

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

WCC NO. F404328

GARY BORCHERT, Employee	CLAIMANT
MERCY HEALTH SYSTEM OF NORTHWEST, Employer ARKANSAS	RESPONDENT #1
COMMERCIAL & INDUSTRY INSURANCE CO., Carrier	RESPONDENT #1
SECOND INJURY FUND	RESPONDENT #2
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT #3

OPINION FILED MARCH 27, 2007

Hearing before ADMINISTRATIVE LAW JUDGE GREGORY K. STEWART in Springdale, Washington County, Arkansas.

Claimant represented by RONALD M. MCCANN, Attorney, Fayetteville, Arkansas.

Respondent #1 represented by MELISSA WOOD, Attorney, Little Rock, Arkansas.

Respondent #2 represented by TERRY PENCE, Attorney, Little Rock, Arkansas.

Respondent #3 represented by JUDY RUDD, Attorney, Little Rock, Arkansas, although not participating in hearing.

STATEMENT OF THE CASE

On February 7, 2007, the above captioned claim came on for a hearing at Springdale, Arkansas. A pre-hearing conference was conducted on July 12, 2006, and a pre-hearing order was filed on that same date. A copy of the pre-hearing order has been marked Commission's Exhibit #1 and made a part of the record without objection.

At the pre-hearing conference the parties agreed to the following stipulations:

1. The Arkansas Workers' Compensation Commission has jurisdiction of the within claim.
2. The relationship of employee-employer-carrier existed between the claimant and respondent #1 at all relevant times.

3. The claimant sustained a compensable injury to his low back on December 3, 2002.

4. Respondent #1 has accepted and is paying benefits based upon a 14% impairment rating.

5. Claimant reached the end of his healing period on December 9, 2005.

At the time of the hearing the parties agreed to stipulate that claimant would be entitled to compensation at the rate of \$233.00 for total disability benefits and \$175.00 for permanent partial disability benefits.

At the pre-hearing conference the parties agreed to litigate the following issues:

1. Claimant's entitlement to permanent total disability benefits.
2. Second Injury Fund liability.
3. Attorney fee.
4. Credit for disability benefits paid by the group carrier.

Prior to the hearing the claimant also raised as an issue respondent's liability for a 36% penalty pursuant to A.C.A. §11-9-802(e) for failure to reimburse the group carrier for medical benefits paid. Claimant also raised as an issue respondent's liability for a 20% penalty pursuant to A.C.A. §11-9-802(d) for failure to pay claimant for out-of-pocket medical expenses. Finally, with respect to the requested attorney fee, claimant's attorney also requests an attorney fee on the 14% impairment rating which was previously paid by the respondent.

The claimant contends that he is permanently totally disabled as a result of his compensable injury. The claimant also contends that respondent is liable for payment of penalties pursuant to A.C.A. §11-9-802 with respect for failure to pay medical expenses to the group carrier and to claimant for his out-of-pocket expenses. Claimant's attorney also requests a fee on all indemnity benefits as well as on the 14% impairment rating previously accepted by the respondent.

Respondent contends that it has paid all appropriate benefits as a result of claimant's compensable injury. Respondent contends that it has paid a 14% impairment rating assigned by Dr. Calhoun; however, claimant is not entitled to any permanent benefits in excess of the impairment rating. In the event claimant is entitled to benefits in excess of the impairment rating, respondent contends that the liability should be the responsibility of the Second Injury Fund. With respect to the penalties on medical benefits, respondent contends that under Rule 30 medical bills have not been submitted on proper forms; therefore, it has been unable to make proper payment of medical benefits. In addition, with respect to the out-of-pocket medical expenses, respondent contends that claimant should be reimbursed by the medical provider. With respect to the attorney fee on the 14% impairment rating, respondent contends that that was not an issue at the prior hearing and that it has not controverted claimant's entitlement to those benefits.

The Second Injury Fund contends it has no liability in this claim and alternatively, that since claimant is no longer contending that he is entitled to vocational rehabilitation benefits the claimant has waived his right to those benefits; therefore, claimant would not be entitled to benefits for a loss in wage earning capacity.

