BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. **H401902**

CHAD HILL, EMPLOYEE CLAIMANT

WASHINGTON COUNTY JUDGE, EMPLOYER RESPONDENT

AAC RISK MANAGEMENT SERVICES, CARRIER/TPA RESPONDENT

OPINION FILED **FEBRUARY 5, 2026**

Hearing before ADMINISTRATIVE LAW JUDGE JOSEPH C. SELF in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN E. BROOKS, Attorney, Fayetteville, Arkansas.

Respondents represented by JARROD PARRISH, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

On November 13, 2025, the above captioned claim came on for a hearing at Springdale, Arkansas. A pre-hearing conference was conducted on August 28, 2025, and a pre-hearing order was filed on that same date. A copy of the pre-hearing order has been marked as Commission's Exhibit #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 The employee/employer/carrier relationship existed on January 23, 2024.

3 Claimant sustained a compensable injury on January 23, 2024.

By agreement of the parties, the issues to be litigated and resolved at the forthcoming hearing were limited to the following:

1. Compensation rate.
2. Whether claimant is entitled to temporary total disability benefits from June 9, 2025, to a date yet to be determined.
3. Whether claimant is entitled to medical benefits.

4. Attorney's fee.

All other issues are reserved by the parties.

The claimant contends that "He is entitled to medical treatment, including surgery by Dr. Blankenship. Claimant contends he is entitled to temporary total disability from June 9, 2025, to a date yet to be determined. Claimant reserves all other issues."

The respondents contend that "All appropriate benefits have been paid with regard to this matter. It is respondents' position that the surgical recommendation is not reasonable and necessary for the claimant's compensable injury and that respondents should not be liable for benefits associated with the same."

From a review of the entire record including medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witnesses and to observe their 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 a pre-hearing conference conducted on August 28, 2025, and contained in a pre-hearing order filed on that same date are hereby accepted as fact.

2. Claimant has met his burden of proof by a preponderance of the evidence that he is entitled to additional medical benefits as recommended by Dr. James Blankenship for his compensable back injury.

3. Claimant has failed to prove by a preponderance of the evidence that he is entitled to temporary total disability benefits from June 9, 2025, to a date yet to be determined.

HEARING TESTIMONY

Claimant testified on his own behalf. He is 41 years old and went to work for Washington

County in early 2019 as a heavy equipment operator. On January 23, 2024, claimant was taking snow chains off the back of his grader when he slipped on cold, wet surfaces. He said he yanked himself back up to avoid falling in the mud and instantly felt pain in his lower back, hip to hip area. The pain started going down his left leg and on the inside of his left groin. Claimant reported the injury to his supervisor, Brian Shumake, within 10 to 15 minutes. Respondents accepted the injury and sent him for treatment.

Claimant's course of treatment began with conservative care, including physical therapy and epidural shots. About four months after the injury, Dr. James Calhoun performed a laminectomy and discectomy. Following surgery, claimant had physical therapy and consulted with Dr. Calhoun approximately three times, one of which was by telephone. Dr. Calhoun released claimant in September 2024. According to claimant, his symptoms at the time he was released included extreme lower back pain, weakness and nerve pain going down his left leg and inside left groin, drop foot, and tingling and burning in his feet, leg, back and groin. Claimant did not believe the surgery improved his condition at all. He explained these symptoms to Dr. Calhoun, who offered no additional treatment except physical therapy.

Claimant testified that before his work accident, he had not had any problems with his back that restricted his activities. When shown medical records from 2016 mentioning low back pain possibly from baling hay, claimant did not recall that visit. He stated that at some point before starting work at Washington County, he began a regular exercise routine of free weights, jogging, walking on treadmills, and stationary bike, Monday through Friday before work. Before the accident, claimant stated that he had no trouble doing his work or his workout, and his back caused him no problems.

Since the accident, claimant testified that his symptoms have never gone away, but the drop foot in his left foot began after the surgery. Claimant described the foot drop as not being able to feel his foot when walking, causing him to trip because he cannot control it. He estimated he has fallen 30

to 40 times since surgery, sometimes catching his foot on something, other times his legs just collapsing when he tries to walk.

After surgery, claimant returned to work at Washington County in light duty, initially in the sign shop and later at the front desk. Dr. Calhoun placed him on restrictions including no bending, twisting, or lifting more than 15 pounds. Claimant testified the sign shop work was difficult because he is tall and had to constantly bend over tables to make signs. He could not stand straight up for extended periods.

On October 23, 2024, approximately five months after his back surgery, claimant's back flared up when he helped a co-worker move sign pedestals while cleaning up the shop. He told his supervisor Derek Morgan that he had hurt his back. Mr. Morgan did not offer to send him to a doctor. The next morning, claimant called Bart Ledgerwood while driving to work, reporting that his back hurt and he had not slept all night. He asked if he could take a vacation day, take a day without pay, or come in and try to work as long as he could. Bart told him he would put him down for a vacation day and to go home. Neither Mr. Morgan nor Mr. Ledgerwood offered to send claimant to a doctor even though both were aware claimant had a workers' compensation claim for his back.

