

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F609483

SHAWN HICKS	CLAIMANT
GNB INDUSTRIAL POWER	RESPONDENT
ZURICH AMERICAN INSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT

OPINION FILED AUGUST 22, 2007

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Fort Smith, Sebastian County, Arkansas.

Claimant represented by GARY UDOUJ, Attorney, Fort Smith, Arkansas.

Respondents represented by NEAL HART, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held in the above styled claim on June 19, 2007, in Fort Smith, Arkansas. The deposition of Dr. James Standefer was taken on April 9, 2007, in Fayetteville, Arkansas. This deposition has been admitted as Respondents' Exhibit No. 3.

A pre-hearing order was entered in this claim on February 6, 2007. This pre-hearing order set out the stipulations offered by the parties and outlined the issues to be litigated and resolved at the present time. Prior to the commencement of the hearing, the claimant amended the period for which he was seeking temporary total disability benefits to the period of November 9, 2006 through May 26, 2007. A copy of this pre-hearing order with that amendment noted thereon was made Commission's Exhibit No. 1 to the hearing.

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

1. On October 14, 2005, the relationship of employee-employer-carrier existed between the parties.

2. The appropriate weekly compensation benefits are \$466.00 for total disability and \$350.00 for permanent partial disability.
3. The claim is controverted in its entirety.

By agreement of the parties, the issues to be litigated and resolved at the present time were limited to the following:

1. whether the claimant sustained a compensable injury to his back on October 14, 2005.
2. The claimant's entitlement to the payment of medical expenses, temporary total disability benefits from November 9, 2006 through May 26, 2007, and attorney's fees.

In regard to these issues, the claimant contends:

- (a) Claimant suffered a compensable back injury on October 14, 2005, when he was bending/lifting a 5 gallon bucket of paint, and felt a severe stabbing pain in his lower back, which caused him to immediately cease work.
- (b) Claimant reported the injury immediately.
- (c) The employer was aware of the disabling injury when claimant was loaded onto a rolling chair and pushed to his vehicle, driven by his wife, who was allowed to drive into the plant to pick up the claimant and take him to the Sparks Hospital emergency room.
- (d) The major cause of the claimant's lumbar spine disc herniation and severe central canal stenosis was his work injury of 10/14/05, and not any preexisting condition.

- (e) The major cause of claimant's need for medical treatment was the work injury of 10/14/05, and not any preexisting condition.
- (f) Claimant's oral medication and epidural steroid injections were a result of the work injury of 10/14/05.
- (g) The work injury of 10/14/05 aggravated the claimant's preexisting condition of moderate disc herniation of L4-5 with mild to moderate canal stenosis.
- (h) Claimant's preexisting condition, as set forth above, combined with his work injury of 10/14/05, however, the major cause of the claimant's current disability was his work injury of 10/14/05 and not the preexisting condition.
- (i) The preexisting condition set forth above combined with the work injury of 10/14/05, so that the major cause of claimant's need for medical treatment was the work injury of 10/14/05 and any aggravations thereto.
- (j) Claimant was released to return to work with restrictions including no lifting, pushing or pulling over 10 lbs. per Dr. Darin K. Wilbourn, M.D.
- (k) On 11/14/06 the company refused to return claimant to work within his restrictions.

In regard to these issues, the respondents contend:

- (a) Claimant did not suffer a compensable accidental injury on the date allegedly caused by a specific incident; identifiable by time and place of occurrence; and supported by acute, objective medical findings.

- (b) Alternatively, there is no causal connection between claimant's current back problems, if any, and his alleged accident of 10/14/05. In particular, claimant was already being treated for a preexisting back problem at the time, which originated in the year 2001 or earlier.
- (c) Alternatively, again, claimant's current problems stem directly from a claim that was accepted by the carrier as compensable in 2001, and is now barred by the applicable statute of limitations.
- (d) If compensability is found, respondents claim all available offsets under Ark. Code Ann. §11-9-411 for benefits paid by Cigna (short term disability) and United Healthcare (group health carrier).

