BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G306906

JAQUANNA LAMBERT, Employee — CLAIMANT

ROGERS SCHOOL DISTRICT, Employer — RESPONDENT

ARKANSAS SCHOOL BOARD ASSOCIATION, Insurance Carrier/TPA — RESPONDENT

OPINION FILED APRIL 18, 2016

Hearing before ADMINISTRATIVE LAW JUDGE ERIC PAUL WELLS, in Springdale, Washington, Arkansas.

Claimant represented by JASON M. HATFIELD, Attorney, Fayetteville, Arkansas.

Respondents represented by CURTIS L. NEBBEN, Attorney, Fayetteville, Arkansas

STATEMENT OF THE CASE

On January 19, 2016, the above captioned claim came on for a hearing at Springdale, Arkansas. A pre-hearing conference was conducted on November 18, 2015, and a pre-hearing order was filed on November 18, 2015. A copy of the pre-hearing order has been marked Commission's Exhibit No. 1 and made a part of the record without objection.

At the pre-hearing conference the parties agreed to the following stipulations:

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

2. On all relevant dates, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to her low back on May 20, 2013.

4. The claimant's weekly compensation rates will be determined at a later time.

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

1. Whether claimant is entitled to medical treatment in the form of a dorsal column stimulator implant as recommended by Dr. Knox, Dr. Blankenship, Dr. Ennis, and Dr. Holt.

2. Whether claimant is entitled to temporary total disability benefits from August 20, 2015 to a date yet to be determined.

3. Whether the claimant's healing period ended on August 20, 2015.

4. Whether claimant's attorney is entitled to an attorney's fee.

The claimant's contentions are as follows:

> "Claimant sustained a compensable injury while working for respondent on or about May 20, 2013. At that time, claimant was in the course and scope of her employment when she incurred a low back injury.
>
> Dr. Luke Knox and Dr. James Blankenship have recommended a dorsal column stimulator implant for claimant, which has been controverted by the respondents. Since respondents refused the recommended medical treatment, Dr. Knox placed claimant at MMI, issuing a 15% whole body impairment."

The respondents' contentions are as follows:

> "Respondents contend that the treatment by way of spinal cord stimulator is unreasonable and unnecessary."

The claimant in this matter is a 31-year-old female who was employed by the respondent as a one-on-one aide for the Special Education Department of the respondent's school district when she sustained a compensable low back injury on May 20, 2013. At the hearing in this matter, the claimant gave direct examination testimony about how her compensable low back injury occurred as follows:

> Q. What happened on May 20th, 2013, to cause your injury?
>
> A. I had picked up my student and was taking him to the special education classroom to drop off his backpack and stuff, and he's a runner with a GPS system so I always have to make sure that he's within an arm's length. Normally we're supposed to hold his hand, so I was holding his hand as we were walking to the regular classroom and he just dropped suddenly.
>
> Q. And what age of a child was it?
>
> A. He's about nine.

The claimant underwent her first surgical intervention for her compensable low back injury in December of 2013. The claimant's intervention was performed at the hands of Dr. Luke Knox who is the claimant's authorized treating physician and a neurosurgeon. According to the discharge summary from Physicians Specialty Hospital in Fayetteville dated December 13, 2013, the claimant underwent an "L5-S1 anterior lumbar interbody fusion utilizing VersaMed stabilization and intraoperative fluroscopy along with spinal cord monitoring."

The claimant underwent an MRI of the lumbar spine "without and with IV Gobolinium" on January 20, 2014 at the request of Dr. Knox. Following is a portion of that diagnostic report found at Claimant's Exhibit 1, Pages 8 and 9:

> FINDINGS: At L4-t there is a central disc protrusion which obliterates the ventral CSF and flattens the ventral cord morphology. There is severe spinal canal stenosis of 5.5 mm in AP diameter. There is no extension of this disc material into the neural foramina, however.
>
> At T12-L1, L1-2, L2-3, and L3-4, the intervertobral discs are normal in signal and in height wit no disc bulge, protrusion or extrusion. The spinal canal and neural foramina are potent at those levels.
>
> At L5-S1, there is a desiccated and collapsed disc with no significant disc bulge, protrusion or extrusion. Anterior spinal fixation hardware is noted.
>
> There is no paraspinous mass evident. The conus is normal in signal and terminates at L1. The CSF and cauda equina are otherwise unremarkable. The visualized portions of the aorta and kidneys are unremarkable.
>
> IMPRESSION: At L4-5 there is a central disc protrusion which obliterates the ventral CSF and flattens the cord with sevore [sic] spinal canal stenosis of 5.5 mm in AP diameter.
>
> Report
> Postsurgical changes are noted at L5-S1.