Claimant testified that later that afternoon, around 3:15 p.m., Mr. Morgan texted claimant saying he needed a doctor's note for missing a day. Claimant panicked because he understood the policy to require a note only for missing a day before or after a holiday, or for missing a third consecutive day. He asked his wife, who works for Baptist Health, if she could get him a doctor's note. Claimant said when he returned to work, Mr. Morgan told him if he did not have a doctor's note, he would be fired. Claimant did not use his personal health insurance because he understood using it for anything related to workers' compensation would be insurance fraud, and he did not have money to pay for a doctor out of pocket.

Claimant received a written reprimand on October 29, 2024, for cursing at a fellow employee

and for excessive use of his personal phone. In the five years he worked for Washington County before his accident, claimant testified he had never received a write-up for misconduct.

After Dr. Calhoun released him, claimant said he wanted a second opinion from another doctor due to his continued symptoms but was denied by the carrier as being too soon after his release. He finally saw Dr. James Blankenship who recommended additional surgery, which claimant is seeking in this hearing.

Claimant testified that he has been unable to work since he was terminated. He applied to a few jobs, but he determined that he could not even work a part-time job. He said he does household chores and yard work—vacuuming, yard work, tilling his garden—by taking frequent breaks, but his back still hurts the next day.

On cross-examination, claimant was confronted with his deposition testimony stating he never had any prior injuries, problems, symptoms, or conditions involving his low back before January 23, 2024. When shown the 2016 medical records documenting lower back pain, paravertebral spasms, positive straight leg raise on the left, and radiculopathy of the lumbosacral region, claimant stated he did not remember that visit until his attorney told him about it before the hearing. He only remembered the 2016 visit was to check if he was diabetic and to get a prostate exam.

Claimant confirmed that he had three MRIs: January 27, 2024 (pre-surgery), July 11, 2024 (post-surgery), and June 23, 2025 (for Dr. Blankenship). He underwent a functional capacity evaluation in October 2024 with a consistency score of 31 out of 49. When asked for an explanation, claimant said he did not know what it meant.

Claimant agreed Washington County brought him back to work in modified duty both before his surgery on May 28, 2024, and then again after surgery, working in the sign shop and office. Claimant worked for the County until his termination in November 2024.

Regarding the note from Dr. Slabbert which took claimant off work on October 24, 2024,

claimant admitted he had never been evaluated by Dr. Slabbert, never seen him, never been to his office, never spoken to anyone in his office, and had never tried to make an appointment with him. Claimant admitted when he turned the note in, he knew it was not legitimate, knew he had no affiliation with that doctor, and knew it would be fraudulent. He conceded it was dishonest to present that note to his employer. Claimant does not disagree with the decision to terminate his employment because of the fraudulent note he submitted to Washington County.

After being terminated, claimant applied for unemployment benefits and listed the reason for termination simply as "Doctor note" without disclosing he had falsified a medical record. Claimant was denied unemployment benefits but testified he thought the denial was because he was receiving permanent partial disability payments. Since termination, claimant applied to Waste Management, Crawford County dump, CARDS trash service, AutoZone, and construction companies. In addition to the outdoor work mentioned earlier, claimant does laundry, dishes, and cooking in what he termed "small portions."

Claimant was asked about cursing at the co-worker at the office. Claimant said sometimes you joke around with co-workers, and he did not think he was yelling at her. He termed it as expressing frustration about not knowing how to use the phone. He conceded that he used profanity.

On redirect examination, claimant's actual deposition answer about prior back problems was "No. Not that I can remember, no," not simply "no." Regarding the functional capacity evaluation, claimant testified the evaluator asked him to stand on his left leg and squat down. When claimant asked if the evaluator would catch him because he knew he would fall, the evaluator said no. Claimant refused because he did not want to hurt himself. Claimant testified he gave good effort in the evaluation and tried to be cooperative, but he has not been able to squat on one leg since his surgery.

Regarding the fraudulent note, claimant testified he had never done anything like that before. He was trying to keep his job and panicked when told he would be fired if he did not have a doctor's

note. He told both Mr. Morgan and Mr. Ledgerwood he had hurt his back moving signposts, but neither offered to send him to a doctor; both knew about his workers' compensation claim for a back injury. He repeated that he offered to come into work, but Mr. Ledgerwood told him to take a vacation day and go home.

Claimant testified he never had to explain why he wanted vacation days when he took accrued vacation. He had never had to bring a doctor's note for one day off work being sick. Requiring a doctor's note was not within the policy as he understood it or as it had been practiced with him before. Before the accident happened, claimant said he had never been reprimanded for using his personal cell phone.

On recross-examination, claimant admitted he was willing to lie to keep his job. He had no sick time left, which is why he asked for a vacation day or to take it without pay. Claimant understood that vacation time requires two weeks' notice to a supervisor, but claimant maintained he was told he could take a vacation day rather than coming into work. Claimant agreed that regardless of what the policy is and whether he should or should not have been asked for a note, there was no justification for producing a fraudulent note and representing that it was true and accurate.

