**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**WCC NO. H404248**

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| SHUNDREKA RICHARD, Employee | CLAIMANT |
| KMJ MANAGEMENT, LLC, Employer | RESPONDENT |
| ACCIDENT FUND INS., Carrier | RESPONDENT |

**OPINION FILED JULY 30, 2025**

Hearing before ADMINISTRATIVE LAW JUDGE ERIC PAUL WELLS in Fort Smith, Sebastian County, Arkansas.

Claimant represented by EDDIE H. WALKER, Attorney at Law, Fort Smith, Arkansas.

Respondents represented by JAMES A. ARNOLD II, Attorney at Law, Fort Smith, Arkansas.

## STATEMENT OF THE CASE

On May 1, 2025, the above captioned claim came on for a hearing at Fort Smith, Arkansas. A pre-hearing conference was conducted on March 17, 2025, and a Pre-hearing Order was filed on March 18, 2025. A copy of the Pre-hearing Order has been marked Commission's Exhibit No. 1 and made a part of the record without objection.

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

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

2. The relationship of employee-employer-carrier existed between the parties on February 14, 2024.

3. The claimant sustained a compensable injury to her low back and left shoulder on or about February 14, 2024.

4. The claimant was earning sufficient wages to entitle her to compensation at the weekly rates of $420.00 for temporary total disability benefits and $315.00 for permanent partial disability benefits.

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

1. Whether Claimant sustained a compensable injury to her cervical spine on or about February 14, 2024.

2. Whether Claimant is entitled to medical treatment for her cervical spine injury in the form of surgery as recommended by Dr. Blankenship.

3. Whether Claimant is entitled to additional medical treatment for her compensable low back injury in the form of surgery as recommended by Dr. Blankenship.

4. Whether Claimant is entitled to temporary total disability benefits from March 26, 2024, through September 22, 2024.

5. Whether Claimant's attorney is entitled to an attorney's fee.

The claimant's contentions are as follows:

> "a. The Claimant contends that she is entitled to temporary total disability benefits from March 26, 2024 through September 22, 2024 and temporary disability benefits in regard to the surgeries that her authorized treating physician is recommending.
>
> b. The Claimant contends that the surgeries recommended by Dr. Blankenship constitutes reasonable and necessary medical treatment and therefore the respondents should be held liable for the same.
>
> c. The Claimant contends that her attorney is entitled to an attorney's fee regarding temporary total disability benefits from March 26, 2024 through September 22, 2024 and in regard to temporary disability benefits associated with the surgeries that her authorized physician is recommending and that the respondents deny liability for."

The respondents' contentions are as follows:

> "Respondents contend that they have paid and continue to pay all appropriate benefits to which the Claimant is entitled."

I note that a clerical was made in my Prehearing Order issued March 18, 2025, which served as a foundational document for this Opinion. That error occurs in Stipulation No. 3, which reads, "The claimant sustained a compensable injury to her low back and left shoulder on or about February 14, 2025." That has been corrected to reflect a date of February 14, 2024. That same error occurs in Issue No. 1, which reads, "Whether Claimant sustained a compensable injury to her cervical spine on or about February 14, 2025." That now reflects a date of February 14, 2024. I also note that the proper date is reflected in Stipulation No. 2, which regards the employee/employer/carrier relationship that the parties agree existed on February 14, 2024, and that the date of February 14, 2024, is recognized by both parties throughout questioning in the course of the hearing and documentary evidence submitted by both parties. There is no dispute regarding the proper date of the claimant's allegations of cervical spine injury and compensable lumbar spine and left shoulder injuries occurring on February 14, 2024.

The claimant in this matter is a 34-year-old female who sustained compensable injuries to her low back and left shoulder on or about February 14, 2024, while employed by the respondent. The claimant has asked the Commission to determine whether she also sustained a compensable cervical spine injury in that same incident. Additionally, the claimant has requested medical treatment for her cervical spine in the form of surgery as recommended by Dr. James Blankenship. On direct examination the claimant testified about the incident and her reporting of it to the respondent as follows:

> Q Ms. Richard, we are here today in regard to an incident that occurred on February 14, 2024, while you were in the employment

> of Fianna Nursing & Rehab. Will you tell us what happened on that day as far as your condition is concerned.
>
> A Yes, sir. I was working four halls. I was working 500, 600, 100 and 200. 200 is the rehabilitation hall. I was helping a resident get from his wheelchair to the bed and he fell back into his wheelchair. When he fell back into his wheelchair, he pulled me down with him and I heard my back pop, so I left him in the wheelchair until someone else got there to assist me getting him in the bed.
>
> Q Did you report that incident to somebody in a supervisory capacity that day?
>
> A When I left, there was no supervisors. No nurses had made it. There was nobody there.
>
> Q So when did you first report it?
>
> A I spoke with Jasmine that Friday before I went to the emergency room.
>
> Q Now, who is Jasmine?
>
> A She was – she is – I think it's the DON.
>
> Q And that is the Director of Nursing?
>
> A Yes, sir.
>
> Q Now, you saw before you went to the emergency room. The records indicate that you went to the emergency room on the 16th, which would have been two days later.
>
> A Yes, sir.

On cross examination the claimant was asked about her direct examination testimony and deposition testimony regarding the February 14, 2024, incident and her reporting of it as follows:

> Q Ms. Richard, you are describing an incident that occurred on February 14th, correct?
>
> A Yes, sir.

Q And it is my understanding that when this incident occurred with the gentleman you were assisting from the wheelchair to the bed, that you felt a pop in your lower back?

A Yes, sir.

Q Not in your neck?

A Not in my neck.

