

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F400639

ALICE KENT

CLAIMANT

WAL MART STORES, INC.
SELF INSURED

RESPONDENT

OPINION FILED SEPTEMBER 4, 2007

Before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

Respondent represented by CURTIS NEBBEN, Attorney, Fayetteville, Arkansas.

STATEMENT OF THE CASE

On October 31, 2006, a pre-hearing order was entered in this case. After various resettings of the scheduled hearing, both parties announced that they wished to submit this case on a stipulated record and waive their right to a hearing. This agreed record consists of a stipulation of fact (consisting of 3 pages) that was filed with this Commission on July 6, 2007, the deposition of the claimant that was taken on November 20, 2006, a 56 page packet of medical exhibits, and a 13 page packet of non medical exhibits. On my own Motion, I have included the prehearing order entered on October 31, 2006. This prehearing order has been identified as Commission's Exhibit No. 1. The subsequently filed stipulations are identified as Commission's Exhibit No. 2. The deposition of the claimant is identified as Joint Exhibit No. 1. The transcript of the hearing on August 29, 2005, is identified as Exhibit No. 2. The 56 pages of medical reports and records are identified as Joint Exhibit No. 3. The 13 page packet of non

medical documents is identified as Joint Exhibit No. 4. This compromises the entire record to be considered in this case.

The following stipulations have been made by the parties and are hereby accepted:

1. On September 24, 2003, the relationship of employee-self insured employer-TPA existed between the parties.
2. On September 24, 2003, the claimant sustained a compensable injury to her right foot.
3. All medical expenses for the compensable injury were paid through Dr. Pleimann's visit on February 2, 2005.
4. An Order dismissing any pending claims for additional benefits without prejudice was entered on August 31, 2005.
5. By letter dated September 8, 2005, and filed with the Commission on September 12, 2005, the claimant requested a change of physicians.
6. The most recent request for additional benefits was filed with the Commission on September 28, 2006.
7. By letter dated September 19, 2005, the Medical Cost Containment Division directed claimant to respondent to establish care in a new state.
8. On August (sic) 11, 2005 the respondent authorized Dr. Todd Northrup of Florida Sports Medicine Institute to be the authorized treating physician.
9. Dr. Northrup of the Florida Sports Medicine Institute refused to be the authorized treating physician on the

basis that it did not want to agree to the Arkansas fee schedule for reimbursement of medical expense. This notification was received by the respondent TPA from Florida Sports Medicine Institute on November 18, 2005.

10. Counsel for respondent informed counsel for claimant that Dr. Northrup of the Florida Sports Medicine Institute would not accept the Arkansas fee schedule. Counsel for the claimant informed counsel for respondent that the claimant was moving from Florida to the Atlanta area and it would not be necessary to attempt to locate a treating physician in Florida.

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

1. The claimant's entitlement to additional medical services.
2. Whether such benefits are barred by Ark. Code Ann. §11-9-702(b).

In regard to these issues, the claimant contends that "claimant was injured on September 24, 2003. Her foot was broken when she slipped on a wet tile floor."

In regard to these issues, the respondent contends that "the statute of limitations ran in this matter on January 6, 2006, last time the claimant received medical treatment."

DISCUSSIONI. STATUTE OF LIMITATIONS

The stipulations and record reveal that the claimant sustained her compensable injury on September 24, 2003. Thus, two years from that date would be September 24, 2005.

The last benefits actually paid by the respondent were for the medical services rendered to the claimant by Dr. Jason Pleimann, on January 26, 2005. Thus, a one year period beginning on that date would expire on January 5, 2006.

In the early part of 2005, the claimant filed a claim for additional benefits with this Commission. Respondent subsequently filed a Motion seeking a dismissal of this claim for failure to request a hearing and lack of prosecution. A hearing was held on the respondent's Motion on August 29, 2005. Claimant's current counsel was present at that hearing and objected to the respondent's Motion. By Order, dated August 31, 2005, the respondent's Motion was granted and any and all pending claims for additional benefits were dismissed without prejudice to refiling within the time allowed by Ark. Code Ann. §11-9-702(b). No appeal was made of this dismissal Order.

Rather, by letter dated September 8, 2005, the claimant sought the assistance of this Commission to obtain further medical treatment in Florida. This letter was couched in terms of a request for a "change of physicians" and was filed with this Commission on September 12, 2005. Under Commission policy, this

request was referred to the Medical Cost Containment Division for consideration of a "change of physicians".

By letter dated September 19, 2005, Pat Capps Hanna, the Administrator of the Medical Cost Containment Division, advised the claimant's attorney that she did not consider this to be a situation where a change of physicians was necessary or appropriate and instead directed the claimant to seek authorization by the respondent of a physician in the area of her current residence. A copy of this correspondence was sent to the respondent's attorney.

There is no evidence that the respondent made any attempt to locate a physician for the claimant in the area of her new residence (i.e. Florida). However, on October 11, 2005 (in the stipulations, it erroneously states August 11, 2005), the respondent conditionally authorized a Dr. Ted Northrup of the Florida Sports Medicine Institute to provide the claimant with any appropriate treatment for her compensable injury. However, this authorization was conditioned upon Dr. Northrup agreeing to abide by the medical fee schedule established by this Commission.

