

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F105594

LINDA KAY JOBE,
EMPLOYEE

CLAIMANT

ST. VINCENT NORTH/SHERWOOD,
EMPLOYER

RESPONDENT

PREFERRED PROF. INSURANCE,
INSURANCE CARRIER

RESPONDENT

OPINION FILED MAY 27, 2005

Upon review before the FULL COMMISSION in Little Rock,
Pulaski County, Arkansas.

Claimant represented by the HONORABLE PHILIP M. WILSON,
Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE WALTER A. MURRAY,
Attorney at Law, Little Rock, Arkansas.

Decision of administrative law judge: Affirmed as modified.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion, which was originally filed on July 7, 2004, and amended on December 13, 2004. In said opinions, the administrative law judge found in relevant part, among other things that, "The claimant was temporarily totally disabled for the period beginning May 2, 2001, and continuing through the end of her healing period, a date yet to be determined."

In addition to this, the administrative law judge found that "The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of April 26, 2001."

After reviewing the entire record *de novo*, the Full Commission affirms as modified the opinion of the administrative law judge.

I. History

The claimant, age 41, began working for the respondent/ employer on October 30, 2000, as a licensed practical nurse. On April 26, 2001, the claimant sustained an admittedly compensable injury to her lower back, while working for the respondent as she attempted to lift a paralyzed patient. The claimant reported the incident to the charge nurse, and went home, thinking that she had only pulled a muscle. Prior to her compensable injury, the claimant denies having been treated for any serious back problems, but she does admit to having suffered some lumbar strains, but nothing serious.

According to the claimant, she returned to work the following workday and worked only a partial day before her supervisor had to send her down to the respondent's

emergency room, (at St. Vincent's Hospital in Sherwood) for treatment. The claimant was given Lortab 10, and released for follow-up care with Dr. Richard McCarthy, an orthopedic surgeon.

On May 15, 2001, the claimant underwent initial evaluation with Dr. McCarthy due to continued complaints of severe back pain. At that time, Dr. McCarthy reported that an MRI that had been brought in by the claimant which showed "a herniated disc at L5-S1, centrally placed and slightly to the right." As a result, Dr. McCarthy diagnosed the claimant as having "a central herniated disc at L5-S1," for which he recommended a course of treatment with epidural steroids and physical therapy.

A further review of the medical notes show that on May 30, 2001, the claimant was initially seen by Dr. Yeshwant Reddy, pursuant to a referral from Dr. McCarthy for the administration of a lumbar epidural steroid injection, which was done. Also, on June 19, 2001, the claimant underwent trigger-point injections with Dr. Reddy. At which time, Dr. Reddy's impression was "L5-S1 central herniated nucleus pulposus, secondary lumbosacral myofascial pain, and rule out bilateral lumbosacral radiculopathy."

In a letter dated July 3, 2001, Dr. Reddy reported the following to Deborah Watson, a claims adjuster for AIMS Health Initiative:

It is my professional opinion that this patient suffered the central disc herniation at L5-S1 secondary to her job-related activities. At present, she is under my care for the same.

On July 5, 2001, the claimant underwent an electrodiagnostic evaluation pursuant to orders from Dr. Reddy for the requested purpose of assessing her low back pain and associated lower extremity radicular symptoms. This study was abnormal, as it revealed electrophysiologic evidence with the following:

In conclusion, there was electrodiagnostic evidence of a subacute to chronic left L5 radiculopathy with established but as of yet incomplete reinnervation of the affected muscles sampled. There was no electrodiagnostic evidence of an acute or chronic right lumbar radiculopathy, right or left sided lumbar plexopathy, peripheral polyneuropathy affecting the lower extremities or myopathy.

The claimant was next seen by Dr. Reddy on July 25, 2001 due to continued complaints of low back and bilateral leg pain (with the left leg pain being greater than the right leg pain), for which he administered a lumbar epidural steroid injection. In addition, on August 14 and 29, 2001,

the claimant underwent L5-S1 lumbar epidural steroid injections, which were also performed by Dr. Reddy.

On September 18, 2001, Dr. Reddy reported that he had reviewed the claimant's MRI from May 3, 2001. He further reported that the claimant had "L5-S1 HNP slightly more towards the left side and degenerative disc changes at L3-4." His impression was L5-S1 central HNP and L3-4 degenerative disc disease. Since the claimant had not responded to conservative treatment, Dr. Reddy recommended that she undergo a lumbar provocative discogram.