Q And when that occurred, you experienced low back pain?

A Yes, sir. I also had pain in my neck and my shoulder.

Q Okay. As a matter of fact, you recall that Ms. Rambo here took your deposition back on August 12, 2024, this last summer?

A Yes, sir.

Q She asked you about what your pain was and she said, "Okay. So you felt your back pop. Was it in your lower back?"

You answered, "My lower back."

MR. ARNOLD: This is Page 19

Q [BY MR ARNOLD]: (Continued) "And I started to have pains like in my neck, my right neck, the right side of my shoulder."

A Uh-huh.

Q And she said, "Okay. Your right shoulder?"

And you said, "Yes."

Is that your testimony?

A It is the left side, but from where I was sitting, it might have looked – seemed like right to me, but it is my left side.

Q Okay. She asked you a little bit later about this report to Jasmine.

A Uh-huh.

Q And you said that you told Jasmine that you were, "Having pain in my neck and my shoulder on my right side."

So in August you were explicit that the pain you felt initially was on the right side of your neck and shoulder.

A I never told Jasmine that it was on my right side. I did tell her that I was having the pain, but I never told her it was on my right side.

Q Okay. At Page 22 of your deposition taken by Ms. Rambo, she asked, "Did you report that you had injured your shoulder to Kim or Jasmine?"

You said, "I did. I told her I was having pains in my neck and my shoulder on the right side."

A Again, I was in pain and it's my left side. And it's also in the paperwork that it is is the left side.

Q Okay. Let's talk about that.

A Yes.

Q You did not report this incident to anyone at the nursing home on February the 14th.

A That's true.

Q Okay. You did not report it to anyone at the nursing home on February the 15th.

A That is true.

Q You did not report it to anyone at the nursing home until February the 16th after you had been to seek the folks in Oklahoma?

A You mean the hospital?

Q Yes.

A No. I talked to Jasmine before I went to the hospital.

> Q Okay. Is that when you told her that it was your right side?
>
> A No. I didn't tell her it was either side. I told her that I was having pain and that I was hurt and I think it was my back and my neck.
>
> Q Again, in your deposition you told us it was your right side.
>
> A And I understand that. And again, I was in pain. And also from the way we were sitting, I was trying to see which way it was, but I said right side, but I gestured my left side.

On February 16, 2024, the claimant was seen at Eastern Oklahoma Medical Center emergency department in Poteau, Oklahoma, by Dr. Jeffrey Johnson. The claimant's medical record from that visit in part states:

> **CHIEF COMPLAINT**
> **Chief Complaint**: LEFT SIDE NECK PAIN
>
> **HPI**
> **Patient Name**: RICHARD, SHUNDREKA M. is a Age: 33 years who presents with left sided neck pain that radiates down into left arm. no trauma or known injury. she works as a CNA at a nursing home and does heavy lifting. no numbness or weakness. no fever or chills. no n/v. no rash. no uri symptoms. no headache.
>
> ***
>
> **PHYSICAL EXAM**
>
> ***
>
> **Neck**: Supple. left crivical [sic] paraspinous muscles are tender to palp. no midline bony tenderness
>
> ***
>
> **Diagnostic Considerations and Summary of Care**:
> Pt here with atraumatic neck pain. no red flags. normal exam
> I gave dose of Toradol here. will dc with rx for meloxicam and robaxin.
> She will call her pcp in one week if not better. I told her that she may need an MRI of neck if not improving.
>
> ***
>
> **Nursing Note**

> 33 year old female presents to ER from home with primary complaint of left neck pain which has been present since Wednesday. Patient works as a CNA at finna nursing home. Patient reports taking home nsaids with no relief reported. Patient is alert and oriented times 4 with clear and appropriate speech. GCS is 15. Spontaneous unlabored respirations assessed with even chest rise and fall. Patient ambulated to ER 4 with a steady gait and was triaged at bedside.
>
> ***
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> **PRESCRIPTIONS WRITTEN**
> Continue regular medicines unless specified below. New medications by the provide will also be stated below.
> Robaxin (methocarbamol) 500 Mg. Tablets, Dispense: 40 (Forty) 500 mg. How To Use; Take two (2) tablets by mouth every 6 hours as needed for muscle spasm, Refills: None (0).
>
> **INSTRUCTIONS**
> 1. You have been given a medicine or prescription for medication called Robaxin (Methocarbamol).
> - This medication is used to relieve muscle spasm.

The claimant's next chronological medical record in evidence is from Mercy Clinic Occupational Medicine – Fort Smith dated February 23, 2024. I find no mention of the claimant having cervical difficulties or complaints in that medical record. That report reflects the claimant having lower back pain from lifting a resident. The claimant was given a diagnosis of "1. Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter (S46.012A). 2. Strain of muscle, fascia and tendon of lower back, initial encounter (S39.012A)" by APN Tawni Glander. The claimant was also placed on restricted work duty at that time.

After the claimant's February 16, 2024, initial visit where she complained of cervical pain, there are 15 medical reports in evidence beginning with a February 23, 2024, visit to Mercy Clinic Occupational Medicine – Fort Smith until she again reports cervical difficulties or complaints to a medical provider on July 24, 2024. That report is made to Eastern Oklahoma Medical Center. Following is a portion of that medical report:

**Chief Complaint: Chief Complaint: Fall**

**History of Present Illness:**
**Patient Name: RICHARD, SHUNDREKA M is a Age: 33 years who presents for evaluation of Chief Complaint: Fall**

Pt reports walking out front door today and her "legs gave out" pt reports hx of bulging disc of L5, S1. Pt reports hitting her left side when she fell.