On November 18, 2005, Dr. Northrup advised the respondent that he could not agree to abide by the Arkansas medical fee schedule. As a result, he did not undertake treatment of the claimant.

From the deposition of the claimant, it would appear that she continued to attempt to obtain an authorization from the respondent for a treating physician, but was unsuccessful in doing so. Ultimately, she filed a claim for additional benefits, in the form

of medical services, on September 28, 2006. It is this claim that gives rise to the current proceeding.

After consideration of the stipulated record, I find that Ark. Code Ann. §11-9-702(b) does not bar the claim for additional benefits that was filed on September 28, 2006. This finding is based upon two separate grounds.

First, I find that the letter of the claimant's attorney to this Commission, dated September 8, 2005 and filed on September 12, 2005, constitutes a "claim for additional benefits", as that term is used in the Act. As early as the case of Long-Bell Lumber Company v. Mitchell, 206 Ark. 854, 177 S.W. 2nd 920(1944), the Arkansas Supreme Court recognized that this state's Worker's Compensation Act required no formal or particular pleading to make a "claim" for benefits under the Act. In fact, the Court indicated that such a technicality would be contrary to the purpose and spirit of the Act. Subsequent decisions have identified certain minimum requirements necessary to constitute a "claim", but have continued to maintain the general rule of informality.

In Little v. Smith, 223 Ark. 601, 267 S.W. 2nd 511 (1954), the Arkansas Supreme Court indicated that a "claim" under the Arkansas workers' Compensation Act must be in writing, it must be filed by or on behalf of the claimant, and it must be filed with the workers' Compensation Commission. Further, it must be clear, direct, and definite, and call for some action by the Commission.

In the present case, the September 8, 2005 letter from the claimant's attorney was in writing, was filed on the claimant's

behalf by her attorney of record, and was directed toward the Commission. This letter was clear, direct, and definite. It was obviously a request by the claimant for additional medical services for her compensable injury. Further, it clearly called for some action by the Commission in assisting her in obtaining this further medical treatment. By copy of this letter, the respondent was also put on notice that the claimant was contending that she required further medical services for her compensable injury. The fact that the Cost Containment Division of the Commission declined to assist the claimant in obtaining further medical services through granting a "change of physicians" and encouraged her to seek these services through the cooperation of the respondent does not change the nature of the claimant's request.

I find that the September 8, 2005 letter from claimant's counsel to this Commission is more closely similar to the request made by the claimant's attorney in Cook v. Southwestern Bell Telephone Company, 21 Ark. App. 29, 727 S.W. 2nd 862 (1987), than it is to the letter written to the claimant's counsel to the Commission in the case of Garrett v. Sears, Roebuck Company, 43 Ark. App. 37, 858 S.W. 2nd 146 (1993).

Thus, the claim for additional benefits made upon behalf of the claimant by her attorney and filed with this Commission on September 12, 2005, was filed within the time period allotted by Ark. Code Ann. §11-9-702(b). This timely filed claim sufficiently tolled the statute of limitations so as to allow this Commission's consideration of the subsequent almost identical claim.

The second basis for my holding that the present claim is not barred by the provision of Ark. Code Ann. §11-9-702(b) is founded upon the doctrine of estoppel. In the present case, the record shows that the respondent had accepted the claimant's injury as compensable and had voluntarily provided her with reasonably necessary medical services for this injury. The record reveals that when the claimant attempted to obtain additional medical services in September of 2005 from a physician in her new area of residence (Florida), the respondent did not deny her entitlement to such additional medical services at their expense. In fact, they appeared to cooperate to some degree, in obtaining such services. She was clearly led by the respondent's statements and actions to reasonably believe that they would provide her with additional medical services she was seeking, if only she could find a physician to provide these services that would agree to abide by the Arkansas Workers' Compensation medical fee schedule. Although the claimant never actually obtained such services, it was not her fault that she could not find a physician that would agree to abide by the Arkansas Worker's Compensation Commission medical fee schedule.

There is no indication that the respondent ever advised the claimant that they were denying liability for any further medical services until on or about the time of the filing of the most recent claim on September 28, 2006. I find the foregoing facts to be similar to those in Ashcraft v. Hunter, 268 Ark. 946, 597 S.W.

2nd 124; Safeway Stores v. Lamberson, 5 Ark. App. 191, 634 S.W. 2d 396(1982).

I would also note that the stipulated record is silent in regard to the matter of whether the respondent had posted, during the claimant's employment and in a conspicuous place accessible to her, a form A-6 (now a form P). However, I am not inclined to accept this silence as proof that such form was, in fact, not posted during the claimant's period of employment. Thus, the respondent would not be estopped from raising the statute of limitations under the rule announced in Rider v. Martin, 31 Ark. App. 144, 789 S.W. 2nd 743 (1990).

