

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F605255

LAVETA LARSON, EMPLOYEE

CLAIMANT

**NORTH ARKANSAS REGIONAL MEDICAL CENTER,
SELF-INSURED EMPLOYER**

RESPONDENT

CROCKETT ADJUSTMENT, TPA

RESPONDENT

OPINION FILED FEBRUARY 8, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on December 7, 2006, at Harrison, Boone County, Arkansas.

Claimant represented by the HONORABLE RONALD M. MCCANN, Attorney at Law, Fayetteville, Arkansas.

Respondent represent by the HONORABLE JOHN D. DAVIS, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-style cause to determine the claimant's entitlement to workers' compensation benefits.

On September 19, 2006, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties's contentions relative to the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. Respondent takes the position that there were no objective findings of a lower back injury.

The testimony of Ms. Laveta Larson, the claimant, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Laveta Larson, the claimant, with a date of birth of January 20, 1973, is a high school graduate who has had additional training to obtain a Certified Nursing Assistant certificate. The claimant completed her CNA training in 2002, after which time she commenced working at a nursing home. The claimant has also worked at United Cerebral Palsy, which entailed taking care of handicapped children while they are at home.

On June 13, 2005, claimant commenced her employment with respondent. In describing her duties in the employment of respondent, claimant testified:

I went in to take care of patients. I bathed them. I helped them, you know, to the bathroom. Whatever they needed, I done. Helped with their meals or whatever. (T. 10).

Claimant performed the same type of job duties in her employment with respondent from the date of her hire until May 2, 2006.

The claimant asserts that she suffered an injury to her low back on May 2, 2006, within the course and scope of her employment with respondent which serves as the basis for the present claim. In describing the mechanics of the May 2, 2006, injury, claimant testified:

Well, I went in to lift a patient, to take the patient to the bathroom, and when I lifted the patient from the bed, she stiffened up on me, and I thought she was going to fall. So I grabbed her, and she - - when she reared back, you know, it startled me, so I - - when I grabbed her, I stiffened up, and I kind of turned her back around, to get her back on the bed, because I was trying to put her on the commode. And I called for help, but, at the time, I felt something had popped in my back, and I felt immediate pain. (T. 11).

Claimant described the area in her back where she felt the “pop” as the lower part of her back

below the belt line and on the right side. Claimant noted that the pain in her back was severe and that it ran down her right leg as well. Claimant's testimony reflects that she had never previously experienced a similar kind of pain nor had she had problems with her right leg before that date.

Approximately thirty (30) minutes following the occurrence of the accident, claimant testified that she reported her injury to the R.N., and was instructed to go tell the main supervisor, Cathy Thompson. The testimony of the claimant reflects that she was sent down to the nurse, who provided her with some pain medicine and muscle relaxers and directed to go home. On May 5, 2006, claimant had x-ray re-done at the hospital after she had failed to improve enough to return to work. Claimant did not see a physician between May 2, 2006, and May 5, 2006.

The testimony of the claimant reflects that the first doctor that she saw following the May 2, 2006, accident was Dr. Clary on May 8, 2006. Claimant maintains that the condition of her low back was such that it was hurting worse at the time that she saw Dr. Clary on May 8, 2006, then it was on the day of the accident. Claimant acknowledged that there was an incident involving her right ankle subsequent to the May 2, 2006, accident:

Well, I got up, and my right leg gave away with me and I fell. I tried to catch myself, but I come down on my left ankle, trying to catch myself, and fractured it.

* * *

Well, I'll tell you what happened. I got up to go to the bathroom, and, when I got up, it just gave way.

Numbness and pain shot across the whole lower part of my back, down in my tail bone, and it [the right leg] just went out from under me.(T. 14).

The claimant's testimony reflects that she fell to the surface and injured her left ankle in the process. The incident involving her ankle occurred on May 7, 2006. Claimant noted that when

she was seen by Dr. Clary on May 8, 2006, she relay a history of both her low back and right leg and her left ankle, and received medical treatment for both problems.

Claimant testified that she was later referred by Dr. Clary to Dr. Ledbetter relative to the left ankle injury. The testimony of the claimant reflects that she was seen by Dr. Ledbetter on two separate occasions, and that the treatment was confined to the left ankle.

Claimant's testimony reflects that she has not been back to work since the May 2, 2006, accident. Claimant offered that she is not able to go back:

Because I still have weakness in my right leg and numbness, and my leg still keeps going out from under me. I would love to be able to go back to work, but, I'm just not able to go. (T. 16).

