

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F512919 (10/26/05)

KIMBERLY GRIFFITH, EMPLOYEE

CLAIMANT

ARKANSAS HEART HOSPITAL, EMPLOYER

RESPONDENT

LIBERTY MUTUAL INSURANCE CO., CARRIER

RESPONDENT

OPINION FILED JULY 24, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on May 7, 2008, at Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE THOMAS W. MICKEL, Attorney at Law, Conway, Arkansas.

Respondents represented by the HONORABLE GUY ALTON WADE, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-style claim to determine the claimant's entitlement to additional workers' compensation benefits. On March 18, 2008, a pre-hearing conference was conducted in the claim, from which a Pre-Hearing Order of the same date 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' contentions relative to the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. The claimant amended her claim for temporary total disability benefits to cover the period from December 22, 2007, until January 11, 2008. Further claimant asserts entitlement to temporary partial disability for the

period commencing February 6, 2008, and continuing to a date to be determined. Respondents assert that there is little if any difference in the claimant's earnings such that she would not be entitled to temporary partial disability benefits.

The testimony of Kimberly Griffith, the claimant, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Kimberly Griffith, the claimant, with a date of birth of February 15, 1975, has a Bachelor's degree in nursing from the University of Central Arkansas in Conway, Arkansas. Claimant attended college immediately following high school.

While pursuing her nursing degree claimant worked at a number of jobs to include Crockett Adjustment Insurance Company, the Roberts Law Firm, a lifeguard at the Community Center in Jacksonville, and as a nanny. Claimant obtained her nursing degree in 1999. The claimant, who is a registered nurse, has worked exclusively as a nurse since obtaining her degree. The testimony of the claimant reflects that she worked in labor and delivery, prenatal intensive care nursing for approximately five years and thereafter went to the Heart Hospital commencing her employment on January 1, 2003.

The claimant sustained an injury within the course and scope to her back on October 26, 2005. In describing the mechanics of the October 26, 2005, accident, claimant testified:

I had a patient that had a stroke, very recent, agitated, anxious, trying to get out of bed quiet frequently and not able to walk. She was getting herself to the end of her bed and then getting her feet off the bed, so she basically was hanging off the bed. So my nurse tech and I would have to go in and get her straight in the bed and then pull her up, and we did that probably every 15 to 20 minutes. We did it quite a lot, and, you know, finally about between 10:00 and 11:00 in the morning, I just had

pain. (T. 12).

Claimant explained that she had pain, of a shooting/burning/throbbing/stabbing sensation, in her entire back, down her legs, and up in her neck. Claimant immediately reported the injury to her supervisor. Thereafter claimant reported to the emergency room of respondent, completed the required forms, was given a preliminary examination, and directed to obtain medical treatment from Concentra.

The testimony of the claimant reflects that she followed up as directed with Concentra. Claimant testified that she was referred by the physician at Concentra to a neurosurgeon, Dr. Adametz, who recommended injections. Claimant's testimony reflects that the referral to Dr. Sprinkle was more the decision/preference of the assigned nurse case manager. The claimant followed up in treatment with Dr. Sprinkle for a period of time until she was released from the care of same as having reached maximum medical improvement.

The claimant testified that at the time of her release by Dr. Sprinkle she did not feel that she was as good as she was going to get from her injury. Claimant described her continuing symptoms as of the date of her release by Dr. Sprinkle:

I was still having lots of pain. I unable to do most of what I had wanted to before, most of what I had done before. I wasn't the nurse that I wanted to be, I wasn't the mother that I wanted to be. (T. 14).

The testimony of the claimant reflects that at that juncture she sought the services of an attorney and pursued a change of physician request. Claimant testified that the actual change of physician was never consummated by the Arkansas Workers' Compensation Commission. As a consequence of the afore, claimant sought treatment under the care of her primary care physician, Dr. Hodges.

The testimony of the claimant reflects that while under the care of Dr. Hodges her treatment consisted of medication. Claimant noted that she was not referred to anyone else by Dr. Hodges until after the December 22, 2007, episode. In describing the December 22, 2007, episode, claimant testified:

I had gotten out of the shower, and I was drying off my legs, and I had pain, very sudden, very sharp going completely down my leg and all the way up. (T. 14-15).

Claimant denies that she either slipped or fell in the tub, noting that she was standing and bent over when she experienced the onset of severe pain. The testimony of the claimant reflects that up to that point she had continued to have problems with her back since she had last seen Dr. Sprinkle. Claimant testified that the pain had changed in character than when she was seeing Dr. Sprinkle, explaining:

It had changed. Well, when I was with Dr. Sprinkle, it was mostly on the right side. By the time I went and saw Dr. Hodges, it was on both sides. (T. 15).

The testimony of the claimant reflects that the pain was more on the left side following the December 22, 2007, episode.

The testimony of the claimant reflects that after trying medication under the care of Dr. Hodges to address her complaints attributable to the October 26, 2005, injury, she was then referred to Dr. Bruffett. Claimant explained that she tried physical therapy, however after receiving the results of an MRI scan she was referred to Dr. Bruffett.

While under the care and treatment of Dr. Bruffett, claimant testified that she has undergone three (3) nerve block injections by Dr. Frankowski and Dr. Stone. Claimant has a return appointment scheduled with Dr. Bruffett. Claimant has utilized her health insurance to

pay for the cost of her medical treatment since being discharged from the care of Dr. Sprinkle.

The testimony of the claimant reflects that no decision has been made regarding any need for back surgery. Regarding her current symptoms, claimant testified that she had lower back pain and pain down her left leg. Claimant noted that any time she sit she has left leg pain.

Claimant testified that she was eventually paid temporary total disability benefits by respondents for the time she missed from work following her October 26, 2005, accident. During the fall of 2006, claimant changed jobs from the Heart Hospital to St. Vincent's Infirmiry Medical Center. Claimant asserts that she was given the choice of either leaving the Heart Hospital or her employment would be terminated.

Claimant maintains that the Heart Hospital changed the manner in which they dealt with her as an employee after she filed her workers' compensation claim. Claimant elaborated:

Initially, I was - - it's a very political hospital. They were very happy with my care. I was taking care of very sick patients, further classes to take on more critical patients, pump therapy and that kind of thing, and after my injury, it just became more and more difficult to deal with them. They were not happy with pretty much anything the I did. (T. 17-18).

The testimony of the claimant reflects that ultimately there was a dispute of a particular patient's care, which lead to the choice or either leaving or being fired. Claimant was without a job for approximately one (1) month following the afore. At the time she ceased her employment with respondent-employer, the testimony reflects that the claimant had been working there pretty much fill-time.

The testimony of the claimant reflects that at the time of her October 26, 2005, injury she earned \$25.00, per hour. Claimant testified that before her injury she did work some overtime.

Claimant's testimony reflects, with respect to the triggering mechanism for overtime:

Anything - - the way it works is kind of difficult. Anything over 40 hours is absolutely considered overtime; however, if you volunteer for an extra shift and weren't on call for that shift, you were - - you got overtime for the entire shift. Like I'll be on call and they called me in like that all the time for - - I got overtime for the entire 12 hours. (T. 18).

Claimant testified that when she went to work at St. Vincent's North she got the same number of hours. The testimony of the claimant reflects that following her October 26, 2005, injury she very rarely worked overtime, explaining that the same was due more to the injury which reduced her desire to volunteer herself for overtime.

In distinguishing her present employment with St. Vincent's-North from that of her employment with respondent-employer, claimant testified:

It is definitely less labor intensive than it was at the Heart Hospital, and I think that's one of the reasons I chose the job, and that's one of the reasons I chose the night shift. (T. 19).

Claimant is assigned to the Intensive Care Unit of the hospital in her present employment. The testimony of the claimant reflects that she is "definitely" doing less patient transfers in her present employment than she was at the Heart Hospital. Claimant added that the reason she chose the night shift was because she knew it would be that way.

Claimant testified that Dr. Burffett restricted her from working overtime. Claimant noted that pursuant to the directions of Dr. Burffett she is only allowed to work every other day. With respect to any problems doing her present job, the claimant testified:

I try not to do many patient if I can - - if I do have to, very, very modified and I make it to the best of my advantage. You don't have to move the patients, yeah. (T. 21).

The testimony of the claimant reflects that prior to her injury she participated in a hobby of Taekwondo. Claimant acknowledged that she still does Taekwondo on occasion. Regarding the afore, claimant testified:

I do. I have a black belt in Taekwondo. I am the assistant instructor which right now requires me sitting there telling other people what to do. Before my injury I was competing. Since my injury, I have not competed at all. At the advice of the physician and physical therapist, they all told me to keep doing it, to keep working out, just to modify how I needed to, which I did, and it wasn't very modified. But I have not worked out, I have not taken a class in Taekwondo since January, I mean December. (T. 22).

Claimant's testimony reflects the after the initial injury of October 26, 2005, she occasionally did very light sparring, but no full contact. However, since the December 22, 2007, emergency room visit claimant has limited her Taekwondo activity to teaching, which entails sitting and giving instructions.

During cross examination, claimant acknowledged that after graduating in 1999, with a Bachelor of Science she has worked as a licensed registered nurse from that point forward. Claimant worked at St. Vincent's in the labor and delivery and neonatal units from 1999 until 2003, as which time she started working for respondent-employer at the Heart Hospital. At the Heart Hospital claimant worked as a floor nurse in critical care, essentially ICU.

The claimant continued in the employment of respondent-Heart Hospital until September/October 2006. Claimant acknowledged that during the month period of time between the end of her employment at the Heart Hospital and beginning her employment at St. Vincents-North, she applied for unemployment benefits. The testimony of the claimant reflects that since she was able to find a job she did not receive any unemployment compensation benefits.

The claimant works nights at St. Vincents-North. The claimant acknowledged that there is a shift differential, and that she makes more pay for working nights. The testimony of the claimant reflects that there is a 30% weekend differential, meaning that should she work a weekend night she receives an additional 30% over the night work. Claimant acknowledge that with the night shift differential and if she worked the weekend her present earnings are comparable to those in the employment of respondent-Heart Hospital.

The claimant acknowledged a prior injury to her back in 2000 when she twisted wrong while picking up her son. Claimant treated with Chiropractor Bennett for the afore, and returned to work following same without any problems.

The testimony of the claimant reflects that her October 26, 2005, injury, which entailed pain from her neck down through her low back, was diagnosed as a complete back strain. The claimant's medical treatment at Concentra included medication therapy and some physical therapy. Claimant acknowledged that "to a point it had improved" in referring to her condition. Claimant testified that while she was not having the same excruciating, extensive pain as initially, she was still having muscle spasms and lower back pain and leg pain.

The claimant performed light duty work at the Heart Hospital following her October 26, 2005, injury until roughly December 2005. Thereafter, claimant testified that she resumed her regular full duty work for a period of time. The claimant returned a light duty status after turning wrong in bed one night which produced some additional pain.

The claimant acknowledged that initially the leg pain was in her right leg. Following an MRI the claimant was seen by a neurosurgeon, Dr. Adametz. The testimony of the claimant reflects that following her evaluation by Dr. Adametz, she was referred to Dr. Sprinkle by the

nurse case manager for treatment. Claimant testified that the requested injections were approved. The testimony of the claimant reflects that Dr. Sprinkle arranged for her to undergo an EMG/nerve conduction study. Claimant concedes that at the time she saw Dr. Sprinkle her pain was localized in her lower back and right leg. Claimant asserts that she was still having muscle spasms for which she was provided a TENS unit by Dr. Sprinkle. Regarding the TENS unit, claimant noted:

Which, by the way, the TENS unit supplies were supposed to be continued and medicine was supposed to be continued for life, and they were stopped. (T. 28).

The testimony of the claimant reflects that she was released to full duty without restrictions or an impairment by Dr. Sprinkle in April 2006.

Claimant concedes that she worked full-time from the point of the April 2006, release by Dr. Sprinkle until roughly either September or October 2006. After leaving the employment of respondent-Heart Hospital, claimant later started working at St. Vincents-North.

The claimant started treating with her family doctor, Dr. Hodges, for complaints attributed to the October 26, 2005, injury in February 2007, and followed with him until December 2007, when she had the episode for which she was seen at the emergency room. Claimant concedes that her pain changed in December 2007.

In describing the pain sensation which resulted in the December 22, 2007, emergency room visit, claimant testified that when she was getting out of the shower she bent over to dry her legs, and felt the sensation of lightning bolts going down her back and left leg. Thereafter, claimant testified that she was unable to stand, lay down or get comfortable in any way. Initially, the claimant saw Chiropractor Bennett. Claimant testified that she took some medicine and

attempted to work that night:

And I did stay the night. It was very difficult, but I could not work on Friday night, and I went to the emergency room on Saturday morning. (T. 30).

The testimony of the claimant reflects that due to increase in her pain following the December 2007, event, she was seen by Dr. Liu, an acupuncturist. The testimony reflects that Dr. Hodges had another MRI done in the interim, thereafter referred the claimant to Dr. Bruffett.

The claimant returned to work at St. Vincents-North on January 11, 2008, and has worked full-time, every other day, since. The claimant primary complaints are low back and left leg pain. Claimant concedes that the only restriction by Dr. Bruffett on her employment is the limitation of working every other day. Claimant added:

He did not write any specific limitations, because they do not have light duty at St. Vincent's. He just said, "Do what you can, you know, try to limit it as much as you can if your co-workers will allow that." (T. 31).

The claimant acknowledged that she has been an instructor in Taekwondo for the past two (2) years. Further, claimant concedes that she got her first degree rating determination in May 2007, and she is now working on her second degree. The claimant continues to instruct in Taekwondo, going three or four times a week. The duration of the instruction varies from an hour to three or four hours depending of the class.

The claimant was initially seen by Dr. Sprinkle on February 9, 2006, at which time she described her symptom attributable to the October 26, 2005, injury as back pain, numbness and tingling in the right foot. The claimant completed an initial history survey wherein she relayed the afore. On February 10, 2006, Dr. Sprinkle had an EMG/nerve conduction study perform on

the claimant which was essentially normal. When the claimant returned to Dr. Sprinkle on April 10, 2006, he found that she was a maximum medical improvement with no impairment.

The claimant was referred to Dr. Bruffett by Dr. Hodges, her family physician. Dr. Bruffett and Dr. Sprinkle are in the same office group. Claimant was seen by Dr. Bruffett on February 6, 2008, at which time she completed another initial history survey. In the afore, the claimant indicated that she was having low back pain and pain radiating down her left leg.

The testimony of the claimant reflects that while Dr. Adametz, the neurosurgeon, recommended injections as a part of his evaluation, the injections were not done until Dr. Bruffett recommended them, and at that point were paid under the claimant's own health insurance coverage. Claimant's testimony reflects that the injections did not really improve her condition.

The claimant's testimony reflects that she has not been symptom free since her October 26, 2005, injury. Claimant testified that the first treatment she received following the April 2006, release by Dr. Sprinkle was had under the care of her family physician, Dr. Hodges in February 2007.

The medical in the record reflects that the claimant was seen at Concentra Medical Centers on October 26, 2006, by Dr. John H. Adametz, Jr., relative to her work-related injury. The claimant's complaints were assessed as lumbar strain, thoracic strain, back pain, and cervical strain. The claimant was prescribed Celebrex, Cyclobenzaprine, and Skelaxin. Daily physical therapy for 1 to 2 week was provided. Limitations were placed on the claimant's physical activities, to include no lifting over 10 pounds, no pushing/pulling over 10 pounds of force, no bending more than five times per hour, and no reaching above shoulders. (JX. #1, p. 1-3).

The claimant treated with the physicians at Concentra through December 5, 2005. The office note relative to the December 5, 2005, visit of the claimant reflects, in pertinent part:

HISTORY OF PRESENT ILLNESS:

She feels the pattern of symptoms is stable. Patient has not been working because no light duty available. Patient has been taking their medications and has not noted any improvement. The pain is located on right lumbar region and thoracic region. Pain Intensity Level: 3/10. The pain is described as aching and dull. The symptoms are exacerbated by movement or activity. Associated numbness of the right leg and the foot. (JX. #1, p. 19).

The claimant's treatment regiment was continued and unchanged as a result of the December 5, 2005, visit, however an MRI of the lumbar spine was order and the claimant was directed to return to the clinic on December 9, 2005.

On December 6, 2005, the claimant underwent an MRI of the lumbar spine at the Arkansas Heart Hospital. The radiologist report relative to the MRI disclosed asymmetric diffuse disc bulge at L5-S1 and L4-S5, greater on the left. (JX. #1, p. 22).

The claimant was next seen by a physician at Concentra on December 8, 2005, relative to her October 26, 2005, work injury. The clinic note relative to the afore visit reflects, in pertinent part:

HISTORY OF PRESENT ILLNESS:

She feels the pattern of symptoms is stable. Patient has been working their regular duty. Patient has been taking their medications and has not noted any improvement. Patient has had physical therapy and does not feel better. The pain is located on bilateral lumbar region, right thoracic region and both sides of her neck. The pain is described as aching, burning, and throbbing. Pain Intensity Level: 3/10. Occasional shooting pain into right leg. The pain radiated to the right leg. The symptoms are exacerbated by Activity. Associated numbness of the right leg. (JX. #1, p. 25).

In addition to noting a returned scheduled appointment for December 12, 2005, the December 8, 2005, clinic note reflected that the claimant was referred to a neurosurgeon at the earliest

convenient time. (JX. #1, p. 26).

On December 30, 2005, the claimant was seen by Dr. James R. Adametz, a Little Rock neurosurgeon, pursuant to the above referral. The December 30, 2005, report of Dr. James Adametz reflects, in pertinent part:

HPI: This is a 30 year old white female who was positioning a patient on October 26, 2005 at the Heart Hospital where she works as a nurse. She developed rather severe muscle spasms and pain all the way from her neck to her buttocks area. Some of that has improved a little bit, but she continues to hurt mostly in her low back, with pain into her right buttock, and intermittent numbness of her right leg, with tingling and discomfort all the way down to the foot.

She had an MRI scan of the lumbar spine and it shows some degenerative disc disease at L4-5 and L5-S1, and some minimal bulges. The worse one is at L5-S1 on the left side. This does not fit well her symptoms and it is not really very bad.

PE: She is a little bit overweight. She is tender, especially around SI joints. She can bend about 70 or 80 degrees, but she says that is a lot less than normal to her. Deep tendon reflexes are 1+ and symmetric. Her strength is good. Her sensation is good at the moment.

MDM: I talked to her about this at some length. I think she has a combination of muscle spasms, a right SI joint sprain, and some symptoms, though, of radiculopathy, where she is obviously irritating the nerves in some fashion. AI went over treatment options with her. She is already on multiple medications and has taken Skelaxin, Celebrex, Tylenol, Ultram and Flexeril, and so I do not think I have much to add to that. Otherwise, I do not think that she is really bad enough to warrant surgery, and so Otherwise, what I have to offer her would be a steroid injection. If I was going to do this, I would do a combination of a epidural to try to get some of the nerve root pain, and an SI joint injection, both under fluoroscopy. We will see if we can get that arranged through her Worker's Compensation carrier. (JX. #1, p. 29).

The claimant was again seen by Dr. James Adametz on January 10, 2006. The medical record relative to the afore visit reflects, in pertinent part:

CHART NOTE: Ms. Griffith came back to the office on January 10, 2006. She came back in because she turned wrong the other day and had a severe flare-up in her back. It seemed to be around her SI joint. She actually went to a chiropractor and he was able to manipulate this, and that did seem to help her, so it is not as bad today.

PHYSICAL EXAM: On examination today she still is rather tender around her SI joint, especially on the right side. She has decreased range of motion.

DECISION MAKING: I talked to her about this at some length. We were planning on doing an ESI and SI joint injection. I still think it would be beneficial to her. We have not gotten final word yet on that from her Worker's Compensation, and so I have not done it yet. (JX. #1, p. 30).

The record reflects that following the January 10, 2006, visit to Dr. James Adametz, the neurosurgeon, the claimant was next seen at Arkansas Specialty Spine Center by Dr. Brent Sprinkle, D.O., pursuant to the directions to the assigned nurse case manager. The February 9, 2006, Initial Evaluation report of Dr. Sprinkle relative to the claimant reflects, in pertinent part:

HISTORY OF PRESENT ILLNESS:

This has been going on since October 26th. She was re-positioning a patient in bed and felt this pain in her back. It is primarily aching and burning. It can be sharp at times. It is moderate to severe. It is worse with standing, walking, lifting, twisting, lying in bed, stairs, sitting, and sneezing. It is improved with heat. She has tried Tylenol, ibuprofen, Celebrex, Skelaxin, Flexeril, and Ultram with minimal response. She had a trigger point injection that helped fairly significantly temporarily. She had some therapy at Concentra. She had some limited core exercise program on the therapy ball. She had x-rays which I have reviewed and an MRI in December of 2005 of the lumbar spine.

* * *

IMPRESSION:

1. Lumbar degenerative disc disease.
2. Disc desiccation at L4-5 and L5-S1.
3. Lumbar facet mediated pain.

PLAN:

1. I will start her on Neurontin. . . .
2. We will get an EMG of the right lower extremity for the intermittent numbness and tingling in her right leg to make sure there is no nerve root impingement that is not readily visible.
3. If the EMG is negative then we may review the core stabilization program a little more aggressively.
4. We could reconsider some facet blocks just to see if this turns off her pain and/or a diagnostic right SI joint injection, but I am not really that convinced that her pain is coming from the SI joint based on the exam today.
5. She can return to work in a light-duty capacity; no lifting greater than 15 pounds, no frequent bending or stooping, no prolonged sitting.
6. I will see her back for the nerve test and make plans based on those results. (JX. #1, p. 38-40).

The claimant was next seen by Dr. Sprinkle on February 10, 2006, during an office visit. The February 10, 2006, office note reflects:

FOLLOWUP VISIT:

The EMG was normal. I could not get a superficial peroneal, but they are somewhat difficult to obtain. I think this is just a technical factor and not representing any specific pathology. However, it is possible it could represent early changes of peripheral neuropathy. She is going to go see the therapist at Health South.

PLAN:

1. She tried the Neurontin. She has not really had a chance to get in a full dose of that. I will see her back in 2-3 weeks to assess her response to the Neurontin.
2. We may consider adding Zanaflex or a deeper trigger point injection to the piriformis muscle. (JX. #1, p. 43).

The claimant was next seen by Dr. Sprinkle on March 3, 2006. The office note relative to the afore visit reflects that the claimant was still having bilateral low back pain, and somewhat in her entire spine. In addition to noting that the Neurontin made her sleepy and groggy, the office note reflects that the claimant had not yet gotten the TENS unit. The March 3, 2006, office note visit

concludes:

IMPRESSION:

1. Thoracic and lumbar somatic dysfunction.
2. Cervical, thoracic, and lumbar myofascial pain.

PLAN:

1. I did a manipulation to the cervical, thoracic, and lumbar spine.
2. We will deferred trigger point injections.
3. I will see her back in 4 weeks.
4. She will continue her therapy. She says she will get into a regular aerobic exercise program. (JX. #1, p. 44).

The claimant was last seen by Dr. Sprinkle on April 10, 2006. The impression of the claimant's injury, as reflected in the April 10, 2006, office note was that of lumbar strain, lumbar somatic dysfunction, and lumbar myofascial pain, for which she received a trigger point injection. The April 10, 2006, office concluded:

PLAN:

1. Continue the TENS unit. I recommend she have that permanently.
2. I did OMT. She was a little bit looser but almost a little sore from that this time.
3. I did a trigger point injection. Post injection, her pain is better.
4. She can complete therapy to the point of the original prescription I have given her.
5. She can return to work with no lifting over 25 pounds and increase by 10 pounds per week until regular duty.
6. She is at maximum medical improvement. She has 0% permanent impairment rating. (JX. #1, p.46).

In a November 14, 2006, letter to the Clerk of the Commission, the claimant, through her attorney, requested that her file be referred to the Medical Cost Containment Division for consideration of a change of physician to Dr. Zachary Mason. (CX. #1, p. 1). In a February 16, 2007, letter to the division head of the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission, claimant filed a Motion to Compel the respondents to

respond to the division's request regarding the change of physician. (CX. #1, p. 2). In a December 12, 2007, letter to the Clerk of the Commission, claimant requested that the claim be referred to an Administrative Law Judge for a hearing on her entitlement to a change of physician, noting the failure of respondents to respond to inquiry by the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission. (CX. #1,p. 3-4). Finally, in a January 11,2008, letter to the Administrator of the Medical Cost Containment Division, claimant relayed:

The Claimant requests that this claim be referred back to the Clerk of the Commission for referral back to an ALJ for a hearing. The claimant has resumed lost time from work and is entitled to additional TTD benefits. Further, Claimant will contend that Respondents have controverted medical treatment in this matter. By copy of this letter, Claimant further notifies the Respondents that she intends to ask her PCP for a referral to Dr. Wayne Bruffett for a surgical consultation and further treatment, if appropriate. (CX. #1, p. 5).

The medical in the record reflects that the claimant was seen in the emergency room of St. Vincent Medical Center-North on December 22, 2007, with complaints of low back pain and pain radiating down the leg, for which she received emergency medical treatment, to include medication. (JX. #1, p.48-55). On January 7, 2007, the claimant underwent a MRI of the lumbar spine which disclosed left paracentral protrusion contacting and displacing the descending left S1 nerve root, likely causing a left S1 radiculopathy. (JX. #1, p. 56-57).

The claimant was seen by Dr. Wayne L. Bruffett, a Little Rock orthopedic surgeon, on February 6, 2008, pursuant to a referral of Dr. Timothy Hodges. The February 6, 2008, Initial Evaluation report relative to the claimant reflects, in pertinent part:

HISTORY OF PRESENT ILLNESS:

. . . She complains of pain in her low back with radiation down her left

leg. She had an original work injury back in October of 2005, but during that occurrence she had some right-sided symptoms. She bent over in December to dry her legs off, I believe after getting out of the shower, and she had severe pain in her left leg. The pain is now severe, sharp, burning and rather constant. It seems to be worse with exercise, lying in bed, sitting, coughing and sneezing, and relieved to some degree by ice. She also takes Anaprox and Ultram. She's had Vicodin in the past, but she says it really didn't help much.

* * *

PHYSICAL EXAMINATION:

On examination, she's 5 feet, 3 inches tall and weighs 190 pounds. Plus rate is regular at 86 beats per minute. She has pain with straight leg raise on the left side. Her reflexes are fine. Strength and sensation appear to be normal in her legs. Her affect and mood are normal. Hip range of motion is full and painless.

RADIOGRAPHIC REPORT:

X-rays show no evidence of spondylolysis or spondylolisthesis.

Her MRI scan is from St. Vincent North. It is somewhat haphazardly put together. She appears to have a left-sided paracentral disk herniation at L5-S1, with probable nerve root impingement.

IMPRESSION:

Herniated disk at L5-S1 on the left.

PLAN:

. . . I think she's having pain now from her disk herniation at L5-S1 on the left. This is not the biggest disk herniation I've ever seen. Hopefully, we can get this to calm down nonoperatively. I'm going to have her obtain a selective nerve root block at S1 on the left. I'm also going to change her work status a bit, where she needs to alternate working the 12-hour shifts instead of three nights in a row hopefully she can have a night break between these shifts. I'll see her back once the injection is completed. (JX. #1, p. 67-68).

After a thorough consideration of all the evidence in this record, to included 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 October 26, 2005, the relationship of employee-employer-carrier existed among the parties, when the claimant sustained an injury arising out of and in the course of her employment to her cervical, thoracic spine, and lumbar spine.
3. On October 26, 2005, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$466.00/\$350.00, for temporary total/permanent partial disability.
4. In addition to prior periods of total incapacitation relative to the October 26, 2005, compensable injury, the claim was temporarily totally disabled for the period December 22, 2007, through February 6, 2008.
5. The claimant has failed to sustain her burden of proof by a preponderance of the evidence that she is entitled to temporary partial disability benefits subsequent to February 6, 2008, pursuant to Ark. Code Ann. §11-9-520.
6. Medical treatment rendered to the claimant subsequent to April 10, 2006, was reasonably necessary in connection with the October 26, 2005, compensable injury, and for which respondents are liable.
7. The respondents have controverted the payment of temporary total disability benefits subsequent to December 22, 2007, and the claimant's entitlement to medical benefits subsequent to April 10, 2006.

CONCLUSIONS

The compensability of the claimant's October 26, 2005, injury is not disputed. Claimant maintains that as a result of the injury she continued to experience symptoms and require medical

treatment subsequent to the April 10, 2006, release by respondents' designated treating physician. The claimant further contends that she was again rendered totally incapacitated from engaging in gainful employment for the period December 22, 2007, through February 6, 2008, for which she is entitled to corresponding temporary total disability benefits. Finally, claimant asserts entitlement to temporary partial disability benefits subsequent to February 6, 2008. Claimant seeks the afore indemnity and medical benefits as well as controverted attorney fees. Respondents take the position that the claimant has been paid all appropriate workers' compensation benefits growing out of the October 26, 2005, work-related injury. Respondents deny that the claimant is entitled to temporary partial disability benefits base on her current actual earnings.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to additional workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

Medical Benefits

As noted above, the compensability of the claimant's October 26, 2005, injury is not disputed. The claimant is a registered nurse as was discharging employment duties at the Arkansas Heart Hospital when she sustained her compensable injury. Prior to the October 26, 2005, injury the evidence reflects that the claimant discharged her regular employment duties without physical restrictions or limitation. Further, there is no evidence in the record to reflect that the claimant was symptomatic relative to her spine or lower extremities.

The claimant was referred to the Concentra Medical Center for treatment of her October 26, 2005, injury, which was essentially diagnosed as a strain of her entire spine (cervical,

thoracic, and lumbar). The claimant received active medical treatment and, when released to return to work, had restrictions imposed on her physical activities. The credible evidence reflects that the claimant has remained symptomatic, attributable to the October 26, 2005, compensable injury since the occurrence of same.

On April 10, 2006, the claimant was released by her treating physician, Dr. Brent Sprinkle, D.O., who was selected pursuant to the directions of respondents, as having reached maximum medical improvement with a 0% impairment. Each of the physicians to render medical treatment to the claimant in connection with the October 26, 2005, compensable injury as of April 10, 2006, had been selected by respondents.

Of note regarding the April 10, 2006, release of the claimant by Dr. Sprinkle, is the fact that the impression of the claimant's injury was reflected as of the date of the release as lumbar sprain, lumbar myofascial pain, and lumbar somatic dysfunction. Further, the claimant was directed to continue use of the TENS unit "permanently". The claimant was provided a trigger point injection on the date of April 10, 2006, visit. Finally, the claimant was released to return to work with no lifting over 25 pounds, with the weight limitation restriction being increased by 10 pounds per week until "regular duty".

Although the claimant remained symptomatic in connection with the October 26, 2005, compensable injury following the April 10, 2006, visit to Dr. Sprinkle, respondents refused to authorize further medical treatment. The evidence reflects that the claimant's efforts to obtain a change of treating physician through the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission were thwarted by respondents' failure to respond. As a consequence of the afore, the claimant sought treatment under the care of her primary care

physician.

Ark. Code Ann. §11-9-508 (a) (Repl. 2002), mandates that the employer promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. The claimant must prove by a preponderance of the evidence that she is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a fact question for the Commission.

The evidence preponderates that the claimant remained symptomatic relative to her October 26, 2005, compensable injury on and subsequent to April 10, 2006. Even Dr. Sprinkle recommended continued use of the TENS unit permanently at the time of the April 10, 2006, final visit. Restriction of the claimant's lifting was in place at the time of the April 10, 2006, visit, and would continue for some time thereafter.

The respondents refused to authorize the claimant to return to the physicians who had treated her in connection with the compensable injury. Respondents' failed to respond to inquiry from the Medical Cost Containment Department regarding a change of treating physician, for all practical purposes, rendered the claim for further medical benefits controverted and the change of physician rules inapplicable.

There is no evidence in the record to reflect that the claimant engaged in activities that were negligent or contrary to the directions of her treating physician, with respects to the incidents away from work which resulted in an increase in her symptoms/complaints growing out of the October 26, 2005, compensable injury. *Davis v. Old Dominion Freight Line*, 69 Ark. App. 74, 13 S.W.3d 171 (2000). In the instant claim claimant sought medical treatment following the

April 10, 2006, visit to Dr. Sprinkle, however respondents refused to authorize same. When respondents refused to cooperate in the change of physician process of the Medical Cost Containment Department the claimant's only recourse was to seek medical treatment on her own. To the credit of the claimant, she sought the afore treatment under care and at the direction of her primary care physician and so notified the respondents. Medical treatment intended to reduce or enable an injured worker to cope with chronic pain may constitute reasonably necessary medical treatment. *Billy Chronister v. Lavaca Vault*, Full Workers' Compensation Commission, June 20, 1991 (D704562).

The evidence in the record preponderates that the medical treatment rendered to the claimant subsequent to April 10, 2006, to include that had under the care of her primary care physician, Dr. Timothy Hodges, and pursuant to the referral of same, as well as the December 22, 2007, emergency room visit, was reasonably necessary in connection to the claimant's October 26, 2005, compensable injury. Respondents have controverted the claimant's entitlement to medical benefits in connection with the October 26, 2005, compensable injury subsequent to April 10, 2006.

Temporary Total Disability Benefits

Entitlement to temporary total disability benefits for an unscheduled injury is contingent upon a showing that the claimant is completely incapacitated from earning wages and remains within her healing period. *Arkansas State Highway Department v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period is defined as that period for healing of an injury resulting from an accident. Ark. Code Ann. §11-9-102 (12). The healing period continues until the employee is as far restored as the permanent character of her injury will permit, when the

underlying condition causing the disability become stable and nothing further in the way of treatment will improve the condition. *Searcy Industrial Laundry, Inc. v. Ferren*, 92 Ark. App. 65, 211 S.W.3d 11 (2005).

The evidence preponderates that the claimant remains within her healing period relative to the October 26, 2005, compensable injury. The fact that respondents refused to authorized the claimant to obtain medical treatment subsequent to April 10, 2006, did not render her at the end of her healing period relative to the compensable October 26, 2005, injury. While asserting the claimant at maximum medical improvement as of the April 10, 2006, visit, the clinic notes of Dr. Sprinkle is self-evident that he anticipated further improvement in the claimant's condition in his progressive increase in the lifting activity and continue use of the TENS unit. More telling is the fact that as he was declaring the claimant at maximum medical improvement he had performed a trigger point injection.

Disability means incapacity because of compensable injury to earn, in the same or any other employment, the wages which the employee was receiving at the time of compensable injury. Ark. Code Ann. §11-9-102 (8). The claimant continued to require active medical treatment prior to the December 22, 2007, emergency room visit. The claimant was off work from December 22, 2007, through February 6, 2008, totally incapacitated from engaging in gainful employment and within her healing period. The claimant has sustained her burden of proof by a preponderance of the evidence that she was temporarily totally disabled for the period December 22, 2007 through February 6, 2008, and correspondingly entitled to appropriate workers' compensation benefits. Respondents have controverted the claimant's entitlement to temporary total disability benefits subsequent to April 10, 2006.

Ark. Code Ann. §11-9-520, Temporary partial disability, provides:

In case of temporary partial disability resulting in the decrease of the injured employee's average weekly wage, there shall be paid to the employee sixty-six and two-thirds percent (66 2/3 %) of the difference between the employee's average weekly wage prior to the accident and his or her wage-earning capacity after the injury.

The claimant left the employment of respondent-employer in October 2006, and later secure employment at St. Vincent Medical Center-North. The evidence reflects that while the claimant was directed to reduce the number of days that she worked to every other day beginning February 6, 2008, with shift differential and her current hourly wage rate her earnings are comparable to those at the time of the October 26, 2005, compensable injury. The claimant has failed to sustain her burden of proof by a preponderance of the evidence that she is entitled to the payment of temporary partial disability benefits subsequent to February 6, 2008.

AWARD

The respondents are herein ordered and directed to pay to the claimant temporary total disability benefits at the weekly rate of \$466.00, for the period December 22, 2007, through February 6, 2008, as a result of the October 26, 2005, compensable injury. Said sums accrued shall be paid in lump without discount.

Respondents are further ordered and directed to pay all reasonably necessary medical treatment in connection with the October 26, 2005, compensable injury of the claimant, to include treatment rendered to the claimant under the care and at the direction of her primary care physician, Dr. Timothy Hodges, to include the referral by same to Dr. Wayne Bruffett, and the December 22, 2007, emergency room, along with medical 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