

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F507280

ANA ALMONDOVAR

CLAIMANT

TWIN RIVERS FOODS, INC.

RESPONDENT

LIBERTY MUTUAL FIRE INS. CO.
INSURANCE CARRIER

RESPONDENT

OPINION FILED MAY 23, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Fort Smith, Sebastian County, Arkansas.

Claimant represented by EDDIE H. WALKER, JR., Attorney, Fort Smith, Arkansas.

Respondent represented by JAMES ARNOLD, II, Attorney, Fort Smith, Arkansas.

STATEMENT OF THE CASE

A hearing was held on April 12, 2007, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on February 20, 2007. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

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

2. On May 20, 2005, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her low back on May 20, 2005.

4. The claimant is entitled to a weekly compensation rate of \$302.00 for temporary total disability and \$227.00 for permanent partial disability.

5. Temporary total disability has been paid from December 14, 2005, to sometime in 2006.

By agreement of the parties the issues to litigate are limited to the following:

1. Additional medical.

2. Temporary total disability from July 22, 2005, through December 14, 2005.

3. Attorney's fees.

In regard to the foregoing issues the claimant contends that Dr. Arthur Johnson recommended a diskogram; however, the claimant was subsequently seen by Dr. Blankenship, underwent physical therapy, and was ultimately released by Dr. Blankenship on July 18, 2006. The claimant contends that she is entitled to return to Dr. Arthur Johnson and receive treatment by or at his direction. The claimant contends that although the parties agreed that the respondents would reinstate temporary total disability benefits as of December 15, 2005, and continue payment so long as temporary total disability was supported by the medical evidence, the parties agreed that the issue of the claimant's temporary total disability benefits prior to December 15, 2005, was reserved. Thus, the claimant now contends entitlement to temporary total disability benefits from July 22, 2005, thru December 14, 2005.

In regard to the foregoing issues the respondents contend that the claimant has received all temporary total disability benefits to which she is entitled for her compensable injury of May 20, 2005. The respondents further contend that the claimant is not entitled to further medical evaluation and treatment of her compensable injury by Dr. Arthur Johnson.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1, Claimant's Exhibit No. 2, and Claimant's Exhibit No. 3. The respondents submitted documentary evidence marked Respondents' Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

Mr. Octavio Almondovar testified that he was the claimant's husband and they had been married for seventeen years. Mr. Almondovar testified that prior to May 2005 the claimant had not received any medical treatment for her back nor did she appear to have any limitations as to her physical activities as it concerned her back. Mr. Almondovar testified that after May 2005 the claimant began complaining about pain and she was not able to do the things like she used to do. Mr. Almondovar agreed that the claimant was seen by Dr. Griffin after May 2005 and there was some dispute as to whether her problem was due to her back or her hip. This witness agreed that the claimant finally went to her own doctor, Dr. Bishop, and he wrote an off work slip for the claimant

on July 22, 2005. Mr. Almondovar testified that the claimant was off work from July 22, 2005, until she was seen by Dr. Blankenship in March 2006. Mr. Almondovar testified that the claimant was under active medical treatment by her physician, Dr. Bishop and then was seen by Dr. Johnson. This witness agreed that after the claimant was seen by Dr. Blankenship, she began physical therapy. This witness testified that his wife only saw Dr. Blankenship one time and once her physical therapy was over, she was not able to go back to Dr. Blankenship. Mr. Almondovar testified that his wife has continued to be seen by their family doctor, Dr. Bishop, and he is prescribing pain medication for her. Mr. Almondovar testified that the claimant is still complaining about pain in her back and that she takes several medications. This witness testified that he made a list of her medications and this list was entered into evidence as Claimant's Exhibit No. 3. Mr. Almondovar testified that these medications are for back pain, high blood pressure, cholesterol, diabetes, and stress all of which were prescribed by Dr. Bishop. Mr. Almondovar testified that the claimant has continued to have problems with her household duties as well as experiences problems with sleep.

Mr. Almondovar testified that Dr. Bishop was his wife's personal physician and had treated her prior to her accident for high blood pressure and other things. Mr. Almondovar agreed that the respondents sent the claimant to see Dr. Clark and Dr. Holder and that she went through physical therapy as prescribed by these physicians. This witness testified that his wife continued to work

for the respondent on light duty until July 5, 2005. Mr. Almondovar testified that once a problem was discovered with his wife's hip, the respondent put her on family medical leave. This witness agreed that his wife then started seeing Dr. Bishop who referred her to Dr. Griffin and that Dr. Griffin referred her to Dr. Barnes, a hip specialist in Little Rock. Mr. Almondovar testified that his wife was eventually seen by Dr. Johnson for her back in December 2005. Mr. Almondovar testified that Dr. Johnson sent his wife to a doctor in Ozark for some injections but after she had a couple of these injections she had a bad reaction. This witness agreed that the claimant was referred to Dr. Blankenship who prescribed physical therapy. Mr. Almondovar testified that his wife has not seen Dr. Johnson since late 2005 or early 2006.