Claimant testified, relative to her employment status with respondent, that while she terminated in the first or second week of June 2006, by Ms. Cathy Thompson because they could no longer hold her position, once she is released medically they would be glad to have her back. Claimant noted that she has not been released by her doctor. At the time of the hearing claimant had a January 4, 2007, appointment with Dr. Littrell, a Little Rock physician.

During cross-examination the claimant was questioned regarding the responses she provided to interrogatories which had been propounded by respondent. The answers provide by the claimant reflects that three to four years prior to May 2, 2006, she had some minor problems with her back when she stepped out of a truck and pulled some muscles. Further, claimant relayed that she had seen Dr. Maes for the complaint. During her deposition the claimant testified that her back was fine after about three weeks.

Claimant concedes that Dr. Maes, at Harrison Internal Medicine Clinic, was her primary care physician in 2002, 2003, and 2004. Contrary to the testimony of the claimant, the medical

records reflect that the claimant was seen on October 21, 2002, with complains of lower back pain and tenderness, having spasm to the right side. The medical record regarding the visit reflects the history that the symptoms had their onset on Saturday and may have been the product of coughing. The medical records reflects that the claimant was prescribed Soma and Darvocet during the October 21, 2002, visit. On October 25, 2002, claimant obtained a refill of the medicines. On November 6, 2002, another refill was okayed at Sims Pharmacy.

The medical record of the claimant also reflect that she was seen at the emergency room of North Arkansas Regional Medical Center in December 2002, due to back pain bought on by slipping on some ice as she stepped out of the truck. Claimant was employed by Lamar Transportation at the time. Claimant was prescribed Darvocet for the back pain. Claimant concedes that she had experienced back pain prior May 2, 2006, although she declined to describe it as chronic pain in the back. The entry in an October 22, 2003, office note of Dr. Maes characterizes the pain as “chronic”.

A review of the claimant’s medical records reflects numerous entries for prescriptions of Darvocet to include 120 on August 21, 2003; 30 on November 1, 2003; 30 each Darvocet and Soma on November 10, 2003; November 25, 2003; refill of Darvocet and Xanax on December 1, 2003; December 11, 2003, as well as periodically through 2004. The medical records reflects an entry of February 2, 2005, of a telephone call to Fred’s Pharmacy to refill 120 Darvocet and 90 Soma. There was also a June 3, 2005, refill of Darvocet and Soma.

Claimant denies that she was using more than one pharmacy to obtain Darvocet, and attributes the actions of Sims Drugs in declining to fill further prescriptions of controlled substances to a mistake:

No. Dr. Maes' office called in my Darvocet at Wal-Mart. It was a mistake there. And, when I went to Sims to pick it up, I called and told them I wanted - - he called and said it's not there. He said the doctor had called none in. So he called the doctor, and the doctor said, well, no, we called it in to Wal-Mart. That's when he [the pharmacist] told me that I was getting it at multiple places. (T. 26).

Claimant denies that she requested Dr. Maes' office to call in her prescriptions to a different pharmacy. Further, the claimant explained:

Now, some places I can get Darvocet - - me being on a fixed income, I can get my Darvocets cheaper, because I had to pay for them. And he would call them in. And, at this time, I may have told him. I don't know. But my Darvocet was used for migraines, too. It was not just for back pain. (T. 27).

Claimant acknowledged that the Soma was just for her back pain. A November 18, 2002, entry in the claimant's medical records reflects that she was given samples of Maxalt for a migraine headache. A February 19, 2003, entry in the claimant's medical records regarding complaints of more frequent migraine headaches reflects that Keflex, Tylenol III, and vitamin B12 was prescribed. A March 4, 2004, entry in the claimant's medical records reflects that Phenergan and Demoral were prescribed for her complaints of migraines. Finally, the medical records reflect that while the claimant was provided a prescription for 120 Darvocets on August 31, 2005, on September 1, 2005, she called the doctor's office and requested Phenergan for a migraine headache.

The testimony of the claimant reflects that she has been on Social Security disability since 1995 because of obesity. At the time of the hearing claimant was receiving SSI benefits because of obesity. Claimant acknowledged that if she returned to work for respondent the amount of her SSI benefits would be reduced to one dollar from its current \$542.00 monthly amount. Claimant does not pay income tax on her SSI benefits. Claimant is also on Medicaid.

