

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F410396

MICHAEL DAVID LUTEN, EMPLOYEE	CLAIMANT
XPRESS BOATS & BACKTRACK TRAILERS, EMPLOYER	RESPONDENT
WAUSAU UNDERWRITERS, CARRIER	RESPONDENT

**OPINION FILED NOVEMBER 27, 2007**

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

Claimant represented by HONORABLE SHANNON MUSE CARROLL,  
Attorney at Law, Hot Springs, Arkansas.

Respondent represented by HONORABLE MICHAEL E. RYBURN,  
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

This claim is presently before the Commission on remand from the Court of Appeals. The respondents appeal a decision of the Administrative Law Judge filed on May 16, 2006, finding that claimant is entitled to additional temporary total disability benefits from November 4, 2004, to a date yet to be determined. Our carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove by a preponderance of the

evidence that he is entitled to additional temporary total disability benefits from November 4, 2004, to a date yet to be determined. Therefore, the decision of the Administrative Law Judge is hereby reversed and these benefits denied.

The claimant, a truck driver for the respondent employer, sustained an admittedly compensable back injury on August 16, 2004, while he was attempting to push a boat back onto a trailer using a 2-by-4 plank. The compensability of the claimant's claim was accepted, and he received medical treatment and temporary total disability benefits for his injury.

The claimant was initially examined for his injury by his family physician, Dr. Robert Daniels, on August 18, 2004. Dr. Daniels treated the claimant conservatively with medications and work restrictions. Due to persistent back complaints, the claimant was referred for an MRI. On September 20, 2004, an open MRI of the claimant's lumbar spine revealed diffuse degenerative changes throughout the claimant's lumbar spine, and a foraminal disc herniation at

L5-S1. No effacement of the thecal sac or narrowing of the neural foramina was evident with this herniation.

On October 1, 2004, the claimant presented to Dr. Michael K. Atta at St. Joseph's Mercy Business Health Clinic. Dr. Atta's physical examination of the claimant's back revealed tenderness along the left paralumbar musculature with mild muscle spasms noted. Dr. Atta referred the claimant for a neurosurgical evaluation and kept him off of work "because of the narcotic medications" he was prescribed.

On October 13, 2004, the claimant was seen by Dr. James Arthur of the Hot Springs Neurosurgery Clinic. In his report of that visit, Dr. Arthur stated the following:

On physical examination he had diminished range of motion in the lumbar spine with paraspinous muscle spasm. His neurologic exam reveals no neurologic deficit. His MRI on the left side is essentially normal. Radiologist suggested he may have a far lateral disc herniation at L,5 S,1 on the right which would probably not even impinge a nerve root, but he doesn't have any right leg pain. I looked at the image myself and I do not feel that it is outside the range of normal. His pain is mostly in the left leg. He does have a positive

straight leg raise but no signs of weakness in the leg.

Dr. Arthur opined that the claimant was suffering from a "fairly significant lumbar strain injury", for which he prescribed lumbar steroid injections and a rehabilitative exercise program prior to his returning to work.

On October 25, 2004, the claimant was examined by Dr. Bruce L. Smith, an orthopedic physician with the Hot Spring Bone & Joint Clinic. Consistent with Dr. Arthur's examination, Dr. Smith noted tenderness in the claimant's left paralumbar region and "some subjective radicular symptoms into the left leg." Dr. Smith reviewed the claimant's recent MRI, which he agreed showed a bulging disc at L5-S1. However, Dr. Smith stated that the claimant's bulging disc was "really on the right", and inconsistent with his present clinical findings. In addition, Dr. Smith noted that, although the claimant had not yet undergone physical therapy or an epidural injection, these treatment modalities should be administered. In the meantime, Dr. Smith kept the claimant off of work.

The claimant underwent a lumbar spine epidural steroid injection on October 26, 2004. As of his follow-up appointment with Dr. Smith on November 3, 2004, the claimant reported that his symptoms were essentially unchanged. In his report of that visit, Dr. Smith reiterated that the claimant's recent MRI suggested a bulging disc on the right side at L5-S1. Dr. Smith added, however, that the claimant's bulge was "quite small and certainly should not account for the pain in his left leg." Dr. Smith concluded his report as follows:

He is basically unchanged since the epidural steroid injection and is presently complaining of pain in the left paralumbar area. I certainly see nothing surgical and I think he has sustained a lumbar strain, which is resolving. I did give him a refill of Soma for muscle spasm, but did not refill any narcotics at this time.