**Time of Symptom Onset**: 6 hour(s) ago

***

**RISK**:
**Drugs**: Rx Medications considered but not prescribed OTC drugs
**Treatment**: Diagnosis or treatment significant risks discussed. Diagnostic test considered but not performed

Patient was seen and evaluated by myself. History and physical exam is consistent with low back and cervical strain. There are no signs or symptoms concerning for spinal cord compression, spinal, infection, or any other neurosurgical emergency. I did consider CT or x-ray imaging, however I do not believe these are necessary at this time. The patient was given IM Toradol and Norflex in the emergency department. I do believe she is safe for outpatient follow-up. I did consider prescription for narcotic pain medication, however I do not believe this is necessary at this time. She has a follow-up appointment tomorrow with pain management for her chronic pain. I recommend over-the-counter Tylenol and topical analgesics. She was given return precautions and follow-up instructions.

**Problem List**
Acute COVID-19
Low back strain
Cervical strain

The claimant begins to report cervical pain to other medical providers after her July 24, 2024, Eastern Oklahoma Medical Center visit where she reported a fall and had a physical exam consistent with cervical strain. The claimant was seen at the Mercy Clinic Department of Pain Medicine for a follow-up after she received a lumbar steroid injection. That report, dated July 25,

2024, in part states, "she does have shoulder and neck pain." On July 30, 2024, the claimant was seen at Mercy Clinic Primary Care in Poteau and reports cervical and low back pain. That report also states:

> **ASSESSMENT AND PLAN**:
> **1. Lumbar radiculopathy**
> Chronic issue, patient is scheduled to see neurosurgery on October 17th. Prescribing tramadol today to help with stability.
>
> **2. Chronic anemia**
> Chronic issue, currently on Ferralet. H&H and ferritin remains low CBC/ferritin now. Hematology appointment on 8/19
> - CBC WITH DIFFERENTIAL; Future
> - FERRITIN; Future
>
> **3. B12 deficiency**
> Chronic issue, stable at this time with B12 replacement. Continue 1 cc IM monthly.

The claimant is seen by Dr. James Blankenship at the Neurosurgery Spine and Pain Management Center on September 23, 2024. That medical report primarily deals with the claimant's lumbar spine but does address her cervical spine in part as follows:

> **HPI:**
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> ***
>
> The patient also had and is still having neck and upper left arm pain. This has not gotten any better since the accident but has really not been worked up.
>
> ***
>
> **Recommendations:**
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> ***
>
> Concerning her neck, we are going to get an MRI, and we will review this. Obviously, if it shows cord compression, we will get her back in here. If not, we will continue on with this conservative treatment plan. The patient left with no further questions.

On October 23, 2024, the claimant underwent an MRI of the cervical spine at MANA MRI. Dr. Blankenship authored the diagnostic report. Following is a portion of that report:

> C2-3: Midline disc bulge is noted with no cord, canal or foraminal compression.
> C3-4: No disc herniation, neural foraminal narrowing, or central or lateral recess stenosis is noted.
> C4-5: Midline disc protrusion with the AP canal diameter measuring in the axial plane 8 mm.
> C5-6: Midline disc protrusion with gross annular fissuring is noted. In the midline where the disc has protruded, the AP canal diameter measures 7 mm.
> C6-7: No disc herniations, neural foraminal narrowing, or central canal stenosis is noted.
> C7-T1: No disc herniations, neural foraminal narrowing, or central canal stenosis is noted.
>
> IMPRESSION: Midline disc protrusions at C4-5 and C5-6 resulting in kyphotic angulation of the spine with the spinal canal AP diameter measuring 8 mm at C4-5 and 7 mm at C5-6.

On October 31, 2024, Dr. Blankenship issued a note for the claimant's chart regarding her cervical spine as follows:

> NOTE FOR CHART: I have reviewed the patient's MRI in its entirety. The main purpose of this was to evaluate whether she has any cord compression. She did have some myelopathic findings on examination. The patient has a significantly flat neck with loss of normal cervical lordosis. She does have posterior disc bulging at C5-6 and C6-7. Her midline disc protrusion at C4-5 does abut the anterior horn of the spinal cord, but there is still CSF signal circumferentially. At C5-6 she has the same thing with less cord impingement. I certainly do not think this is bad enough that we need to talk about surgical intervention at present. We need to stick with the conservative game plan, and then we will see how she is doing when she come back in to see us.

On November 21, 2024, the claimant is again seen by Dr. Blankenship. Following is a portion of that medical record regarding the claimant's cervical spine:

> **Chief Complaint:**
> **Chief Complaint:** LEFT SIDE LOW BACK PAIN; NECK PAIN.

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**Diagnosis:**
M54.2 Cervicalgia
M50.20 Other cervical disc displacement, unspecified cervical region.

**Impression:**
The patient returns today increasing in pain. She did not get any relief with her SI joint injection. She is still complaining of neck pain, left subscapular and left hand pain. The patient had posterior disc protrusions at C4-5 and C5-6 that abut the anterior horn of the spinal cord. Her degree of stenosis is borderline with CSF signal noted posteriorly. Certainly her disc protrusion and kyphotic angulation are the etiology of her neck pain and headaches. I do not think there is enough crowding on the spinal cord, I told the patient, that she needs to have surgery, although her increasing balance problems are a little bit of a concern. At well over 6 months out from her injury and having failed conservative treatment, a discussion about surgical intervention on her neck is not unreasonable.

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**Recommendations:**
From the standpoint of pain, I have offered her surgical intervention on both. I have talked to her about a C4-5, C5-6 anterior cervical arthrodesis and fusion with spinal cord decompression and correction of alignment.

