discogenic and discogenic degenerative change". (RX. #1, p. 32).

The record reflects a April 21, 2003, return to work without restrictions release authored by Dr. Monroe relative to the claimant. (RX. #1, p. 33). The evidence reflects that on April 21, 2003, a telephone call was originated by Dr. Monroe's office to respondent regarding the claimant's medical status. The note reflects, in pertinent part:

> Summary:
> called and spoke with andy regarding mrs. pringle. instructed him that mrs. pringle is now released from dr. monore and could return to work without any restrictions. instructed him that pringles back pain now, should be followed up with her family physician.
> I also called and instructed pt of the same per dr. monroe. (RX. #1, p. 88).

On June 16, 2003, claimant was seen by Ms. Judy A. Leach, APN, relative to complaints of pain in her low back. Claimant provided a history to Ms. Leach that after having been on light duty she was returned to regular duty and that while bending and moving at work she felt increase pain in her back. The incident was reported. The June 16, 2003, office note further reflects that claimant was of the opinion that she had not suffered a new injury but rather "just a flare up of previous injury". Claimant was directed to remain off work until she could be seen by Dr. Monroe on the following morning, June 17, 2003. (RX. #1, p. 37-38).

On June 17, 2003, claimant was again seen by Dr. Monroe. The office note relative to the afore visit reflects that on June 16, 2003, while bending at work claimant "noticed back pain

immediately". Claimant missed work on the afternoon of the incident and on the date of her June 17, 2003, doctor visit. The June 17, 2003, office note also reflects the entry, "old injury from about 1 year ago. Aggrevated at work yesterday". (RX. #1, p. 34). Claimant was prescribed Toradol and released to light duty following the June 17, 2003, visit. (RX. #1, p. 35-36). On June 20, 2003, claimant called Dr. Monroe's office regarding her pain medication. The phone note regarding the afore reflects, in pertinent part:

> Summary: Pt called and stated that the Toradol was not helping in her pain in her back. Spoke with Dr. Monroe. Stated that he would more that happy to send her to a pain clinic, but that he was not comfortable continuing to prescribe pain medication for an unidentifiable lesion. But that also since this pain was not related to her Workmans Comp then it would come out of her own pocket. Relayed message to pt. Stated that no she was not interested in going to the pain clinic. Stated that she was going to see her regular physician. Relayed pt's message to Dr. Monroe. (RX. #1, p. 89).

The medical evidence in the record reflects that claimant was again seen by Dr. Eubanks on September 11, 2003, pursuant to a referral of her family physician, Dr. Sandra Stubblefield. The September 11, 2003, report of Dr. Eubanks characterizes the claimant's visit as one of a return for followup after her second opinion from another neurosurgeon. The only other neurosurgeon to see the claimant since she was last seen by Dr. Eubanks was Dr. Brophy. The claimant, in returning to Dr. Eubanks, had decided not to use workers' compensation insurance in pursuing medical treatment relative to her low back complaint which she continue to attribute to the March 20, 2002, accident. The September 11, 2003, report of Dr. Eubanks concludes, regarding the claimant:

> I went over her case again and I think that with this central protrusion at L4-5 and with a positive discogram there, she is a good candidate for ALIF at L4-5 and avoid the posterior root structures.

> Unfortunately, Dr. Ameika has decided that he does not wish to provide access for anterior lumbar thoracic cases. This leaves me without anyone to provide surgical access for these. That being the case, Ms. Pringle asked me who I would go to and I told her that I would personally go to Dr, Adam Lewis in Jackson, Mississippi, who has extensive experience in ALIFs. Towards that end, we are going to ask him to take a look at her and we will try to make sure that all of her films and records are sent down there with her. (RX. #1, p. 61).

