BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. **H300389**

TRACY MILLER, EMPLOYEE	CLAIMANT
BAPTIST HEALTH REGIONAL HOSPITALS, EMPLOYER	RESPONDENT
CLAIMS ADMMINISTRATIVE SERVICES	RESPONDENT

OPINION FILED **APRIL 24, 2025**

Hearing before ADMINISTRATIVE LAW JUDGE JOSEPH C. SELF in Fort Smith, Sebastian County, Arkansas.

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

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

STATEMENT OF THE CASE

On February 10, 2025, the above captioned claim came on for a hearing at Fort Smith, Arkansas. A pre-hearing conference was conducted on November 7, 2024, 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 March 26, 2021.
3. The compensation rates are the maximum.

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

1. Whether claimant is entitled to additional medical benefits.

2. Determination of the extent of permanent injury to claimant's back.

3. Attorney fees.

All other issues are reserved by the parties.

The claimant contends that "She is not only entitled to an updated MRI regarding her back; she is also entitled to further evaluation regarding her hip as recommended by Dr. Frank Tomecek. She was assessed an 18% impairment rating to the body as a whole regarding her back; however, it is her recollection that she only was paid for a 10% impairment rating. The claimant contends that it is premature to determine the extent of her permanent impairment at this time since diagnostic evaluation regarding her back and hip as directed by Dr. Tomecek is still pending. However, the claimant reserves her right to litigate extent of permanent impairment as well as possibly extent of wage loss disability. The claimant contends that her attorney is entitled to an attorney's fee in regard to any disability benefits to which she is determined to be entitled that the respondents have not already paid."

The respondents contend that "The MRI recommended by Dr. Tomecek was actually approved by respondent/adjuster on September 18, 2024. Respondents are unsure why that diagnostic test has not been scheduled. With regard to the impairment rating, it is respondents' position that the 8% assigned subsequent to testing and measurements taken by the Functional Testing Centers on August 24, 2022, is per the AMA Guides, Fourth Edition, and is the appropriate rating for claimant's lumbar spine. It is respondents' position that Dr. Tomecek's rating was not assigned per the AMA Guides, Fourth Edition, and is a liability of respondent/carrier."

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 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 a pre-hearing conference conducted on November 7, 2024, and contained in a pre-hearing order filed on that same date are hereby accepted as fact.

2. Claimant has met her burden of proof by a preponderance of the evidence that she is entitled to additional medical treatment as directed by Dr. Frank Tomacek.

3. Claimant's request for a permanent impairment rating was withdrawn.

FACTUAL BACKGROUND

There was an unusual amount of activity in this matter after the hearing. On February 12, 2025, respondent submitted an email regarding the use of a double inclinometer by Dr. Tomacek to assess an 18% impairment rating to claimant. Having reviewed that email, claimant agreed that test was not an objective finding and withdrew her claim for a permanent impairment rating of 18%. This exchange is blue backed to this record.

Shortly after the hearing, claimant's attorney became aware of a document prepared by Dr. Tomacek which had been requested by the claims adjuster for respondents, but which had not been provided to claimant. A Motion to Submit Newly Discovered Evidence was filed on February 17, 2025. Respondents opposed this motion. After considering the circumstances, I entered an Order granting the claimant's motion, allowing respondents the opportunity to depose Dr. Tomacek or otherwise present evidence in response to that document. Respondent declined to do so. This exchange is blue backed to this record. The addendum from Dr. Tomacek is addressed in the review of the medical records section of this opinion.

When preparing this Opinion, I noticed that the compensability of claimant's injury was not specifically addressed in the stipulations. Respondent had paid for medical treatment in the past and had paid claimant's impairment rating, so I understood that I did not need to decide compensability. To clarify that this was a stipulation, I emailed the attorneys on April 23, 2025, and they both confirmed this was an accepted claim. This exchange is blue backed to this record.

HEARING TESTIMONY

Claimant was the only witness to testify at the hearing. She was injured in March 2021 when she was helping a patient get on to an x-ray table when the patient started to fall. Claimant grabbed him to keep him from falling and felt a pop in her back immediately. She was sent to Occupational Medicine and eventually wound up under the care of Neurosurgeon Dr. Frank Tomecek. Dr. Tomecek recommended that claimant have surgery on her back, but she wanted to try other options before undergoing an invasive surgery. Claimant said she underwent physical therapy and had a couple of injections; she also went to Genesis Neck and Back for decompression treatment. She recently had undergone an MRI, after which Dr. Tomecek recommended a lumbar epidural steroid injection[1]. She had not had that injection as of the time of the hearing because the insurance carrier denied that it was appropriate. She stated that she was still having pain in her back and was willing to undergo the lumbar epidural steroid injection.