On November 7, 2001, Dr. Reddy performed a lumbar discography at L3-4, L4-5 and L5-S1, which revealed the following:

IMPRESSION:

1. Valid abnormal study.
2. L3-4 revealed 8/10 discordant pain with a (low back pain) with a posterior annular tear.
3. L4-5 was normal-no pain.
4. L5-S1 revealed a complete posterior annular tear with 10/10 concordant low back and left leg pain. The dye was seen only in the anterior epidural space. Minimal dye was seen in the center of the disc space. The tip of the needle was in the center of the disc.

There was a central left sided disc herniation, which was noncontained at L5-S1.

On November 20, 2001, Dr. Reddy reported that the discogram had now confirmed that the claimant's L5-S1 herniated nucleus pulposus was the offending agent. Therefore, Dr. Reddy referred the claimant back to Dr. McCarthy for consideration of surgical options, as she had failed conservative treatment, including medication management, physical therapy, and a series of epidural injections.

The claimant underwent an MRI lumbar spine without contrast on March 14, 2002, which revealed the following:

IMPRESSION:

Degenerative disk disease at L3-4 and L5-S1 with a central disk herniation at L5-S1 causing mass-effect on the bilateral S1 nerve roots.

Therefore, pursuant to the aforementioned diagnostic findings, the claimant underwent surgery under the care of Dr. McCarthy, on March 21, 2002, in the form of posterior spinal fusion at L5-S1 with instrumentation. The claimant tolerated this procedure without difficulty, and on March 23, 2002, she was discharged home and directed to return to the office for a follow-up evaluation in six weeks. However, prior to this time, on April 10, 2002, the claimant was seen on an emergency basis due to concerns about her

wound, as she had some swelling, redness, and fluctuance around the incisional site, from which approximately 120 cc of dark red bloody aspirate was obtained.

On April 25, 2002, the claimant was seen by Dr. McCarthy for regular follow-up care after her surgery. At that time, the claimant had some recurrence of swelling in her low back. Dr. McCarthy reaspirated the right graft site area, which yielded approximately 70 cc of serosanguineous looking material, which did not appear infected, but it did not appear to be clear.

Although prior to having surgery the claimant had right leg pain; after her surgery, she had right leg pain that was somewhat different than before surgery. Specifically, on July 3, 2002, the claimant was seen and evaluated by Dr. McCarthy, at which time, she reported continued symptoms of burning in her right foot and bilateral buttock region, as she described this pain as stinging. Dr. McCarthy reported that the claimant had tried heat, ice, and Neutrontin, without relief, as her post operative pain appeared to be getting worse. As a result, Dr. McCarthy ordered an MRI of the lumbar spine to evaluate her pain, which was performed on July 8, 2002, and it revealed the following:

IMPRESSION:

Degenerative disk disease at the L3-4 level. At this level there was minimal diffuse bulge of the disk. There were postoperative changes at the L5-S1 level including placement of pedicle screws and evidence for anterior fusion. I do not see evidence for recurrent or residual disk herniation at this level. There was evidence for a very small postoperative fluid collection posterior to the thecal sac at this level. This measures approximately 1 ½ x 1 by ½ cm in size. This finding most likely represents a small postoperative seroma. There was evidence for a larger post-op fluid collection which lies between the subcutaneous fat and paraspinal muscle just to the right of the midline. This extends from the L5 level to the sacrum. This fluid collection measures 8 cm in length x 2.3 cm in AP diameter x 3 cm in transverse diameter. This again most likely represents a simple post-op seroma. However, based solely on the MRI findings it would be difficult to exclude a [sic] infected fluid collection.

Therefore, based on these findings, Dr. McCarthy referred the claimant back to Dr. Reddy for further evaluation and treatment of her pain and related symptoms. On July 18, 2002, after physically examining the claimant and reviewing the results of diagnostic testings, Dr. Reddy's impression was "Status post L5-S1 fusion with ongoing right leg pain, rule out bilateral lower extremity deep venous thrombosis (DVT), and right S1 radicular pain/neuropathic pain." As a result, Dr. Reddy recommended bilateral lower extremity Doppler studies to rule out DVT,

which were done. However, no evidence of DVT in the left or right lower extremity was revealed. In addition to this, Dr. Reddy also recommended a myelogram to rule out if there was any dural tear.