Dr. Smith released the claimant to return to full duty and he released him from his care on this date.

The claimant was next seen by Dr. Ronald Williams for a neurosurgical evaluation on December 7, 2004.

Dr. Williams ordered a repeat MRI of the claimant's lumbar

spine. In Dr. Williams' opinion, this study, which was conducted on December 14, 2004, showed degenerative disc disease predominately at L2-3 and L4-5, with some moderate foraminal narrowing on the right. Dr. Williams did not view the claimant's left-sided pain as significant, and he did not consider the claimant as a candidate for surgery. Accordingly, Dr. Williams referred the claimant for a second steroid injection and for a work evaluation.

The claimant underwent a functional capacity evaluation on January 18, 2005. The results of this study indicated that the claimant was able to work in a light duty capacity. However, the evaluator noted that the claimant "put forth inconsistent effort and demonstrat[ed] inconsistencies with appropriate illness response", which made his results for effort unreliable.

On February 1, 2005, Dr. Williams reported that the claimant was still having difficulty with his left hip in spite of two epidural steroid injections. Therefore, Dr. Williams ordered another MRI of the claimant's back and one of his left hip. These studies were conducted on

April 6, 2005. The repeat MRI of the claimant's back reaffirmed multilevel degenerative disc disease, most pronounced at L2-3. The claimant's right-sided diffuse bulge at L4-5 was also evident on this study. The MRI of the claimant's hip showed a paralabral cyst, which the radiologist noted is sometimes associated with labral tears. Therefore, Dr. Williams referred the claimant to an orthopedic surgeon for an evaluation of his paralabral cyst.

On April 6, 2005, Dr. Hefley examined the claimant and determined that he suffered from discogenic lumbar pain with referred pain into his left lower extremity. Dr. Hefley acknowledged that there were diagnostic findings consistent with the "incidental possibility" of a labral tear, but he did not think that the claimant's symptoms were reflective of hip pathology. Therefore, Dr. Hefley declined to refer the claimant to a specialist with regard to his hip complaints. However, Dr. Hefley opined that the claimant would benefit from a continued conservative, non-surgical approach to treatment, including an "aggressive and well coordinated lumbar rehabilitation program and physical

therapy". Moreover, Dr. Hefley recommended that the claimant might benefit by seeing a pain specialist. Pursuant to Dr. Hefley's recommendations, Dr. Williams referred the claimant to a program of physical therapy. The medical records reflect that the claimant attended five physical therapy sessions from June 1, through June 9, 2005. The claimant was then given a home exercise program to follow.

On July 18, 2005, the claimant was seen by Dr. Barry Baskin for an independent medical evaluation at the respondent carrier's request. In his lengthy report of that evaluation, Dr. Baskin offered that he was providing his services in order to render opinions regarding the claimant's diagnosis, prognosis, point of maximum medical improvement, and need for further testing. Based on his review of the claimant's medical records and his own physical examination of the claimant, Dr. Baskin opined that the claimant's pain was coming primarily from his back, rather than his hip. Because the source of the claimant's pain was unidentifiable, Dr. Baskin recommended that he undergo a myelogram with post myelogram CT scan. In

addition, Dr. Baskin recommended that the claimant participate in additional physical therapy and in a work hardening program. "I advised him that the worst thing he could do for himself at this point is to stay in bed where he will get weaker and also gain more weight," stated Dr. Baskin. "He needs to be as active as possible," Dr. Baskin concluded.