The claimant testified through a Spanish interpreter.

The claimant testified that she had worked for the respondent for one year and eleven months performing the job of weighing chicken breasts. The claimant testified that she did not have any kind of medical treatment for her back before her accident in May 2005. The claimant testified that in May 2005 she was coming back to her department from break when she slipped and fell. The claimant testified that she does not have much memory of what happened because she lost consciousness. The claimant testified that she was taken to the nurse's station but the nurse was not there so her supervisor gave her some ibuprofen. The claimant testified that she had pain immediately after her fall. The claimant testified that her accident happened on a Friday and that

she was in pain all weekend. The claimant testified that when she reported to work on Monday she went to the nurse's station and told the nurse she was in pain. The claimant testified that the nurse gave her a bag of ice to put on her back and a belt and sent her back to work. The claimant testified that her back has continued to hurt since her fall. The claimant testified that when she fell she felt pain in her back which went over into her hip. The claimant testified that once she was put on FMLA due to her hip problems, the respondents quit paying anything on her back. The claimant testified that at that point because her back was hurting she went to see Dr. Bishop in order to get some medicine. The claimant agreed that Dr. Bishop gave her an off work slip on July 22, 2005, which she took to the respondents. The claimant testified that she has not worked since then because the pain is too great. The claimant testified that she remained under Dr. Bishop's care until she was referred to Dr. Johnson. The claimant testified that Dr. Johnson has recommended a diskogram but she has not been able to have it because she does not have the money. The claimant testified that she sees Dr. Bishop every six months and that she is still having muscle spasms in her back. The claimant testified that when she was seen by Dr. Blankenship he recommended physical therapy and gave her a letter which stated that she could only work for four hours and lift only up to ten pounds. The claimant testified that she would like to be sent back to Dr. Johnson so he could do something to help her with her pain. The

claimant testified that she would agree to be seen by anyone who would help her who was not of the respondents' choosing.

The medical records set forth that the claimant was seen by Dr. Terry Clark on May 23, 2005, due to a slip and fall accident while working. The doctor notes that the claimant complains of pain in her low back. X-rays of the claimant's low back were normal and after examination the claimant was diagnosed with a lumbar strain and contusion. Dr. Clark prescribed medication for the claimant and writes that she may work with alternate sit, stand, and walk as tolerated but to limit bending, stooping, and twisting. The claimant underwent an MRI of her lumbar spine on June 6, 2005, which revealed degenerative disc changes and disc bulge at L4-5. The claimant was seen by Dr. Keith Holder on June 13, 2005, for follow up after her MRI. Dr. Holder notes that the claimant reports that after three weeks of treatment she has not improved and is unable to move around her house. The claimant also reports that the physical therapy has not improved her situation. After examination and review of the claimant's MRI, Dr. Holder diagnoses the claimant with having lumbar strain with lumbar spondylosis noting further that the claimant's complaints of pain outweigh the objective findings. Dr. Holder recommended that she continue her medication and home exercise. On June 14, 2005, the claimant was seen by Dr. Terry Clark for her continued complaints of low back pain which is now radiating to the left hip and left knee. Dr. Clark notes that the claimant's x-ray of her pelvis is without definite fracture but there is some question in the left

hip area which he recommended radiology review. After examination, the claimant was diagnosed with lumbar strain and degenerative disc disease for which Dr. Clark prescribed medication and indicated that she should do no lifting over twenty pounds and do sedentary work only. The claimant underwent an MRI of her left hip on June 22, 2005, which revealed a small lesion in the left femoral head with generally a benign appearance. Dr. Hammcock notes that this could be a bone cyst. This test also revealed probable uterine fibroid and nabothian cyst on the cervix. Dr. Clark writes on June 28, 2005, that the claimant continues to complain of pain in her left hip and low back with no true radicular symptoms. Dr. Clark notes that the claimant has been going to physical therapy with no improvement. Dr. Clark reviewed the claimant's MRI of her left hip and opined that her discomfort is most likely coming from the hip than from her low back. Dr. Clark recommended that the claimant be seen by an orthopedist and reported to the claimant that he did not feel that her discomfort at the present time is secondary to her original injury. Dr. Clark restricted the claimant's work to no lifting over thirty pounds, to limit her bending, stooping, and twisting. There is a note from Dr. Bishop dated July 22, 2005, where the doctor takes the claimant off work noting that he feels her symptoms are a result of her lumbar strain resulting from a fall at work. Dr. Bishop also writes on July 22, 2005, that he feels that the claimant has sustained acute lumbar strain and that additionally she has lumbar radiculitis due to this strain. Dr. Bishop writes that he is advising a lumbar CT mylogram and physical

therapy with a goal to return the claimant to work. Dr. Bishop again writes that in his opinion the claimant's symptoms are a direct result of her injury. Dr. Bishop signed an FMLA form for the claimant on July 26, 2005, where he indicates that the claimant will be off for a period of more than three consecutive days due to acute lumbar strain and radiculitis. Dr. Bishop notes that the claimant should be excused from work from July 1, 2005, through August 30, 2005.