On cross-examination, claimant stated that she no longer worked for respondent Baptist but is working a different type of radiology at Mercy Hospital now. She has been able to perform her duties at Mercy without her job being modified because of her back injury. She was aware that she had a nerve conduction study on her extremities that revealed no evidence of peripheral neuropathy.

[1] I used the term claimant used in her testimony. As the medical records show, Dr. Tomacek recommended a transforaminal epidural steroid injection. While that involves an injection into the back, it is not the same procedure.

She had bilateral medial branch block injections which did not help. In July 2022, claimant stated that she had an L3-4 epidural steroid injection and still had pain in her buttocks that was causing her to have difficulty sleeping at night. Claimant did not recall what Dr. Tomecek found during her examinations on September 5, 2024, and January 9, 2025, but would not argue with what was contained in the report. She believed her gait was normal and that her sensation to touch was intact. She stated that it was correct that she had not undergone physical therapy since 2022.

On redirect-examination, claimant stated that she was shifting in her chair because she always has a burning pain in her left buttock area. Switching her position in the chair relieves the pressure she feels.

Claimant again stated that she had not undergone surgery on her back since Dr. Tomecek recommended it but had no idea if the herniated disc had just disappeared over-time. She knew the pain had not disappeared and it was pain that she did not have before she was injured.

On recross-examination, claimant agreed with the MRI report that showed that she had mild disc bulges at a few levels with no stenosis. She did not have a report that showed a herniated disc.

REVIEW OF THE EXHIBITS

Claimant submitted thirty-eight pages of medical records beginning April 2, 2021, and ending January 13, 2025. Respondents submitted seventy-three pages with little duplications to what was submitted by claimant. This review will attempt to summarize these records in chronological order.

There were records predating the injury in question going back to August 2011 and concluding in November 2012. These records demonstrate that in 2012, claimant was treated for moderate persistent lower hip and lower back pain with shooting pains in her left leg. Claimant related that she had tripped over clothes and twisted her back, but this does not appear to be related to her employment. Claimant had a CT on February 10, 2012, which showed:

1. Left paracentral bulging of the disc at level L4-L5. The spinal canal and bilateral neuroforamina remained patent.

2. Otherwise, negative non-contrast CT of the lumbar spine.

3. MRI would be more sensitive for further characterization of disc pathology as clinically indicated.

Subsequent records mention that claimant was mildly improved with physical therapy and medication. On March 1, 2012, claimant was released to light duty only. This was increased to light-moderate duty on April 3, 2012, and then to "full duty as she feels comfortable doing so. She was last seen for this injury on July 2, 2012, when she reported that she continued to hurt herself at work and did not think she could keep doing her job. She was not restricted in her duties at that time. The records in 2012 conclude with a referral to pain management regarding claimant's chronic back and left shoulder pain. There were no records submitted regarding the treatment by the pain management physician or any other treatment for her back from 2012 through March 2021.

Claimant was seen by Dr. Ian Cheyne on April 7, 2021. She described how she was injured while assisting a patient out of a wheelchair and fell on her lower back and left hip on March 26, 2021. Dr. Cheyne diagnosed her with a muscle strain of her facia and tendon of lower back and radiculopathy in her lumbar region. The plan of care was reported to do physical therapy three times a week for two weeks and an MRI was scheduled. Claimant was placed on restricted duty, with a lifting limitation of twenty pounds or less, repetitive lifting of ten pounds or less, with limited bending, stooping, and twisting. She was to alternate sitting and standing and walking as tolerated.

Claimant next saw Dr. Cheyne on April 29, 2021, where Dr. Cheyne reviewed the MRI results with her. Claimant reported that she had some improvement with physical therapy. The diagnosis remained the same and the plan of care was for more physical therapy and an MRI on her left hip. Claimant was also referred to pain management for a lumbar epidural steroid injection (LESI). Her

restrictions remained the same.