The Death & Permanent Total Disability Trust Fund contends that pursuant to A.C.A. §11-9-525(b)(1), Second Injury Fund liability must be determined prior to consideration of the Death & Permanent Total Disability Trust Fund liability. If the Second Injury Fund is found to not have liability and the claimant is found to be permanently and totally disabled, the Trust Fund stands ready to commence weekly benefits in compliance with A.C.A. §11-9-502. Therefore, the Trust Fund has not controverted the claimant's entitlement to benefits.

From a review of the record as a whole, to include medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witnesses and to observe their demeanor, the following findings of fact

and conclusions of law are made in accordance with A.C.A. §11-9-704:

### FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The stipulations agreed to by the parties at the pre-hearing conference conducted on July 12, 2006, and contained in a pre-hearing order filed that same date, are hereby accepted as fact.

2. The parties' stipulation that claimant would be entitled to compensation at the rate of \$233.00 for total disability benefits and \$175.00 for permanent partial disability benefits is also hereby accepted as fact.

3. Claimant is not barred from receiving permanent benefits in excess of his impairment rating pursuant to A.C.A. §11-9-505(b)(3).

4. Claimant has failed to prove by a preponderance of the evidence that he is permanently totally disabled as a result of his compensable injury. Claimant has suffered a loss in wage earning capacity in an amount equal to 60% to the body as a whole as a result of his compensable injury.

5. Respondent has failed to prove by a preponderance of the evidence that the Second Injury Fund is liable for payment of compensation benefits attributable to claimant's loss in wage earning capacity.

6. Respondent is not liable for a 20% penalty for failure to reimburse claimant for out-of-pocket medical expenses. A.C.A. §11-9-803(c) does not apply to medical benefits.

7. Claimant has failed to prove by a preponderance of the evidence that respondent is liable for a 36% penalty for failure to reimburse the group carrier for medical benefits paid. Claimant has failed to prove that respondent's failure to pay medical benefits is willful and intentional.

8. Respondent has controverted claimant's entitlement to all unpaid indemnity benefits. In addition, respondent is also liable for payment of an attorney fee on the 14%

impairment rating previously accepted and paid.

### FACTUAL BACKGROUND

The claimant is a 58-year-old man who suffered a compensable injury to his back on December 3, 2002, while working for the respondent. As a result of that compensable injury, the claimant came under the care of Dr. Gallaher, neurosurgeon. Dr. Gallaher has performed three surgical procedures on the claimant's low back. These surgeries occurred on March 4, 2004; July 6, 2004; and December 9, 2004.

The last medical report in evidence from Dr. Gallaher is dated February 28, 2005. At that time, Dr. Gallaher noted that claimant was still recovering from his third operation and that recovery times are compounded with subsequent surgeries. Accordingly, Dr. Gallaher stated that it might take the claimant six months to a year to completely recover from the third operation. No additional medical reports from Gallaher were submitted into evidence subsequent to that date although medical reports from other providers indicate that claimant was seen by Dr. Gallaher subsequent to February 28 and indicating that he was released by Dr. Gallaher in September 2005.

Following this apparent release by Dr. Gallaher claimant was seen at the request of respondent by Dr. Calhoun. Dr. Calhoun in a report dated March 22, 2006, indicated that claimant had reached maximum medical improvement and assigned claimant a permanent physical impairment rating in an amount equal to 14% to the body as a whole. Respondent has accepted and paid permanent partial disability benefits in accordance with this impairment rating.

Following Dr. Calhoun's evaluation, claimant was evaluated by Sarah Moore, a vocational consultant, at the request of claimant's attorney. Moore has authored a report and testified at the hearing that in her opinion the claimant will not be able to return to

gainful employment.

In addition, claimant also worked with Edward Johnson, the Local Veteran's Employment representative at the Arkansas Department of Work Force Services. Finally, claimant was also evaluated by Edie Nichols, a vocational rehabilitation counselor, at the request of the respondent.

Claimant has filed this claim contending that he is entitled to permanent total disability benefits as a result of his compensable injury. He also seeks penalty payments for respondent's failure to pay medical expenses and he also seeks a controverted attorney fee.

### ADJUDICATION

#### WAIVER OF WAGE LOSS.

Although claimant contends that he is permanently and totally disabled as a result of his compensable injury, both the respondent and the Second Injury Fund contend that claimant waived his right to rehabilitation and refused to cooperate in job placement assistance; therefore, claimant is barred from permanent disability benefits in excess of his impairment rating.

The appropriate statute is codified at A.C.A. §11-9-505(b)(3). It states as follows:

The employee shall not be required to enter any program of vocational rehabilitation against his or her consent; however, no employee who waives rehabilitation or refuses to participate in or cooperate for reasonable cause with either an offered program of rehabilitation or job placement assistance shall be entitled to permanent partial disability benefits in excess of the percentage of permanent physical impairment established by objective physical findings.

I do not find based upon the evidence presented that claimant has failed to cooperate with an offered program of rehabilitation or job placement assistance. Prior to

the hearing the claimant did make an effort on his own to develop a program of rehabilitation whereby he would work from his home performing a job involving video editing. In order to perform this job claimant would need various computer and video equipment which would cost approximately \$50,000.00. When respondent did not agree to pay for the cost of obtaining this equipment, claimant withdrew his requested plan of rehabilitation. I do not find under these circumstances that claimant has waived his right to vocational rehabilitation. Respondent did not offer a specific program of vocational rehabilitation, but claimant nevertheless on his own attempted to develop a program. It was only after the program became cost prohibitive that claimant no longer pursued the program. I do not find that this constitutes a waiver of rehabilitation.

Nor do I find that claimant failed to cooperate with job placement assistance. The evidence in this case indicates that Edie Nichols, a vocational consultant, was hired by the respondent to evaluate the claimant for the purpose of vocational assistance. Following her initial evaluation, Nichols ordered a functional capacities evaluation which indicated that claimant was capable of performing work in the light category over the course of an eight-hour day. As a result, Nichols sent claimant various jobs which she believed fell within the light category. At the time claimant was evaluated by Nichols, he had already been seen by Sarah Moore, another vocational consultant, who had indicated that claimant was not capable of being employed. With respect to the specific jobs provided to claimant by Nichols, I note that Edward Johnson, an employee of the Arkansas Department of Work Force Services, indicated that he discussed these jobs with claimant and referred claimant to one or two of them. Furthermore, claimant testified that he made an effort to contact some of these employers with the help of Johnson. He also testified that he contacted some employers on his own.

While claimant obviously did not contact all of the employers provided to him by Nichols, Nichols testified that she was not aware if all the jobs she provided to claimant fell

into the light duty category. Furthermore, Nichols testified that she did not know how much effort the claimant put into looking for work and that claimant did inform her that he had been looking for work on his own.

Given the evidence presented, I find that respondent has failed to prove by a preponderance of the evidence that claimant failed to cooperate or participate in job placement assistance. Therefore, claimant is not barred from receiving permanent benefits in excess of his impairment rating.

#### WAGE LOSS.

Claimant contends that he is permanently totally disabled as a result of his compensable injury. In determining the extent of claimant's loss in wage earning capacity, the Commission must consider various factors including the claimant's age, education, work experience, and all other factors which could reasonably be expected to affect his future earning capacity. A.C.A. §11-9-522(b)(1).

After review of the relevant wage loss factors presented, I find that claimant has failed to prove by a preponderance of the evidence that he is permanently totally disabled. However, I do find that claimant has suffered a loss in wage earning capacity as a result of his compensable injury an amount equal to 60% to the body as a whole.

As previously noted, the claimant is 58 years old. Claimant has a high school education and has a significant work history. After graduating from high school the claimant worked as an actor for a few years in Atlanta. Subsequently, claimant served in the military for five and one-half years, at which time he was in the security police and he also cross-trained into the American Forces Radio and Television. After his discharge from the military the claimant worked in broadcasting and commercial radio for approximately 27 years. Claimant worked as a disc jockey and also as a program director. As a program director claimant would determine the music played by the radio station, schedule announcers, make sure commercials were prepared and that they were aired

when scheduled.

Claimant also worked for a short period of time in the insurance business and eventually started his own business - GDS Enterprises. In this business claimant raised, showed, and bred horses and it also sold and built modular barns. Claimant's final job occurred for the respondent where he was a courier, transporting equipment and supplies between the respondent's various medical clinics. Claimant testified that he currently suffers from pain in his low back as well as a numbness in his left foot which makes him feel as if he is walking on a club. Claimant testified that he uses a cane in order to help take weight off of his back. Claimant testified that he has to recline or lie down three to four times a day for 30 minutes to one hour. In addition, claimant testified that there are three to four times a month in which he stays in bed basically all day. Claimant testified that standing puts weight on his back and causes numbing in his left foot. In addition, after he sits for one to two hours he has to get up and move around and he can only walk for 10 to 20 minutes maximum.