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In summary, the rationale for offering her an arthrodesis in her neck is due to her segmental spinal stenosis as well as her kyphotic angulation.

On December 9, 2024, the claimant was seen by Dr. Wayne Bruffett. Following is a portion of that medical record regarding the claimant's cervical spine:

**Chief Complaint:**
Neck pain and low back pain

**HPI:** Shundreka Richard is a 34 y.o. year old female who got hurt at work on February 14th. She works as a CNA. She was lifting a resident who became dead weight and the patient experienced pain in her neck and low back. She has had an MRI scan of her cervical

> and lumbar spine and she reports that she has had extensive treatments with medications physical therapy and spinal cord injections. Surgery has been recommended in both the cervical and lumbar spine. She is here for an IME.
>
> ***
>
> **Diagnosis cervical degenerative disc disease with cervical strain**
> **Lumbar degenerative disc disease with lumbar strain**
> **Disc herniation L5-S1 on the left without specific S1 radiculopathy**
>
> **Assessment**:
> Shundreka Richard is a 34 y.o. year old female with 3 young children who had a work related injury resulting in neck and low back pain. She is here for a 2nd opinion/IME.
>
> **Plan**:
> I was asked to assess whether the proposed surgeries are indicated or not. I would say with a reasonable degree of medical certainty that the proposed cervical and lumbar fusion surgeries are not indicated. In the cervical spine there is no evidence of nerve root or spinal cord compression there is no instability or fracture. In my opinion she does not have "segmental spinal stenosis" nor does she have "kyphotic angulation in the cervical spine" as described by Dr. Blankenship.
>
> ***
>
> It also appears that the patient will be given a cervical brace and a lumbar brace and a cervical bone stimulator and a lumbar bone stimulator to be used after the surgery. The cost for these items apparently is $1200 for each brace and $5000 for each stimulator "all to be given by Dr. Blankenship".
>
> ***
>
> But she certainly does not need a 2 level cervical fusion nor does she need an anterior lumbar fusion. I would not recommend any surgery for her.

On January 30, 2025, Dr. Blankenship authored a letter to the claimant's attorney. Following are portions of that letter concerning the claimant's cervical spine:

> I have received Dr. Bruffett's report regarding his 12-09-2024 evaluation of Ms. Richard. I have also reviewed my previous

> notes. First of all, the patient has certainly failed all routine and usually conservative measures. I respectfully disagree with Dr. Bruffett's report. I have been following this patient for some time. She does have significant pain.
>
> ***
>
> Concerning her cervical spine, again, as I have indicated in my notes, she has anterior disc protrusion with kyphotic angulation. In her cervical spine, this is a little bit more difficult diagnosis and offering of treatment. She does have a narrowed spinal canal but is not myelopathic on examination. Alignment issues have become more and more apparent thanks to our orthopedic brethren. I still think is a very good probability that correcting her alignment will afford her long-term relief.
>
> I would also be reasonable to fix her back and then try to be more focused on her neck after recovering from her back.
>
> ***
>
> At present, given the description of her job, I do not feel she is able to return to work in her current job description.
>
> This narrative has been based on a reasonable degree of medical certainty. Any questions or concerns can be forwarded to me.

On February 19, 2025, Dr Theodore Hronas authored a letter to the respondent's attorney regarding a records review of the claimant's case. Following are portions of that letter related to the claimant's cervical spine:

> The clinical history is of a work-related accidental injury that occurred on 02/14/2024 and described as "she was lifting a resident who became dead weight and the patient experienced pain." MRI exams of the cervical and lumbar spine are presented for review. The studies are of good quality and sufficient for diagnostic purposes. I am a board-certified radiologist with additional training in body and musculoskeletal MRI, and therefore my focus will be on the imaging studies provided.
>
> ***
>
> The MRI of the cervical spine, 10/23/2024, demonstrates straightening but normal alignment of the cervical spine, with no evidence of fracture, subluxation, or presence of a kyphotic deformity. The visualized posterior fossa and the cervical cord are

> normal. There is mild disc height loss and desiccation with diffuse disc bulging at C2/3, C3/4, C4/5, and C5/6, with superimposed small central disc protrusions at C2/3, C4/5, and C5/6 resulting in mild central canal stenosis without cord deformity at these levels. The C6/7 and C7/T1 disc levels are normal. The foramina are patent at all cervical levels. The posterior elements are intact.

The claimant has asked the Commission to determine whether she sustained a compensable cervical spine injury on February 14, 2024, in the same incident in which she sustained a compensable lumbar spine and left shoulder injury.

In order to prove a compensable injury as the result of a specific incident that is identifiable by time and place of occurrence, a claimant must establish by a preponderance of the evidence (1) an injury arising out of and in the course of employment; (2) the injury caused internal or external harm to the body which required medical services or resulted in disability or death; (3) medical evidence supported by objective findings establishing an injury; and (4) the injury was caused by a specific incident identifiable by time and place of occurrence. *Odd Jobs and More v. Reid*, 2011 Ark. App. 450, 384 S.W. 3d 630.