On September 23, 2003, claimant was evaluated by Dr. Adam Lewis at Jackson Neurosurgery Clinic, pursuant to the referral of Dr. Eubanks. (RX. #1, p. 90-92). In a September 23, 2003, report regarding his evaluation of the claimant, Dr. Lewis noted, in pertinent part:

> On examination, there is good strength in the lower extremities. The deep tendon reflexes are hypoactive and symmetric. Sensation to pinprick and light touch is diminished in both lower extremities over the L5 and S1 dermatomes. The patient ambulates with a normal station and base. There is a straight leg raise sign referred to the back.
>
> An MRI of the lumbar spine, performed April 8, 2002, shows degeneration and annular tears at the L4/5 level. There is a small central disc bulge. A lumbar discogram by report shows concordant back pain at the L4/5 level.
>
> Ms. Pringle suffers from L4/5 discogenic disease. The pain is intractable and significantly affects her lifestyle. The options of an anterior lumbar interbody fusion versus a posterior lateral fusion were discussed with the patient.
>
> Dwayne, I am in agreement with you that Ms. Pringle is an excellent candidate for an anterior lumbar interbody fusion at the L4/5 level. We will proceed with repair of the L4/5 disc space. (RX. #1, p. 93).

On September 24, 2003, claimant was admitted to St. Dominic-Jackson Memorial Hospital, in Jackson, Mississippi, under the care of Dr. Lewis and underwent an anterior lumbar interbody fusion at L4-L5 with anterior instrumentation. (RX. #1, p. 96-99). A September 24, 2003, correspondence of Dr. Jacob L. Mathis of Jackson Neurosurgery Clinic, to Dr. Eubanks noted that the claimant had been admitted to the hospital and undergone surgery under the care of Dr.

Lewis for treatment of degenerative and herniated lumbar disc. (RX. #1, p. 100).

Claimant was again seen by Dr. Eubanks on October 2, 2003. The office note of Dr. Eubanks regarding the visit reflects:

> Ms. Pringle has had her L4-5 ALIF done by Dr. Adam Lewis down in Jackson, Mississippi, about 10 days ago. (I was going to perform ALIF at L4-5, but the only available "access surgeons" at Regional Medical Center decided they did not want to perform access surgery for spine surgery patients.) She is doing perfectly. She had immediate relief of her back as well as her leg pain. She was up and walking immediately. She is here in the office today, very comfortable appearing and normal in her neurologic exam with negative straight leg raise, no back pain and no leg pain. Her wound on her anterior abdomen looks perfect and we have removed staples And applied Steri-Strips. I am going to get some baseline films today, then she will come back in six weeks and we will get followup films then, and I will continue seeing her. (RX. #1, p. 62).

The medical in the record reflects that the claimant was seen in followup at the Jackson Neurosurgery Clinic on several occasions following the September 24, 2003, surgery. A November 14, 2003, report of Dr. Lewis to Dr. Eubanks regarding a visit by claimant on the same date reflects, in pertinent part:

> Postoperatively, she has done very well. There is occasional stiffness in the mornings. The symptoms are made better with Tylenol. There is no radiating leg pain. The incision is well healed. Strength is 5/5 in all muscle groups. Sensation to pinprick and light touch is preceived.
>
> . . . . Ms Pringle will undergo repeat x-rays of the lumbar spine in six weeks to evaluate the fusion process. (RX. #1, p. 101).

Claimant was seen at the Jackson Neurosurgery Clinic on December 30, 2003, and a follow-up report to Dr. Eubanks regarding the visit reflects, in pertinent part:

> . . . . . It has now been three months since she underwent an anterior lumbar interbody fusion at L4/5 for treatment of a painful degenerative lumbar disc. The surgery was accomplished at St. Dominic Hospital on September 24, 2003. Biplane bending films accomplished reveal

> a solid L4/5 fusion.
>
> She has been instructed to discontinue her brace and bone stimulator. She feels improved. She has returned to employment at a factory. She takes no medications. Sh has a return appointment to the Jackson Neurosurgery Clinic in two months. (RX. #1, p. 103).