Except for x-rays of her spine at Northeastern Health Systems in Sallisaw, Oklahoma on November 3, 2021, there is a gap in the records from April 29, 2021, until March 30, 2022, that was not fully explained through the testimony. However, I note that Dr. Tomecek was the physician that ordered the x-rays and from the testimony, claimant was referred to Dr. Tomecek by respondents. The x-ray findings were "sacralization of the L5 vertebrae. No fracture of spondylolisthesis including on flexion extension lateral views. The lumbar vertebral body height and disc spaces are normal. No abnormal curvatures." The impression was that claimant had "no acute disease process."

The next notes provided were from Baptist Health Pain Management Clinic on March 30, 2022. The history provided at that visit revealed that claimant had undergone an LESI and a left SI joint injection with some relief.[2] She also had a TENS unit which she reported was also of some help. In his assessment, Dr. David Florencio Fran found the following:

1. 51-year-old female with a history of chronic low back pain, lumbar spondylosis, lumber facet mediated pain, left sacroiliac joint dysfunction, left SI joint pain, left trochanteric bursitis who failed conservative treatment measures in the past. We will schedule a bilateral medial branch block of the L3, L4, L5, S1 for possible radial frequency ablation for long term relief.

2. Tramadol 50 mg 1p.o. four times daily as needed for pain.

3. Follow up in the main clinic one week post injection for reevaluation and further recommendations.

4. Consider a repeat left sacroiliac joint injection in the future.

Dr. Fran noted that the lumbar spine study of April 16, 2021, showed:

1. Grade one retrolisthesis of the L4-5.

2. Posterior disc protrusions at L1-L2, L2-L3, L3-L4, L4-L5, without significant canal narrowing.

[2] There was no record documenting which level of claimant's spine received the referenced LESI, or when it was performed.

3. Mild right foraminal narrowing at L2-L3 mild left foraminal narrowing at L3-L4.[3]

On April 12, 2022, claimant had the aforementioned injection at the L3, L4, L5, and S1. She returned to see Dr. Fran on May 13, 2022, and reported that she failed to get any significant relief from the injections. On June 7, 2022, claimant had a L3-4 transforaminal epidural steroid injection (TFESI); on July 15, 2022, she reported that her low back had improved but she continued to have a burning sensation in her left buttocks down the lateral aspect of her left ankle.

Claimant saw Dr. Tomecek on August 4, 2022, and when she declined surgical intervention, Dr. Tomecek did not have anything else he could provide for her. She was released from medical care with permanent restrictions of no lifting over twenty-five pounds and no repetitive bending. She should be able to alternate sitting and standing while working.

Claimant was then referred by respondents to Functional Testing Centers for a Functional Capacity Evaluation (FCE) on August 24, 2022. Claimant put forth a reliable effort, demonstrating an occasional bimanual lift or carry up to forty pounds, with the ability to perform lifting or carrying of up to twenty pounds on a frequent basis. Claimant also demonstrated an occasional right extremity lift of twenty pounds as well as a left extremity lift of up to twenty pounds of lifting unilaterality from the floor to shoulder level. The examiner noted muscle spasms on the right side of claimant's lumbar region.

There were no records submitted between the FCE and a nerve conduction test conducted on May 22, 2024. The referring provider for that test was Dr. Margaret Cox, and the complaint was "numbness and tingling in the upper and lower extremities of both sides." The impressions were "normal nerve conductions studies of all four extremities. There is no evidence of peripheral

[3] Dr. Cheyne's records of April 29, 2021, stated that claimant was in the office to see him for MRI results, but there was no mention in his record of what was related to claimant in that visit. However, I see no reason to believe claimant had more than one MRI in April 2021.

neuropathy in the study."

Following the nerve conduction study, claimant returned to see Dr. Tomecek on September 5, 2024. Dr. Tomecek recited the history of her previous treatment and noted that claimant is using a TENS unit and has seen a chiropractor to help her deal with her pain. Dr. Tomecek ordered an MRI of the lumbar spine, which was performed on October 16, 2024. For reasons that were not explained, the admissions and final diagnosis mentioned an unspecified injury of the right ankle. However, it is apparent that there was an MRI of the lumbar spine performed with these findings:

> "There are four non-rib bearing lumbar vertebrae bodies. S1 is transitional in appearance. There are no fractures. The conus is unremarkable. Mid-posterior or lateral bulging disc at L2-L3, and L3-L4 and certainly centrally at L4-S1. No disc protrusion or significant canal or foraminal stenosis."