The claimant was clear in her testimony that she experienced a "pop" in her low back but not her neck. However, the claimant testified that she felt pain in her cervical spine or neck at that time. The claimant reported her incident two days later and was seen at the Eastern Oklahoma Medical Center emergency department that same day. During that visit she reported cervical pain. Her physical exam from that visit states, "Neck: Supple. left crivical [sic] paraspinous muscles are tender to palp. No midline bony tenderness." The claimant was diagnosed with a cervical strain and prescribed Robaxin specifically "to alleviate muscle spasm." Dr. Jeffrey Johnson was the physician at the EOMC emergency department. He clearly made objective findings regarding the claimant's cervical spine in the physical exam noting "left

crivical [sic] paraspinous muscles are tender to palp." In conjunction with specifically prescribing Robaxin for muscle spasm, this finding is consistent with the Court of Appeals decision in *Melius vs Chapel Ridge Nursing Center, LLC,* 2021 Ark. App. 61, 618 S.W.3d 410, regarding objective medical findings. The claimant is also able establish a causal connection between her objective medical findings and the incident in which she alleges the cervical injury. That same incident resulted in compensable lumbar spine and left shoulder injuries. The claimant first reported her cervical pain to her first medical provider, Dr. Johnson. I find the claimant is able to prove she sustained a compensable cervical injury on February 14, 2024, in the form of a cervical strain.

It appears that the claimant's cervical strain resolved quickly as the claimant did not again make medical providers aware of cervical difficulties until a fall in July of 2024. The claimant's medical records do not indicate cervical pain or difficulties after her February 16, 2024, emergency department visit until her fall in July of 2024. The claimant then begins to often complain of cervical pain.

It is at that time that the medical records show she begins to seek treatment which has ultimately brought Dr. Blankenship to the conclusion that the claimant needs cervical surgery. I note both Dr. Bruffett and Dr. Hronas disagree with Dr. Blankenship's recommendation for surgery. The claimant must prove that the medical treatment in the form of surgical intervention is reasonable and necessary treatment for her compensable cervical spine injury.

Employers must promptly provide medical services which are reasonably necessary in connection with the compensable injuries, Ark. Code Ann. §11-9-508(a). However, injured employees have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31

(2004). What constitutes reasonable and necessary medical treatment is a fact question for the Commission, and the resolution of this issue depends upon the sufficiency of the evidence. *Gansky v. Hi-Tech Engineering*, 325 Ark. 163, 924 S.W.2d 790 (1996).

While I recognize the medical opinions of Dr. Blankenship differ regarding the claimant's cervical spine on the course of treatment, they also differ on how the claimant's MRI results are read. I agree with the position of Dr. Bruffett and Dr. Hronas that the claimant does not need the recommended cervical spine surgery. Furthermore, I find that any cervical spine treatment the claimant is in current need of is the result of her July 2024 fall when she begins to complain of cervical spine pain again or some other condition. The claimant has failed to prove by a preponderance of the evidence that the cervical surgery recommended by Dr. Blankenship is reasonable and necessary treatment for her compensable cervical strain of February 14, 2024.

The claimant has also asked the Commission to determine whether she is entitled to additional medical treatment for her compensable low back injury of February 14, 2024. I note that several of the later dated medical records admitted into evidence deal with both the claimant's lumbar and cervical spine. I have attempted above to isolate the portions of those medical records that deal with the cervical spine. I will attempt to do the same here regarding the claimant's lumbar spine.

The claimant's medical records clearly indicate that she has continuously sought treatment for her lumbar spine beginning with her February 23, 2024, visit to Mercy Clinic Occupational Medicine – Fort Smith, including a lumbar MRI performed on March 22, 2024. The diagnostic report was done by Dr. Alan Richard at Mercy Hospital and gave the following Impression:

> Impression:

> IMPRESSION:
> Mild degenerative change throughout the lumbar spine. The most significant finding is a broad-based disc bulge eccentric to the left at L5-S1 which abuts the proximal S1 nerve root.

The claimant has undergone conservative treatment including prescription medications, lumbar epidural steroid injections, and physical therapy. The claimant eventually finds herself under the care of Dr. Blankenship on September 23, 2024. Following is a portion of that visit note regarding the claimant's lumbar spine:

> **HPI:**
> The patient has lower back pain, bilateral hip and buttock pain left greater than right, posterior lower extremity pain left greater than right, and decreased strength in both legs left greater than right. She has fallen a couple of times. She denies any incontinence or retention. Standing, walking, and bending increase her pain. She was injured in 2/2024 lifting a resident and turned and her back popped with progressive increase in her pain. She was given some home exercises but has had no significant conservative treatment other than an LESI that was done in 6/2024 that actually exacerbated her pain. She is currently only taking gabapentin 300 mg 3 times a day. The patient also had and is still having neck and upper left arm pain. This has not gotten any better since the accident but has really not been worked up.
>
> **Chief Complaint:**
> **Chief Complaint:** LEFT SIDE LOW BACK PAIN.
>
> ***
>
> **Diagnosis:**
> M51.26 Other intervertebral disc displacement, lumbar region
> M54.50 Low Back Pain
>
> **Impression:**
> Her general neurological examination reveals the patient has decreased sensation in the L5 and S1 dermatomes on the left. Interestingly, she has some myelopathic findings on exam with mostly brisk reflexes throughout the upper and lower extremities with a positive Hoffmann's on the right. Her SI joint examination is markedly positive on the left-hand side. Her piriformis examination is also positive.