Following a March 4, 2004, visit to Jackson Neurosurgery Clinic and examination by Dr. Robert P. Uteg, claimant was discharged from followup care and medical treatment. (RX. #1, p. 105). Pursuant to a January 31, 2005, inquiry from claimant's attorney, in correspondence of February 3, 2005, Dr. Mathis of Jackson Neurosurgery Clinic responded:

> Please be advised that Ms. Pringle reached the maximum medical improvement category with regard to her low back injury on March 4, 2004. As she had a herniation of the L4/5 disc, she received a PDR of 10% to the whole person based upon AMA Guidelines. She was given restrictions of no heavy lifting or repetitive bending and stooping as she underwent surgery on September 24, 2003. She underwent an anterior lumbar interbody fusion for treatment of the herniated and extruded disc at L4/5. (RX. #1, p. 104).

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

**FINDINGS**

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

2. On March 20, 2002, the relationship of employee-employer existed between the parties.

3. On March 20, 2002, the claimant earned wages sufficient to entitle her to weekly compensation benefits of $295.00/$221.00, for temporary total/permanent partial disability.

4. On March 20, 2002, the claimant sustained an injury to her back arising out of and

in the course of her employment.

5. The claimant was temporarily totally disabled for the period September 7, 2003, and continuing through January 4, 2004, as a result of the March 20, 2002, compensable injury.

6. Medical treatment rendered to the claimant subsequent to June 23, 2003, relative to her back, to include that pursuant to direction/referral of Dr. Sandra Stubblefield, Dr. K Dewayne Eubanks, Dr. Adam Lewis and Jackson Neurosurgery Clinic, St. Barnards Medical Center, was reasonably necessary and related to the March 20, 2002, compensable injury.

7. The claimant reached the end of her healing period relative to the March 20, 2002, compensable injury and surgery on March 4, 2004, with a residual permanent partial disability in the amount of 10% to the body as a whole.

8. The respondent shall pay all reasonable hospital and medical expenses arising out of the claimant's injury of March 20, 2002.

9. The respondent has controverted the payment of all workers' compensation benefits in this claim subsequent to June 17, 2003, to include medical, temporary total and permanent partial disability indemnity benefits.

## CONCLUSIONS

The compensability of the claimant's March 20, 2002, accidental injury to her low back is not disputed. The March 20, 2002, accident was reported to appropriate supervisory personnel of respondent by the claimant and access to medical treatment provided. Claimant contends that as a result of the March 20, 2002, injury to her back she continued to experience residual symptoms which required medical treatment, to include surgery, however respondent declined to provide workers' compensation benefits subsequent June 17, 2003. Claimant asserts entitlement to

temporary total, and permanent partial disability benefits, as well as medical benefits subsequent to the point in time that respondent ceased to authorize and pay same.

Respondent takes the position that the March 20, 2002, injury suffered by the claimant is not the major cause of the permanent partial disability rating of the claimant. Further, respondent asserts that the surgery and resulting medical and temporary total disability were not the result of the March 20, 2002, injury. Additionally, respondent maintain that the claimant's surgery was not reasonable or necessary.

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.

Neither the mechanics nor the compensability of the claimant's March 20, 2002, low back injury is disputed. The evidence reflects that the claimant consistently discharged her employment duties with respondent prior to the March 20, 2002, accident without physical restrictions or limitations. Further, claimant engaged in physical demanding recreational activities of horse back riding and bowling prior to her March 20, 2002, accident. There is no evidence in the record to reflect that the claimant sought or required medical treatment relative to her low back prior to the March 20, 2002, compensable injury in the employment of respondent.

The credible evidence in the record reflects that following her March 20, 2002, compensable injury claimant remained symptomatic relative to her low back and lower left extremity until she underwent the September 24, 2003, surgical procedure under the care of Dr. Adam Lewis, a Jackson, Mississippi, neurosurgeon. In the instant claim, respondent provided access to medical treatment for the claimant and paid the cost of same through June 2003.

Although claimant continued to discharge assigned job duties subsequent to the March 20, 2002, accident, as noted above, she remained symptomatic with low back pain and left lower extremity tingling, weakness and pain.

