

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F511763

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| NORMA MIROS                               | CLAIMANT   |
| RYAN'S FAMILY STEAK HOUSE                 | RESPONDENT |
| CRAWFORD AND COMPANY<br>INSURANCE CARRIER | RESPONDENT |

OPINION FILED FEBRUARY 27, 2007

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

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

Respondent represented by LEE J. MULDROW, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on December 14, 2006, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on July 31, 2006. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

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

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

2. On August 3, 2005, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her left hip on August 3, 2005.

4. The claimant is entitled to a weekly compensation rate of \$172.00 for temporary total disability and \$154.00 for permanent partial disability.

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

1. Compensability of the claimant's low back injury.

2. Related medical.

3. Temporary total disability from November 1, 2005, to a date to be determined. The respondent will be due a credit for temporary total disability paid up to May 2, 2006 if temporary total disability is awarded herein.

4. Attorney's fees.

In regard to the foregoing issues the claimant contends that the August 3, 2005, job related accident not only resulted in injury to her hip but also to her back. The claimant contends that she sustained a herniated disc in her lumbar spine. The claimant contends that she is entitled to temporary total disability benefits from November 1, 2005, until a date yet to be determined and reasonably necessary medical treatment. The claimant contends that her attorney is entitled to an appropriate attorney's fee.

In regard to the foregoing issues the respondents contend that regarding claimant's low back condition, respondents contend: (1) that said condition did not arise out of and in the course of the employment; (2) that there is no objective medical evidence of a low back injury; and (3) that the work does not represent the major cause of claimant's disability or need for treatment.

The documentary evidence submitted in this matter consists of the Commission's Pre-hearing Order, marked Commission's Exhibit No. 1. The respondent submitted a packet of medical records marked Respondent's Exhibit No. 1. These exhibits were admitted without objection.

#### DISCUSSION

Frank Miros testified that he had been married to the claimant for four years, agreeing that they were married prior to her accident on August 3, 2005. Mr. Miros testified prior to the claimant's accident she had no problems with her back nor did he observe her acting in any manner which would indicate that she was having any problem with any activity or movements that she was doing. Mr. Miros testified that the claimant would often help him with outside work as well as work in the house. Mr. Miros testified that since her accident in August 2005, the claimant's activities have been severely limited and her ability to travel has been interfered with as well. Mr. Miros testified that the claimant was sent to Fayetteville to be examined by Dr. Hendrix and that trip took them approximately one hour and 45 to 50 minutes because they had to stop several times for the claimant to get out and stretch. Mr. Miros testified that he has taken the claimant to the University of Arkansas Medical Center in Little Rock noting that they had to stop a couple of times in order for the claimant to get out and walk around.

The claimant testified that she was working for the respondent as a waitress on August 3, 2005. The claimant testified that she

was asked to change a light bulb. The claimant stated that she got up onto one of the booths, took the light bulb out, and as she was replacing the bulb she was shocked and fell off the bench injuring her left side. In trying to describe what she injured, the claimant demonstrated by pointing to her left hip and left thigh. The claimant testified that there also is a lump on her left side just below her belt line. The claimant testified that her injuries were in her hip area close to the center of her back and close to her tail bone. It should be noted that the parties have earlier stipulated in the Pre-hearing Order that the claimant sustained a compensable injury to her left hip on August 3, 2005. The claimant testified that she has had pain in this area which has increased over time ever since her fall. The claimant agrees that she first saw Dr. Kyle on August 9, 2005, for her complaints of pain in her left hip and back part of her left hip area. The claimant testified that her pain was running all down her explaining that it was difficult for her to explain. The claimant testified that Dr. Kyle examined her, gave her pain medication, and recommended that she stay off work for three days. The claimant testified that her pain did not get any better and that she reported this to the respondent. The claimant testified that the respondent sent her to Dr. Terry Clark on August 26, 2005. The claimant testified that when she was seen by Dr. Clark, she was still in pain which was radiating and the pain did not stop even with the medication she was taking. The claimant testified that Dr. Clark examined her and prescribed medications as well as physical therapy but none of the

treatments improved her situation. The claimant was asked about a physical therapist report dated August 31, 2005, which indicates that her condition had worsened and the claimant agreed that yes it had. The claimant testified that on September 1, 2005, she was seen by Dr. Clark at which time she reported that her pain was progressively getting worse and that she felt it was swollen inside. The claimant testified that Dr. Clark took her off work for two weeks and recommended that she continue her pain medication. The claimant testified that she will occasionally have a bulge in her left buttock area, noting that when it is bulging out her pain is increased and when it goes down, the pain eases up a little bit. The claimant testified that she returned to see Dr. Clark on September 21, 2005 but he was not in so she was seen by Dr. Holden who gave her an injection. The claimant testified that this shot eased her pain for about two and a half days and then the pain came back the way it was before. The claimant testified that she saw Dr. Clark on September 26, 2005, and agreed that Dr. Clark's notes are correct in that she was crying from her pain.