Mr. William Bartley Ledgerwood testified for respondents. He is superintendent of the Washington County Road Department. He testified claimant did not fully cooperate with efforts to keep him working. He believed claimant hated working the front desk and telephone and was usually a no-show when assigned there. Claimant received a written reprimand on October 29, 2024, for cursing at a secretary at the front desk. The incident was significant enough to draw attention from other employees and supervisors. Claimant had received verbal reprimands about phone usage before receiving a written reprimand for excessive personal cell phone use on the same date.

In response to claimant’s testimony about working at a table too low for him in the sign shop, Mr. Ledgerwood said claimant was provided with a table at the right height with a stool to avoid

discomfort to his back.

Regarding the events October 23-24, 2024, Mr. Ledgerwood testified Superintendent Crowder felt a doctor's note was relevant because of claimant's past history of not showing up and taking off for jobs he did not want to do, indicating a pattern of claimant taking off whenever he wanted to. The note was requested based on this pattern; claimant had depleted all his sick time. Mr. Ledgerwood explained the vacation time policy requires two weeks' notice to structure who will be working. When somebody calls in asking to take a vacation day, it has always been denied. However, Mr. Ledgerwood told claimant he could take a vacation day because claimant had no other way to take time off—Washington County policy does not give unpaid days if vacation time is available. The superintendent asked Derek Morgan to request the note from claimant.

Mr. Ledgerwood stated the reason claimant was terminated was because he produced a forged doctor's note; but for the fraudulent note, claimant would have continued working in modified duty as he had since January 2024. Mr. Ledgerwood stated claimant was one of the better grader operators they had. As such, the intent was always for him to go back to operating the grader if he could. He denied there was collusion to set up traps for write-ups or reprimands; the write-ups were all the result of claimant's behavior and conduct.

On cross-examination, Mr. Ledgerwood said he was field superintendent when claimant was first employed and was aware claimant had a back injury at work. He agreed when claimant called that morning saying his back hurt, Mr. Ledgerwood told claimant to go home, and he would put it down as a vacation day. He explained this was not the first time claimant had been asked to bring a note when taking a vacation day as a sick day. Since claimant came back to work after surgery, he would schedule doctor visits and use vacation time because he had no more sick time. Mr. Ledgerwood allowed him to use vacation time as sick time; whether workers' compensation should pay for those appointments was not his decision to make. He personally had observed the pattern of claimant calling

in when he was at the front desk. When asked why claimant was not fired for this pattern, Mr. Ledgerwood could not answer.

Mr. Ledgerwood admitted he brought no documents to support the pattern of calling in when claimant was going to be on the front desk. The personnel file contained only two write-ups from October 29, 2024—nothing before that date. Mr. Ledgerwood conceded his knowledge about videos and TikToks on claimant's phone was secondhand. Mr. Ledgerwood could not answer how many vacation days claimant had, whether the pattern of calling in sick was documented in the personnel file. When claimant was a grader operator, Mr. Ledgerwood would not have known about cell phone use. It was only when claimant was at light duty in a public place could his phone use be observed.

On redirect examination, Mr. Ledgerwood confirmed he personally observed the pattern of claimant calling in sick as he described. The County kept claimant working until the fake doctor's note. Claimant expressed often that he hated light-duty and did the work begrudgingly, but he eventually did what was asked. If claimant had not been terminated for the false medical record, Mr. Ledgerwood stated that the County would have continued to accommodate him.

On recross-examination, the County would have continued to accommodate claimant even after full release, keeping him in the sign shop or front desk as they do with other injured employees. The County makes jobs for injured workers because they are "more of a family than a business." Mr. Ledgerwood agreed it is normal practice to send an employee to a doctor when they report being hurt at work.

REVIEW OF THE EXHIBITS

In addition to the prehearing order discussed above, the exhibits admitted into evidence in this case were Claimant's Exhibit # 1, consisting of two index pages and 33 numbered pages of medical records thereafter; Respondent's Exhibit # 1, consisting of one index pages and 33 numbered pages of medical records; Respondent's Exhibit # 2 consisting of one index page and 31 pages of non-

medical documents. There were emails from the parties following the hearing, which are blue backed to this record.

Reviewing the medical records in chronological order, the records that predate the January 23, 2024, incident that gave rise to this claim were those from January 27, 2016, when Dr. Carolyn Dillard examined claimant. One of the chief complaints was lower back pain on the left side that started two weeks prior with no injury and no fever. Physical examination showed paravertebral spasms on left paraspinal lumbar area with tenderness to palpation, full flexion, full extension, full lateral bending, full rotation, and positive straight leg raise on the left. Claimant's diagnoses included radiculopathy of the lumbosacral region. He was prescribed cyclobenzaprine as needed for muscle spasm and advised to use NSAIDs, stretching of low back, and to return in two weeks if no improvement. No records were provided of a return visit.

On January 27, 2024, claimant underwent an MRI of his lumbar spine at Northwest Medical Center Bentonville. The MRI showed five non-rib-bearing lumbar vertebral bodies with normal vertebral body heights. There was T1 and T2 hyperintense signal with STIR hyperintense signal in the inferior endplate of L4, superior part of L5, inferior endplate of L5, and superior endplate of S1, likely degenerative. Disc space narrowing and desiccation were noted at L4-L5 and L5-S1. At L4-L5, there was a disc bulge with bilateral subarticular and foraminal components and central protrusion, mild bilateral facet osteoarthritis and ligamentum flavum thickening, mild spinal canal stenosis, effacement of bilateral traversing L5 nerve roots, and mild bilateral neural foraminal stenosis. At L5-S1, there was a broad disc bulge, mild bilateral facet osteoarthritis and ligamentum flavum thickening, no spinal canal stenosis, and mild bilateral neural foraminal stenosis greater on the left. The impression was degenerative disc disease and facet osteoarthritis at L4-L5 with mild spinal canal stenosis and mild bilateral neural foraminal stenosis, with effacement of bilateral traversing L5 nerve roots requiring

correlation for radiculopathy. At L5-S1, mild degenerative disc disease and facet osteoarthritis with mild bilateral neural foraminal stenosis.

Claimant first saw Dr. James Calhoun at Pain Treatment Centers of America on May 6, 2024. Dr. Calhoun noted claimant was a new patient with uncontrolled lower back and leg pain not managed with activity modification, home exercise, over-the-counter NSAIDs, and current pain medication. Claimant described constant pain with intermittent flare-ups, worsened by any physical activity and relieved by rest and medications. Associated symptoms included restrictions in activities, mood changes, and difficulty sleeping. Claimant had completed 12 sessions of physical therapy with no improvement in left leg symptoms. He had returned to driving a grader and developed some right leg symptoms, reporting continued weakness in the right foot. He had a central disc herniation at L4-5. Dr. Calhoun discussed a left L4-5 microdiscectomy, including the risks and postoperative course. On May 28, 2024, Dr. Calhoun performed a laminotomy including decompression of nerve root at one interspace, lumbar, for herniated nucleus pulposus at L4-5 left.

On June 27, 2024, claimant saw Dr. Calhoun for a telemedicine follow-up, one-month post-surgery. Claimant had done very poorly with continued low back and right leg pain worsened with any increase in activity. He was using a cane. On the pain disability scale, claimant reported family/home responsibilities 7/10, recreation 8/10, social life 8/10, work-related activities 8/10, sexual behavior 8/10, self-care 6/10, and life support activities 3/10, for a Pain Disability Index score of 48. Dr. Calhoun's assessment was postoperative pain after spinal surgery. The plan was to try a Medrol dose pack. Current restrictions were no lifting more than 20 pounds, no repetitive bending/twisting, no standing or sitting more than 30 minutes, and no walking more than 15 minutes. Claimant was not at maximum medical improvement. A telemedicine follow-up was scheduled in one month.

On July 11, 2024, a postoperative MRI was performed at Fort Smith Hospital. The study showed moderate loss of disc height and endplate edema and enhancement at L4-L5 suspected to be degenerative Modic type 1 changes, with infection considered less likely. Left laminotomy changes were noted with enhancing soft tissue in the laminotomy bed and left lateral recess; the radiologist recommended correlation with duration since surgery as findings may represent postoperative granulation tissue, with epidural fibrosis not excluded. There was persistent disc bulge asymmetric to the left with stenosis of the left lateral recess and mass effect on the L5 nerve root. Moderate narrowing of the proximal right lateral recess with displacement of right L5 nerve root was noted. The canal was patent. There was moderate foraminal stenosis. At L3-L4, there was a left extraforaminal zone annular fissure with broad-based 4mm disc protrusion and moderate foraminal stenosis with displacement of exiting L3, with the canal narrow due to short pedicles. The impression noted primary canal stenosis due to short pedicles and degenerative and postoperative changes at L4-L5 including left laminotomy and persistent lateral recess narrowing with probable mass effect on L5 nerve roots. Enhancement in the left laminectomy bed and lateral recess was likely granulation tissue given recent surgery. No pseudo meningocele or arachnoiditis was seen. Minimal edema in the disc and edema/enhancement in the endplates was likely degenerative, with infection considered less likely.

On July 17, 2024, claimant saw Dr. Calhoun for postoperative follow-up, two months post-surgery. Claimant continued to complain of diffuse weakness and numbness in the left leg after the uncomplicated microdiscectomy. He reported the entire left leg felt numb and would give way, causing him to fall. After riding a lawn mower, it affected his right leg as well for 24 hours. Dr. Calhoun reviewed the postoperative MRI and stated the radiologist reported some lateral recess stenosis, but Dr. Calhoun disagreed. He found no significant neural compromise above that area to explain claimant's entire left leg weakness. The physical examination showed give-way weakness in every muscle tested on the left. Dr. Calhoun's assessment was postoperative pain after spinal surgery and

post-laminectomy syndrome of lumbar region. Dr. Calhoun had no explanation for the diffuse complaints in the lower left extremity. He started claimant on physical therapy, kept him on the same restrictions plus allowed him to attend physical therapy, and scheduled telemedicine in one month. Dr. Calhoun stated claimant's prognosis was poor.