The testimony of the claimant reflects that during the period that she worked for respondent from June 2005 until May 2, 2006, she was physically able to perform all of her assigned job duties. Claimant denies that she had problems with back pain during the afore period. The claimant's medical records regarding her treatment at Dr. Maes's office stop in August 2005. Claimant denies that she was going anywhere to get any kind of treatment for pain in any part of her body from 2005 until the time of her injury. Claimant denies that she missed any time from work at respondent due to back pain, migraine headaches, or joint pain.

When the claimant was seen by Dr. Clary on October 30, 2006, an off work slip was issued noting that the claimant remained off work due to abdominal pain and leg weakness. Claimant testified that the abdominal pain started at the end of September 2006, and is one of the reasons for the pending Little Rock evaluation. In describing her present physical complaints which prevents her from working, and for which she attributes to the May 2, 2006, accident in the employment of respondent, claimant testified:

Well, I have a hurt across the lower part of my back, down in my tail bone. It's numb, and it goes - - my right leg goes numb, and it'll go out from under me. And I can't sit, I can't stand, I can't walk very long, and it's hard to work. (T. 33).

The medical in the record reflects that the claimant underwent x-rays of her lumbar spine on May 5, 2006, at respondent-employer, pursuant to the directions of the employee health nurse, which disclosed mild osteoarthritis without acute abnormality being noted. The x-rays were obtained three days after the claimant's work-reported accident, however prior to the May 7, 2006, left ankle injury. (CX. #1, p. 1A).

The first physician to see the claimant following the May 2, 2006, work-reported incident

was Dr. Cathy Clary, the claimant's primary care physician, on May 8, 2006. The chart note generated as a result of the May 8, 2006, visit reflects, in pertinent part:

This 33 yr old female presents for evaluation of low back pain. She hurt her back at work, lifting pt., last Tuesday, 5/2/06. She felt both her low back pop. She was seen in the ER, and they X-rayed her lumbar spine, which revealed mild osteoarthritis. She is now on flexeril and ibuprofen, and She reports that they do not help. Also, she is now having pain and numbness, down her right leg.

* * *

Neurologic Screening:

Decreased sensation to fine touch, diffusely down the posterior and lateral aspect of the right leg, to the right ankle. (CX. #1, p. 3-4).

X-rays were also obtained of the claimant's left ankle on May 8, 2006, pursuant to the directions of Dr. Clary, and disclosed either a small chip or avulsion type fracture at the tip of the lateral malleolus. (CX. #1, p. 3). Dr. Clary arranged for the claimant to undergo an MRI scan of the lumbar spine on May 11, 2006.

The radiology report relative to the claimant's May 11, 2006, MRI scan of the lumbar spine reflects, in pertinent part:

There are mild diffuse changes of degenerative disc disease with disc desiccation throughout the lumbar spine. There is minimal posterior disc protrusion at multiple levels but there is no evidence of significant neural encroachment or disc herniation. The vertebrae are normal. There is no stenosis.

OPINION: Mild diffuse degenerative disc disease. (CX. #1, p. 9).

The claimant was again seen by Dr. Clary on June 1, 2006. The Progress Notes relative to the visit reflect, in pertinent part:

This 33 yr old female is still having pain in the top of her ankle and foot and numbness in her 3rd, 4th, and 5th toes, leg. She has been in a walking

boot, since finding the avulsion fracture, 5/8. She developed a burning type pain approx. 2 weeks ago, and the toes have been numb for several days. She was suppose to return to work tomorrow, but she does not think she is ready. She is also still having pain in her low back. MRI confirmed diffuse osteoarthritis, no HNP, no fracture.

* * *

O:

Back: normal except spinal tenderness in the lower lumbar region.

* * *

P:

Repeat X-ray of her ankle, at NARMC today.

Medications: continue Diclofenac CR 75mg 1 po bid, and D/C Skelaxin, instead use Zanaflex 4mg ½-1 po tid prn muscle spasm. She may continue darvocet, prn. (CX. #1, p. 16).

The claimant was directed to follow-up with Dr. Charles Ledbetter, an orthopedic physician, relative to her left ankle. The claimant was released by Dr. Clary relative to the lumbar spine complaint as of the June 1, 2006, visit, however her work leave was continued until June 6, 2006, with further release per Dr. Ledbetter.(CX. #1, p. 17).

The medical in the record reflects that the claimant was seen by Dr. Ledbetter on at least two (2) separate occasions. During the initial June 5, 2006, visit, Dr. Ledbetter noted that the claimant provided a history reflecting that the injury to her left ankle was the product of her back giving out on her and her right leg going out from under her resulting in a fall. The back and right leg complaints growing out of the May 2, 2006, work accident. (CX. #1, p. 23).