Temporary total disability is that period within the healing period in which an employee suffers a total incapacity to earn wages. K II Constr. Co. v. Crabtree, 78 Ark. App. 222, 79 S.W.3d 414 (2002). When an injured employee is totally incapacitated from earning wages and remains in his healing period, he is entitled to temporary total disability. Id. The healing period is statutorily defined as that period for healing of an injury resulting from an accident. Dallas County Hosp. V. Daniels, 74 Ark. App. 177, 47 S.W.3d 283 (2001). The healing period ends when the employee is as far restored as the permanent nature of his injury will permit, and if the underlying condition causing the disability has become stable and if nothing in

the way of treatment will improve that condition, the healing period has ended. Crabtree, supra. The question of when the healing period has ended is a factual determination for the Commission. The persistence of pain may not in and of itself prevent a finding that the healing period is over, provided that the underlying condition has stabilized. Id.; Mad Butcher, Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982). Conversely, the healing period has not ended so long as treatment is administered for the healing and alleviation of the condition. McWilliams, supra; J.A. Riggs Tractor v. Etkorn, 30 Ark. App. 200, 785 S.W.2d 51 (1990).

The detailed history of the claimant's compensable injury demonstrates that each time the claimant was released with regard to his low back, he would redirect his complaints to his hip. However, the claimant has undergone multiple diagnostic procedures in association with his compensable injury, none of which have confirmed that the claimant has a compensable hip injury. For example, diagnostic studies conducted in association with the claimant's injury, which include 3 MRI's of the claimant's

lumbar spine and one of his left hip, verify that the claimant suffers from degenerative disc disease in his lumbar spine, and no conclusive pathology in his left hip. In fact, Dr. Hefley opined that the claimant's source of pain originates from his lumbar spine, versus his hip. Again, objective medical testing and the opinion of a hip specialist fails to support a finding of hip pathology. Moreover, the claimant's lumbar spine condition, which has been found to be the source of the claimant's continuing complaints of pain, is degenerative in nature and does not require surgical intervention.

Turning more specifically to the claimant's alleged inability to work throughout the course of his treatment, the claimant has been seen by numerous physicians, none of which, with the exception of Dr. Williams in June of 2005, have expressly taken him off of work since his release by Dr. Smith in November of 2004. In addition, none of claimant's treating physicians have specifically opined that the claimant is unable to work in some capacity. Rather, on November 3, 2004, Dr. Smith

released the claimant to return to full duty. Subsequently, a functional capacity evaluation conducted on January 18, 2005, demonstrated that the claimant was able to work in a light duty capacity. On April 6, 2005, Dr. Hefley opined that the claimant's pain was not hip related, and that he should continue with a conservative course of treatment. Although Dr. Hefley's report of that visit reflects that the claimant reported having been "unable to work due to his low back pain", the doctor did not indicate that he agreed that the claimant was unable to work. Subsequently, the claimant returned to Dr. Williams, who continued to treat him for chronic back pain. On June 15, 2005, Dr. Williams advised the claimant to stay off work pending an evaluation by orthopaedic surgeon, Dr. Kleinhenz. Unfortunately, Dr. Kleinhenz retired from practice before this evaluation was performed. Pursuant to his evaluation of the claimant in July of 2005, Dr. Baskin recommended that physical activity would actually benefit the claimant. Finally, on August of 2005, Dr. Williams assigned the claimant with a 5 percent physical impairment rating to the body as a whole based

solely on his degenerative disc disease. However, Dr. Williams did not place permanent work restrictions on the claimant at that time, nor did he specifically take him off of work.

The claimant testified that his level of pain has worsened since August of 2004. He further testified that the pain in his left hip prevents him from rising from his left side from a seated position; from driving; from grocery shopping; and from helping with certain household chores. The claimant admitted, however, that his pain has not stopped him from attempting to deer hunt. The testimony of the claimant's wife, Janie Luten, and his neighbor, Theresa Goolsby, corroborates the claimant's testimony with regard to his subjective complaints of pain and his decreased level of inactivity since his injury. Notwithstanding the testimony of the claimant and his witnesses, however, the medical evidence does not corroborate the claimant's alleged inability to function either at home or in employment.

In mid-October of 2004, Dr. Arthur diagnosed the claimant with a "fairly significant lumbar strain injury".