> Her MRI demonstrates a gross annular fissure off to the left-hand side consistent with her back pain on that side as well as her leg pain. She has significant foraminal narrowing due to disc space settling and a posterior disc protrusion along with a caudally migrated disc fragment on the left. I told her concerning this we need to treat this conservatively.
>
> ***
>
> **Recommendations:**
>
> ***
>
> I would recommend that we have Dr. David Cannon evaluate her for a left-sided SI joint injection at the lumbosacrum on the left. If she does not get any significant relief with this, I do want to go ahead with the transforaminal ESI at L5-S1 on the left if Dr. Cannon agrees. It is complicated is the as we get her back in to work with Velvet's folks, I do not want to start doing anything with her neck until we get the MRI. Once I see it, if it is okay, we will add that to her treatment regimen. I have recommended we start her on meloxicam and have her continue on her gabapentin. I told her most importantly we need to get her started with an aggressive active physical therapy program. She lives in Podo. I told her my preference would be to have this done in Fort Smith, but I realize that is 30 minutes away. We will coordinate that with her before she leaves today. I do want to go ahead and get her set up to see Dr. Cannon. Unfortunately for her, there is nobody here today, and we will have to get it authorized.
>
> ***
>
> In summary, she does have a posterior disc protrusion eccentric off to the left. I do think this is the probable culprit of her pain, although she certainly does have some S1 findings, and the mechanism of injury would be consistent with either. I would like to get her SI joint injected first and if that does not bear fruit do a transforaminal ESI at the lumbosacrum on the left-hand side. We are going to start working the Velvet's folks. I will plan on seeing her back in about 8 weeks. Since her work cannot accommodate restrictions, she is off work until she sees me back. She understands and agrees with the game plan.

The claimant again saw Dr. Blankenship on November 21, 2024. Following is a portion of that visit note regarding the claimant's lumbar spine:

> **HPI:**

The patient is in today with a new cervical MRI. She has been doing her physical therapy for her neck and her low back. She states it does not afford any relief; if anything, it aggravates her pain. She is still taking her meloxicam and rates her pain about 80% toward the worst pain imaginable. Her greatest pain complaint is her left-sided low back pain that radiates into the left hip, left buttock, and goes down the posterior aspect of the bilateral lower extremities to her feet with her left greater than right. She has decreased strength in both legs, left greater than right. She did get her left SI joint injection but had no relief.

***

**Chief Complaint:**
**Chief Complaint:** LEFT SIDE LOW BACK PAIN; NECK PAIN.

***

**Diagnosis:**
M54.2 Cervicalgia
M50.20 Other cervical disc displacement, unspecified cervical region.

**Impression:**
The patient returns today increasing in pain. She did not get any relief with her SI joint injection.

***

Concerning her lumbar spine, she has marked disc space settling and foraminal stenosis at the lumbosacrum. She does have some mild bilateral lateral recess stenosis at L4-5, and she has a midline disc protrusion with several bilateral foraminal stenosis at the lumbosacrum. I do not have any doubt that that is the etiology of her back pain and leg pain.

**Recommendations:**

***

At the lumbosacrum, she would need to undergo an anterior lumbar interbody arthrodesis with ENZA-A stabilization. I told her initially I would rely on indirect decompression rather than opening her back up to openly decompress the nerve roots. After a very lengthy discussion, she does want to proceed on with cervical and lumbar arthrodesis. I have told her we would do the cervical first and then a week or 2 later do her lumbar standalone arthrodesis. She left with no further questions.

***

> The rationale for the lumbar spine is failure of conservative treatment with a midline disc herniation with retrolisthesis and sagittal plane malalignment.

On December 9, 2024, the claimant was seen by Dr. Wayne Bruffett. Following is a portion of that medical record regarding her lumbar spine:

> **Chief Complaint:**
> Neck pain and low back pain
>
> **HPI:** Shundreka Richard is a 34 y.o. year old female who got hurt at work on February 14th. She works as a CNA. She was lifting a resident who became dead weight and the patient experienced pain in her neck and low back. She has had an MRI scan of her cervical and lumbar spine and she reports that she has had extensive treatments with medications physical therapy and spinal cord injections. Surgery has been recommended in both the cervical and lumbar spine. She is here for an IME.
>
> ***
>
> **Diagnosis cervical degenerative disc disease with cervical strain**
> **Lumbar degenerative disc disease with lumbar strain**
> **Disc herniation L5-S1 on the left without specific S1 radiculopathy**
>
> **Assessment**:
> Shundreka Richard is a 34 y.o. year old female with 3 young children who had a work related injury resulting in neck and low back pain. She is here for a 2nd opinion/IME.
>
> **Plan**:
> I was asked to assess whether the proposed surgeries are indicated or not. I would say with a reasonable degree of medical certainty that the proposed cervical and lumbar fusion surgeries are not indicated.
>
> ***
>
> Apparently his indication for the lumbar fusion is "failure of conservative treatment with a midline disc herniation with retrolisthesis and sagittal plane malalignment". It also appears that the patient will be given a cervical brace and a lumbar brace and a cervical bone stimulator and a lumbar bone stimulator to be used

> after the surgery. The cost for these items apparently is $1200 for each brace and $5000 for each stimulator "all to be given by Dr. Blankenship".
>
> The patient has positive Waddell signs. Today she is using a rolling type walker. Her description of her pain is in excess of any objective findings on her imaging. She does have a disc herniation at L5-S1 on the left. If she had a specific S1 radiculopathy down her left leg and failed specific treatments directed towards this then a microscopic partial diskectomy at L5-S1 on the left in my opinion would be a reasonable surgical procedure for her. However, she does not really complain of a specific S1 radiculopathy down her left leg and does not have any type of neurological deficit associated with this so in my opinion a surgery such as that would even have risks that would outweigh the benefit.
>
> ***
>
> I would not recommend any surgery for her.

On January 30, 2025, Dr. Blankenship authored a letter to the claimant's attorney regarding Dr. Bruffett's medical report pertaining to the claimant's lumbar spine. Those portions follow:

> I have received Dr. Bruffett's report regarding his 12-09-2024 evaluation of Ms. Richard. I have also reviewed my previous notes. First of all, the patient has certainly failed all routine and usually conservative measures. I respectfully disagree with Dr. Bruffett's report. I have been following this patient for some time. She does have significant pain. She does have lower back pain along with her left posterolateral leg pain. I think that her leg pain is probably coming from the severe foraminal stenosis that she has bilaterally. The disc protrusion with caudal migration and annular fissuring is noted. A simple discectomy that Dr. Bruffett mentioned is not going to treat her foraminal stenosis at all. It is for that reason I offered her an anterior lumbar interbody arthrodesis as a standalone procedure to avoid operating and cutting open her back, which will lead to increased morbidity. As far as the risk/benefit ration, anterior lumbar interbody arthrodesis in young and healthy people has a very low risk of morbidity, which I have gone over with her, and she has accepted those risks for surgical intervention. At the lumbosacrum, we are working between the vessels. The incident of vascular injury is not significantly higher.

> In summary, it is my opinion based on a reasonable degree of medical certainty that the offering of an anterior lumbar interbody arthrodesis as a standalone procedure to decrease morbidity in postoperative recovery is a very reasonable thing to offer a patient who has railed routine and usual conservative measures.
>
> ***
>
> I would also be reasonable to fix her back and then try to be more focused on her neck after recovering from her back.
>
> Again, concerning her lumbar spine, in my clinical practice and years of experience, this is a very reasonable offering of surgical intervention, and I respectfully disagree with Dr. Bruffett.
>
> At present, given the description of her job, I do not feel she is able to return to work in her current job description.
>
> This narrative has been based on a reasonable degree of medical certainty. Any questions or concerns can be forwarded to me.

On February 19, 2025, Dr. Theodore Hronas authors a letter to the respondent's attorney regarding his review of a portion of the claimant's medical records. Following is a portion of that letter regarding the claimant's lumbar spine:

> The clinical history is of a work-related accidental injury that occurred on 02/14/2024 and described as "she was lifting a resident who became dead weight and the patient experienced pain." MRI exams of the cervical and lumbar spine are presented for review. The studies are of good quality and sufficient for diagnostic purposes. I am a board-certified radiologist with additional training in body and musculoskeletal MRI, and therefore my focus will be on the imaging studies provided.
>
> Radiographs of the lumbar spine 02/23/2024, demonstrate normal vertebral body alignment with no evidence of fracture or subluxation. The posterior elements are intact. There are no radiographic findings of an acute lumbar spine injury.
>
> The MRI exam of the lumbar spine, 03/22/2024, was performed approximately five weeks after the date of injury. This exam demonstrates normal alignment of the lumbar spine with no evidence of fracture or subluxation. The conus medullaris is

> normal. Sagittal STIR images demonstrate no evidence of bone, disc space, or soft tissue edema. The T12/L1, L1/2, L2/3, and L3/4, disc spaces are preserved, but there is bilateral mild facet arthropathy at these levels, with no associated central canal stenosis or foraminal narrowing. At L4/5, there is mild diffuse disc bulging, bilateral mild facet arthropathy, and ligamentum flavum thickening resulting in mild to moderate central and lateral recess stenosis and bilateral mild to moderate foraminal narrowing. At L5/S1, there is disc desiccation, diffuse disc bulging, with a superimposed broad-based left paracentral disc protrusion causing narrowing of the left lateral recess with mild mass effect on the adjacent S1 nerve root. There is bilateral mild facet arthropathy and mild ligamentum flavum thickening resulting in mild to moderate foraminal narrowing at the L5/S1 level. The posterior elements are intact. There are no paraspinal abnormalities.
>
> ***
>
> In summary, the MRI of the lumbar spine demonstrates chronic degenerative changes at L4/5 and L5/S1 with a broad-based left paracentral disc protrusion at L5/S1 resulting in mild mass effect on the adjacent S1 nerve root. I defer to the clinical evaluation of Dr. Blankenship and Dr. Bruffett in regard to whether there is a symptomatic left S1 radiculopathy. In regard to Dr. Blankenship's comment, "I think that her leg pain is probably coming from the severe foraminal stenosis that she has bilaterally," I see only mild to moderate bilateral foraminal narrowing, not severe foraminal narrowing, at L4/5 and L5/S1 with no objective findings of foraminal nerve root impingement within the lumbar spine at any level. The MRI of the cervical spine demonstrates multi-level degenerative changes, and multiple small central disc protrusions without cord deformity or foraminal narrowing at any level within the cervical spine. In regard to Dr. Blankenship's comment, "she has anterior disc protrusion with kyphotic angulation," I see no evidence of an anterior disc protrusion and no evidence of kyphosis.

Employers must promptly provide medical services which are reasonably necessary in connection with the compensable injuries, Ark. Code Ann. §11-9-508(a). However, injured employees have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004). What constitutes reasonable and necessary medical treatment is a fact question for the

Commission, and the resolution of this issue depends upon the sufficiency of the evidence. *Gansky v. Hi-Tech Engineering*, 325 Ark. 163, 924 S.W.2d 790 (1996).

The claimant has continually complained of lumbar spine difficulties as a result of her February 14, 2024, compensable lumbar spine injury. The claimant has undergone conservative treatment and Dr. Blankenship, her treating physician, has recommended "At the lumbosacrum, she would need to undergo an anterior lumbar interbody arthrodesis with ENZA-A stabilization. I told her initially I would rely on indirect decompression rather than opening her back up to openly decompress the nerve roots."

Here, clearly Dr. Blankenship and Dr. Bruffett disagree. Dr. Bruffett says he ultimately would not recommend any surgery for the claimant, but if he did, it would be a microscopic partial discectomy at L5-S1 on the left. It appears Dr. Bruffett is basing his opinion, at least in part, on his clinical findings including positive Waddell signs and "pain in excess of any objective findings." As to Dr. Hronas, he does differ on the review of the claimant's lumbar MRI. Dr. Hronas finds only mild to moderate bilateral foraminal narrowing. Dr. Blankenship finds there to be severe foraminal stenosis bilaterally. However, Dr. Hronas does state, "I defer to the clinical evaluations of Dr. Blankenship and Dr. Bruffett in regard to whether there is a symptomatic left S1 radiculopathy."

I find Dr. Blankenship to be in the best position to clinically diagnose and recommend treatment for the claimant. Given the consistency of the claimant's lumbar spine complaints, her treating physician's clinical observations of her, and the failed conservative treatment, I find Dr. Blankenship's surgical recommendations for the claimant's lumbar spine to be reasonable and necessary treatment for the claimant's compensable lumbar spine injury.

The claimant has asked the Commission to determine whether she is entitled to temporary total disability benefits from March 26, 2024, through September 22, 2024.

In order to be entitled to temporary total disability benefits, the claimant has the burden of proving by a preponderance of the evidence that he remains within his healing period and that he suffers a total incapacity to earn wages as a result of his compensable injury. *Arkansas State Highway & Transportation Department v. Breshears,* 272 Ark. 244, 613 S.W. 2d 392 (1981).

The claimant gave direct examination testimony regarding her last treatment with Mercy Clinic Occupational Medicine – Fort Smith, her work restrictions and discontinuing work as follows:

> Q At some point did Occupational Medicine stop providing you treatment?
>
> A Yes.
>
> Q Do you know when, approximately?
>
> A I honestly don't remember the date.
>
> Q What is your understanding of why Occupational Medicine stopped providing you treatment?
>
> A I was told that she didn't know why they sent me. There was nothing else that she could do for me. And that I should continue to follow up with my primary care physician.
>
> Q And your primary care physician was another Mercy doctor, but over in Oklahoma, I believe; is that right?
>
> A Yes, sir.
>
> Q So when did you start missing work?
>
> A When I went to work and I had a conversation with Jasmine about my restrictions not being followed. They wanted me to help put residents in the bed and run meal trays. Anything aside from sitting work and vitals is what they wanted me to do.

> And that day I told – I had a conversation with Jasmine and I told her that that was outside of my restrictions. She never messaged me back, but I left that day.
>
> Q So was that on or about March 26th of 2024?
>
> A Yes, sir.
>
> Q Have you been back to work since then?
>
> A Yes, I did.
>
> Q Now, my records show that that was on or about September 23rd of 2024 and the workers' compensation insurance carrier started your benefits as of that date; is that correct?
>
> A Yes, sir.
>
> Q Between March 26th of '24 and when you saw Dr. Blankenship, did our condition stay the same, get better or get worse?
>
> A It got worse.
>
> Q If you were unable to perform your job duties on September 23rd of 2024, would you have also been unable to perform your job duties during the period of time between March 26th and September 23rd?
>
> A Yes, sir.
>
> Q What was there about your condition that caused you not to be able to work?
>
> A Walking. I was having muscle spasms. Well, I still have muscle spasms when I walk. I have a pain in my legs, my butt, my back, and my neck. Bending hurts. Looking up or looking down for too long, I get headaches in my head and I have to lay down. It makes me nauseous. It makes me feel like I am going to pass out.

The work restrictions placed on the claimant were from Mercy Clinic Occupational Medicine – Fort Smith in a report dated March 25, 2024. Those restrictions were as follows,

"Recommended Activity Restrictions Alternate sit/stand/walk as tolerated. Primarily sedentary duty." The next medical record removing the claimant from work or restricting the claimant is from Dr. Blankenship on September 23, 2024, when he removes the claimant from work until November 21, 2024.

I find the claimant to have still been in her healing period from March 26, 2024, through September 22, 2024. However, the claimant must also prove by a preponderance of the evidence that she suffers a total incapacity to earn wages as a result of her compensable injuries. The claimant cannot meet that proof regarding total incapacity. In fact, she was able to sit/stand/walk as tolerated and perform sedentary duties. At one point in testimony, the claimant complains of taking meal trays as she believes it to be outside of her restrictions. I do not find that to be so. The claimant was asked, "What was there about your condition that caused you not to be able to work?" The first part of her response is "Walking," which is clearly allowed at least in part under her restrictions during that period. I also note that the claimant saw several other medical providers between March 26, 2024, and September 22, 2024, and to my knowledge, no provider placed restrictions or removed the claimant from work. The claimant is unable to prove her entitlement to temporary total disability benefits from March 26, 2024, through September 22, 2024.

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

## FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The stipulations agreed to by the parties at the pre-hearing conference conducted on March 17, 2025, and contained in a Pre-hearing Order filed March 18, 2025, are hereby accepted as fact.

2. The claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her cervical spine on or about February 14, 2024.

3. The claimant has failed to prove by a preponderance of the evidence that she is entitled to medical treatment for her compensable cervical spine injury in the form of surgery as recommended by Dr. Blankenship.

4. The claimant has proven by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable low back injury in the form of surgical intervention as recommended by Dr. Blankenship.

5. The claimant has failed to prove by a preponderance of the evidence that she is entitled to temporary total disability benefits form March 26, 2024, through September 22, 2024.

6. The claimant has failed to prove by a preponderance of the evidence that her attorney is entitled to an attorney's fee in this matter.

## ORDER

The respondent shall pay the cost associated with the surgical recommendations of Dr. Blankenship for the claimant's compensable lumbar spine injury, including its aftercare.

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).

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

**IT IS SO ORDERED.**

**HONORABLE ERIC PAUL WELLS**
**ADMINISTRATIVE LAW JUDGE**