Pursuant to Ark. Code Ann. §11-9-508 (a) an employer is required to provide such medical services as may be reasonably necessary in connection with the employee's injury. On March 20, 2002, the claimant suffered an injury to her low back arising out of and in the course of her employment which caused internal harm to her body and which required medical services and resulted in disability. There is medical evidence supported by objective findings, as defined by Ark. Code Ann. §11-9-102 (16), establishing the injury, and the injury was caused by a specific incident which is identifiable by time and place of occurrence.

The presence of objective findings establishing the claimant's injury is replete throughout the diagnostic studies administered to the claimant subsequent to the March 20, 2002, accident. Because the claimant had not experience complaints relative to her low back or lower extremities prior to the March 20, 2002, accident, the record does not reflect the presence of medical reports or diagnostic studies to compare to the post injury studies.

Claimant received sanctioned medical treatment under the care of Dr. K. Dewayne Eubanks, a Jonesboro neurosurgeon, relative to the March 20, 2002, injury in November 2002, following the failure of conservative treatment measures. After further diagnostic studies, Dr. Eubanks recommended proceeding with the surgical procedure which the claimant ultimately underwent on September 24, 2003, under the care of Dr. Lewis. Contrary to the prognosis of Drs. Riley Jones and John Brophy, the credible evidence in the record reflects that following the claimant's September 24, 2003, surgery there was an immediate relief of her symptoms and

improvement in her physical condition. As a consequence of the afore the claimant was able to return to the employment of respondent on or about January 2004.

Whether a medical procedure or device is reasonable and necessary is a question of fact. The evidence clearly reflects that claimant was not symptomatic relative to her low back or lower left extremity prior to her compensable injury of March 20, 2002. Claimant remained symptomatic following her March 20, 2002, compensable injury until she underwent surgery under the care of Dr. Adam Lewis on September 24, 2003. The evidence preponderates that the medical treatment rendered to the claimant subsequent to June 17, 2003, was reasonably necessary in connection with her March 20, 2002, compensable injury. Respondent controverted the claimant's entitlement to medical benefits relative to her March 20, 2002, compensable injury subsequent to June 17, 2003.

Because respondent declined to further furnish claimant access to medical treatment under its self-insured workers' compensation program, claimant filed her claim on the respondent's fund health insurance program. The afore entailed the claimant being responsible for a portion of the medical bills incurred in her treatment. The evidence preponderates that the medical treatment received by the claimant subsequent to June 17, 2003, was reasonable, necessary, and related to the March 20, 2002, compensable injury. Pursuant to Ark. Code Ann. §11-9-508 (a) respondent is liable for the cost of the claimant's medical treatment, to include medical related travel.

Ark. Code Ann. §11-9-102 (13) defines the" healing period" as, "that period for healing of an injury resulting from an accident". The healing period ends when the employee is as far restored as the permanent character of the injury will permit. The claimant is entitled to

temporary total disability during her healing period if she shows by a preponderance of the evidence that she had a total incapacity to earn wages. *Carroll General Hospital v. Green,* 54 Ark. App. 102, 923 S.W.2d 878 (1996). While it is undisputed that the claimant continued to discharge assigned job duties subsequent to the March 20, 2002, compensable injury, claimant nevertheless remained within her healing period until March 4, 2004.

The evidence further reflects that when respondent declined to further furnish claimant workers' compensation benefits, both medical and indemnity, pursuant to its self-insured workers' compensation program, claimant took medical leave. Indeed, claimant was totally incapacitated from engaging in gainful employment from September 7, 2003, through January 4, 2004, and correspondingly entitled to the payment of temporary total disability benefits. Respondent controverted the claimant's entitlement to workers' compensation benefits, medical and indemnity, subsequent to June 17, 2003.

Respondent's assertion that the injury of March 20, 2002, is not the major cause for the permanent physical impairment rating of the claimant is not persuasive. Ark. Code Ann. §11-9-102 (4)(F) provides, in relevant part:

> (ii) (a) Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment.
>
> (b) If any compensable injury combines with a preexisting disease or condition or the natural process of aging to cause or prolong disability or a need for treatment, permanent benefits shall be payable for the resultant condition only if the compensable injury is the major cause of the permanent disability or need for treatment.