The claimant continued to complain of back and leg pain and was referred by Dr. Knox to Dr. Jason Holt at Interventional Pain Specialists. She was seen by Dr. Holt on

February 26, 2014. A report from that visit is found at Claimant's Exhibit 1, Pages 10 and 11.

On April 9, 2014, the claimant was again seen by Dr. Knox. At that time Dr. Knox reviewed the January 20, 2014 post-surgical MRI of the claimant and gave the claimant an examination. Following are portions of that medical record found at Claimant's Exhibit 1, Pages 12 through 17.

> PLAN
> Medical Advice: Activity modification - as to avoidance act. Avoid cigarette smoke. Continue - back brace. Continue conditioning program. Contact the office if there are any problems. Patient's questions were answered. Discontinue physical therapy. Treatment options reviewed.
> Medication Notes: Continue with current medication.
> Work Status: unable to work.
> Comments: plan L4-S1 fusion and PLIF at 4-5.
> Impression: The surgical and non-surgical treatment options available for the management of the patient's spine problem were discussed. The details of lumbar disk surgery, including the potential risks, were discussed with the patient. Especially mentioned were infection, hemorrhage, anesthesia, transfusion, failure to help, worsening of symptoms, nerve and/or spinal cord injury causing numbness, weakness and/or paralysis of limbs, bowel and bladder control, pulmonary embolism causing cardiac arrest, recurrence at another level leading to reoperation, etc. All questions were answered. The patient requested that we proceed as advised.
>
> * * *
>
> HPI: Ms. Jaquanna Lambert was seen in the Neurosurgery Clinic for follow-up on 04/09/14. She has been found to have a large recurrent disc at the 4-5 level, which I believe to be related to her surgery with the L5-S1 stabilization done this past December. She was seen in January, and we noticed instability at the level above, which most definitely is related to the surgical stabilization of her lumbrosacaral junction. This was not present prior to the surgery.
>
> Unfortunately, she has been through the course of physical therapy, pain management, epidural steroids, time, etc. She is miserable with her complaints. She continues to be plagued with severe L5-S1 radiculopathy on the left that does go over to the right with any significant bending, lifting and stooping. There is no way she can return to her job duties.

> DISCUSSION/PLAN: I have recommended that she go ahead and start considering surgical avenues. I would recommend an extensive decompression at L4-5 with removal of the disc, reformation of the disc with PLIF spacer implant, pedicle fixation and stabilization of L4-5 and L5-S1. This would be done at Springdale with the Arcadis Orbic intraoperative navigation. She was counseled in detail. I showed her x-rays to her as well as the spine model, which demonstrates the L4-5 and L5-S1 pedicle fixation. I drew it out on her x-rays. She was counseled in detail concerning the risks and complications. She has failed an extensive conservative trial and is ready to consider surgical avenues.
>
> Thank you again for allowing us to take part in Jaquanna's care.

The claimant was sent by the respondent to Dr. James Blankenship for a second opinion of Dr. Knox's medication recommendations for additional surgical intervention. Following is a portion of Dr. Blankenship's second opinion review of the claimant:

> HPI:
> Patient is in today with her case manager to discuss what type approach Dr. Blankenship would do if he were to do her lumbar fusion. Patient states her pain complaints have not changed. She is now taking OxyContin and Oxycodone for her pain. She also just completed a steroid dose pack that did not give her any relief. Rates her pain today at 80% towards worse pain imaginable.
>
> * * *
>
> DIAGNOSIS:
> 722.10 Displacement Of Lumbar Interve Rtebral [sic] D
> 722.83 SPINAL CORD COMPRESSION LUMBAR REGION
> 724.2 LOW BACK PAIN - LUMBAGO/LUMBALGIA
>
> IMPRESSION:
> Ms. Lambert's worker's compensation carrier requested she get back in to see me. I had already seen her for an IME for a postsurgical intervention for Dr. Knox. As I indicated in my IME, I do think that a consideration of adjacent segment surgery is certainly warranted. I did also state in my report that I would approach this differently but that certainly does not mean the way that I approach it is the best way. It is just simply the way that I do it. I was very clear with Ms. Lambert on her IME that there is no spine physician in Northwest Arkansas or for that matter probably anywhere that I have more respect for than Luke Knox. I have told her that she is under excellent care with