On August 21, 2024, claimant had another telemedicine visit with Dr. Calhoun. Claimant had attended 7 of 8 physical therapy sessions with no improvement. He still fell when his left leg "gave out." Dr. Calhoun's assessment remained post-laminectomy syndrome of lumbar region. He talked with claimant's case manager and offered more physical therapy. A return visit was scheduled in September, and Dr. Calhoun stated claimant would most likely be declared at maximum medical improvement.

On September 18, 2024, Dr. Calhoun saw claimant for follow-up. Claimant reported he was unchanged with severe burning pain across his lower back with radiations superiorly and hypersensitive skin. He reported continued weakness in his left leg despite more physical therapy. Dr. Calhoun noted there was no good explanation for this on the postoperative MRI. Physical examination showed 4/5 strength in left iliopsoas, quadriceps, hamstrings, and gastrocnemius/soleus, 3/5 strength in left tibialis anterior, and give-way weakness in every muscle tested on the left. Dr. Calhoun's assessment was postoperative pain after spinal surgery. His plan stated no further treatment would be of benefit. Claimant was at maximum medical improvement with 10% impairment of the whole person according to the fourth edition of the AMA Guidelines to Permanent Impairment. Claimant was kept on the same restrictions. Dr. Calhoun suggested claimant undergo a functional capacity evaluation to determine permanent restrictions.

On October 3, 2024, claimant underwent a functional capacity evaluation. In an addendum dated October 7, 2024, Dr. Calhoun noted claimant gave an unreliable effort, making the results

invalid. Claimant remained at maximum medical improvement. Because claimant gave an unreliable effort, Dr. Calhoun released him to work full time with no restrictions.

On October 15, 2024, claimant was examined at Conservative Care Occupational Health Springdale. The work note stated claimant could not perform essential job functions as a heavy equipment operator. The examination noted claimant required a cane for walking, had left foot drop and left leg radiculopathy, and decreased range of motion in low back to 60 degrees with positive straight leg raising test on the left. The examining physician stated claimant had failed back surgery with multiple pain medications and muscle relaxants providing no relief.

On October 24, 2024, claimant submitted a purported off-work slip from Dr. Slabbert to his employer. On October 29, 2024, Baptist Health Family Clinic sent a letter stating the patient had no visit history of being seen in their clinic on October 24, 2024, and that Dr. Slabbert was out of town on that date.

On November 20, 2024, Dr. Calhoun sent a letter to Ms. Brooks stating claimant should return to his primary care physician for further prescriptions of gabapentin or muscle relaxants.

On June 9, 2025, claimant saw Dr. James Blankenship at The Neurosurgery Spine & Pain Management Center. Chief complaint was lower back pain and bilateral hip and buttock pain, left greater than right. Claimant also complained of left testicular pain and bilateral lower extremity symptoms down to his toes on the right and to the popliteal fossa on the left. He described decreased strength in both lower extremities, left greater than right. He denied incontinence but had urinary urgency. Claimant reported his May 2024 laminectomy did not significantly help and if anything increased his pain. He did three months of physical therapy postoperatively, with the last therapy in August. He was originally injured in January 2024 pulling a chain off a grader when he slipped and fell. He worked postoperatively at light duty until November 2024. Since then, he had been off work.

Conservative treatment included physical therapy, NSAIDs, heat/ice, and epidural steroid injection in April 2025. On examination, claimant had 4/5 extensor hallucis longus and foot dorsiflexors weakness on the left. He had an L5 radiculopathy on examination with sensory deficits in the L5 dermatome and straight leg raising positive at 10 degrees. His gait was ataxic and assisted by cane with foot drop. Lumbar radiographs showed severe disc space settling at L4-L5 and L5-S1 with severe foraminal stenosis. Examination of the spine showed range of motion restricted with flexion and extension limited due to pain. Straight leg raising test was positive on the left side.

Dr. Blankenship stated claimant's neurologic examination revealed an L5 radiculopathy with sensory deficits in the L5 dermatome, 4/5 strength in extensor hallucis longus and foot dorsiflexors on the left, and straight leg raising positive at 10 degrees. Dr. Blankenship reviewed claimant's functional capacity evaluation and was concerned that some of the inconsistencies had more to do with pure avoidance of falling due to weakness and the fact that claimant had been falling. Dr. Blankenship stated he would not weigh those findings given the condition claimant was in when he got the test and what was going on, to preclude further intervention based on what he saw on the MRI.

Dr. Blankenship noted claimant had a fairly large recurrent disc herniation in the midline, eccentric off to the left, with severe foraminal stenosis and marked endplate changes resulting in bilateral lateral recess stenosis, left much more significant than right. The L3-L4 level showed marked facet arthropathy but no significant neural impingement. The lumbosacral level also had significant degenerative changes with foraminal narrowing. Dr. Blankenship stated claimant had certainly failed routine and usual conservative measures and had an early disc recurrence at L4-L5. Both findings were consistent with claimant's current pain complaints and physical examination findings. Surgical consideration was warranted. Unfortunately, due to significant changes at the lumbosacral level, this

level would have to be incorporated into an arthrodesis, with the main focus of surgical intervention at L4-L5.