Dr. Frankie Griffin writes on September 15, 2005, that he has seen the claimant only for her left hip symptoms. Dr. Griffin writes that since the claimant's slip and fall accident on May 20, 2005, she has continued to have persistent low back pain and left hip pain that radiates down her leg. Dr. Griffin notes that the claimant reports that she has also had some tingling and mild numbness along the buttock all the way down to her foot for the last four months since her injury. After examination and review of the claimant's x-rays and MRIs, Dr. Griffin assesses the claimant with having left hip pain and symptomatology on clinic examination that seems to be out of proportion to any obvious physical abnormalities noted on her MRI or plan films. Dr. Griffin notes that the claimant does have a benign appearing cyst in the femoral neck of her left hip. Dr. Griffin writes that the MRI of the claimant's low back done on August 30, 2005, revealed a small central disc protrusion at L4-5 with mild impression on the ventral thecal sac. Dr. Griffin again writes that the claimant's symptoms certainly seem to be out of proportion to these MRI findings. In

conclusion, Dr. Griffin writes that he thinks that the majority of the claimant's complaints may be related to her lower back in some type of nerve root compression syndrome and recommended that she be seen by a back specialist. Dr. Griffin does note that the claimant appears to have a benign cyst and recommended that she be non weight bearing on the left further prescribing a walker and referring her to a hip specialist in Little Rock, Dr. Lowry Barnes. Dr. Bishop writes on November 21, 2005, that the claimant is released from work due to her back injury now through November 21, 2005, noting that she has an appointment with a spine specialist on December 15, 2005. Dr. Bishop also writes that the claimant has a benign cyst on her left hip. The doctor notes that this existed way before her work injury and before she developed acute low back pain. Dr. Author Johnson writes on December 15, 2005, that he has seen the claimant for her low back pain since May 20, 2005, when she fell at work. The claimant reports that her back throbs and sometimes her back swells when she gets severe bouts of pain. After examination and review of the claimant's MRI, Dr. Johnson diagnosed the claimant with having a small central disc herniation at L4-5 with low back pain and left lower extremity radiculopathy. Dr. Johnson recommended that the claimant undergo lumbar epidural steroid injections and prescribed medications. Dr. Johnson recommended that the claimant be off work, noting further that it is his impression that the claimant's pain onset was related to a fall by history and that the small central disc herniation is related to this as well. Dr. Johnson gave the claimant an off work

slip indicating that she was disabled from December 15, 2005, to March 15, 2006, and should be off work. Dr. Johnson took the claimant off work after she was in his office on March 9, 2006, from March 15, 2006, to April 15, 2006, noting that she is to have a diskogram.

The claimant was seen by Dr. James Blankenship on March 29, 2006, at the request of the respondent. Dr. Blankenship sets forth a concise history of the claimant's treatment program subsequent to her May 20, 2005, fall resulting in her experiencing low back pain. Dr. Blankenship notes that after physical examination her neurological exam is normal but noted that she has increased pain with almost any movement of her low back. After review of the claimant's MRI, Dr. Blankenship writes that the claimant does have degenerative changes at L4-5 with a midline disc bulge. Dr. Blankenship writes that there is no frank disc herniation noted and no marked increased signal posteriorly that would be indicative of annular tearing. Dr. Blankenship opines that the claimant has a significant myofascial component to her back pain. The doctor writes that the claimant also has what appears to be somewhat of an inappropriate illness behavior with the waddell signs. Dr. Blankenship continues to write that he thinks that the claimant has a lot of guarding and a lot of fear of movement due to pain which is consistent with deconditioning. Dr. Blankenship recommended an exercise oriented reconditioning program noting that it is his opinion that surgical intervention is not something that the claimant would benefit from. Dr. Blankenship writes that based on