On June 6, 2006, the claimant was again seen by Dr. Clary. The Progress Note relative to the afore visit reflects, in pertinent part:

. . . She saw Dr. Ledbetter yesterday, and he told her that she must either go to a sit down job or be off work, if a sit down job is not available.

She talked to her supervisor this morning, and was told to get a note from me that would have her off work till 7/3. She will see him again 7/3. She is tearful today, because she is frustrated that she can not work. She has underlying depression, but since breaking her ankle and being unable to work, it has worsened. (CX. #1, p. 29).

At the time of the claimant's June 29, 2006, visit to Dr. Ledbetter regarding her left ankle injury, she was released as having reached maximum medical improvement. Dr. Ledbetter opined that the claimant had not sustained any permanent physical impairment as a result of the left ankle injury. Further, the claimant was released by Dr. Ledbetter to return to her regular job without restriction. (CX. #1, p. 23).

The evidence in the record reflects that on June 27, 2006, the claimant scheduled an appointment with Neurological Associates relative to her right leg and low back complaint pursuant to a referral of Dr. Clary. (RX. #1, p. 48). On July 7, 2006, claimant was examined by Dr. Kejian Tang, and underwent additional diagnostic studies. Dr. Tang's July 7, 2006, narrative report regarding his evaluation of the claimant reflects, in pertinent part:

IMPRESSION: Ms Leveta Larson had an accident while she was helping a patient. Since then, she has experienced pain in her right side lower back and the back of the right thigh. Her gait is affected. On physical exam, she does not appear to have focal neurological deficits, but she does have remarkable tenderness in the right side lower back and the back of the right thigh. The MRI showed bulging disc in the lower lumbar spine which could be due to degeneration or from trauma, but there was no neuroforaminal stenosis. There was no nerve impingement. Most likely, the patient has muscle strain with musculoskeletal features. However, peripheral nerve impairment cannot be ruled out at this time.

PLAN: The patient is on physical therapy. I encouraged the patient to continue physical therapy for pain management. I will prescribe Ultracet two tablets p.o.q. six hours prn for pain. I will also proceed with a nerve conduction study on her right lower extremity to verify a peripheral

impairment. (CX. #1, p. 33).

The July 7, 2006, EMG/Nerve Conduction Velocity test report reflects:

IMPRESSION: This is an abnormal EMG/nerve conduction velocity test. The results show no evidence of peripheral neuropathy, but the patient might have right-sided lumbar radiculopathy from L4-5 which would be due to the bulging disc. However, her symptoms are not consistent with these test results. The musculoskeletal abnormality could be the major problem. (CX. #1, p. 31).

On July 17, 2006, Dr. Clary authored an off work slip reflecting that the claimant was still under her care and that of Dr. Tang for low back and leg pain and leg numbness and weakness following a work-related injury. (CX #1, p. 34).

The claimant was again seen by Dr. Tang on August 18, 2006, for neurological reevaluation of her right sided back and thigh pain. The August 18, 2006, narrative report of the afore visit reflects, in pertinent part:

An MRI of the lumbar spine showed bulging discs in her lower lumbar spine, which could be due to degeneration or from trauma, but there was no neuroforaminal stenosis. There was no nerve impingement.

I evaluated the patient on 07/07/06, which revealed tenderness in her right-sided lower back and the back of her right thigh. I suspected a muscle strain and lumbar radiculopathy. An NCV/EMG was performed which suggested right-sided lumbar radiculopathy from L4-5. I prescribed Ultracet, p.r.n. for severe pain. She received physical therapy, but she did not feel better.

* * *

On physical examination, the patient has remarkable tenderness in the right side of her back and the back of her right thigh. The other physical examination is the same as the last office visit.

IMPRESSION: I believe the patient's symptoms are largely due to muscle strain. The neurological deficit is minimal. I suggested the patient use alternative treatment such as lumbar puncture or massage. The patient used

a TENS unit. For her muscle strain, I will allow the patient to take Soma. .
(RX. #1, p. 56).

A August 22, 2006, Progress Note from Jan Rose in Dr. Clary's office reflects that the claimant need aggressive physical therapy for sacroillitis and piriformis syndrome , to including stretching. (CX. #1, p. 35).