Dr. Blankenship recommended claimant undergo anterior lumbar interbody arthrodesis at L5-S1, lateral approach at L4-L5, and posterior decompression and pedicle screw fixation. After a lengthy discussion, claimant wanted to proceed with revision surgery. The rationale for offering surgery was the obvious recurrent disc herniation with severe left and moderate right lateral recess and foraminal stenosis at L4-L5. The reasons for suggesting arthrodesis were twofold: first, a very early recurrence, which is always an indication of segmental instability; second, claimant would need a significant amount of his facet joint taken off to safely and adequately decompress both the L4 and L5 nerves on the left, which would further destabilize his spine. Lastly, he had severe foraminal collapse at both L4-L5 and L5-S1 requiring elevation of the disc space with implants. Dr. Blankenship told claimant it was unlikely he would get any foot strength back after a year, but it was possible. Claimant would need a new MRI as a preoperative tool, as Dr. Blankenship would not operate based on a near year-old MRI.

On June 23, 2025, an MRI was performed at MANA MRI and read by Dr. Shawn Barnhill. The study showed postoperative changes at L4-L5 with marked endplate changes both at L4-L5 and L5-S1, more significant at L4-L5. Mild disc space desiccation was noted at L3-L4. The conus medullaris sat appropriately at the thoracolumbar junction with no distal conus medullaris pathology or pathology at the cauda equina appreciated. No pathologic enhancement was noted. At L4-L5, there was a post-hemilaminectomy on the left with recurrent disc herniation with bilateral foraminal stenosis secondary to broad-space disc protrusion, left much greater than right, resulting in bilateral lateral recess stenosis, left greater than right. At L5-S1, there was midline disc protrusion without significant neural impingement. The impression was L4-L5 recurrent disc herniation on the left with extension

to the neural exit foramen with L4 neural compression and milder right-side lateral recess stenosis and foraminal stenosis.

On July 7, 2025, Dr. Blankenship issued a work note stating claimant should be excused from work obligations until after he had surgery.

Dr. Ryan Fitzgerald, a board-certified diagnostic radiologist, was retained by respondents to provide a radiology review opinion dated November 5, 2025. Dr. Fitzgerald personally reviewed the actual MRI images from January 27, 2024, July 11, 2024, and June 23, 2025.

Dr. Fitzgerald's review of the January 27, 2024, MRI revealed moderate disc space narrowing and mild endplate osteophytes at L4-5 and L5-S1, hallmarks of chronic degenerative disease. Mixed Modic type I and II signal at L4-5 and L5-S1 represented active degenerative endplate inflammation superimposed upon background chronic degenerative marrow signal alteration. A minimal disc bulge at L3-4 was accompanied by an annular fissure across the left foraminal/extra-foraminal zones with mild/moderate left neural foraminal stenosis. A small central disc protrusion superimposed upon a diffuse disc bulge at L4-5 contributed to mild spinal canal stenosis and mild/moderate bilateral subarticular recess narrowing with crowding of the intracanalicular L5 nerve roots. Neural foraminal stenosis was moderate on the right at L4-5.

On the July 11, 2024, postoperative MRI, Dr. Fitzgerald found Modic type I signal on both sides of the L4-5 interspace (active degenerative endplate inflammation) was more widespread than on the comparison exam. Enhancement indicative of granulation tissue was demonstrated within the surgical bed. Ill-defined STIR hyperintense signal had developed within the paraspinous musculature on the left from L4 through S1. A residual disc protrusion in the central zone at L4-5 superimposed upon a mild disc bulge was no larger than on the comparison study. Persistent spinal canal stenosis at

L4-5 was mild and the left subarticular recess was moderately stenotic. Crowding versus impingement of the left L5 nerve root was evident.

Dr. Fitzgerald's review of the June 23, 2025, MRI showed no evidence of acute traumatic injury. Mild ill-defined STIR signal on both sides of the L4-5 and L5-S1 interspaces was again consistent with degenerative Modic type I signal. Residual enhancing scar in the surgical bed at L4-5 was much less pronounced than on the comparison exam. A minimal disc bulge and endplate osteophytes at L3-4 did not compromise the spinal canal and were unchanged. A mild disc bulge persisted at L4-5; however, the previously demonstrated central disc protrusion had regressed relative to the July 2024 exam. No residual or new disc herniation was evident. Mild spinal canal stenosis and moderate left-sided subarticular recess narrowing at L4-5 were unchanged. Dr. Fitzgerald concluded claimant's June 23, 2025, MRI revealed no evidence of acute traumatic injury. At L4-5, chronic degenerative disease and a residual disc bulge were present as on prior imaging, but no herniation or other new disc abnormality was found.

ADJUDICATION

There are two distinct parts to claimant's request for relief. He seeks additional medical care as recommended by Dr. Blankenship and temporary total disability benefits from June 9, 2025, until a date to be determined.

IS CLAIMANT ENTITLED TO ADDITIONAL MEDICAL TREATMENT

It was stipulated that claimant sustained a compensable injury on January 23, 2024. Claimant has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. *Goyne v. Crabtree Contracting Company*, 2009 Ark. App. 200, 301 S.W.3d 16. Once compensability is established, claimant need not offer objective medical evidence to prove entitlement to additional benefits. *Ark. Health Ctr. v. Burnett*, 2018 Ark. App. 427, 558 S.W.3d 408.