the claimant's examination he would not recommend a diskogram. Dr. Blankenship notes that he does feel that the claimant's current back complaint is directly related to her work related injury. Dr. Blankenship writes that he agrees with Dr. Barnes that the claimant does not have any primary pathology. Dr. Blankenship recommended an aggressive exercise program and physical therapy to be followed up with a functional capacity evaluation. Dr. Blankenship writes on May 17, 2006, that he has been contacted by Terri Suggs concerning the claimant's request for pain medication. Based on information provided by Ms. Suggs that the claimant has been having quite a bit of anxiety and making trips to the emergency room it was his opinion that prescribing narcotic pain medication would be detrimental to the claimant. Dr. Blankenship writes that due to the type of problems the claimant has the treatment plan for her is to continue aggressive exercise. The claimant underwent a functional capacity evaluation on July 6, 2006. The evaluator writes that the overall test findings in combination with clinical observations suggests the presence of near full, though not entirely full, effort on the claimant's behalf. The evaluator recommended that the claimant not return to her preinjury job at this time noting that she may be able to return to a four-hour shift at a sedentary to light physical demand level which is lifting up to fifteen pounds from thirty-six to sixty inches on an occasional basis. The evaluator notes that the claimant may benefit from additional rehabilitation noting that the medical cause of her pain may need to be addressed before any further

program can be made. Dr. Blankenship writes on July 18, 2006, that he has reviewed the claimant's functional capacity evaluation. Dr. Blankenship followed the evaluator's recommendation as to the claimant not returning to her preinjury job but could work a four-hour shift at a sedentary job and to observe a weight lifting restriction of fifteen pounds. Dr. Blankenship writes that based on his clinical examination and review of the claimant's functional capacity evaluation he feels that her psychodynamics preclude any further invasive type treatment. Dr. Blankenship recommended that the claimant continue her home exercise program noting that he feels like the claimant has reached maximum medical improvement. Dr. Blankenship writes on July 20, 2006, that based on the Forth Edition of the A.M.A. Guides the claimant would not qualify for an impairment rating noting that she does not have any objective findings that would allow a rating. Dr. Blankenship writes that this is based on physical examination and review of the claimant's MRI that showed only a minimum disc bulge, which would be considered physiologic.

After a complete review of this matter, I find that the claimant has proven by a preponderance of the evidence that she is entitled to additional temporary total disability from July 22, 2005, through December 14, 2005. Dr. Bishop, the claimant's family doctor, took the claimant off work on July 22, 2005, as a result of her lumbar strain due to her fall at work. Dr. Griffin, whom the claimant saw on September 15, 2005, notes that in his opinion the claimant's symptoms seem to be out of proportion to her objective

findings, however he does write that the majority of the claimants complaints are related to her low back in some type of nerve root compression syndrome. Dr. Griffin recommended that the claimant be seen by a back specialist. Dr. Bishop on November 21, 2005, continued the claimant off work until she is seen by a spine specialist. When the claimant was seen by Dr. Arthur Johnson on December 15, 2005, he recommended that she undergo lumbar epidural steroid injections and took her off work. The respondents, therefore, shall pay temporary total disability to this claimant from July 22, 2005, through December 14, 2005, as recommended by her treating physicians. I further find that the claimant has failed to prove by a preponderance of the evidence that she is entitled to additional medical treatment for her slip and fall injury. Based on the claimant's clinical examinations as well as the various tests, none of the doctors have recommended any type of surgery for this claimant. The claimant has undergone physical therapy with no improvement, injections which were not beneficial and has been prescribed a variety of medications which have not resolved her discomfort. The claimant has lastly been seen by Dr. Blankenship who also notes that the claimant has an inappropriate illness behavior. Dr. Blankenship reviewed the claimant's MRI which he notes to have no frank disc herniation and no annular tearing. After reviewing the claimant's functional capacity evaluation, Dr. Blankenship agreed with the evaluator's assessment of the claimant and recommended that she continue her home exercise program and found her to be at maximum medical improvement. On

July 20, 2006, Dr. Blankenship assessed the claimant with a 0 percent impairment rating based in the Forth Edition of the A.M.A. Guides, noting that this is based on physical examination and review of the claimant's MRI that showed only a minimal disc bulge which would be considered physiologic. Therefore, I find that any further medical treatment for this claimant's low back complaints would be unnecessary and not reasonable.

FINDINGS & CONCLUSIONS

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

2. On May 20, 2005, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her low back on May 20, 2005.

4. The claimant is entitled to a weekly compensation rate of \$302.00 for temporary total disability and \$227.00 for permanent partial disability.

5. Temporary total disability has been paid from December 14, 2005, to sometime in 2006.

6. The claimant has proven by a preponderance of the evidence that she is entitled to additional temporary total disability from July 22, 2005, through December 14, 2005. See discussion above.

7. The claimant has proven by a preponderance of the evidence that she is not entitled to additional medical treatment for her compensable low back strain. See discussion above.

8. The respondents have controverted this claimant's claim for additional benefits.

9. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that she is entitled to additional temporary total disability from July 22, 2005, through December 14, 2005. Therefore, the respondents should pay temporary total disability to this claimant for this period of time.

The claimant has failed to prove by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable low back strain.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE