

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F605281

MARY A. COLEMAN, EMPLOYEE	CLAIMANT
FRIEDMAN'S INC., EMPLOYER	RESPONDENT
AMERICAN PROTECTION INSURANCE CO., CARRIER	RESPONDENT

OPINION FILED MARCH 5, 2008

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

Claimant is not represented by counsel, but appears *pro se*.

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

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

This claim is presently on appeal by Respondents from an opinion filed by the Administrative Law Judge finding that the claimant has proven by a preponderance of the evidence that she is entitled to additional medical benefits and finding that the claim is not barred by the statute of limitations. Based upon our de novo review of the entire record, without giving the benefit of the doubt to either party, we find that this claim is barred by the statute of limitations. Therefore, we find that the decision of the Administrative Law Judge must be reversed.

Arkansas Code Annotated §11-9-702(b) sets forth the statute of limitations for the filing of a claim for additional compensation. This statute specifically states:

(1) In cases in which any compensation, including disability or medical, has been paid on account of injury, a claim for additional compensation shall be barred unless filed with the commission within one (1) year from the date of the last payment of compensation or two (2) years from the date of the injury, whichever is greater.

The claimant contends that she has at all times continued to receive medical treatment for her compensable left knee injury and that the respondents should be responsible for her continued medical treatment. In support of this contention, the claimant testified that she continued to receive treatment for her left knee while she was receiving treatment for her right knee. Likewise, she testified that the respondents paid for medical treatment to her left knee as a result of her visits with Dr. Stroope on in April and September 2005. Conversely, respondents contended that they had paid all benefits to which the claimant was entitled; that any claim for additional

benefits was barred by the statute of limitations; and that in the event that the claim was not time barred, the claimant cannot prove that the additional medical treatment requested was reasonable and necessary in connection with her compensable injury.

The claimant sustained an admittedly compensable injury to her left knee on August 4, 1999. The claimant received appropriate medical treatment for this injury and eventually underwent surgery by Dr. Henry Stroope for cartilage repair in June of 2000. The claimant was off work eleven days as a result of this surgery for which she received temporary total disability benefits. The claimant was assigned a 7% permanent impairment rating to the left lower extremity which was also paid by respondents.

The claimant continued to receive follow-up treatment from Dr. Stroope which was paid by respondents through April 27, 2004. In his office note for this April 27, 2004, visit, Dr. Stroope noted:

Ms. Coleman is seen in follow-up today for her bilateral OA of her knees with the left side being taken care of by workers' compensation. On presentation

today she really is doing rather well. She still occasionally has pain in her knee, but not near as severe as she has had in the past. The Synvisc injections which she received several months back have done an excellent job of relieving her symptoms. Overall, she feels that she is doing reasonably well.

* * *

We will see her back in six months for routine repeat x-ray on her knee to make sure that again she is doing okay and that her arthritis doesn't rapidly progress.

The respondents' Payment History reflects that Dr. Stroope was paid \$127.43 for this office visit.

The claimant received a payment for mileage reimbursement for medical treatment received on April 15, 2003, October 14, 2003, and the above mentioned April 2004 office visit which was paid on January 3, 2005.

Claimant's next visit with Dr. Stroope occurred on September 2, 2004, for which she received treatment for complaints of right knee pain. Dr. Stroope's office notes from this visit reflect:

9-2-04 Ms. Coleman is seen today for a CC of right knee pain. She has known OA in both of her knees.

Clinical exam of her right knee today shows minimal effusion and significant crepitation with ROM.

Weight bearing AP of both knees and lateral x-ray of the right knee are reviewed. The x-rays show severe OA of the right knee with bone on bone contact in the medial compartment. medial subluxation of the femur in relation to the tibia on the AP view. She also has significant patellofemoral disease on the lateral x-ray.

ASSESSMENT: Severe OA of the right knee

PLAN:

1. Inject the right knee joint with some Depo-Medrol and Lidocaine to give her some provisional relief.
2. I have counselled(sic)with the patient regarding TK replacement arthroplasty. She is considering having this done and all the risks and benefits of the surgery explained. She will call and let me know in the future when she decides to have this done this fall.

A review of the Payment History does not reflect a corresponding payment for this office visit, nor is there any evidence that the respondents were ever billed for this treatment.

The claimant was seen on September 5, 2004, and October 6, 2004, at the Wynne Medical Clinic. The medical

records for these visits make no mention of any treatment or complaints involving the claimant's left knee, nor is there any evidence respondents were billed for this treatment.

The claimant underwent total right knee replacement surgery by Dr. Stroope on October 11, 2004. The claimant was seen in follow-up for this procedure by Dr. Stroope on October 26, 2004; November 9, 2004; November 23, 2004; January 4, 2005; and April 19, 2005. A thorough review of each of these medical records evidences treatment was only provided for the claimant's right knee. The respondents' Payment History does not reflect any payments made for any of these treatments, nor is there any evidence that the respondents were billed for or made aware of these office visits.

The claimant introduced her receipt for the office visit with Dr. Stroope on April 19, 2005. On the top of this receipt where pertinent information is contained identifying the patient and insurance carrier, notations for which carrier is responsible for which knee have been made. Under the "Description" "Injections" and "X-ray" sections several

procedure codes were circled, but do not reflect to which body part each relates. However, clearly written under "Diagnosis" is "Osteoarthritis Right Knee." In addition, this receipt reflects that the claimant made a \$30.00 payment for the services rendered on that date. This receipt only reveals treatment for the claimant's noncompensable right knee. The claimant argues that the notation under the insurance carrier information that indicates the left knee is covered by workers' compensation implies that treatment was rendered to the left knee during that office visit. We cannot reach such a finding. Neither the office note for the April 19, 2005, office visit, nor the diagnosis reflected on the receipt indicate that any treatment was rendered for the claimant's left knee during that visit. The notation reflecting workers' compensation is merely a means by which Dr. Stroope's billing office was able to discern which carrier to bill for which knee.

On September 6, 2005, the claimant returned to Dr. Stroope for her one year follow-up on her right knee total knee replacement. After recommending hardware removal,

Dr. Stroope wrote that the claimant also had x-rays on her left knee for follow-up on her workers' compensation claim. Dr. Stroope noted that the x-rays showed minimal loss of the medial joint and patellofemoral joint space, which was consistent with moderate arthritis. He recommended that the claimant return in one year to check on the deterioration of her arthritis. The respondents' Payment History shows that they paid Dr. Stroope \$61.37 for this treatment.

The claimant returned to Dr. Stroope on March 28, 2006, for follow-up treatment. Claimant testified that after this office visit she returned home and called the workers' compensation carrier to inquire about where to mail her request for mileage reimbursement at which time she was informed that her claim for additional benefits was barred by the statute of limitations and that all further treatment would be denied. Nevertheless, the respondents' Payment History reveals that respondents paid for the March 28, 2006, office visit with Dr. Stroope.

After reviewing the evidence in this claim, we find that the statute of limitations bars any claim for

additional benefits as of September 2, 2005. The claimant went over one year without receiving any medical treatment for her left knee as of that date. After the claimant initiated treatment for her noncompensable right knee on September 2, 2004, when an x-ray was also taken of her left knee, the claimant did not receive any medical treatment for her left knee until September 6, 2005. September 2, 2005, is the last date that the claimant received medical treatment for her compensable left knee.

Claimant was receiving medical treatment for her compensable injury well beyond two years from the date of injury, so the only applicable time period in this claim for the statute of limitations is whether a claim for additional benefits was filed with the commission within one year from the date of the last payment of compensation. A.C.A. § 11-9-702(b)(1). The claimant filed her claim for additional benefits on May 11, 2006. The record reveals that the last treatment for her left knee was on or September 2, 2004. More than one year passed before further compensation was paid on September 6, 2005, when the claimant received

additional medical treatment for her left knee. A.C.A. § 11-9-702(b) unambiguously states that a claim for additional compensation "shall" be barred unless filed with the commission within one year from the last payment of compensation. A.C.A. § 11-9-704(c) (3) further provides that the "Administrative law judges, the commission, and any reviewing courts shall construe the provisions of this chapter strictly." Accordingly, strictly construing A.C.A. § 11-9-702(b) this claim became barred on September 2, 2005, when the claimant failed to file a claim with the commission within one year after she received treatment on September 2, 2004.