However, because of claimant's willingness to submit a fabricated note from a physician he had never seen and because he suffered a very convenient memory lapse in his deposition about previous issues with his back, I am examining this portion of the case to see if the evidence independent of his testimony supports the need for the surgery Dr. Blankenship has recommended. To that end, the medical records summary above is more detailed than what I normally feel is necessary to render an opinion.

Looking first at Dr. Calhoun's records, I find significant inconsistencies therein. Post surgery, he documented objective findings including weakness on examination, opined that claimant had done "very poorly" after surgery, stated claimant's prognosis was "poor," found "no explanation" for claimant's symptoms on the MRI, diagnosed post-laminectomy syndrome, and assigned permanent restrictions and a permanent impairment rating. Despite those findings, he declared claimant at maximum medical improvement with no further treatment of benefit, then released claimant to full duty with no restrictions based solely on an unreliable functional capacity evaluation. Dr. Calhoun's release of claimant to full duty work based on the FCE results is puzzling. The functional capacity evaluation measured claimant's effort and consistency during testing for a part of a day; it did not cure claimant's underlying spinal pathology or eliminate the objective findings Dr. Calhoun had documented on examination. Dr. Calhoun did not explain how a patient can simultaneously have a permanent anatomical impairment warranting restrictions and also be able to work full duty with no restrictions. His statement that "no further treatment would be of benefit" appears to be his way of ushering claimant out of his office. Dr. Calhoun did not suggest claimant see a neurosurgeon to address the issues he had documented but left untreated.

I found the testimony of Mr. Ledgerwood insightful on this issue. He established claimant's reports to Dr. Calhoun took place before claimant had any incentive to exaggerate his post-surgery

symptoms. Just the contrary; claimant hated working in the shop or office and was very eager to return to operating the grader. Having unnecessary treatment would only delay claimant's desired outcome. As such, his complaints to Dr. Calhoun following surgery are believable in light of Mr. Ledgerwood's observations. The Commission has the authority to accept or reject medical opinion and to determine its medical soundness and probative force. *LVL, Inc. v. Ragsdale*, 2011 Ark. App. 144, 381 S.W.3d 869. In light of all the evidence, I reject Dr. Calhoun's finding that claimant reached maximum medical improvement with no further treatment of benefit.

Dr. Blankenship documented clinical findings consistent with those of Dr. Calhoun, including weakness in the left lower extremity, sensory deficits in the L5 dermatome, positive straight leg raising, and L5 radiculopathy on examination. Dr. Blankenship also observed that claimant's gait was ataxic with foot drop and that claimant required a cane for ambulation. He ordered a new MRI which was performed on June 23, 2025. Dr. Barnhill reported "recurrent disc herniation" with bilateral foraminal stenosis and lateral recess stenosis at L4-L5. Based on his clinical examination and the MRI, Dr. Blankenship recommended anterior lumbar interbody arthrodesis at L5-S1, lateral approach at L4-L5, and posterior decompression and pedicle screw fixation.

Respondents retained Dr. Ryan Fitzgerald, a board-certified diagnostic radiologist, to provide an independent review. Unlike Dr. Barnhill, Dr. Fitzgerald personally reviewed and compared all three MRI studies that had been done in this matter. On the June 23, 2025, MRI, Dr. Fitzgerald found the disc protrusion had regressed relative to the July 2024 study and stated "no residual or new disc herniation was evident." However, Dr. Fitzgerald also found moderate left-sided subarticular recess narrowing at L4-5 that was unchanged from prior studies, along with mild spinal canal stenosis and chronic degenerative disease with endplate changes.

Dr. Fitzgerald's interpretation conflicts with Dr. Barnhill's characterization of "recurrent herniation." I find no fault with Dr. Fitzgerald's interpretations of the studies he reviewed; however, Dr. Fitzgerald's findings do not resolve the question before me. Dr. Fitzgerald is a radiologist who interprets imaging; he did not examine claimant. He did not opine on whether the pathology he documented—the unchanged moderate stenosis, the degenerative disease, the endplate changes—explains claimant's clinical symptoms or warrants surgical intervention. Those are clinical determinations outside the scope of a radiologist's expertise.

Both Dr. Calhoun and Dr. Blankenship documented claimant's neurological deficits. Dr. Calhoun found weakness and stated he had "no explanation" for claimant's symptoms based on the imaging. Dr. Blankenship found similar weakness, along with radiculopathy, sensory deficits, and foot drop requiring use of a cane. Both radiologists who reviewed the June 2025 MRI documented pathology. Dr. Barnhill characterized it as "recurrent herniation" with stenosis. Dr. Fitzgerald characterized it as regressed disc protrusion with unchanged moderate stenosis and degenerative disease. They appear to be describing the same pathology using different terminology.

Dr. Fitzgerald's finding that there is "no evidence of acute traumatic injury" on the June 2025 MRI does not undermine Dr. Blankenship's recommendation. Dr. Blankenship, as a neurosurgeon with specialized expertise in spinal surgery, correlated the clinical findings recorded by both examining physicians with the imaging pathology documented by both radiologists and determined that surgical intervention is warranted. After carefully weighing all the medical evidence, I find claimant has proven by a preponderance of the evidence that the surgery recommended by Dr. Blankenship is reasonable and necessary.