DISCUSSION

I. COMPENSABILITY

The first issue to be addressed is whether the claimant sustained a "compensable injury" to his back, as the result of a specific incident on October 14, 2005. The burden rests upon the claimant to prove all of the facts required by the Act to establish a "compensable" injury.

The first of these required facts are contained in Ark. Code Ann. §11-9-102(4)(D). This subsection requires that the claimant prove by medical evidence the actual existence of the physical injury or condition that is alleged to be compensable. Further, the claimant must prove that the actual existence of this physical

injury or condition is supported by “objective findings”, as that term is defined by Ark. Code Ann. §11-9-102(16)(A)(i).

The second group of these facts is contained in Ark. Code Ann. §11-9-102(4)(A)(i). In order to meet the definitional requirements for this category of “compensable” injuries, the claimant must prove:

- (1) That his physical injury arose out of and occurred in the course of his employment;
- (2) That his physical injury was caused by a specific incident;
- (3) That his physical injury is identifiable by time and place of occurrence;
- (4) That his physical injury caused internal or external physical harm to his body; and
- (5) That his physical injury required medical services or resulted in disability.

The medical evidence presented clearly shows the claimant has a longstanding history of numerous periodic episodes of lower back or lumbar difficulties. He has also experienced episodes of radicular symptoms involving both of his lower extremities. On some occasions, these radicular symptoms have been more severe in the right lower extremity and on other occasions have been more severe in the left lower extremity. In October of 1995, the claimant sought medical treatment for symptoms involving his lower back.

In January of 1998, the claimant sought medical treatment for right thoracolumbar back pain. He also complained of pain radiating into the right buttock.

In September of 1998, the claimant sought medical treatment for lumbar pain radiating into his right side. Again he also complains of pain into his right buttock.

In November of 1998, the claimant again sought medical treatment for lumbar pain. However, at this time he also complained of radicular pain into his left hip.

In March of 1999, the claimant underwent a CT scan of his lumbar spine. This test was interpreted as showing a mild intervertebral disc bulge at L1-2, a mild bulge and paracentral disc protrusion and L2-3, a mild to moderate disc bulge at L3-4, that was slightly eccentric to the right with a minimal central disc protrusion, a moderate central disc protrusion at L4-5 with a probable extruded disc fragment, and a mild to moderate diffuse disc bulge at L5-S1. An MRI was then performed on March 13, 1999. This test was interpreted as showing a right paracentral disc bulge or protrusion at L2-3, a midline bulge or protrusion at L3-4, and a midline protrusion or herniation of the disc at L4-5 (opined to be the largest of the defects).

On March 23, 1999, the claimant was evaluated by Dr. Standefer for lumbar pain radiating into his left hip and left lower extremity. At that time, Dr. Standefer diagnosed degenerative disc disease at multiple levels of the claimant's lumbar spine, facet hypertrophy involving multiple lumbar vertebra, and a focal midline protrusion at L4-5.

A myelogram and enhanced CT scan was performed on March 30, 1999. This study was interpreted as showing mild central and right

paracentral disc protrusion/herniation with mild canal stenosis at L2-3, mild disc bulge at L3-4, moderate disc herniation at L5 with bilateral neural foraminal narrowing, and a mild central disc protrusion at L5-S1.

In April of 1999, Dr. Standefer diagnosed the claimant's current difficulties as a focal disc protrusion at L4-5 of moderate severity. Although he recognized that surgical intervention could well be an option, he recommended epidural steroid injections. The claimant received the recommended epidural steroid injections from Dr. John Swicegood.

In November of 1999, the claimant returned to Dr. Standefer, as the result of a new episode of difficulties. At that time, he was complaining of lumbar pain and right hip and leg pain. He was again treated by Dr. Swicegood for these complaints through January of 2001.

In January of 2001, another MRI was performed on the claimant's lumbar spine which was interpreted as showing disc dessication and mild disc bulges at L2-3, and L3-4, disc dessication at L4-5 with small central disc herniation that impinged on the thecal sac and both exiting L5 nerve roots. In February of 2001, the claimant returned to Dr. Swicegood. This visit followed another incident and the onset of increased difficulties. The claimant's complaints remained those of lumbar pain and right buttock pain.

In March of 2001, the claimant was seen by Dr. Lennington (a partner of Dr. Swicegood) with a chief complaint of low back pain

and pain radiating down the posterior lateral aspect of his right leg. He was also complaining of numbness involving his entire right foot. Dr. Lennington diagnosed an L5 radiculopathy and performed another epidural steroid injection.

In August of 2002, Dr. Koenig (the claimant's family physician) ordered an MRI of the claimant's lumbosacral spine. This study was interpreted as showing degenerative disc disease at L2-3 with an annular tear, and a small right paracentral disc protrusion, a small to moderate central disc protrusion at L3-4, a moderate central disc protrusion indenting the subarachnoid space at L4-5, and a mild diffuse disc bulge at L5-S1. On September 13, 2002, the claimant saw Dr. William Burke with complaints of back pain radiating into his right leg.

On February 20, 2003, the claimant consulted Dr. Randall Carson. At that time, the claimant was complaining of severe pain in his upper back with radiation into his right buttocks and down his right posterior thigh. This episode of difficulties was attributed to a work related incident, when the claimant picked up a board with lead posts.

On December 17, 2003, the claimant consulted Dr. Standefer for complaints involving his back. Dr. Standefer referred to a note of Dr. Koenig, purportedly dated October 7, 2003, and which indicated that the claimant's recent flare up of back complaints was due to the claimant digging post holes (the actual report of Dr. Koenig has not been introduced). On December 22, 2003, yet another MRI scan of the claimant's lumbar spine was performed. This study was

interpreted as showing central canal protrusion and herniation of L4-5, diffuse bulging of L2-3, and L3-4, central canal narrowing that was mild at L2-3 and L3-4, and moderate at L4-5. Hypertrophic degenerative changes of the facets of the actual vertebral bodies was also demonstrated.

On September 1, 2004, the claimant was seen at Sparks Preferred Medical Care complaining of low back pain and pain radiating down his right leg with numbness in his right foot. Although these records indicated that this episode of difficulties or "injury" was work related, no specific description was given.

On August 9, 2005, the claimant was seen at Sparks Occupational Medical Clinic with complaints of low back pain and left leg pain. This episode of difficulties were attributed by the claimant to an incident on August 8, 2005, when he stepped over something at work.

On August 31, 2005, the claimant was seen at Sparks Family Medical Care with complaints of passing out at work two weeks prior and back pain that began following a subsequent incident when he bent over and felt a mild pop in his back.

On September 26, 2005, the claimant was seen at Family Medical Care with complaints of low back pain that began when he hurt his back the previous Saturday.

As a result of these complaints, the claimant was taken off work. On September 27, 2005, the claimant saw Dr. Standefer with complaints of severe low back pain that began when he was attempting to move a boat. At that time, no lower extremity

complaints were noted, but the paraspinal muscle spasms were observed to be more severe on the right than the left. On September 28, 2005, another CT scan was performed at Dr. Standefer's request. This test was interpreted as showing a small right paracentral disc protrusion at L2-3, a mild broad disc protrusion and mild canal stenosis at L3-4, a more moderate broad central disc protrusion at L4-5, and a small centrally based disc protrusion at L5-S1 but might be more prominent or worse than shown on the 2002 MRI. The claimant was seen by Dr. Standefer on October 5, 2005, and apparently released to return to work on October 10, 2005.

On October 14, 2005, the claimant appeared at the emergency room of Sparks Regional Medical Center complaining of severe low back pain and inability to walk. He attributed this episode of difficulties to picking up paint at work, earlier that same day. The emergency room records note a history of chronic low back difficulties, but indicates that the pain, this time, is somehow "different". The complaints recorded include moderate low back pain radiating into his legs. A physical examination, which was performed at that time, noted decreased range of motion, vertebral point tenderness, and muscle spasms. However, the only neurological symptoms noted were positive straight leg raising in both legs.

On October 18, 2005, the claimant kept his previously scheduled appointment with Dr. Lennington, which had been made prior to October 14, 2005. At that time, Dr. Lennington noted complaints of back pain that would occasionally go around into the claimant's groin. However, there is no note of any complaints

involving either of the claimant's lower extremities. Dr. Lennington further recorded a history that the initial onset of the difficulties began when the claimant was attempting to move a boat during the last week of September, that these difficulties improved, but then worsened following a work related incident when the claimant bent over to pick up a paint bucket. On physical examination, Dr. Lennington specifically noted that the claimant's reflexes were equal and symmetrical, that at that time, straight leg raising was negative on both sides, that a Patrick's test was negative on both sides, that strength was equal and normal in both lower extremities, that sensation was intact in both lower extremities, and that circulation in both lower extremities was normal. Although he observed that the claimant's gait was extremely antalgic, he further observed that the claimant could walk on his heels and toes without difficulty. Dr. Lennington performed the epidural steroid injection that had been previously scheduled. The claimant was directed to return to Dr. Lennington in one month.

However, the claimant did not return to Dr. Lennington or any other medical provider, until March 7, 2006. At that time, the claimant saw Dr. Lennington for yet another episode of back difficulties that apparently began when he was bucked by a horse. The only abnormalities were a decreased sensation in both of the claimant's lower extremities.

On June 29, 2006, the claimant was seen at the Family Medical Care Clinic with a number of varied complaints. One of these complaints was back pain.

On July 27, 2006, the claimant was seen at the Family Medical Care Clinic for complaints of back pain beginning two weeks prior and getting worse. No specific precipitating event or activity is given for this episode of difficulties. It was again noted that since the claimant's last visit at this facility he had begun to experience "joint pain" and numbness, weakness, and tingling in at least one of his feet.

On August 16, 2006, the claimant again consulted Dr. Lennington for back difficulties of three weeks duration with "no instigating circumstances". Again, some decrease in sensation was noted in both of the claimant's legs. The claimant was treated with another epidural steroid injection.

On August 24, 2006, the claimant was seen by Dr. Darin Wilbourn, who appears to be a physiatrist. Dr. Wilbourn records a history of chronic low back pain for many years and an injury at work, on October 14, 2005, when the claimant was picking up a 5 gallon bucket. He further records that the claimant related increased pain in his right lower leg and numbness in his right foot, following the October 14, 2005, work related incident. Curiously, no history was recorded by Dr. Wilbourn of the various increases or exacerbations in difficulties that had occurred after the incident of October 14, 2005. The physical examination performed by Dr. Wilbourn appears to be similar to the other physical examinations performed after October 14, 2005, with the exception that the claimant again exhibited positive straight leg raising but only on the right at approximately 45 degrees.

At Dr. Wilbourn's request, yet another lumbar myelogram and enhanced CT scan was performed on September 1, 2006. The myelogram was interpreted as showing mild spinal canal stenosis at the L2-3 level that was consistent with a diffuse disc bulge, mild to moderate spinal canal stenosis at the L3-4 level with no nerve root impingement, and moderate to moderately severe spinal canal stenosis at the L4-5 level with effacement of the bilateral exiting nerve root sheaths. The enhanced CT scan was interpreted as showing moderate canal stenosis at L4-5 and L5-S1 with bulging annuli and central disc herniations, mild bulging annulus at L2-3 and L3-4, and no neural foraminal compromise. On September 14, 2006, Dr. Wilbourn released the claimant to return on an as needed basis, and to return to work without restriction.