II. ADDITIONAL MEDICAL SERVICES

As I have found that the claimant's entitlement to additional benefits is not barred by the expiration of the statute of limitations, which is contained in Ark. Code Ann. §11-9-702(b), it becomes necessary to determine her entitlement to additional medical services under Ark. Code Ann. §11-9-508. In order to be entitled to such services, the burden rests upon the claimant to prove that such services represent "reasonably necessary medical services", as that term is used in the Act.

Medical services are "reasonably necessary" when they are necessitated by or connected with the compensable injury. Such services must also have a reasonable expectation of accomplishing the purpose or goal for which they are intended.

In the present case, I would note that the records of Dr. Jason Pleimann shows that the claimant was initially released from

medical treatment on February 24, 2004, but was further directed to return as needed. At that time, it was noted that the wound from her surgical procedure had healed, that there was only minimal swelling in the area, that the claimant was non tender, that the claimant exhibited good strength in her injured foot, and that her pain was completely gone. X-rays were taken at that time and showed a complete excision of the non union bone fragment from her fifth right metatarsal.

The medical record further shows that the claimant sought no further medical treatment, until she returned to Dr. Pleimann on January 19, 2005. At that time, Dr. Pleimann recorded that the claimant was only experiencing minimal symptoms and has been doing "pretty well". He recorded symptoms of some occasional achy pain, especially toward the end of the day, in the area of the surgical site, and not really much swelling. He stated that the claimant simply wants to be checked to make sure everything was "okay". On physical examination, he noted minimal tenderness, a non tender scar, negative Tinel's, and good passive range of motion without discomfort. He did note significant weakness to the peroneal tendons and mild discomfort when her peroneals fire against resistance. X-rays, which were taken at that time, were indicated to "look good". An MRI was recommended to evaluate any potential tendon damage.

This MRI was subsequently performed and was interpreted by Dr. Pleimann, on February 2, 2005, as showing no significant abnormality of the tendon. It was Dr. Pleimann's diagnosis that

the claimant's mild persistent right foot pain was likely due to a lack of proper rehabilitation. The claimant was directed to work on her therapy exercises and to return only as needed.

In her deposition, the claimant testified that she had gotten progressively worse, since her last visit with Dr. Pleimann. She described her symptoms as pain at the site of the surgery, numbness in the foot, sharp pains in her foot, and aching of the leg at times (T.10).

After consideration of all the evidence presented, it is my opinion that the claimant has proven that a one time evaluation by an orthopaedic physician, in the area of her current residence, would be reasonably necessary to ascertain the etiology of her continuing symptoms and complaints, to determine if any further medical services would have a reasonable expectation of resolving or reducing her chronic symptoms and complaints and to identify the type of such treatment, if appropriate. As such, I find that at least an initial evaluation by an orthopedic specialist would constitute reasonably necessary medical services, under the provisions of Ark. Code Ann. §11-9-508. Pursuant to the provisions of this subsection, the respondent is liable for the expense of this evaluation, subject to the Commission's medical fee schedule.

I would note that this is no more or no less than the claimant would have been entitled to had her initial request for a change of physicians been granted or had the respondent authorized a physician in her previous place of residence.

Finally, I would note that the Act imposes upon the respondent the duty and obligation to provide the claimant with reasonably necessary medical services for her compensable injury. Although the Act limits the respondent's liability for the expense of such services to the medical fee schedule established by this Commission, it does not impose upon the claimant the obligation of finding a medical provider that will agree to be bound by this fee schedule. This obligation also rests on the respondent.

FINDINGS OF FACT & CONCLUSIONS OF LAW

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

2. On September 24, 2003, the relationship of employee-self insured employer-third party administrator existed between the parties.

3. On September 24, 2003, the claimant sustained a compensable injury to her right foot.

4. All medical expenses for the claimant's compensable injury, which have been incurred to date, have been paid.

5. An evaluation of the claimant's right foot difficulties by an orthopedic specialist in the area of her current residence, represents a reasonably necessary medical service, under Ark. Code Ann. §11-9-508. Pursuant to the provision of this subsection, the respondent is obligated to provide the claimant with such services at the respondent's expense. It is the right and obligation of the respondent to select or obtain such an appropriate medical provider.

6. For the reasons heretofore stated in this Opinion, the current claim for additional medical services is not barred by the statute of limitations that is contained in Ark. Code Ann. §11-9-702(b). Specifically, this claim was timely filed and the respondent is estopped from raising the statute of limitations.

7. The respondent has controverted the claimant's entitlement to any additional benefits.

8. As no controverted benefits have been herein awarded to the claimant, no controverted attorney's fee can be awarded to her attorney.

ORDER

The respondent shall select an orthopaedic specialist in the area of the claimant's residence, who is agreeable to abiding by the Arkansas Workers' Compensation medical fee schedule. The respondent shall be liable for the expense of an evaluation of the claimant by such specialist for the purpose of determining the extent of her continuing difficulties with her right foot and to determine if any further treatment would be reasonably necessary or medically appropriate.

IT IS SO ORDERED.

MICHAEL L. ELLIG
ADMINISTRATIVE LAW JUDGE