> Dr. Knox and his proposal is valid and that if I ever needed to have back surgery, Luke Knox would be the person that would do it. Since he is in today for discussion of a different surgical approach, I did explain to her the way that I would approach this with a combined XLIF, posterior decompression with possible MAS PLIF pedicle screw fixation. I have explained the differences in surgical techniques with a posterior decompression and PLIF with pedicle screws compared to XLIF and I have also explained the reasons that I do the approach this way. I have explained to her that there are risks Inherent with the XLIF that are not present with the posterior approach, namely psoas [sic] weakness, which in my current clinical experience of over 450 XLIFs is less than one quarter of 1 percent to be present after six months. There is an inherent risk of possible lateral nerve root injury, but this is also present with the posterior approach, and I think that at least in my clinical experience of almost 30 years, it is about the same. I told her the reason that I approach the spine from this way has to do with bi-apophyseal placement of the implant with stability and then it minimizes the amount of surgical exposure needed posteriorly. After a lengthy discussion of the differences of surgical approaches, we left the visit as such.
>
> Diagnostic/Lab:
> Diagnostic Center of your choice
> XRAY LUMBAR SPINE AP/LAT/FLEX/EXT

The claimant underwent a second surgical intervention at the hands of Dr. Knox on June 24, 2014. Dr. Knox performed the following procedures:

> PROCEDURE: L4-L5 posterior lumbar interbody fusion, status post anterior lumbar fusion with stabilization from L4-S1. This was done with intraoperative fluoroscopy and spinal cord monitoring.
>
> CONSULTS: Pain management.
>
> * * *
>
> HOSPITAL COURSE: On June 24, 2014, Ms. Jaquanna Lambert was admitted to Northwest Medical Center, Springdale for the above procedure which she tolerated without complication. She was taken to recovery room and into the floor for postoperative convalescence. Immediately upon arriving at the floor, she began having severe low back pain. She was actually ridling in pain. Pain management was consulted for assistance with her pain control and they evaluated her and changed her medication. It was determined at that time, she needed some more closely watched care and she was transferred back from 2400 floor down to the SICU. During her time on the floor, she was given everything from

> Nucynta to morphine to Demerol to Dilaudid, PCA, Valium, Soma, Flexeril and none of these medications seem to improve her condition. After transfer to the SICU, she was given a dose of Phenagran which immediately calmed her down and improved her overall pain. She was later transferred back to the floor and was followed by pain management. She denied any leg pain and continued to be afebrile and vital signs were all stable. She is very slow to mobilize, but on June 28, 2014, she was ready for discharge home. She was given instructions regarding possible signs of infection along with postoperative restrictions. She was given a appointment to follow up in 2 to 3 weeks with Dr. Knox in clinic. She was also to put in touch with Dr. Regina Thurman, clinic for follow up for pain management. Prescription for pain were provided by Dr. Regina Thurman service.

The claimant continued to have difficulties after her second surgical intervention that included bilateral leg pain. Dr. Knox continued the claimant on medications and initiated a course of physical therapy. Due to the claimant's ongoing symptoms, Dr. Knox ordered an ongoing MRI of the lumbar spine that was conducted on December 22, 2014. Following are the findings and impression portion of that diagnostic report:

> FINDINGS:
> The spinal cord ends at the L1 level and is normal in appearance. The lumbar vertebral bodies from T11 through the sacrum show no pathological intestities, other than postoperative changes.
>
> T11 through L3-4 show normal intervertebral disc spaces. The neural exit foramina are patent. There is no disc herniation or stenosis.
>
> The L4-5 level shows laminectomy and fusion both anteriororly and posteriorly. There is no evidence of stenosis or recurrent disc herniation. The neural exit foramina are patent.
>
> The L5-S1 level shows an anterior fusion, as well as pedicle screws posteriorly. There is a laminectomy on the right. There is no evidence of recurrent disc herniation or neural exit foraminal narrowing.
>
> The administration of intravenous contrast produced no pathologic enhancement.
>
> IMPRESSION:

> 1. Laminectomy and fusion at L4-5. Pedicle screws are seen posteriorly and there is an interbody fusion device anteriorly. There is no evidence of recurrent disc herniation or stenosis.
>
> 2. The L5-S1 level shows a right laminectomy, pedicle screws, and anterior fusion. There is no evidence of recurrent disc herniation or stenosis.