On October 16, 2006, the claimant returned to see Dr. Standefer. Dr. Standefer recorded a history of continuous back and right lower extremity pain that began when the claimant was lifting a 5 gallon bucket of paint at work. Again, no history was taken of any of the various incidents and episodes of increased difficulties that occurred after October 14, 2005. However, Dr. Standefer indicated that the claimant's detailed neurological examination showed no evidence of an overt radiculopathy. He noted that the claimant's muscle strength and tone was normal in his right lower extremities, that his reflexes were symmetrical in his lower extremities, and that his sensory examination was normal. Straight leg arising was only positive on the right at 90 degrees.

In his report of November 1, 2006, Dr. Standefer indicated that he has reviewed the myelogram and the enhanced CT scan that was performed at the request of Dr. Wilbourn. He concurs that this test shows moderate canal stenosis at L4-5 that is related to both a focal disc protrusion or bulging at this level together with the effects of ligament hypertrophy and facet hypertrophy at this level. Dr. Standefer reiterated his opinion that the appropriate treatment for the claimant's overall condition should be conservative in nature and should include a modification of his employment to eliminate potential stress and trauma on his lumbar spine. This has consistently been Dr. Standefer's opinion since 1999.

On November 2, 2006, the claimant returned to Dr. Wilbourn with complaints of increasing pain in his back and into his legs. In his physical examination, Dr. Wilbourn noted normal and equal strength in the claimant's lower extremities, a mildly antalgic gait, continued difficulty in performing toe raises on the right, normal and symmetrical reflexes in both lower extremities, positive straight leg raising on the right at 45 degrees, and on the left at 50 degrees, and a full and normal range of motion and sensation in both lower extremities. At that time, he referred the claimant to Dr. Ted Saer, an orthopaedic surgeon.

On January 4, 2007, the claimant saw Dr. Saer. In the history he completed for Dr. Saer, the claimant indicated that his problems were due to an accident and injury that occurred at work on October 25, 2005, which caused pain in his lower back and legs with

tingling and weakness in his legs. However, he stated that these difficulties were worse on the left side than on the right. He also described a new problem of occasional incontinence or loss of bladder control. Again, no mention was made of the episodes of increased difficulties that occurred after October 14, 2005. In his physical examination, Dr. Saer notes that the claimant had a normal gait with normal heel and toe walking. He did observe right sided lower lumbar paraspinal tenderness with some spasm in that area. The claimant's range of motion was noted as normal for extension and side to side bending that significantly decreased in regard to flexion. The claimant's pulses were normal and equal with no signs of edema, his reflexes were equal and symmetrical in both lower extremities. His strength was also equal and normal in the lower extremities. He exhibited a positive straight leg raising test on the right with numbness occurring on the bottom of his foot. Other neurological testing was deemed to be normal. On the basis of this evaluation, Dr. Saer recommended a discogram.

This test was subsequently performed, and the claimant returned to Dr. Saer on April 17, 2007. At that time Dr. Saer noted that the discogram showed a less than normal disc at L2-3, but that the injection in this area caused non concordant pain. The L3-4 and L4-5 discs were definitely abnormal with the injection causing 7/10 concordant back pain. The L5-S1 disc was determined to be normal. Dr. Saer opined that the only surgical option, at this time, would be a two-level back pain. However, it was his recommendation that the claimant not undergo such a procedure, at

this time, but wait for further treatment options to become available.

The claimant testified that at mid-morning on October 14, 2005, he bent down to pick up a 5 gallon bucket of paint from a pallet and felt a sudden and immediate pain in his back (“like somebody had stabbed” him). He further testified that he had never experienced a pain similar to this before. He stated that his pain was so severe he dropped to his knees and couldn’t get up for 5 to 10 minutes. It was his testimony that his pain continued to be so severe that he had extreme difficulty walking. He went immediately to the office and reported the incident and onset of his difficulties. His wife was contacted, and she came and took him from work.