"Major cause" means more than fifty percent (50%) of the cause, and is established according to the preponderance of the evidence.

The claimant was released to return to work following her September 24, 2003, surgery on or about January 4, 2004. After reviewing the claimant's medical records at the Jackson Neurosurgery Clinic, including the surgical procedure performed by Dr. Lewis on September 24, 2003, relative to the claimant's March 20, 2002, compensable injury, she was assessed with a permanent physical impairment in the amount of 10% to the body as a whole, "based upon the AMA Guidelines", relative to her herniation of the L4/5 disc. Claimant underwent an anterior lumbar interbody fusion at L4/5 with anterior instrumentation. Additionally, claimant was given restrictions of no heavy lifting or repetitive bending and stooping. Further, the medical records unequivocally states the basis for the claimant's anatomical impairment, "an anterior lumbar interbody fusion for treatment of the herniated and extruded disc at L4/5". *Wal-Mart Stores, Inc. v. Westbrook,* 77 Ark. App. 167, 72 S.W.3d 889 (2002). The evidence preponderates that the major cause of the claimant's permanent partial disability rating is the March 20, 2002, compensable injury. Respondent had controverted the claimant's entitlement to all workers' compensation benefits in this claim subsequent to June 17, 2003.

While it is undisputed that claimant was released to return to work on January 4, 2004, and in fact returned to the employment of respondent, she did not return to her pre-injury job. The afore was as a direct result of the residuals of her March 20, 2002, compensable injury. As a result of the her surgery in the treatment of her compensable injury claimant underwent a fusion with interbody anterior instrumentation. Claimant is restricted from the physical activities of heavy lifting, repetitive bending and stooping. Claimant no longer engages in her pre-injury recreational activities of bowling and horse back riding.

The wage-loss factor is the extent to which a compensable injury has affected the

claimant's ability to earn a livelihood. *Wal-Mart Stores, Inc. v. Connell,* 340 Ark. 475, 10 S.W.3d 882 (2000). The claimant has a consistent work history, is a high school graduate, and has medically imposed permanent restrictions on her physical activity, all growing out of the compensable injury of March 20, 2002. Nevertheless, Ark. Code Ann. §11-9-522 (b)(2), provides that so long as an employee, subsequent to her injury, has returned to work at wages equal ro or greater than her average weekly wage at the time of the accident, she shall not be entitled to permanent partial disability benefits in excess of the percentage of permanent physical impairment established by a preponderance of the evidence.

**AWARD**

Respondent is hereby ordered and directed to pay to the claimant temporary total disability benefits at the weekly compensation benefit rate of $295.00, for the period commencing September 7, 2003, and continuing through January 4, 2004, as a result of her compensable injury of March 20, 2002. Said sums accrued shall be paid in lump without discount. Respondent may claim credit for sums paid to the claimant as short-term disability payments during the afore period pursuant to Ark. Code Ann. §11-9-411.

Respondent is further ordered and directed to pay all reasonable related medical, hospital, nursing and other apparatus expenses growing out of the claimant's compensable injury of March 20, 2002, to include medical related travel. Respondent may claim credit for sums paid on behalf of the claimant through its self-funded health care program. Respondent shall reimburse the claimant for sums paid out of pocket toward her medical treatment relative to her compensable injury.

Respondent is further ordered and directed to pay to the claimant permanent partial

disability benefits at the weekly rate of $221.00, to correspond with the claimant's 10% permanent partial disability growing out of the March 20, 2002, compensable injury. Said sums accrued shall be paid in lump without discount.

Maximum attorney fees are herein awarded to the claimant's attorney on the controverted indemnity benefits herein awarded to the claimant, pursuant to Ark. Code Ann. §11-9-715.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809, until paid.

Matters not addressed herein are expressly reserved.

**IT IS SO ORDERED.**

______________________________________

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