In late October of 2004, Dr. Smith confirmed that diagnosis, which he opined was resolving. The claimant was released to full work duty by Dr. Smith in November of 2004, and a subsequent functional capacity evaluation confirmed that, at the very least, he is able to work in a light capacity job. After he was released by Dr. Smith, the claimant was treated by a neurosurgeon and evaluated by several other specialists, none of whom offered a medical opinion stating that the claimant was totally incapacitated from work activity. Further, objective medical tests confirmed that the claimant's physical injury was not worsening with time, as were his subjective complaints of pain. In fact, the claimant's multiple MRI's repeatedly revealed consistent findings of degenerative disc disease, with no particular hip pathology that could account for the his reported symptoms. In August of 2005, the claimant was given a 5% permanent physical impairment rating. Dr. Williams failed at that time, however, to place the claimant on any permanent work restrictions. The claimant admitted that he had applied for social security benefits, which were denied. The

claimant further admitted that his wife currently receives social security disability benefits.

In conclusion, the claimant has failed to prove by a preponderance of the evidence that he remained within his healing period and totally incapacitated from earning wages since his release by Dr. Smith in November of 2004. The credible evidence presented in this claim simply does not corroborate the claimant's self-serving testimony regarding his alleged inability to function. In short, the preponderance of the evidence demonstrates that the claimant sustained a severe lumbar strain on August 16, 2004, and regardless of the claimant's personal beliefs as to whether he is currently disabled as a result of that strain, the evidence does not support a finding that the claimant is, or has been totally incapacitated from earning wages since November of 2004, when he was released by Dr. Smith.

Based on the above and foregoing, we find that the claimant has failed to prove by a preponderance of the evidence that he is still in his healing period and totally incapacitated from earning wages for the time during which

he has been awarded additional temporary total disability benefits. Therefore, the decision of the Administrative Law Judge is hereby reversed and additional temporary total disability benefits are hereby denied.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

This case comes before the Commission on remand from the Court of Appeals. On October 24, 2007, the Court of Appeals issued a decision finding that the Commission had erred in denying the claimant additional temporary total disability benefits for an admittedly compensable injury. The Court of Appeals instructed the Commission that the claimant did not have to prove objective medical evidence that he had to remain in his healing period. The Majority,

however, erred in finding that the claimant failed to prove by a preponderance of the evidence that he is entitled to additional temporary total disability benefits from November 4, 2004, to a date yet to be determined. After a de novo review of the record, it is my opinion that the Claimant has met his burden of proving entitlement to additional temporary total disability benefits from November 4, 2004, until a date yet to be determined. As such, I must respectfully dissent.

The Claimant sustained a compensable injury to his low back on August 16, 2004, while attempting to push a boat back onto a trailer using a 2-by-4 plank. The Claimant reported the incident and received conservative medical care. The Claimant underwent an MRI scan of his lumbar spine on September 20, 2004, which revealed a herniated disc at L5-S1. Additional MRI scans were performed on the lumbar spine on December 14, 2004, and on April 6, 2005, when the Claimant's left hip was also scanned.

The Claimant has been seen by the company physician, Dr. Michael Atta, and the Claimant's family

physician, Dr. Robert J. Daniels, Jr., and his assistant, Mr. James Huffman. The Claimant has also been seen by Hot Springs neurosurgeon Dr. James M. Arthur, Hot Springs orthopedic surgeon Dr. Bruce L. Smith, Jr., Little Rock neurosurgeon Dr. Ronald N. Williams, and Little Rock orthopedic surgeon Dr. William F. Hefley, Jr. The Claimant was examined by Dr. Barry D. Baskin for a second opinion, at the direction of the respondents.

The Claimant's symptoms included pain in his low back and left hip and leg, which did not correlate well with the MRI findings of degenerative changes in his low back and a right-sided herniated disc at L5-S1. Claimant was seen by Dr. Michael Atta on October 1, 2004, who recommended a neurosurgical evaluation. It was noted at that time that Claimant was to remain off work because of the narcotic medications he was taking. Claimant's neurosurgical evaluation was done by Dr. James Arthur on October 13, 2004. Dr. Arthur opined that the Claimant had a "fairly significant lumbar strain injury". Dr. Arthur recommended

steroid injection therapy and physical therapy three times a week for three weeks.

The Claimant was seen on October 25, 2004, by Dr. Bruce L. Smith, Jr. It was noted that Claimant had not had any physical therapy or epidural steroid injections as of the date of that appointment. Dr. Smith agreed with the recommendation for physical therapy and steroid injections. Claimant received a lumbar steroid injection on October 26, 2004.

On November 3, 2004, Dr. Smith wrote to the insurance adjuster that the Claimant had received a lumbar steroid injection and his symptoms had not really changed. Claimant was still complaining of pain in the left paralumber area. Dr. Smith indicated that he did not see anything that would require surgery and thought that the Claimant had sustained a lumbar sprain which was resolving. He prescribed Soma for muscle spasm. Dr. Smith's note dated November 12, 2004, indicated that the Claimant was released to full duty and released from his care as of November 3, 2004.

As of November 3, 2004, the Claimant had received one lumbar steroid injection. The Claimant had not had any physical therapy even though it had been recommended by two physicians. Dr. Smith does not discuss whether the Claimant had reached maximum medical improvement. As stated above, Dr. Smith is an orthopaedic surgeon and because he did not see anything that would require surgery, he releases the Claimant from his care.

The Claimant began to see Dr. Williams in December of 2004, and underwent the second MRI scan of his lumbar spine. Dr. Williams' letter of December 7, 2004, did not address the Claimant's ability to work. However, Dr. Williams' letter of December 14, 2004, indicated that he would like to get a work evaluation to see if it was safe for the Claimant to return to work. A functional capacity evaluation dated January 18, 2005, indicated that the Claimant was capable of light work at that time. On February 1, 2005, Dr. Williams noted that in spite of two epidural steroid injections the Claimant was still having difficulty in his left hip and he recommended a repeat MRI

of the back and left hip. On April 6, 2005, Dr. Williams noted that the MRI of the left hip showed a paralabral cyst which the radiologist noted is sometimes associated with labral tears, and the Claimant was referred to Dr. Hefley for evaluation.

On April 6, 2005, Dr. Hefley found that there were diagnostic testings consistent with the possibility of a labral tear, although he did not think that the claimant's symptoms were reflective of hip pathology. Dr. Hefley opined that the claimant would benefit from conservative, non-surgical approach to treatment, including an "aggressive and well coordinated lumbar rehabilitation program and physical therapy. Additionally, Dr. Hefley recommended that the claimant might benefit from seeing a specialist.

On April 27, 2005, following Dr. Hefley's examination, Dr. Williams recommended that the Claimant undergo physical therapy three days a week for six weeks. The record indicates that the Claimant received a total of five (5) visits to physical therapy instead of the recommended eighteen (18). On June 15, 2005, Dr. Williams

indicated that the Claimant was to remain off work until further notice.

In a letter dated June 24, 2005, Dr. Daniel's assistant, Mr. James Huffman, indicated that the Claimant was unable to work in any capacity due to Claimant's current condition.

On July 10, 2005, the Claimant was examined by Dr. Barry Baskin at the request of the respondents. Dr. Baskin recommended a lumbar myelogram and a post myelogram CT scan and stated that at the very least it would be reasonable to try and get the Claimant involved in a work-hardening program with a little more extensive physical therapy and reconditioning, given that the Claimant has been off work since August 16, 2004. Dr. Baskin also noted that he did not get the impression that the Claimant was seeking secondary gain with his injury.

In an August 22, 2005 letter, Dr. Williams notes that he referred the Claimant to Dr. Robert Kleinhenz, an orthopedic surgeon in Hot Springs. Dr. Williams gave the Claimant a 5% impairment rating to the body as a whole, but

he also indicated that it would depend on whether the Claimant was still being treated by Dr. Kleinhenz as to whether or not Claimant would be considered at Maximum medical improvement. Due to Dr. Kleinhenz's pending retirement, Claimant was never seen by him.

In a letter dated December 19, 2005, Dr. Daniel indicates that the Claimant is completely disabled due to his injury and he is in need of further evaluation by either an orthopedist or a neurosurgeon.

The Claimant testified that his pain has worsened since August of 2004. He further testified that his pain level is such that he cannot drive, grocery shop, or help with household chores. Claimant also testified that he did attempt to deer hunt in November of 2005. Claimant's brother-in-law set up a recliner about 100 yards from Claimant's home on their farm land. Claimant testified that he walked slowly out to the chair with the assistance of a cane and sat in the chair for approximately 30 minutes without ever shooting his gun.