On July 31, 2002, the claimant underwent an x-ray lumbar spinal puncture and lumbar myelogram pursuant to orders from Dr. Reddy, which revealed the following:

Impression:

The patient has had a fusion procedure at L5-S1 using pedicle screws, paired intervertebral fusion components and bony fusion masses bilaterally. At this time the fusion does not appear to be completely dense. I do not see any evidence of nerve root displacement or other signs of disc herniation. I do not see an etiology for the right leg radiculopathy.

Further review of the medical evidence of record shows that on August 21, 2002, Dr. Reddy administered a right S1 transforaminal epidural steroid injection after having diagnosed the claimant with "post laminectomy syndrome with right leg radicular pain."

On September 5, 2002, the claimant was seen by Dr. Reddy for follow-up treatment due to right buttock and leg pain. Dr. Reddy's impression was "right iliac crest graft sit pain, most likely due to cluneal nerve neuropathy," for which he recommended diagnostic blocks of the cluneal nerves

followed by cryotherapy. At that time, Dr. Reddy advised the claimant of his relocation from Little Rock and recommended that she seek these procedures from his colleague, William Ackerman.

However, instead of seeing Ackerman, at the request of the respondent, on September 19, 2002, the claimant underwent initial evaluation and treatment for lower lumbar pain with Dr. Bruce Safman. His impression was "failed back syndrome, possible residual right S-1 radiculopathy," for which he administered a trigger point into the lower lumbar paravertebral muscles, and he also injected the periarticular structures of the right hip, which were extremely tender.

Subsequently, on October 3, 2002, the claimant reported to Dr. Safman that she was in a great deal of pain and that the trigger point injection did not help. In addition to this, the claimant reported that she had begun developing paresthesias in the toes of both feet.

On October 14, 2002, Dr. Safman reported that he had done an EMG and nerve conduction studies that had demonstrated "fairly marked, bilateral, tarsal tunnel syndrome."

Dr. McCarthy reported on October 30, 2002 that pursuant to x-rays, he did not see a posterior solid fusion. Therefore, Dr. McCarthy ordered an MRI to see if there were any signs of infection or if there was something going on with the nerve root.

An MRI of the lumbar spine taken on November 5, 2002 with and without contrast, which revealed the following:

IMPRESSION:

Postoperative changes at L5-S1. Fluid collections seen previously have diminished in size. The large fluid collection in the deep subcutaneous space has completely resorbed. There was a small fluid collection adjacent to the thecal sac to the left of midline posterior to L5. This fluid collection is slightly smaller on the current exam. There was no evidence for a direct communication between this fluid collection and the thecal sac.

Postoperative changes in the disk space at L5-S1 consistent with prior fusion. Posterior stabilization by pedicle screws and interlocking vertical bars.

The claimant continued under treatment with Dr. Safman due to continued complaints of back pain, and on December 12, 2002, he recommended that she see Dr. Steven Kulik, as she still had a very positive Tinel's sign over the posterior tibial nerve of both ankles, and she was still reporting a great deal of foot and ankle pain.

Therefore, on December 19, 2002, the claimant underwent initial evaluation with Dr. Kulik for bilateral foot pain. At that time, Dr. Kulik assessed the claimant as having, "bilateral tarsal tunnel syndrome," and he stated that she may be having some component of referred pain from her back. Moreover, Dr. Kulik reported that he felt that the claimant's tarsal tunnel was directly related to her back problem, which was from her original injury, for which he recommended that the claimant undergo left tarsal tunnel release.

The respondent accepted this condition as a natural consequence of the claimant's compensable back injury and paid the appropriate benefits. As such, the claimant underwent left tarsal tunnel release on December 26, 2002, with Dr. Kulik.

On February 19, 2003, Lynn McCullough, a registered nurse practitioner, who works in association with Dr. McCarthy reported that the claimant was seen by Dr. McCarthy due to resulting symptoms from her posterior spinal fusion at L5-S1. At that time, Nurse McCullough reported that the claimant's range of motion had improved and that she was not complaining of a lot of pain. Nurse McCullough further

reported that the standing AP and lateral x-rays of the lumbar spine showed the claimant to have good fusion posteriorly. However, Dr. McCarthy did not believe that the claimant was at maximum medical improvement yet, but he felt that at her next visit she would have reached this. As such, the claimant was scheduled for a return visit within six months. According to notations on this progress report, although Nurse McCullough was the reporting party, the claimant was seen and evaluated by Dr. Richard McCarthy, who determined her plan of care.

In response to a fax that had been forwarded to Dr. McCarthy by Sally Paulsen, a claims representative for the respondent, on March 7, 2003, he wrote in relevant part the following.

....Ms Jobe was recently reevaluated in the office, and at this time I do feel she could return to a part-time sedentary position. While she has not had a formal functional capacity evaluation performed, I feel that she should be able to sit for approximately 20 minutes with the ability to change positions at will. Her other restrictions remain; however, she may be able to walk greater than the 20 yards of last report.

On March 31, 2003, Dr. Kulik assessed the claimant with "postop tarsal tunnel, no significant improvement and

continued low back pain." In addition to this, Dr. Kulik reported:

RECOMMENDATION:

1. Ms. Jobe has reached maximum medical improvement. She does have permanent restrictions, minimal activity.
2. Follow up with Dr. McCarthy since she is still continuing to have back problems.

The claimant also continued under treatment with Dr. Safman for her lower lumbar pain and related symptoms without very much relief until May 1, 2003. At which time, Dr. Safman reported in relevant part, the following:

The patient has had surgery on her back. She has failed back syndrome. I suspect depression is playing a significant role in her symptomatology. In so far as I not know her prior to her surgery, I am not certain as to whether depression was a pre-existent or a response to her pain. Her only objective findings are the fact that she had pathology that lead [sic] to surgery, which would give her a 10% disability rating. She is at maximum medical improvement but require medication maintenance because of the severity of her pain.

The claimant was seen for follow-up care on August 6, 2003, with Dr. McCarthy, at which time, x-rays were taken. Although Dr. Terrance Walker dictated the progress notes of this date for Dr. McCarthy, it is stated on these notes that claimant was seen and examined with Dr. McCarthy, who formulated the impression and plan. Specifically, Dr.

McCarthy reported that "X-rays showed maintained hardware with good alignment of the motion segment at L5-S1. Ferguson view, however, shows that she may not have completely consolidated the interbody fusion at that level." Therefore, Dr. McCarthy ordered a repeat MRI and CT scan of the L5-S1 segment with reconstructions in the sagittal plane to evaluate for evidence of a pseudoarthrosis.

On September 11, 2003, the claimant underwent a CT lumbar spine without contrast due to continued bilateral leg pain and buttock pain, which revealed the following:

Impression:

No evidence of disk herniation from L3-4 through L5-S1. Previous anterior and posterior column fusion at L5-S1. No evidence of a foraminal stenosis.

An MRI of the lumbar spine was also performed on September 11, 2003, which showed:

Conclusion:

Status post anterior and posterior fusion L5-S1 with pedicle screw fixation. No evidence of significant residual or recurrent focal disk herniation. No neural impinging lesion were seen.

Addendum: Also noted was mild disk bulging at L3-4 and moderately severe facet osteoarthritis at L4-5.

The respondent accepted the claimant's back injury and resulting tarsal-related problems as compensable, and paid appropriate medical benefits until September 15, 2003. In addition to this, the respondent also paid appropriate temporary total disability benefits through November of 2003. However, the respondent has since controverted the payment of additional temporary total disability benefits subsequent to November of 2003, and the payment of medical benefits subsequent to September 30, 2003. As a result, the claimant has filed this claim requesting the payment of additional medical and temporary total disability benefits.

A hearing was held in this matter on April 15, 2004. At the hearing, the claimant gave testimony. The claimant testified that to her knowledge, neither Dr. McCarthy, Dr. Reddy, or Dr. Safman has released her to return to any type of work. Upon further questioning, the claimant denied having been released to return to work by any of the specialists that she has seen. In addition to this, the claimant essentially testified that since her injury she has been unable to work, as she spends majority of her time at home.

According to the claimant, she is able to perform light chores around the house, bathe and dress herself, fix small meals, and various other things of this nature. However, the claimant testified that she has difficulty sitting, and is able to sit for 30 minutes to an hour, with positioning every so often. She also has difficulty bending, lifting, stooping, and standing. According to the claimant, she is able to stand maybe 30 to 45 minutes without having to shift back and forth. However, the claimant further testified that she is unable to do anything on a eight-hour day, 40-hour basis, as she spends three to four hours a day lying down or resting on the couch, bed or easy chair.