This portion of the claimant’s testimony is substantially corroborated by the testimony of the claimant’s supervisors and co-employee, Gary Mott, Grady Rice, and Felicia Chandler. These witnesses further testified that, when they saw the claimant on October 14, 2005, it was their opinions that he appeared to be in severe pain.

The claimant next testified that immediately following the October 14, 2005 injury, he was unable to stand and one of his legs would not work. Curiously, neither party inquired as to which leg would not work, and this leg was never specifically identified at the hearing.

However, in his deposition, he stated he had experienced immediate pain in his right leg and that his right foot went numb.

He also stated in his deposition that he had explained to the emergency room nurse that his pain was “different” because it was now radiating into his “other” leg. However, at the hearing, his testimony was that he could not recall whether he immediately experienced pain in his right leg and numbness of his right foot at the time of the October 14, 2005 employment related injury.

At the hearing, the claimant described his current complaints of pain and numbness as involving only his left leg and left foot, rather than his right. He did not state when these radicular symptoms switched from right to left.

The claimant conceded that he was only off work for approximately one week following the October 14, 2005 employment related incident. At that time, he returned to his preinjury job, but did not do any more painting or heavy lifting (50 pounds or more). He worked in this position for a few months and then transferred to a lighter job for approximately 3 to 4 months. During this time, he testified that he took off intermittently for difficulties with his heart as well as difficulties with his lumbar spine. It was his testimony that on November 9, 2006, he took off on medical leave and drew group short term disability benefits. He gave as his reason for this action that his lighter duty job had been eliminated and he would have had to go back to a job requiring repetitive bending and lifting. It was his testimony that on May 26, 2007, he returned to regular employment with the respondent and has continued to be employed there through the date of hearing.

On November 2, 2006, Dr. Wilbourn completed a multiple choice and fill in the blank report provided to him by the claimant's attorney. On December 22, 2006, Dr. Standefer completed this same report. Both Dr. Wilbourn and Dr. Standefer indicated that the claimant's employment related accident and injury on October 14, 2005, aggravated and combined with his pre-existing lumbar defects. Both of these physicians also indicated that it was their expert medical opinion that the claimant's employment related incident and injury on October 14, 2005, was the "major cause" (more than 50 percent of the cause) of all the medical treatment he had received after October 14, 2005 and the disability he had experienced after October 14, 2005.

In his deposition, Dr. Standefer testified that one of the facts upon which he based his opinions, in the report of December 22, 2006, was that the claimant's radicular symptoms in his right lower extremity represented a "new" complaint that first appeared contemporaneously with or within a reasonable period of time after this employment related incident and injury (T.45, T.54-55, T.58). Another fact upon which he had relied was that the claimant had continuously experienced significant pain and difficulties with his lumbar spine and right lower extremity from the date of the employment related incident, on October 14, 2005, for over a year (T.65). In his deposition, Dr. Standefer acknowledged that he was unaware of any subsequent incidents or exacerbations of the claimant's lumbar and lower extremity complaints that may have occurred after October 14, 2005 (T.60, 61, and 78). Dr. Standefer

further acknowledged that he was unaware that the claimant had returned to regular employment shortly after the October 14, 2005 incident and had continuously worked for a significant period of time thereafter (T.82-83). Finally, in his deposition, Dr. Standefer somewhat amends his prior opinions to reflect that he is limiting them only to the conditions that produced the claimant's right radicular symptoms (T.83).

No reasons are given by Dr. Wilbourn for the conclusions he gave in his report of November 2, 2006. However, it would appear logical from his other reports that he assumed and relied upon the same facts as Dr. Standefer.

After consideration of all the evidence presented, it is my opinion that the claimant has proven by the greater weight of the credible evidence that, on October 14, 2005, he sustained an employment related injury to his lumbar spine that satisfies all of the statutory requirements for a "compensable injury". However, it is my further opinion that this compensable injury was in the form of a temporary aggravation of the claimant's extensive pre-existing lumbar defects and that the claimant had returned to his baseline or preinjury state before March 7, 2006.

In reaching my decision, I have considered the expert medical opinions stated by Dr. Standefer and Dr. Wilbourn. However, I do not find their opinions, as stated in the reports of November 2, 2006 and December 22, 2006, to be entirely credible. I find that their opinions concerning the cause of the claimant's need for medical treatment and the cause of the claimant's disability, on

and after March 7, 2006, are based upon a mistake of material facts.

The greater weight of the evidence presented shows that the claimant had previously experienced episodes of pain and radicular complaints with his right lower extremity, which were essentially identical with the symptoms and complaints he exhibited on and after October 14, 2005. In fact, the evidence shows that all of the symptoms voiced by the claimant following the injury on October 14, 2005, were identical with those which had occurred following various other prior incidents. The greater weight of the evidence further shows that the claimant's objective findings following the injury of October 14, 2005 were identical with findings observed following previous incidents and periods of exacerbated symptoms. The medical evidence reveals that the extensive testing performed on the claimant, both before and after his injury of October 14, 2005, shows no observable change, due to acute trauma, following his injury of October 14, 2005.

The greater weight of the evidence also fails to show that the claimant continuously experienced the same type and degree of symptoms in his low back and right lower extremity from the date of the injury on October 14, 2005 through the date of the evaluation by Dr. Wilbourn and Dr. Standefer in the latter part of 2006. In fact, the evidence shows that within a week the claimant's symptoms had improved to the point where he could return to and continue in his preinjury position. The evidence also shows exacerbations or increases in symptoms from other causes after the employment

incident on October 14, 2005 and after the symptoms caused by this incident had improved. As noted from the claimant's own testimony at some point in time his right lower extremity complaints appear to have resolved and his left lower extremity complaints have substantially worsened.

In summary, the record reveals that the claimant has extensive and severe lumbar defects. These defects will, unfortunately, only worsen with time. These underlying defects make the claimant unusually susceptible to periodic exacerbations or flare ups in his symptoms. In fact, the claimant has experienced a multitude of these exacerbations over the years. The exacerbation experienced by the claimant on October 14, 2005, appears no different than these previous episodes. The evidence presented fails to show that the injury of October 14, 2005, has caused any noticeable permanent or lasting change in the claimant's preexisting defects.

II. BENEFITS

Next, it becomes necessary to determine the nature and extent of benefits to which the claimant is entitled as a result of his compensable injury of October 14, 2005. Again, the burden rests upon the claimant to prove his entitlement to any particular benefits.

Clearly, the claimant is entitled to reasonably necessary medical services for his compensable injury of October 14, 2005. In order to be "reasonably necessary", the medical services must be necessitated by or connected with the actual compensable injury and

have a reasonable expectation of accomplishing the purpose or goal for which they are intended.

After consideration of all the evidence presented, it is my opinion that the medical services provided the claimant at the emergency room of Sparks Regional Medical Center on October 14, 2005, and by and at the direction of Dr. Jerry Lennington on October 18, 2005, meet the necessary criteria for "reasonably necessary medical services." Thus, the claimant would be entitled to these services at the respondents' expense (subject to the medical fee schedule established by this Commission).

However, I find that the medical services the claimant received for his various lumbar spine difficulties on and after March 7, 2006, have not been shown to have been necessitated by or connected with the claimant's compensable injury of October 14, 2005. Rather, the greater weight of the evidence shows that these services were necessitated by subsequent incidents, not shown to be employment related, or by the material deterioration or progression of the claimant's preexisting spinal defects and conditions. Therefore, these medical services would not constitute reasonably necessary medical services under the Act, and the respondents would not be liable for the expense of these services.

In order to be entitled to temporary total disability benefits, the claimant must prove that he continued within his healing period from the effects of his compensable injury and was rendered totally disabled from performing regular gainful employment as a result of this injury. However, the claimant is

not entitled to any temporary total disability benefits, if the foregoing period does not extend for at least 7 calendar days, excluding the date of injury.