In addition to claimant's back injury, he also suffered from bacterial endocarditis in 1979. In 1995, the claimant had a heart valve replacement for which he takes medication and has his blood tested every month. Claimant underwent a right knee scope in the 1980s and tore a ligament in his left leg while playing softball in 2000. Claimant also testified he has been taking medication for depression since the mid 1990s.

With respect to the claimant's medical condition and specifically his physical limitations, I note that the medical record does not contain any rating or restrictions assigned by Dr. Gallaher, the neurosurgeon who performed the three surgical procedures on the claimant's low back. Respondent did send claimant to Dr. Calhoun, a neurosurgeon for an independent medical evaluation in March 2006. As a result of that evaluation Dr. Calhoun indicated that claimant had suffered a permanent physical impairment rating in an amount equal to 14% to the body as a whole. Dr. Calhoun also

indicated in his medical report "I do not think he will ever return to gainful employment and it appears he has receives [sic] social security disability." Notably, Dr. Calhoun did not indicate that claimant was physically incapable of returning to work, but simply indicated that he did not think the claimant would return to gainful employment. It is unclear from a review of Dr. Calhoun's report the basis of this opinion; namely, whether claimant was physically incapable of returning to work or simply Dr. Calhoun's opinion that claimant would not return to work based upon claimant's condition as well as the fact that he was drawing social security disability benefits. Dr. Calhoun's report contains no specific physical limitations.

Also testifying at the hearing was Sarah Moore, a vocational consultant. Moore was hired by the claimant and has opined both in a written report and through her testimony at the hearing that in her opinion the claimant is not capable of being gainfully employed. Significantly, Moore's opinion that claimant cannot be gainfully employed is based in large part upon claimant's statement to her that he must lie down for 30 minutes to one hour several times a day and that he would miss four to five days each month because of back pain. Likewise, Edward Johnson, an employee of the Arkansas Department of Work Force Services, also indicated that he knew of no jobs claimant could perform given the restrictions of having to recline several times per day and not being able to work four or five days per month.

In contrast to the testimony of Moore and Johnson is the testimony and opinion of Edie Nichols. While no treating physician or any other individual addressed the claimant's specific physical limitations, Nichols ordered a functional capacities evaluation after her initial evaluation of the claimant. That functional capacities evaluation was performed on October 10, 2006. A review of the evaluation report indicates that claimant gave a reliable effort with no signs of symptom magnification or any other inappropriate illness responses. Significantly, the functional capacities evaluation indicated that claimant was capable of

pushing or pulling a cart weighing up to 40 pounds on a frequent basis. The FCE also indicated that claimant could sit and stand on a frequent basis. On an occasional basis the claimant could walk and carry up to 50 pounds, kneel, stoop, and climb stairs. The evaluation acknowledged that claimant would require occasional changes from a sitting to a standing position. The evaluation went on to indicate that claimant was capable of performing work in the light physical demand over the course of an eight-hour day.

Overall, Mr. Borchert demonstrates the ability to perform work at the LIGHT Physical Demand Classification over the course of an eight hour workday as determined through the Department of Labor guidelines with the above limitations/restrictions. It is noted that Mr. Borchert does demonstrate material handling characteristics at the Medium work level, but when taking into account his general mobility limitations as noted above, he is best suited for LIGHT level work over the course of an 8 hour workday.

Thus, in contrast to the opinions of Moore, Johnson, and the claimant, the functional capacities evaluation indicates that claimant is capable of performing light physical work over the course of an eight hour day. There is no indication in the evaluation that claimant must recline for 30 minutes to one hour several times a day or that claimant must miss work four or five times per month. Significantly, I also note that no treating physician has placed these limits on the claimant. Neither Dr. Gallaher or Dr. Calhoun has indicated that claimant must recline several times per day or that he would be incapable of working four or five times per month.

Finally, it should also be noted that claimant is currently drawing social security disability benefits at the rate of \$830.00 per month.