As to her compensable back surgery, the claimant testified that initially after her surgery she felt a little better. However, the claimant further testified that since that time her condition has progressively gotten worse. The claimant denied having any subsequent accidents or incidents.

The administrative law judge questioned the attorneys concerning those issues reflected in the Prehearing Order. The respondent's attorney testified:

administrative law judge: Very well. There is, and let me ask both counselors, the issues reflected in the Prehearing Order are entitlement to additional temporary total disability benefits, medical benefits and attorneys fees. There is not a question or dispute about unpaid medical benefits and attorneys[sic] fees. There is not a question or dispute about unpaid medical at this point.

The respondent's attorney: No, Sir.

administrative law judge: Okay --

The respondent's attorney: No, we think she's still probably entitled to some medical benefits, continuing medical treatment. But she had been referred Dr. Safman and he was the treating Doc, and he's the one that's been treating her for a long period of time.

A prehearing conference was conducted in this matter on March 2, 2004, from which a Prehearing Order of the same date was entered. In said order, the parties agreed to the following stipulations:

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

2). The existence of the employment relationship on April 26, 2001, when the claimant sustained a compensable injury to her low back, an injury which was accepted as compensable by the respondent.

3). That the respondent has paid some medical and temporary total disability benefits.

The Prehearing Order also set forth the issues to be litigated at the hearing, which were limited to the following:

1). The claimant's entitlement to additional temporary total disability benefits.

2). Continued medical benefits.

3). Attorney's fees.

The claimant contended that as a result of her April 26, 2001, compensable injury she remains within her healing period and totally incapacitated from engaging in gainful employment and has remained so since the last payment of temporary total disability benefits. The claimant further contended that she continue to require medical treatment relative to her compensable injury.

In contrast, the respondent contended that the claimant is no longer entitled to temporary total disability or medical benefits relative to the April 26, 2001, compensable injury.

After a hearing before the Commission, the administrative law judge found "The claimant was temporarily

totally disabled for the period beginning May 2, 2001, and continuing through the end of her healing period, a date yet to be determined." In addition to this, the administrative law judge found that "The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of April 26, 2001."

The respondent appeals to the Full Commission.

II. Adjudication

A. Medical Report

In the present matter, at the center of controversy is the admissibility of a September 15, 2003, medical report, which was authored by, Dr. Richard McCarthy's nurse practitioner, Lynn McCullough. Due to the alleged significance of this report and its subsequent admission, the Full Commission finds it appropriate to address this issue first. Specifically, we note that a Prehearing Order was filed in the present matter on March 2, 2004, wherein a hearing was scheduled for 1:00 p.m., on April 15, 2004. The Prehearing Order provided, in relevant part:

All medical reports and documentary evidence, not previously identified and exchange during the Prehearing Conference, relied upon by the parties and to be introduced and made a part of the record in this claim shall be identified and furnished to

opposing party within seven(7) days of authorship [the date reflected on the document]. **Failure to comply with this provision of the Prehearing Order shall result in the exclusion of the document(s).**

All medical reports, medical depositions, documentary evidence relied upon by the parties and to be introduced and made a part of the record in this claim shall be exchanged among the parties, with a copy being furnished for the Commission's file, pursuant to Ark Code Ann. § 11-9-705 seven (7) days prior to the scheduled hearing.

This claim in fact came on for hearing before the Commission on April 15, 2004, but the claimant did not provide the respondent with a copy of the aforementioned September 15, 2003, medical report until April 12, 2004. However, during the hearing, the claimant offered into evidence this medical report. At which time, the respondent objected to the admission into evidence of this report, first, on the basis that it was not submitted to them within the guidelines of the Prehearing Order, which requires that, "All medical reports relied upon by the parties and to be introduced and made part of the record in this claim shall be exchanged among the parties seven days prior to the hearing. Secondly, the respondent objected to the admission into evidence of this report on the basis it contained information that they had not been made aware of (namely,

the possibility of further surgery), and given sufficient time to develop, as they allege that the report and recommendation for surgery had been rendered by the nurse practitioner.

Although the administrative law judge noted the respondent's objection with respect to both, the timeliness of the document and the content of the report, he entered it into evidence. The Full Commission finds that the administrative law judge erred by entering into evidence this report because it was not timely submitted to the respondent in accordance with the Prehearing Order's seven-day rule. Therefore, in our adjudication of this case, we will not take into consideration the medical report from September 15, 2003, which was untimely submitted to the respondent.