In reaching this finding, it is noted that the claimant was issued a check on January 3, 2005, for mileage reimbursement for reasonable and necessary medical treatment received on April 15, 2003, October 14, 2003, and April 2004. It has long been held that the furnishing of medical services constitutes payment of compensation not the actual date a check was issued when determining the last date of payment of compensation for statute of limitations purposes.

Heflin v. Pepsi Cola Bottling Co., 244 Ark. 195, 424 S.W.2d 365 (1968); Spencer v. Stone Container Corp., 72 Ark. App. 450 (2001).

Claimant contends that the respondents' payment of benefits on September 6, 2005, revived her claim or reopened the statute of limitations period. Once a claim has been barred by the passage of time, it cannot be revived by the furnishing of medical services. In Woodard v. Itt Higbie Manufacturing Co., 271 Ark. 498, 609 S.W.2d 115 (1980), the Arkansas Court of Appeals held stated:

Although the parties properly do not regard it as an issue, we may prevent confusion by pointing out that the payment by INA did not have the effect of "reviving" any claim as to which the statute might have run with respect to the employer. See, Larson, *Workmen's Compensation Law*, § 78.43(b) (1976), at pp. 15-131 and 15-132:

Once the claim has been barred by the passage of time, it will not be revived and a new period will not be set in motion by the furnishing of medical services years after the injury. The objective of the statute being to protect the claimant who reasonably refrains from making claim

because of the receipt of benefits voluntarily supplied, no claimant can allege that his failure to make timely application was excused by something that happened after the claim was already barred. Moreover, since the employer was under no obligation to furnish such benefits once the right to them was barred, it cannot be said that he provided them as voluntary compensation payments.
[Footnotes omitted.]

Although this text mentions only medical payments made after the limitations period has run, the rule should apply to all compensation benefits.

Presently, Larson's Workers' Compensation continues to espouse this as the holding in the majority of states. See Larson's Workers' Compensation § 126.07[9]. Accordingly, once the statute of limitations ran, barring any further claim, it cannot be revived. Kent v. Single Source Transportation, FC Opinion, Nov. 16, 2007 (AWCC No. E606338)
The statute of limitations ran, barring any further claim in this case on September 2, 2005. Respondents were under no obligation to furnish any further benefits. Respondents

actions of making payment for medical treatment after the statute of limitations ran cannot and did not revive the claim. Therefore, we find that this claim is barred by the statute of limitations as more than one year passed from the date of last payment of compensation barring any further claim for benefits.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority's opinion. The Majority, by reversing the Administrative Law Judge, finds that the statute of limitations is a bar to this claim. Based upon a de novo review of the record, I find that the statute of limitations does not bar this claim, and therefore, I must respectfully dissent.

The claimant sustained an admittedly compensable injury to her left knee on August 4, 1999. Following that injury, the respondent provided the claimant appropriate medical treatment, temporary total disability benefits, and permanent partial disability benefits based upon a 7% impairment to her lower extremity. The respondent continued to pay the claimant's occasional doctor visits through April 27, 2004. However, when a dispute subsequently arose over additional medical treatment, the claimant filed a claim for additional benefits on May 11, 2006.