After the MRI, claimant returned to Dr. Tomecek on January 9, 2025. At that time, claimant was working on pain management with Dr. Strickland and Dr. Goodman (from whom no records were submitted). Following his examination Dr. Tomecek recorded:

> "This is a pleasant 54-year-old female who has had chronic low back pain, left paraspinal pain, left buttock pain, and hip pain. She is not interested in any type of major surgical intervention. She has a degenerative disc at L4-L5 with a facet arthropathy at L4-L5, causing mild to moderate foraminal stenosis. Her symptoms are worse on the left consistent with left L5 radiculopathy. I am recommending a left L4-L5 transforaminal epidural steroid injection by Dr. Strickland at the facility where she works.
>
> I feel she can continue to work light-duty with the following temporary restrictions: no lifting over forty pounds, no pushing or pulling over sixty pounds. I did not prescribe her any medications today. I would like to see her back in a month for routine follow-up. She is approaching maximum medical improvement. I would expect to see her be at maximum medical improvement in one to two months."

Although claimant did not see Dr. Tomecek on January 24, 2025, he had an addendum to his records at the request of respondents' claim representative. The question posed to Dr. Tomecek was whether the claimant's need for medical treatment related to an injury that occurred in 2012 or was

related to her most recent back injury. Dr. Tomecek stated that within a reasonable degree of medical certainty, her current condition was related to her 2021 lifting injury.

Respondents submitted a Notice of Non-Certification prepared by Dr. Michael Levy. Dr. Levy was provided only the October 15, 2024, radiology report, and the notes from Dr. Tomacek's January 9, 2025, examination of claimant. Dr. Levy issued a denial based in part on "there should be a failure of conservative treatments including NSAID and physical therapy for 4 weeks or more." He applied the Official Disability Guidelines to what little information he was provided and issued an unfavorable decision to Dr. Tomacek's recommended course of treatment.

ADJUDICATION

As set forth above, claimant withdrew her claim for a permanent impairment rating based on the results of the double inclinometer test Dr. Tomacek relied upon in assessing a rating. The only issue remaining is whether claimant proved she is entitled to additional medical benefits as recommended by Dr. Tomacek. A claimant bears the burden of proving entitlement to additional medical treatment for a compensable injury. *LVL, Inc. v. Ragsdale*, 2011 Ark. App. 144, 381 S.W.3d 869. Once it has been established that a claimant has sustained a compensable injury, she is not required to offer objective medical evidence to prove entitlement to additional benefits, *Ark. Health Ctr. v. Burnett*, 2018 Ark. App. 427, at 9, 558. S.W.3d 408, 414.

There were two conflicting medical opinions as to whether the recommended TFESI is reasonable and necessary. I have assigned minimal evidentiary weight to the opinion of Dr. Levy, as he lacked an adequate set of records on which to base an informed opinion. For instance, he did not know the full extent of the treatment claimant has received to date including the failed conservative treatment and the persistent pain claimant has endured. On the other hand, Dr. Tomacek is the claimant's treating physician, and has had the benefit of seeing claimant over many visits. I have

therefore assigned significant evidentiary weight to his opinion.

That did not end my evaluation, however, as claimant still has the burden of proving by a preponderance of the evidence that medical treatment she seeks is reasonable and necessary. *Goyne v. Crabtree Contracting Company*, 2009 Ark. App. 200, 301 S.W. 3d 16. She has had mixed success with injections in her back. In the notes of his first visit with claimant on March 30, 2023, Dr. Fran mentioned an SI joint injection that provided some relief and that a LESI had been performed; those records were not provided. He later did a bilateral medial branch block that did not alleviate claimant's pain. Claimant had a left L3-4 TFESI on June 29, 2022, and reported improvement on her low back following that procedure. Dr. Tomacek is recommending a TFESI at the L4-5 level, which has not been so treated. Given claimant's positive outcome with the TFESI at L3-4, I find she has proven it is both reasonable and necessary for this procedure to be performed as recommended by Dr. Tomacek.

ORDER

Claimant has met her burden of proving by a preponderance of the evidence that she is entitled to additional medical treatment as recommended by Dr. Tomacek.

After the hearing, claimant withdrew her claim for permanent impairment, and such was not considered in this decision.

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 controverted and 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 in the amount of $403.45.

IT IS SO ORDERED.

JOSEPH C. SELF
ADMINISTRATIVE LAW JUDGE