In summary, I find that claimant has failed to prove by a preponderance of the evidence that he is permanently totally disabled. The claimant is 58 years old and has a significant work history with transferrable skills that do not involve physical labor. While Dr. Calhoun prescribed a 14% impairment rating, he also indicated that he did not think the

claimant would return to gainful employment; however, Dr. Calhoun did not place any specific physical restrictions on the claimant and did not indicate that claimant was incapable of returning to gainful employment. As previously discussed, it is unclear from a review of his report the basis of Dr. Calhoun's opinion. Furthermore, although Moore and Johnson both indicated that they did not believe the claimant was capable of returning to employment, their opinions are based upon the claimant's testimony that he must recline several times a day and that he would not be able to work four or five times per month. No treating physician has placed those limitations on the claimant. Finally, the functional capacities evaluation indicates that claimant is capable of performing work in the light classification. The evaluation indicates that claimant can frequently sit and stand as long as he is allowed to alternate. The evaluation also indicates that claimant can walk on an occasional basis.

In short, after consideration of all the relevant wage loss factors, I find that claimant is not permanently and totally disabled, but instead find that claimant has suffered a loss in wage earning capacity in an amount equal to 60% to the body as a whole as a result of his compensable injury.

#### CREDIT FOR DISABILITY BENEFITS.

Respondent contends that it is entitled to a credit for long-term disability benefits the claimant received from a group carrier. Claimant testified at the hearing that he received long-term benefits for approximately one year at the rate of \$780.00 per month; however, he also testified that he had to reimburse the carrier approximately \$8,000.00 for disability benefits received. To the extent claimant did receive any long-term disability benefits in excess of the amount he reimbursed the carrier, respondent is entitled to a credit for benefits paid by a third party pursuant to A.C.A. §11-9-411.

#### SECOND INJURY FUND LIABILITY.

The respondent contends the Second Injury Fund is liable for payment of any

benefits awarded in excess of the claimant's permanent physical impairment rating. In *Mid-South Construction Company v. Second Injury Fund*, 295 Ark. 1, 746 S.W. 2d 539 (1988), the Court indicated that three things must be shown in order for the Second Injury Fund to have liability. First, the employee must have suffered a compensable injury at their present place of employment. Second, prior to that injury the employee must have had a permanent partial disability or impairment. Third, the disability or impairment must have combined with the recent compensable injury to produce the current disability status.

After reviewing the evidence in this case, I find that the respondent has failed to satisfy all requirements for Second Injury Fund liability. Even if the first two requirements for Second Injury Fund liability were satisfied, I find that respondent has failed to prove that the claimant's pre-existing disability or impairment combined with his recent compensable injury to produce his current disability status. In other words, I find that claimant's current wage loss is attributable to his most recent low back injury, not to a combination of the low back injury and his pre-existing conditions.

As previously noted, the claimant did have several pre-injury medical conditions. This included a bacterial endocarditis in 1979 for which he was hospitalized for fourteen and a half weeks. In addition, claimant had a heart valve replacement in 1995 for which he still takes medication and has his blood checked on a monthly basis. The claimant also had surgery on his right knee in the 1980s and tore a ligament in his left leg while playing softball in 2000. Finally, claimant has been taking medication for depression since the mid 1990s.

Despite these various prior medical conditions, I find insufficient evidence that they are contributing to claimant's current disability status. Claimant testified that he had no limitations as a result of his heart condition. In fact, claimant testified that he was able to continue playing softball after his valve replacement. Claimant testified that before his injury with the respondent he was very active working in the yard, hunting, fishing, training

and showing horses and bowling in a league two or three days a week with no problems caused by his back or knee.

With respect to this issue, I note that the majority of the limitations provided for in the functional capacities evaluation involve limitations caused by the claimant's compensable back injury, not the claimant's prior medical condition. The only prior medical condition addressed involves claimant's inability to crouch due to the prior knee injury. However, claimant's inability to crouch does not appear to significantly impact his ability to return to work.

In short, I find that respondent has failed to prove by a preponderance of the evidence that claimant's disability or impairment combined with his most recent injury to produce his current disability status. In my opinion, claimant's current disability status is a result of the compensable injury considered alone and of itself. Therefore, the Second Injury Fund is not liable for payment of compensation benefits.

#### 20% PENALTY ON OUT-OF-POCKET MEDICAL EXPENSES.

Claimant contends that pursuant to A.C.A. §11-9-803(c) the respondent is liable for payment of a 20% penalty for failure to reimburse him for out-of-pocket medical expenses which he incurred as a result of his compensable injury. I find that the respondent is not liable for payment of a 20% penalty pursuant to A.C.A. §11-9-803(c) because that penalty does not apply to the payment of medical benefits. See *Smith Store v. Kirker*, 6 Ark. App. 222, 639 S.W. 2d 751 (1982); *Frank J. Rooney, Inc. v. Pitts*, 268 Ark. 911, 597 S.W. 2d 120 (Ct. of App. 1980).