B. Medical treatment

An employer shall promptly provide for an injured employee such treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). The claimant bears the burden of proving that she is entitled to additional medical treatment. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d. 543

(1999). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W. 2D 750 (1984).

On April 26, 2001, the claimant suffered injuries to her back while in the employ of the respondent. The claimant subsequently underwent extensive conservative treatments due to her back injury, including medication management, physical therapy, and a series of epidurals, all of which failed. As a result, on March 21, 2002, Dr. McCarthy performed surgery on the claimant's back in the form of posterior spinal fusion at L5-S1, with instrumentation due to a herniated disc at L5-S1, which Dr. Reddy opined the claimant had suffered as a result of her April 26, 2001, compensable injury. As such, the respondent accepted the claimant's herniated disc at L5-S1 as a compensable injury and paid appropriate medical benefits until September 30, 2003.

However, since her surgery, the claimant has credibly complained of continual pain and related symptoms, which have been corroborated by the medicals, wherein it was revealed via x-rays, which were taken on August 6, 2003, and an MRI, which was taken on September 11, 2003 that showed her fusion was not

solid. It is also specifically noted that the claimant has undergone multiple episodes of seroma drainage at the incisional site, all of which resulted due to her surgery. In addition to this, the respondent's attorney admitted on the record during the hearing that he believed that "the claimant was probably entitled to continuing medical treatment." The claimant has denied any subsequent accidents or incidents, and there is no evidence before the Full Commission indicating that the claimant suffered some other injury or accident.

Therefore, based on the claimant's credible complaints of ongoing pain, the corroborating medicals, multiple episodes of seroma drainage, the statement of the respondent's attorney admitting the need for continuing/additional medical treatment, and the lack of any independent intervening cause, the Full Commission finds that the claimant has proven by a preponderance of the evidence that additional medical treatment is reasonably necessary in connection with her compensable injury. As a result, the Full Commission affirms the administrative law judge's finding on this issue.

C. Temporary Total Disability Benefits

An injured employee is entitled to temporary total disability benefits during the time that she is within her

healing period and totally incapacitated to earn wages. Arkansas State Highway and Transportation Department v. Breshears, 272 Ark. 244, 613 S.W. 2d 392 (1981).

In the present claim, the respondent has paid temporary total disability benefits from May 2, 2001 through November of 2003. As a result, the claimant is essentially requesting additional temporary total disability compensation from November of 2003, until a date yet to be determined. The administrative law judge found in the present matter, "The claimant was temporarily totally disabled for the period beginning May 2, 2001, and continuing through the end of her healing period, a date yet to be determined." The Full Commission affirms the administrative's law judge's finding. Specifically, we find that the preponderance of the medical evidence shows that the claimant remains within her healing, as is evidenced by the subsequent x-rays from August 6, 2003, wherein the Ferguson view reveals that she may not have completely consolidated the interbody fusion at L5-S1, and the September 11, 2003, MRI, which shows a lack of fusion at this level. More importantly, we think it should also be noted that at no time has Dr. McCarthy pronounced maximum medical improvement. Although on March 31, 2003, Dr. Kulik pronounced

that the claimant had reached maximum medical improvement, this was solely in reference to her "postop tarsal tunnel," as he referred her for follow-up with Dr. McCarthy for her continuing back problems. In addition to this, it should also be noted that although on May 1, 2003, Dr. Safman pronounced that the claimant was at maximum medical improvement for her back injury and gave her a 10% disability rating, the Full Commission attaches very minimal weight to Dr. Safman's opinion given his speciality, (he is a pain specialist, whereas Dr. McCarthy is an orthopedic surgeon) and because his recommendation was made prior to the x-rays and MRI, which revealed objective findings of a lack of fusion at L5-S1.

Regarding the claimant's capacity to earn wages; the Full Commission finds that the preponderance of the evidence shows that the claimant has been totally incapacitated from earning wages since the time (November of 2003) the respondent terminated payment of temporary total disability benefits. It is specifically noted that although on March 7, 2003, Dr. McCarthy opined that the claimant was probably able to perform sedentary work, from this time until November 2003, the respondent continued to pay total disability compensation, and subsequent diagnostic testings in the form of x-rays and

an MRI, have revealed objective findings of nonfusion. We find that these subsequent objective findings strongly suggest that the claimant has suffered and continues to suffer debilitating residuals from her surgery, so as to totally incapacitated her from earning wages. In addition to this, the claimant has credibly testified that she has been unable to work since her injury, and at no time has Dr. McCarthy stated that she is at maximum medical improvement. Therefore, considering the claimant's credible testimony concerning her inability to work, the subsequent objective findings, and the fact that Dr. McCarthy has not pronounced maximum medical improvement, the Full Commission finds that it is more probable than not that the claimant has been totally incapacitated from earning wages since her compensable injury of April 26, 2001.

Therefore, due to all of the foregoing reasons, the Full Commission finds that the claimant has proven by a preponderance of the evidence that she remains within her healing period and has been totally incapacitated from earning wages since May 2, 2001, and continuing through the end of her healing period, a date to be determined. Accordingly, we affirm the decision of the administrative law judge concerning

the claimant's entitlement to additional temporary total disability benefits.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant has proven by a preponderance of the evidence that she is entitled to additional medical and temporary total disability benefits. We therefore affirm the administrative law judge's finding that "The claimant was temporarily totally disabled for the period beginning May 2, 2001, and continuing through the end of her healing period, a date yet to be determined." In addition to this, the Full Commission also affirms the administrative law judge's finding that "The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of April 26, 2001."

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the administrative law judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 1996).

Since the claimant's injury occurred prior to July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as it existed prior to the amendments of Act 1281 of 2001. Compare Ark. Code Ann.

§ 11-9-715 (Repl. 1996) with Ark. Code Ann. § 11-9-715 (Repl. 2002). For prevailing in part on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$250.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 1996).

_____IT IS SO ORDERED.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney concurs in part and dissents in part.

CONCURRING AND DISSENTING OPINION

I respectfully concur in part and dissent in part from the majority opinion. Specifically, I agree with the majority's opinion finding that the September 15, 2003, medical reports should be excluded from the evidence in the record. However, I must respectfully dissent from the majority's finding that the claimant was entitled to additional medical treatment and additional temporary total disability benefits. Based upon my de novo review of

the record, I find that the claimant has failed to meet her burden of proof.

In my opinion, a review of the evidence demonstrates that the claimant is not entitled to additional medical treatment for her compensable injury. The claimant has been provided with all possible treatments related to her compensable injury. There are medical reports in the record which indicate that the claimant's continuing symptoms are related to psychological factors. Specifically, the medical reports of Dr. Reddy and Dr. Safman indicate that the claimant's complaints of pain are due to psychological factors. On March 20, 2003, Dr. Safman reported that the claimant appeared to be in a great deal of distress and appeared to be very depressed. In a report dated May 1, 2003, Dr. Safman reported, "I suspect depression is playing a significant role in her symptomology." Doctor Safman also opined on that date:

I am not certain that there is anything I will do that is going to remove her pain. This patient is not competitive for vocational reentry. Psychological counseling may be of some benefit for her but I will await workers' comp. decision as to whether

they wish to support this or not. The patient is convinced that she still has significant pathology present, which has not been fully addressed. She did see Dr. McCarthy in February and he reported that he did not have anything additional to offer her.

Simply put, I cannot find that the claimant is entitled to additional medical treatment. Accordingly, I dissent from the majority's finding that the claimant is entitled to additional treatment.

I also dissent from the majority's finding that the claimant is entitled to additional temporary total disability benefits. The respondents paid temporary total disability benefits through November of 2003. The record indicates that the claimant was released by Dr. McCarthy on March 7, 2003, to work part time. His report specifically stated, "Ms. Jobe was recently re-evaluated in the office, and at this time I do feel that she could return to a part time sedentary position." On March 31, 2003, Dr. Kulik declared that the claimant had reached maximum medical improvement. Further, on April 18, 2003, Dr. Safman stated that there was nothing further that he could do for the claimant's subjective complaints of pain.

On May 1, 2003, he declared that the claimant had reached maximum medical improvement. Doctor Safman also awarded the claimant a 10% permanent impairment rating. A permanent impairment rating cannot be accessed until the claimant has reached the end of her healing period. In my opinion, the claimant has failed to prove by a preponderance of the evidence that she is entitled to temporary total disability benefits because she has reached the end of her healing period.

Accordingly, for all the reasons set forth herein, I must respectfully concur in part and dissent in part from the majority's opinion.

KAREN H. MCKINNEY, Commissioner