The duration of the healing period is a medical question, which must be resolved based upon the medical evidence presented. The healing period continues until the claimant has achieved the maximum benefit of time and medical treatment in the resolution of the actual physical damage caused by the compensable injury. Once this physical damage resolves or at least stabilizes, then the healing period has ended.

In the present case, the greater weight of the medical evidence presented shows that any actual physical damage or harm caused by the claimant's compensable injury of October 14, 2005 had resolved prior to March 7, 2006. The evidence shows that at some time before that date, the claimant had returned to his stable preinjury state.

The evidence presented fails to prove that the claimant missed more than 7 calendar days, excluding the date of injury, during his healing period. The only evidence he has presented, in this regard, is his testimony that he was only off for approximately a week beginning October 14, 2005 and then returned to work.

The period for which he currently seeks temporary total disability benefits (November 9, 2006 through May 26, 2007) lies outside his proven healing period. He has also failed to prove that any disability which he may have experienced at this time was caused by the compensable injury of October 14, 2005.

In summary, I find that the claimant has failed to prove that he is entitled to any temporary total disability benefits for his compensable injury of October 14, 2005. He has clearly failed to prove his entitlement to such benefits for the period of November 9, 2006 through May 26, 2007.

FINDINGS OF FACT & CONCLUSIONS OF LAW

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

2. On October 14, 2005, the relationship of employee-employer-carrier existed between the parties.

3. On October 14, 2005, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$466.00 for total disability and \$350.00 for permanent partial disability.

4. On October 14, 2005, the claimant sustained a compensable injury to his low back or lumbar spine. This compensable injury was in the form of a temporary aggravation of a preexisting condition. Specifically, the claimant has established by medical evidence the actual existence of a physical injury to his back or lumbar spine by medical evidence, which is supported by objective findings (i.e. muscle spasms). He has further proven that this injury arose out of and occurred in the course of his employment with the respondent, was caused by a specific incident, is identifiable by time and place of occurrence, caused internal physical harm to his body (on a temporary basis), and required medical services.

5. The medical services provided to the claimant at the emergency room of Sparks Regional Medical Center, on October 14, 2005, and by and at the direction of Dr. Jerry Lennington, on October 18, 2005, represent reasonably necessary medical services for the claimant's compensable injury. The expense of these services is the liability of the respondents herein, subject to the medical fee schedule established by this Commission.

6. The claimant has failed to prove that any medical services provided him for lumbar and radicular difficulties on and after March 7, 2006, represent reasonably necessary medical services for his compensable injury. Specifically, he has failed to prove that such services were necessitated by or connected with his compensable injury of October 14, 2005. Thus, the respondents are not liable for any such medical services provided the claimant on and after March 7, 2006.

7. The claimant has failed to prove that he is entitled to any temporary total disability benefits. Specifically, he has failed to prove that he was disabled from gainful employment by his compensable injury for more than 7 calendar days (excluding the day of his injury) during his healing period from the effects of his compensable injury.

8. The respondents have denied the occurrence of any compensable injury to the claimant's back or lumbar spine and have controverted this claim in its entirety.

9. As no controverted benefits have been awarded directly to the claimant, no controverted attorney's fee can be awarded to his attorney.

ORDER

The respondents are liable for the expense incurred by the claimant as the result of medical services provided him for his compensable injury at the emergency room of Sparks Regional Medical Center on October 14, 2005, and by and at the direction of Dr. Jerry Lennington on October 18, 2005. This liability is subject to the medical fee schedule established by this Commission.

For the reasons heretofore stated in this Opinion, the claimant's request for temporary total disability benefits must be and hereby is denied and dismissed.

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

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

IT IS SO ORDERED.

MICHAEL L. ELLIG
ADMINISTRATIVE LAW JUDGE