The claimant agreed that as of September 26, 2005, she was still having lots of problems. The claimant was asked about Dr. Kendrick's report indicating that her condition with proper treatment should have been taken care of in six weeks. The claimant responded that no one did anything for her. The claimant agreed that she was then seen by Dr. Tursell and that the information she filled out for him indicated that she was having problems with her hip. The claimant testified that she did not

know exactly where her problem was located but she did know that her left hip hurt and it ran down through her legs. The claimant testified that she does not know her hip from her buttocks and all she knows is that she has pain and it has not changed. The claimant agreed that she did not know medically whether it was her hip, her buttock, or her back when she was talking to the doctor. The claimant testified that she had nothing to do with how Dr. Tursell wrote his examination report on October 5, 2005. The claimant agreed that the same problem that is talked about in the orthopedic exam sheet is what she is testifying about and describing as her hip and buttock. The claimant testified that subsequent to October 5, 2005, she has gone to the emergency room in order to get pain medications. The claimant agreed that her workers' compensation carrier has denied this service. The claimant agreed that besides having been seen at UAMS she has also been to the Good Samaritan Clinic and currently has an appointment with a neurosurgeon scheduled for February 22, 2007, at UAMS. The claimant testified that there has not been a time since her accident in August 2005 that she has felt like she had recovered from the effects of that accident. The claimant testified that she has never had any medical treatment for her back before August 2005. The claimant testified that she was 58 years old and her duties working for the respondent included everything that is expected of a waitress and required her to stand on hard floors for at least six hours a day six days a week. The claimant testified

that she has not been able to do any work for money since November 2005.

On cross examination, the mechanics of the claimant's fall on August 3, 2005, was gone over thoroughly. The claimant agreed that when she was shocked she came down hard on her left leg in sort of an awkward fashion but did not actually fall on the ground. The claimant testified that she had pain immediately and that this pain worsened throughout the day. The claimant agreed that she worked her entire shift the day of her accident and continued to work for the respondent until Dr. Kyle took her off work on August 9, 2005. The claimant testified that after she was seen at the walk-in clinic on the 9<sup>th</sup> she presented the respondent with her off work slip at which time she was told that she would need to be seen by the company doctor, Terry Clark. The claimant agreed that after having some conservative treatment by Dr. Clark, she did undergo an MRI of her hip as well as her low back. The claimant agreed that whether the doctors refer to the term sciatic or sciatic area, she showed the doctors where her pain was localized. The claimant agreed that she last saw Dr. Clark on November 1, 2005 which is when she learned that the respondent was not going to pay for any treatment for her low back but would pay for treatment for her hip. The claimant agreed that she then saw Dr. Kyle a few times after November 1, 2005, and that much later it was agreed by the parties that she could be seen by a specialist and she was sent to Dr. Kendrick. The claimant agreed that she has had two MRIs of her

back, one in September 2005 and one in October 2006 and she has also had an MRI of her hip.

On redirect examination, the claimant testified that she has not been involved in any kind of accident subsequent to August 3, 2005. The claimant testified that Dr. Kendrick examined her approximately seven minutes. The claimant then explained exactly what Dr. Kendrick did further noting that he would not tell her anything or even talk with her. The claimant testified that she was devastated when Dr. Kendrick was so disinterested in her case. The claimant testified that her husband drove her to Fayetteville and back for a seven minute examination.

The medical records set forth that the claimant was seen by Dr. Lamar Kyle on August 9, 2005. Dr. Kyle writes that the claimant was changing a light bulb when she accidentally got shocked and stepped off the stool fairly quickly in a twisting motion. The doctor notes that the claimant came down hard on her left leg and a couple of hours later she started having pain in the left posterior hip and sacral area which continued to worsen over time. After examination, Dr. Kyle assessed the claimant with having strained her left scrum and hip. Medications were prescribed by Dr. Kyle. On August 25, 2005, the claimant was seen by Dr. Terry Clark for complaints to her left hip. Dr. Clark notes that the claimant has been seen by another physician and she has had a steroid injection in her hip with no improvement and she has taken medications with no improvement. Dr. Clark writes that the claimant complains that the pain is a throbbing pain which is