Even though I find that respondent is not liable for payment of a 20 percent penalty, I do note that pursuant to Commission Rule 099.30, Part I, Section J, an employee who has incurred out-of-pocket expenses must be fully reimbursed by the carrier.

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date a carrier is determined to be responsible for

the payment, then the employee shall be fully reimbursed by the carrier.

Accordingly, pursuant to Commission Rule 099.30, respondent is hereby ordered to reimburse claimant for his out-of-pocket medical expenses. These medical expenses total \$4,589.85 as set out in Claimant's Exhibit Number 2.

36 % PENALTY FOR FAILURE TO REIMBURSE GROUP MEDICAL PROVIDER.

Claimant contends that the respondent is liable for payment of a 36% penalty pursuant to A.C.A. §11-9-802(e) for failure to reimburse a group carrier for medical benefits paid. A.C.A. §11-9-802(e) provides for a 36% penalty in the event the Commission finds the failure to pay any benefit to be willful and intentional. I find that claimant has failed to prove by a preponderance of the evidence that respondent's failure to reimburse the group carrier is willful and intentional. According to respondent's attorney, medical bills have not been submitted on proper forms as required by Commission Rule 099.30. Furthermore, while I do note that respondent was ordered to pay for medical expenses, no authority has been cited indicating that the respondent is required to reimburse a group carrier directly as opposed to paying the medical provider.

Irregardless, I find no evidence indicating that respondent's failure to reimburse a group carrier has been willful and intentional.

ATTORNEY FEE.

Respondent has controverted claimant's entitlement to all unpaid indemnity benefits awarded in this claim. This equals permanent partial disability benefits in an amount equal to 60% to the body as a whole. In addition, claimant's attorney also contends that he is entitled to a controverted attorney fee on the 14% impairment rating accepted and paid by the respondent. Respondent contends it is not liable for payment of an attorney fee on benefits associated with the impairment rating because it never controverted claimant's entitlement to those benefits.

While the respondent did accept liability for payment of the 14% impairment rating, at the time of the hearing on June 8, 2005, the respondent contended that claimant was not entitled to any additional benefits in connection with this compensable injury. By contending that claimant was not entitled to any additional benefits relating to his compensable injury at the time of the hearing on June 8, 2005, respondent in effect controverted claimant's entitlement to all benefits subsequent to that date; therefore, it is liable for an attorney fee on all benefits whether paid or not. See *Cleek v. Great Southern Metals*, 335 Ark. 342, 981 S.W. 2d 529 (1998); *Goodwin v. Phillips Petroleum Company*, 72 Ark. App. 302, 37 S.W. 3d 644 (2001) and *Mark Stamper v. A. Tennenbaum Company*, Full Commission Opinion filed February 19, 2002 (F011937 and F001609).

#### AWARD

Claimant is not barred by A.C.A. §11-9-505(b)(3) from receiving permanent disability benefits in excess of his permanent impairment rating.

Claimant is not permanently totally disabled as a result of his compensable injury, but has suffered a loss in wage earning capacity in an amount equal to 60% to the body as a whole. Respondent is liable for payment of permanent partial disability benefits.

Respondent is not liable for payment of a 20% penalty or a 36% penalty in this case. Respondent has controverted claimant's entitlement to all unpaid indemnity benefits as well as the impairment rating of 14% to the body as a whole.

Pursuant to A.C.A. §11-9-715(a)(1)(B), claimant's attorney is entitled to an attorney fee in the amount of 25% of the compensation for indemnity benefits payable to the claimant. Thus, claimant's attorney is entitled to a 25% attorney fee based upon the indemnity benefits awarded. This fee is to be paid one-half by the carrier and one-half by the claimant. Also pursuant to A.C.A. §11-9-715(a)(1)(B), an attorney fee is not awarded on medical benefits.

All sums herein accrued are payable in a lump sum without discount and this award

shall bear interest at the maximum legal rate until paid.

IT IS SO ORDERED.

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GREGORY K. STEWART  
ADMINISTRATIVE LAW JUDGE