It is evident that the claimant was still within his healing period and has been totally incapacitated to earn wages from his compensable injury from November 4, 2004, until a date yet to be determined. Temporary total disability for unscheduled injuries is that period within the healing period in which claimant suffers a total incapacity to earn wages. Ark. State Highway & Transportation Dept. v. Breshears, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period ends when the underlying condition causing the disability has become stable and nothing further in the way of treatment will improve that condition. Mad Butcher, Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982). The healing period has not ended so long as treatment is administered for the healing and alleviation of the condition. Breshears, supra; J.A. Riggs Tractor Co. v. Etzkorn, 30 Ark. App. 200, 785 S.W.2d 51 (1990).

The Claimant's incapacitating symptoms have continued to require medical care for his admittedly compensable injury. First, on October 1, 2004, Dr. Michael Atta, a company doctor, recommended a neurosurgical

evaluation and that Claimant was to remain off work because of the narcotic medications he was taking. Second, Dr. Williams noted that in spite of two epidural steroid injections the Claimant was still having difficulty in his left hip and he recommended a repeat MRI of the back and left hip. On April 6, 2005, Dr. Williams noted that the MRI of the left hip showed a paralabral cyst which the radiologist noted is sometimes associated with labral tears. Third, Dr. Hefley also found that there were diagnostic testings consistent with the possibility of a labral tear. Dr. Hefley opined that the claimant would benefit from conservative, non-surgical approach to treatment, including an "aggressive and well coordinated lumbar rehabilitation program and physical therapy. Additionally, Dr. Hefley recommended that the claimant might benefit from seeing a specialist. Fourth, Dr. Baskin, the respondents chosen physician, recommended a lumbar myelogram and a post myelogram CT scan and stated that at the very least it would be reasonable to try and get the Claimant involved in a work-hardening program with a little more extensive physical

therapy and reconditioning. As such, the Claimant's incapacitating symptoms have continued to require medical care for his admittedly compensable injury.

Furthermore, the Claimant has not been afforded all of the testing and physical therapy that has been suggested by various physicians. First, On October 13, 2004, Dr. Arthur recommended steroid injection therapy and physical therapy three times a week for three weeks. By October 25, 2004, the Claimant had not had any physical therapy or epidural steroid injections as of the date of that appointment. Additionally, Dr. Williams recommended that the Claimant undergo physical therapy three days a week for six weeks. The record indicates that the Claimant received a total of five (5) visits to physical therapy instead of the recommended eighteen (18). Even Dr. Baskin, the respondents chosen physician, stated that at the very least it would be reasonable to try and get the Claimant involved in a work-hardening program with a little more extensive physical therapy and reconditioning. As such, the Claimant has not been afforded all of the testing and

physical therapy that has been suggested by various physicians.

Although the Claimant's physicians have not been careful to address the issue of his off-work status consistently and clearly, the record shows that the Claimant has continued in his healing period and has been incapacitated to earn wages. As stated above, even Dr. Baskin, respondent's second opinion physician, indicated that the claimant needed a work-hardening program to assist him back into the workforce. Additionally, all of the claimant's physicians, with the exception of the company doctor, did not return the claimant to work. Furthermore, even though Dr. Williams assessed the Claimant with a 5% impairment, he did not state that the Claimant had reached maximum medical improvement. Dr. Williams did, however, refer the claimant to Dr. Kleinhenz and indicated that it would depend on whether the Claimant was still being treated by Dr. Kleinhenz as to whether or not Claimant would be considered at Maximum medical improvement.

As such, it is evident that the claimant was not only still being treated by physicians, but that he had certainly not reached maximum medical improvement. Therefore, the claimant was still in his healing period and entitled to temporary total disability benefits. As such, claimant has met his burden of proving entitlement to temporary total disability benefits from November 4, 2004, until a date yet to be determined.

\_\_\_\_\_ For the aforementioned reasons, I must respectfully dissent.

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PHILIP A. HOOD, Commissioner