The respondent contends, and the Majority has found, that the claim for benefits was not filed in a timely manner. The Majority reaches that conclusion because they find that the last compensation provided to the claimant was the doctor visit in April 2004. The Majority reaches that conclusion even though they concede that the respondent's payment record established that the respondent paid the claimant a mileage reimbursement check on or about January 3, 2005, and paid for the medical treatment the claimant received on September 6, 2005. However, the

Majority holds that, as a matter of law, after the respondent furnished the claimant medical treatment in April 2004, she would have had until April 2005 to file a claim for additional benefits. Therefore, the medical treatment in September 2005, which the respondent furnished, was outside the applicable statute of limitation and did not extend the time to file a claim. The Majority also dismisses the mileage payment in January 2005 as being irrelevant, since it was for mileage the claimant incurred in April and October 2003 and April 2004. However, I find that the Majority has misinterpreted the relevant case law as it applies to the January mileage payment and that, consequently, the medical treatment provided by the respondent in September 2005 was within the applicable statute of limitation and extended the time limits of the claimant to file a claim until September 2006. Therefore, her claim filing on May 11, 2006 was timely.

The Majority has mischaracterized the mileage payment made by the respondent on January 3, 2005. The Majority refers to cases which have held that medical

treatment is considered to have been furnished on the date it was received, not when the respondent paid for it. The Majority also references AWCC Advisory 89-2, which states that the AWCC approves mileage reimbursement rates as medical expenses. While I agree with the Majority that the above-referenced cases and advisory do apply to medical treatment and to mileage, I strongly disagree with the Majority's conclusion that monies paid directly to a claimant for mileage expenses is medical treatment for the purposes of the statute of limitation. Mileage reimbursement is not an expense paid to a medical provider or a third party. Rather, it is a direct benefit paid to the claimant. Paying a claimant for accrued mileage is no different than paying a claimant benefits for accrued disability.

The Courts have previously dealt with situations in which benefits payable to the claimant were not paid in a timely fashion and have held that, in those situations, the statute of limitation time is based upon when the payments were made, not when they came due. For example, in Jones Furniture Manufacturing Company v. Evans, 244 Ark. 242, 424

S.W.2d 880 (1968), it was held that when a respondent was late paying benefits due the claimant, the statute of limitations ran from the date the payment was made, not when it was due. The same result was reached in Myles v. Paragould School District, 28 Ark. App. 81, 770 S.W.2d 675 (1989).

Here, the benefit in question was for payment of the claimant's mileage, which was accrued in May and October 2003 and April 2004. However, the benefit was not paid to the claimant until January 2005. Therefore, that is the date that this benefit was provided to the claimant.

A far different situation is presented in regard to medical treatment. In those circumstances, a claimant receives the benefit of the medical treatment when he sees his doctor. The fact that the treatment is not paid until later is irrelevant, as far as the claimant is concerned. In other words, the paying for the medical treatment is a benefit to the doctor not directly to the claimant. A claimant receives the benefit of the medical treatment when he or she sees their physician.

In this case, the claimant incurred the expenses of providing her transportation to the doctor in 2003 and 2004. However, she did not receive the benefit of being paid for that expense until January 2005. Therefore, the fact that these payments should have been made to her many months in the past is not relevant as to when the benefit was provided to her. Clearly, she received compensation in the form of a mileage benefit payment in January 2005.

Since the respondent provided the claimant compensation in January 2005, which was within a year of her last medical treatment in April 2004, she would have had until January 2006 to file a claim for additional benefits or to receive further medical treatment or other compensation to extend the filing deadline. There is no question that the respondent provided the claimant medical treatment in September 2005. Therefore, the claimant would then have until September 2006 to file a claim for additional benefits. Since she filed a claim in May 2006, the claim was timely.

The benefits the claimant would be entitled to had the majority not found this claim to be barred are substantial. I find that the evidence of record shows that the claimant has met her burden of proving by a preponderance of the evidence her entitlement to additional reasonable and necessary medical treatment for her compensable left knee injury, which will most likely include a total knee replacement. Not only does the Majority's conclusion represent a severe unfairness to this claimant, it represents a severe unfairness to all other claimants in similar situations. Inequitable interpretations and applications of Ark. Code Ann. §11-9-702 must be addressed, not only by the Full Commission, but by the Courts and the legislature as well.

For the aforementioned reasons, I must respectfully dissent.

PHILIP A. HOOD, Commissioner