exacerbated with walking and weight bearing and that the claimant states that, "I feel a bulge in my hip." X-rays of the claimant's left hip were negative for fractures but is noted to have some arthritic changes. Dr. Clark assessed the claimant with having left hip and left SI joint strain for which he prescribed physical therapy, medications and placed her on light duty work. Dr. Clark writes on September 1, 2005, that the claimant complains that her pain is worsening, stating that it feels as though it is swollen inside. Dr. Clark notes that the claimant has not improved with physical therapy and her pain has progressively worsened despite the conservative measures. Dr. Clark ordered an MRI of the claimant's left hip and left SI joint and restricted her work to sedentary duty only. On September 19, 2005, the claimant underwent an MRI of her left hip which was normal. The claimant was seen by Dr. Keith Holder on September 21, 2005, who writes that she reports constant pain at the level of a nine to ten. After examination, Dr. Holder recommended and administered a Traumeel injection in the claimant's left para spinous muscles above the left SI. Dr. Holder assessed the claimant with having left SI joint strain and continued her physical therapy as well as her work restrictions. Dr. Terry Clark writes on September 26, 2005, that the claimant reports worsening pain stating that her pain is constant and throbbing. The claimant reports that her pain got so bad she had some vomiting. Upon examination, it is noted that the claimant is in tears crying from her pain. Dr. Clark assessed the claimant with left SI joint strain, prescribed medications, continued her

work restrictions and an appointment with an orthopedic doctor was made. On October 5, 2005, Dr. Clark writes that the claimant continues to have pain in the posterior aspect of her left hip and now complains of pain in the area of the low back with paresthesias down the anterior aspect of her left thigh. Dr. Clark notes that the claimant indicates the distribution of the L2 and L3. Dr. Clark writes that the claimant was scheduled for an appointment with Dr. Tursell and that Dr. Tursell's nurse reviewed the claimant's MRI and came to the conclusion that it was not her hip but rather her back that was causing her problems and for that reason Dr. Tursell did not see the claimant. Dr. Clark writes that the claimant arrived at his clinic in tears. After examination, Dr. Clark diagnosed the claimant with having left SI strain and lumbar strain with left lower extremity radicular symptoms. Dr. Clark ordered an MRI of the claimant's lumbar area, a nerve conduction study of the claimant's left lower extremity, refilled her medications, took her off work until after her MRI and other tests were run. The claimant underwent an MRI of her lumbar spine on October 6, 2005, which revealed a left foraminal disc herniation at the L4-L5 level and mild channel stenosis from L3 through S1. The nerve conduction study done of the claimant's left lower extremity is noted to be within normal limits further noting that there was no definite evidence to support the diagnosis of neuropathy or radiculopathy affecting the left lower extremity. On October 18, 2005, the claimant was seen by Dr. Clark where he notes that the claimant's MRI of her lumbar spine did reveal a left disc

herniation at L4-5, however no mention of nerve root impingement further noting that her nerve conduction study was normal. After examination, Dr. Clark prescribed medications, referred her to Dr. Swicegood and she is to be off work until she is seen by Dr. Swicegood. Radiographic tests of the claimant's lumbar spine made on October 18, 2005, reveals severe marked calcific atherosclerotic change as well as mild lower lumbar spine degenerative change without definite fracture.

Dr. Lamar Kyle saw the claimant on November 30, 2005, for complaints of left lower back pain. After examination of the claimant Dr. Kyle recommended that she be seen by a neurosurgeon and prescribed medications. The medical records indicate that the claimant was seen at the St. Edwards emergency room on March 25, 2006, for her complaints of back pain. The claimant was seen by Dr. Carl Kendrick on April 4, 2006, for what the doctor termed an independent medical examination. After examination and review of the claimant's various tests, Dr. Kendrick notes that the MRI of her back does show a disc at the L4-5 level on the left noting however that she has significant foraminal stenosis with significant degeneration of her disc spaces and several levels of facet changes. Dr. Kendrick opines that the claimant's problem is more related to spinal stenosis than to her injury, noting that her injury may have played a minor role in the onset of her symptoms. Dr. Kendrick notes that the claimant could be helped by an exercise program, noting that there is a reasonable chance that her symptoms can improve. In a letter from the respondent's attorney dated

April 21, 2006, to Dr. Carl Kendrick the doctor was asked if the claimant's aggravation of a pre-existing condition resulted in a temporary or a permanent exacerbation and if temporary there was a need to know how long the claimant's debilitating symptoms were attributable to her on the job aggravation. Dr. Kendrick was also asked if he could determine when the claimant's medical care shifted from treatment of the aggravation to treatment of her underlying condition. Dr. Kendrick writes on May 2, 2006, that it is his professional opinion that the claimant's aggravation was temporary and does not contribute to long standing disability. In a letter from the respondents' attorney dated August 2, 2006, Dr. Kendrick was asked; (1) how long would the claimant's disability be attributable to her job aggravation versus pre-existing factors and; (2) how long would it be reasonable to conclude that the claimant would need treatment for her aggravation versus pre-existing factors. Dr. Kendrick writes on August 8, 2006, in response to the respondents' letter as follows:

"In answer to your first question, it would amount to a strain from her injury and that usually clears within a period of about six weeks or so when properly treated. In answer to your second question, I think after six weeks."

The claimant underwent an MRI of her lumbar spine on October 6, 2006, at the University of Arkansas Medical Center. The impressions from this test are as follows; (1) moderate size bilateral herniations on the left at L3/4 and more prominently on the left at L4/5 with displacement of the L3 and 4 nerve roots respectfully; (2) abnormal facet at the L5/S1 level on the right

with substantial increased facet size with compensatory increase in facet size on the left causing left lateral recess stenosis with displacement of the left S1 nerve root. It is further noted in the impressions that if request is made a CT examination through the lumbar sacral region may be of value for further clarification of the architecture of the facet.

The medical records set forth that the claimant was also seen at the Summit Medical Center for treatment of her back complaints as well as at the Good Samaritan Clinic.

After a complete review of this entire record, I find that the claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back while working for the respondent on August 3, 2005. It is not questioned and the respondents have accepted that the claimant had a fall while at work changing a light bulb injuring her left hip. The claimant's testimony has been consistent that she has had constant increasing pain in the left hip buttock area since August 3, 2005. It is obvious that the claimant has no medical background and has explained her symptoms in the area of her problem as best she can to the various treating physicians. When the claimant was first seen by Dr. Clark on August 25, 2005, his impression after examination was that the claimant has problems with her left hip as well as left SI joint strain. The MRI of the claimant's low back done at the direction of Dr. Clark revealed a left foraminal disc herniation at the L4-L5 level as well as mild channel stenosis from L3 through S1. A more extensive MRI done by the University of

Arkansas Medical Center in Little Rock sets forth that the claimant has a moderate size bilateral herniation on the left at L3/4 and more prominently on the left at L4/5 with displacement of the L3 and 4 nerve roots respectively. This MRI also sets forth abnormal facet at the L5/S1 level on the right with substantial increased facet size with compensatory increase in facet size on the left causing a left lateral recess stenosis with displacement of the left S1 nerve root. I find that the MRI conducted at the University of Arkansas Medical Center in Little Rock to be more thorough. It is further noted that there is no testimony in this record of this claimant sustaining or experiencing any other type of injury subsequent to her August 3, 2005, incident while working for the respondent. Therefore, I find that the respondents should pay for all reasonable and necessary medical treatment for this claimant's low back and that the claimant is entitled to temporary total disability from November 1, 2005, to a date to be determined with the respondents due credit for any portions of temporary total disability which they may have paid during this period of time.

#### FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.
2. On August 3, 2005, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to her left hip on August 3, 2005.

4. The claimant is entitled to a weekly compensation rate of \$172.00 for temporary total disability and \$154.00 for permanent partial disability.

5. The claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back while working for the respondent on August 3, 2005. See discussion above.

6. The respondents should pay for all reasonable and necessary medical treatment for this claimant's low back problems.

7. The respondents should pay temporary total disability to this claimant from November 1, 2005, to a date to be determined, noting that the respondents should be entitled to credit for any temporary total disability which they have paid during this period of time.

8. The respondents have controverted the claimant's entitlement to benefits for her low back in their entirety.

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

#### ORDER

The claimant has proven by a preponderance of the evidence that she sustained a compensable low back injury while working for the respondent on August 3, 2005.

The respondents should pay for all reasonable and necessary medical treatment for this claimant's compensable low back injury.

The respondents should pay temporary total disability to this claimant from November 1, 2005, to a date to be determined with the

respondents being entitled to a credit for any periods of temporary total disability which they have paid during this period of time.

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

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

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

IT IS SO ORDERED.

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ELIZABETH DANIELSON  
ADMINISTRATIVE LAW JUDGE