The claimant was seen by Dr. Holt on January 29, 2015 regarding her continuing pain and difficulties. Following is a portion of that medical record:

> History of Present Illness:
> Painful area(s); back, leg
> Progress in treatment: presents for treatment
> Pain description: lower back pain radiating into left leg
> Average activity level since last visit: unchanged/worse
> Jaquanna presents today by recommendation of Dr. Knox to return to trial epidural injection therapy. Since her surgery, her pain continues to radiate to her left leg and into last 2-3 toes. She continues to use OxyContin, Percocet, Cymbalta, and gabapentin. Will return to Dr. Knox in March. She has been released to light duty, although not able to perform. She is currently still off duty.
>
> * * *
>
> Young woman with hx of issues with back and leg pain, had discectomy in 2005 with good response to pain, but had resurgence of pain after incident at school with child pulling on her arm with jerking/twisting injury. MRI showing post (fusion) with Dr. Knox on the 24th of June and pain is unfortunately progressively worsening. She has completed round of PT at TS w/some benefit. Visited with Dr. Knox in early January and obtained new imaging, which shows fusion to be stable. He has recommended to continue epidural injection. He may consider removing hardware at 2 year mark and SCS trial. Today her pain presents in an S1 pattern on the left. Will treat there today, have approval with workman's comp. Plan to see her back in a month. If not seeing improvement, will consider moving towards SCS.

The claimant was again seen by Dr. Holt on February 26, 2015. Following is a portion of that report:

> Young woman with hx of issues with back and leg pain, had discectomy in 2005 with good response to pain, but had resurgence of pain after incident at school with child pulling on arm with jerking/twisting injury. MRI showing post fusion at L5/S1 with NEW L4/5 disc herniation, somewhat severe. She had surgery (fusion) with Dr. Knox on the 24th of June and pain

> is unfortunately progressive worsening. She has completed round of PT at TS w/some benefit. Visited with Dr. Knox in early January and obtained new imaging, which shows fusion to be stable. Began repeat series of injections last month. Minimal benefit from LTF (10%). Pain continues in left leg, back. Will switch approach to caudal today, but strongly consider SCS discussion next visit if still poor improvement. Will give SCS info today for her review.

On March 13, 2015 the claimant was seen by Dr. Knox with a chief complaint of low back pain. Dr. Knox noted in his report the recommendations from Interventional Pain Specialists of a spinal cord stimulator. The plan portion of the medical record under the subheading "Comments" states "Comments: Consider DCS."

On April 29, 2015 the claimant was seen by Dr. Richard Back, a clinical psychologist at Northwest Arkansas Psychological Group. Following are portions of the medical record from that visit found at Respondent's Exhibit 1, Pages 152 through 154:

> PERTINENT HISTORY: "It (injury) happened at the end of May 2013, I think. I'm a one on one aid for a child with Down's Syndrome. That day we were leaving the room holding his hand and he just dropped on me. I didn't report it at first, I'd had back surgery a couple years earlier. It kept hurting so I started seeking Dr. B. Tried cortisone shots. Didn't get any better so they sent me to see Dr. Knox. He recommended physical therapy. Did that until August when I went bac to work a few days. Still hurting, so we went back to Dr. Knox. More physical therapy. No better so Knox did fusion in December 2013. It wasn't a week later I was having a lot of pain. Another MRI showed disc above had ruptured. More physical therapy, epidural injections. Doctors Holt and Enis. Then workers' comp sent me for another opinion. Dr. Blankenship explained how he would do it differently. Decided to go with Dr. Knox. He fused the disc above, it had ruptured. That's helped sharp pains in the back. I still have sciatica. More epidural injections." Currently, left leg goes numb at times and "foot especially." A spinal cord stimulator is being considered at this time. Her understanding is that it's electrical and blocks pain signal to the brain. "First, there'd be temporary placement, one week. Then permanent one. They said my leg will get relief. I think up to 70% pain relief. I know it won't take away pain 100%. Risks include those during surgery and wound care. Afterwards, simulators might need to be repositioned."
>
> Ms. Lambert gets temporary relief by changing positions frequently. Ice helps "sometimes."

* * *

RECOMMENDATIONS:
1. In view of patient's elevated Paindex Score (15), she is a poor surgical candidate for pain relief. Only 15% of patients with this score respond favorable to surgery. There are too many psychological factors.

On June 18, 2015, the claimant was again sent by the respondent to Dr. James Blankenship for a second opinion regarding her dorsal or spinal column stimulator. Following are portions of Dr. Blankenship's medical record:

HPI:
Patient is in today for a independent medical evaluation. She had her lumbar fusion with Dr. Knox. States she did get any relief with her surgery. She continues to have low back pain but this is much improved since surgery. Her greatest pain is posterior left leg pain. She sees Dr. Ennis/Holt for pain management. They recommend a dorsal column stimulator. Dr. Knox agrees that they may be of benefit. She is in today for evaluation and placement for the DCS.

* * *

LUMBAR SPINE: Inspection of the thoracic spine reveals surgical scar well healed. Range of motion is restricted with flexion limited because of due to pain and extension limited because due to pain. Gaenslen's was negative. Stretch of the piriformis was negative. Straight leg raising test is positive on the left side. FABER test is negative. Pelvic compression test is negative. Distraction test was negative. Thigh thrust was negative.

* * *

Diagnosis:
722.83 SPINAL CORD COMPRESSION LUMBAR REGION

Impression:
The patient was referred back in to see me for an independent medical evaluation by Workers' Compensation. The patient had originally seen me for an IME in May 2014. I at that time agreed with Dr. Knox to proceed on with surgical intervention, which she underwent on 06/24/2014. The patient underwent a decompressive laminectomy at L4-L5 with implantation and pedicular fixation at L4-L5 and L5-S1. The patient had significant improvement in her mechanical lower back pain postoperatively. The patient had persistent radicular pain, however, and has an MRI postoperatively that does not show any residual compression. Patient sees Dr. Ennis and Dr. Holt for pain management who recommended a dorsal column

stimulator trial. Dr. Knox agreed to proceed on with this. The patient has a functional capacity evaluation that demonstrated 45/45 consistency measures, which is very beneficial, as far as looking at the possible benefit from a dorsal column stimulator. The problem with her approval comes from her psych evaluation that was done by Richard Back. Dr. Back felt that she was a poor surgical candidate for pain relief, based on her elevated pain index score. He stated there were too many psychological factors involved. This independent medical evaluation was then proceeded to me for evaluation on what I would recommend from a standpoint of the possibility of performing a dorsal column stimulator on the patient.

The patient's general, physical and neurologic examination are unchanged from my visit with her original IME. Her structural radiographs look good and I have looked at her postoperative MRI that shows good neural decompression.

* * *

Recommendations:

High blood pressure counseling. Counseled patient on controlling high blood pressure. Recommended consulting with PCP.

Spent a long time talking with her and discussing what I would recommend to her if she were in fact my patient. I have told her first of all I have known Richard Back for a long, long time, and he does an excellent neuropsychological evaluation. It is very rare that I feel like it probably should not be the last word on these situations, but there are several factors involved in this that lend me to recommend that so go ahead and agree that a dorsal column stimulator trial is reasonable and these are as follows:

The patient had excellent resolution of her mechanical lower back pain with surgery. Since she has only leg pain this is a much more amenable treatment with the dorsal column stimulator electrode trial. We will also have a trial period, which is much more beneficial in patients dealing with leg pain, to see if she gets any benefit.

The patient gave 45/45 positive consistency measures with her functional capacity evaluation. If there had been any evidence of any inappropriate illness behavior in this fact I probably would be on the other side of the fence, but given the fact that she did give full effort, I feel like it is reasonable.

This is the second change that I have had the opportunity to meet the patient. She does not appear to be overly depressed, and I get absolutely no indication that there is any secondary gain involved. She could very well have some degree of inappropriate illness behavior, but patients that have had chronic pain almost always do.

> In summary, although the patient does not have a good clearance from her neuropsychological evaluation, I think in this very isolated event that I would agree with Dr. Knox at proceeding on with a dorsal column stimulator trial as a reasonable thing to do based on the data I have been provided.

On June 19, 2015, the claimant was again seen by Dr. Knox. In this report, Dr. Knox gives the following plan for the claimant's continued difficulties:

> PLAN
> Medical Advice: Activity modification - as tol
> avoidance act. Avoid cigarette smoke. Continue - back brace. Discontinue - back brace. Discontinue conditioning program. Contact the office if there are any problems. Patient's questions were unanswered. Discontinue physical therapy.
> Medication Notes: Continue with current medications.
> Schedule Follow-up: in 1 year
> Impression: 1 Yr po
> still with po sciatica
> needs DCS
> see report.

On that same date, Dr. Knox issues an off-work slip for the claimant and states, "Ms. Jaquanna Lambert is under my care and should remain off work until she can receive a spinal cord stimulator. If you have any questions please feel free to contact me at . . .." That record is found at Claimant's Exhibit 1, Page 59.

On August 17, 2015 the claimant was again seen by Dr. Holt of Interventional Pain Specialists. At that time Dr. Holt indicates that the spinal cord stimulator has been denied by workers' compensation and states, "She is miserable and hurting all day, unable to control pain w/current regimen." He also states:

> Young woman with hx of issues with back and leg pain, had discectomy in 2005 with good response to pain, but had resurgence of pain after incident at school with child pulling on her arm with jerking/twisting injury. MRI showing post fusion at L5/S1 with NEW L4-5 disc herniation, somewhat severe. She had surgery (fusion) with Dr. Knox in 6/2014 and pain is unfortunately progressively worsening. Returns today w/severe uncontrolled pain. She is ready to pursue SCS, unfortunately has been denied by WC. She has obtained a lawyer to help appeal for this procedure. Medications have

> become inadequate, providing little benefit. Would like for her to discontinue gabapentin and start lyrica 75 mg BID, may increase dosage next visit. Trying to avoid opiate increase at this time.

On August 20, 2015 Dr. Knox authors a letter "TO WHOM IT MAY CONCERN." Following is the body of that letter:

> Ms. Lambert has been followed in the Neurosurgery Clinic dating back over the last two years. She originally underwent an anterior lumbar interbody fusion in December of 2013, and the later underwent lumbosacral fusion from L4 through S1 in June of 2014. Postoperatively, it was completed with persistent, non _____ Sciatic complaints.
>
> She has reached that point of maximum medical improvement. According to the *Guides to the Evaluation of Permanent Impairment*, Fourth Edition, Page 113, Table 75-IV, she would qualify for a 12T permanent partial disability to the body as a whole. Added to this for the extra level would be 1% per level, as well as 2% for a second operation, for a total of 15% permanent partial disability to the body as a whole.
>
> Again, Ms. Lambert is over one year status post extensive reconstructive spine surgery. According to the *Guides to the Evaluation of Permanent Impairment*, Fourth Edition, she would qualify for a 15% permanent partial disability to the body as a whole, this being derived from Page 113-IV, Section D, with added percentage levels "E" along with a second operation.
>
> If you have any further questions, do not hesitate to contact me.

On September 2, 2015 the claimant's attorney authors a letter to Dr. Knox. Following is the body of the letter:

> Dear Dr. Knox:
>
> I have recently been hired by Jaquanna Lambert to help with her Workers' Compensation claim. In reviewing your records and Dr. Blankenship's records, you both have recommended a dorsal column stimulator for her.
>
> I assume you believe that the dorsal column stimulator is medical treatment that will improve her work related condition.

> Unfortunately, the insurance carrier has quit making any payments to Miss Lambert based upon her being at "maximum medical improvement." It appears that you expressed that opinion only after they refused the dorsal column stimulator. Therefore, I ask that you answer this question:
>
> > Do you believe the recommended dorsal column stimulator is reasonable and necessary medical treatment that is reasonably likely within a reasonable degree of medical certainty to improve Ms. Lambert's work related injury?
> >
> > Yes _____ No _____

Dr. Knox responded September 3, 2015 with an "x" marked next to the response "Yes".