The claimant was again seen by Dr. Clary on August 23, 2006, with continuing complaints of pain in her right hip and low back. The August 23, 2006, Progress Note relative to the visit reflects, in pertinent part:

. . . Her leg gave way again, causing her to fall. She saw Dr. Routsong, 8/18, and he did not think she had a neurosurgical problem, but rather "Right sacral somatic dysfunction and right piriformis syndrome" He said "I see no sign of spinal nerve or cauda equina compression".

* * *

O:

General: normal except walking with a limp

Back: normal except tender on the right lower paraspinal muscles

Extremities: positive straight leg raise, no pain with abduction or lateral rotation.

* * *

P:

Medication: Increase Amitriptyline to 100mg po q hs and increase

Lyrica to 100mg tid, . . . continue Diclofenace and Zanaflex

Patient Education: resume aggressive PT

Other: Pt. is requesting another neurosurgical opinion. (CX. #1, p. 36).

The final medical document contained in the record is an October 20, 2006, off work slip authored by Dr. Clary reflecting that the claimant remains under her care for abdominal pain and leg weakness. (CX. #1, p. 38).

After a thorough consideration of all of the evidence in this record, to include the

testimony of the claimant, review of the medical reports and other documentary evidence, application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On May 2, 2006, the relationship of employee-employer existed between the parties.
3. On May 2, 2006, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$189.00, for temporary total disability.
4. On May 2, 2006, the claimant sustained an injury arising out of and in the course of her employment with respondent.
5. The claimant was temporarily totally disabled for the period beginning May 3, 2006, through June 29, 2006, and continuing through the end of her healing period, a date to be determined.
6. The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of May 2, 2006.
7. The respondent has controverted this claim in its entirety.

CONCLUSIONS

The claimant asserts that she suffered an injury to her lower back within the course and scope of her employment with respondent on May 2, 2006, which required medical treatment and has resulted in a period of total incapacitation. Claimant seeks corresponding temporary total disability and medical benefits. Respondent deny that the claimant sustained a compensable injury to her lower back and controvert this claim.

The present claim is one governed by the provisions of Act 796 of 1993 in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision. In order to prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, a claimant must establish by a preponderance of the evidence: an injury arising out of and in the course of employment; that the injury caused internal or external harm to the body which required medical services or resulted in disability or death; medical evidence supported by objective findings, as defined in Ark. Code Ann. §11-9-102 (16), establishing the injury; and that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. §11-9-102 (4)(A) (i).

While the claimant in the instant claim had suffered prior injuries to her back for which she had received medical treatment and medication, the credible evidence in the record reflects that she successfully discharged her assigned job duties as a CNA with respondent from her date of employment in June 2005 until May 2, 2006. The medical in the record reflects that prior to May 2, 2006, claimant had last been seen for medical treatment on October 3, 2005, at the emergency room for migraine headaches.

The evidence in the record preponderates that the claimant sustained an injury to her lower back area on the right side on May 2, 2006, within the course and scope of her employment. The mechanics of the May 2, 2006, work-related accident are not disputed. Claimant was assisting a patient when she suffered her injury. Further, the injury was reported to appropriate supervisory personnel of respondent. Since respondent-employer is a health care provider, claimant's initial medical treatment was directed by the employee health nurse, to

include directions remain off work and to obtain x-rays on May 5, 2006.

Prior to seeing her primary care physician, Dr. Clary, on May 8, 2006, on the night on May 7, 2006, the claimant suffered a fall which resulted in the fracture of her left ankle which her right leg gave way. The claimant's right leg complaint grew out of the May 2, 2006, lower back injury. There is no evidence in the record to reflect that claimant experienced giving way in the right leg prior to her May 2, 2006, injury.

At the time of her May 8, 2006, visit to Dr. Clary claimant relayed the history of her May 2, 2006, work accident and resulting physical complaints of low back and right leg pain as the basis for the visit. Of note is the fact that Dr. Clary's office records reflect that the claimant was "now on flexeril and ibuprofen" at the time of the visit. Dr. Clary was the claimant's primary care physician. There is no evidence that the claimant had heretofore been prescribed the afore medicines by Dr. Clary. Accordingly, the Flexeril and ibuprofen were the product of the medical treatment claimant had received pursuant to the direction of the employee health nurse of respondent for the complaints the claimant experienced as a result of the May 2, 2006, accident.

A review of the claimant's medical records regarding her treatment subsequent to the May 2, 2006, accident disclose that in addition to the Flexeril and ibuprofen that she was taking for her low back complaints at the time of the May 8, 2006, visit to her primary care physician, she was later prescribed Skelaxin and Zanaflex for muscle spasm. (CX. #1, p. 16). Respondent asserts a lack of objective findings as a basis for its controversion of the claimant's low back claim. The evidence is to the contrary.