IS CLAIMANT ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS?

Claimant seeks temporary total disability benefits from June 9, 2025, the date he first saw Dr.

Blankenship, to a date yet to be determined. For an injured employee to be entitled to temporary total disability compensation, he must prove that he remains within his healing period and that he suffers a total incapacity to earn wages. *Ark. State Hwy. & Transp. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period ends when the underlying condition stabilizes such that further treatment will not improve the condition. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S.W.2d 457 (1994).

Because I have found that Dr Calhoun's release of claimant at maximum medical improvement was not supported by the evidence in this case, and that the surgery recommended by Dr. Blankenship is reasonable and necessary, it follows that claimant remains within his healing period. However, claimant has failed to prove he suffered a total incapacity to earn wages from June 9, 2025, forward.

Dr. Blankenship's July 7, 2025, letter regarding work—issued after reviewing the June 23, 2025, MRI—stated claimant "should be excused from work obligations until after he has surgery." While this reflects Dr. Blankenship's legitimate medical judgment, it does not constitute proof of total incapacity to earn wages. The note is a general work excuse, but does not take into account claimant's proven capacity to perform the specific light duty he successfully performed at Washington County. A physician's statement that a patient should not work differs from medical proof that the patient is totally incapacitated from earning wages in suitable employment. Ark. Code Ann. § 11-9-102(8).

Dr. Blankenship documented 4/5 strength in the left lower extremity, L5 radiculopathy, sensory deficits, and foot drop requiring use of a cane—findings substantially similar to those documented by Dr. Calhoun in July through September 2024 while claimant was working light duty. Dr. Calhoun found give-way weakness in every muscle tested on the left, 4/5 strength in multiple muscle groups, 3/5 strength in left tibialis anterior, left leg giving out causing falls, and post-

laminectomy syndrome. The physicians differed not in their clinical findings regarding claimant's condition, but in their treatment approach. Dr. Calhoun declared claimant at maximum medical improvement despite objective neurological deficits he acknowledged having "no explanation" for on imaging. Dr. Blankenship, as a neurosurgeon, determined surgical intervention was warranted to address the documented pathology.

Claimant successfully performed light duty work at Washington County from July through November 2024 despite these physical deficits. He worked in the sign shop and at the front desk performing sedentary and light tasks within his restrictions. If claimant could perform this work from July through November 2024 with the clinical condition that warranted surgical intervention, nothing in Dr. Blankenship's June 2025 findings demonstrated he had become totally incapacitated from continuing that same work.

Furthermore, the objective imaging demonstrated no worsening of claimant's condition. Dr. Fitzgerald's review of the June 23, 2025, MRI revealed the disc protrusion had regressed relative to the July 2024 postoperative study, with no residual or new disc herniation evident. The moderate left-sided subarticular recess narrowing and mild spinal canal stenosis documented on the June 2025 MRI were unchanged from prior studies. Claimant performed light duty work with Dr. Calhoun's documented deficits and the findings on the post-surgery MRI. Nothing in Dr. Blankenship's examination or in the June 2025 MRI demonstrates total incapacity from continuing that work.

Claimant's counsel argues in her post-hearing email that the termination was unreasonable due to short notice for the work note requirement. *Tyson Poultry v. Narvaiz*, 2012 Ark. 36, 386 S.W.3d 1, holds that a termination for misconduct does not forfeit temporary total disability benefits but claimant must still prove both healing period and total incapacity to earn wages. Even assuming *arguendo* the termination was unreasonable, claimant fails the incapacity requirement—he successfully

performed light duty despite the same clinical deficits Dr. Blankenship documented. Washington County provided modified duty work to claimant from January 2024 through his November 2024 termination. Mr. Ledgerwood credibly testified that Washington County would have continued providing modified duty consistent with claimant's restrictions absent the fraudulent note, and that fraud was the sole reason for termination.

For these reasons, I find claimant has failed to prove by a preponderance of the evidence that he suffered a total incapacity to earn wages from June 9, 2025, forward, and he is therefore not entitled to temporary total disability benefits.

ORDER

Claimant has met his burden of proving by a preponderance of the evidence that he is entitled to additional medical treatment as recommended by Dr. Blankenship for his compensable back injury.

Claimant has failed to prove by a preponderance of the evidence that he is entitled to temporary total disability benefits from June 9, 2025, to the date of the hearing. Pursuant to A.C.A. § 11-9-715(a)(1)(B)(ii), attorney fees are awarded "only on the amount of compensation for indemnity benefits controverted and awarded." Here, no indemnity benefits were awarded; therefore, no attorney fee has been awarded. Instead, claimant's attorney is free to voluntarily contract with the medical providers pursuant to A.C.A. § 11-9-715(a)(4).

Respondent is responsible for paying the court reporter's charges for preparation of the hearing transcript.

IT IS SO ORDERED.

JOSEPH C. SELF
ADMINISTRATIVE LAW JUDGE