On October 23, 2015 the claimant's attorney also authored a letter to Dr. Jason Holt. Following is the body of that letter:

> Dear Dr. Holt:
>
> I have recently been hired by Jaquanna Lambert to help her with her Workers' Compensation claim. In reviewing Dr. Knox's records and Dr. Blankenship's records, they both have recommended a dorsal column stimulator for her.
>
> I assume you believe that the dorsal column stimulator is medical treatment that will improve her work related condition. Unfortunately, the insurance carrier has quit making TTD payments to Miss Lambert based upon her being at "maximum medical improvement." Dr. Knox expressed that opinion only after they refused the dorsal column stimulator. Dr. Knox believes the stimulator will improve Ms. Lambert's work injury, and I have attached a copy of that opinion. Do you agree with Dr. Knox? If so, please answer this question:
>
> > Do you believe the recommended dorsal column stimulator is reasonable and necessary medical treatment that is reasonably likely within a reasonable degree of medical certainty to improve Ms. Lambert's work related injury?
> >
> > Yes _____ No _____

Dr. Holt also responded to that letter in handwriting with an "x" indicating "Yes", in a response which was dated October 26, 2015.

The central issue in this matter is whether or not the claimant is entitled to a spinal or dorsal column stimulator implant. It is the claimant's burden to prove that a spinal or dorsal column stimulator implant is reasonable and necessary medical treatment for her compensable low back injury. It is clear from the medical records that have been submitted into evidence that both Dr. Knox and Dr. Holt fully support the claimant's treatment in the form of a spinal or dorsal column stimulator implant. However, the respondent chose to send the claimant to Dr. Blankenship for a second opinion. Dr. Blankenship reveals in his medical records that he is also supportive of this spinal or dorsal column stimulator. I note that both Dr. Knox and Dr. Blankenship are both highly qualified neurosurgeons and I believe their opinion should be given great weight. The only doctor to disagree with the recommendation of a spinal or dorsal column stimulator implant is Dr. Back, a psychologist. I have reviewed Dr. Back's deposition which was taken on January 12, 2016. While Dr. Back gave insightful deposition testimony, I feel that it falls short in that we have two neurosurgeons and a pain specialist that continue to recommend a spinal or dorsal column stimulator implant over and above Dr. Back's recommendation. As such, I find that the claimant has proven by a preponderance of the evidence that the spinal or dorsal column stimulator is reasonable and necessary medical treatment for the claimant's compensable injury.

The claimant has also asked the Commission to decide whether or not she is entitled to temporary total disability benefits from August 20, 2015 to a date yet to be determined. It is clear that Dr. Knox removed the claimant from work at that time until she received her spinal or dorsal column stimulator. I agree with Dr. Knox that the claimant is unable to perform employment services until such time. Given the medical reports and the claimant's level of pain, it seems that she would be unable to work until such time. As such, the respondent shall be responsible for the payment of temporary total disability

benefits from Dr. Knox's August 20, 2015 off-work note until such time that she receives a spinal or dorsal column stimulator.

The claimant has also asked the Commission to consider whether or not her healing period ended as of August 20, 2015. Given the fact that the claimant has not resolved her course of treatment and that at least some form of surgical intervention, which includes the implementation or a spinal or dorsal column stimulator, is still before her, I find that the claimant has not reached the end of her healing period as of August 20, 2015.

From a review of the record as a whole, to include medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witness and to observe her demeanor, the following findings of fact and conclusions of law are made in accordance with A.C.A. §11-9-704:

FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The stipulations agreed to by the parties at the pre-hearing conference conducted on November 18, 2015, and contained in a pre-hearing order filed that same date, are hereby accepted as fact.

2. The claimant has proven by a preponderance of the evidence that a spinal or dorsal column stimulator is reasonable and necessary medical treatment for her compensable injury.

3. The claimant is entitled to temporary total disability benefits from August 20, 2015 until the claimant receives a spinal or dorsal column stimulator.

4. The claimant has proven by a preponderance of the evidence that her healing period did not end on August 20, 2015.

5. The claimant's attorney is entitled to an attorney's fee in this matter commensurate with the benefits awarded herein and the Arkansas Workers' Compensation Act.

ORDER

The respondents shall be responsible for the costs associated with the implementation and after care of a spinal or dorsal column stimulator for the claimant. They shall also pay the claimant temporary total disability benefits from August 20, 2015 until such time as that spinal or dorsal column stimulator is implanted into the claimant.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the 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 pursuant to Ark. Code Ann. §11-9-715.

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.

If they have not already done so, the respondents are directed to pay the court reporter, Veronica Lane, fees and expenses within thirty (30) days of receipt of the invoice.

IT IS SO ORDERED.

ERIC PAUL WELLS
ADMINISTRATIVE LAW JUDGE