Regarding the medical evidence supported by objective findings establishing the injury component of compensability, the evidence preponderates that the claimant has sustained her

burden of proof. As noted above, at the time of the May 8, 2006, visit to her primary care physician the claimant was taking Flexeril and ibuprofen, which had been provided in connection to the May 2, 2006, accident. *Fred's Inc., v. Jefferson*, 361 Ark. 258, ___ S.W.3d___ (2005). A June 1, 2006, Progress note of the claimant's treating physician reflects that Skelaxin was being discontinued and instead Zanaflex would be used for muscle spasm. *Estridge v. Waste Management*, 343 Ark. 276, 33 S.W.3d 167 (2000). Subsequent diagnostic studies also disclosed objective finding evidencing the claimant's injury. The claimant has established by a preponderance of the evidence all of the requirements for establishing the compensability of her claim. Respondent has controverted this claim in its entirety.

When an employee sustains a compensable injury, then every natural consequence of that injury is also compensable. *Hublely v. Best Western Governor's Inn*, 52 Ark. App. 226, 916 S.W.2d 143 (1996). Consequential injuries need not arise within the time and space boundaries of the employment. The basic issue is whether there is a causal connection between the initial injury and the alleged consequential condition. *Jeter v. B.R. McGinty Mechanical*, 62 Ark. App. 53, 968 S.W.2d 645 (1998). In the instant claim the evidence preponderates that the claimant's left ankle injury, which was sustained at home on May 7, 2006, was a compensable consequence of the May 2, 2006, compensable injury. The claimant reached maximum medical improvement relative to her left ankle injury on June 29, 2006, with no permanent physical residual as a result of same. Respondent is liable for the cost of the claimant's medical treatment associated with the left ankle injury.

Respondent terminated the claimant's employment on or about June 2, 2006. Ark. Code Ann. §11-9-102 (13) defines "healing period" as, "that period for healing of an injury resulting

form an accident”. If the underlying condition causing the disability has not stabilized and further in the way of treatment will improve that condition, the healing period has not ended. The claimant had medical documentation from her treating physician directing her to remain off work, which was provided to respondent-employer. *High Capacity Products v. Moore*, 61 Ark. App. 1, 962 S.W.2d 831 (1998). At the time of the afore the claimant remained within her healing period and was totally incapacitated from engaging in gainful employment as a result of her compensable injury.

Temporary total disability is that period within the healing period in which a claimant suffers a total incapacity to earn wages. *Georgia-Pacific Corp. v. Carter*, 62 Ark. App. 162, 969 S.W.2d 677 (1998). In the instant claim, while the claimant was released to return to work as of June 29, 2006, by Dr. Charles Ledbetter relative to her left ankle injury, she remained under the active care and treatment of her primary care physician, Dr. Cathy Clary, who on June 27, 2006, recommended further treatment under the care of a neurologist. The claimant had not been released from the care of Dr. Clary relative to injury growing out of the May 2, 2006, accident as of the date of the hearing in this claim.

The claimant has sustained her burden of proof by a preponderance of the evidence that she remains within her healing period and totally incapacitated from engaging in gainful employment from May 3, 2006, and continuing through the end of her healing period, a date to be determined. Respondent has controverted this claim in its entirety. While respondent initially accepted the claimant’s claim as compensable and paid medical and indemnity benefits through June 29, 2006, as of the date of the pre-hearing conference, September 19, 2006, the compensability of the claim was controverted. As a consequence of the afore, claimant was not

required to prove by a preponderance of the evidence her entitlement to temporary total disability benefits subsequent to June 29, 2006, but the compensability of the claim and entitlement to all workers' compensation benefits flowing therefrom commencing with the date of the accident.

Cleek v. Great Southern Metals, 335 Ark. 342, 981 S.W.2d 592 (1998).

AWARD

Respondent is herein ordered and directed to pay to the claimant temporary total disability benefits at the weekly compensation benefit rate of \$189.00, for the period commencing May 3, 2006, and continuing through the end of her healing period, a date to be determined, as a result of the May 2, 2006, compensable injury. Said sums accrued shall be paid in lump without discount. Respondent may claim credit for sums heretofore paid toward the afore obligation.

Respondent is further ordered and directed to pay to all reasonably necessary and related medical, hospital, nursing and other apparatus expenses growing out of the May 2, 2006, compensable injury, to include medical related travel.

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

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

Matters not addressed herein are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE

