

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION  
AWCC NO. F106463**

**KAREN ASHCRAFT, EMPLOYEE**

**CLAIMANT**

**VS.**

**ARVEST BANK, EMPLOYER**

**RESPONDENT**

**CLARENDON NATIONAL INSURANCE CO., CARRIER**

**RESPONDENT**

**OPINION FILED AUGUST 19, 2003**

Hearing held June 27, 2003, in Little Rock, Arkansas, before *ADMINISTRATIVE LAW JUDGE KAREN McKINNEY*.

Claimant is represented by Mr. Zan Davis, Attorney at Law, 400 W. Capitol, Suite 2422, Little Rock, AR 72201.

Respondents are represented by Mr. William C. Frye, Attorney at Law, 111 Center Street, Suite 1120, Little Rock, Arkansas 72201.

**STATEMENT OF THE CASE**

The above-styled claim came on for a hearing in Little Rock, Arkansas, on June 27, 2003. A prehearing telephone conference was held on this claim on January 27, 2003, with a Prehearing Conference Order filed on that same date. The Prehearing Conference Order was marked as Commission's Exhibit No. 1, and introduced into evidence without objection. Pursuant to the Prehearing Conference Order, the parties agreed upon the following stipulations:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim;
2. The employee-employer-carrier relationship existed between the parties on or about January 26, 2001;
3. The parties anticipate stipulating to the claimant's average weekly wage and compensation rates.

With regard to the claimant's wages, the parties agreed at the beginning of the hearing that the claimant earned \$26,000 per year. This calculates to an average weekly wage of \$500.00, and a temporary total disability rate of \$334.00 per week.

During the prehearing telephone conference the parties agreed to limit the issues to:

1. Whether claimant is entitled to reasonable and necessary medical treatment;
2. Whether the treatment provided by Dr. Peek and through his referrals is reasonable and necessary medical treatment;
3. Whether claimant is entitled to additional temporary total disability benefits from the date such benefits ceased until a date yet to be determined;
4. Controversion and attorney's fees.

With regard to these issues, claimant contends that she is entitled to continued medical care and treatment from Dr. Richard Peek as he is an authorized treating physician. Claimant further contends that she remains within her healing period and that she is temporarily totally disabled. Claimant contends that temporary total disability benefits should be reinstated as of the date they were discontinued with a credit for any permanent partial disability benefits paid. Finally, claimant contends that this claim has been controverted in its entirety and that the maximum attorney's fee should be awarded. Conversely, respondents agree that

they have controverted additional temporary total disability benefits and the treatment of Dr. Peek with regard to the spinal fusion. Respondents contend that they have not controverted permanency as they have accepted and paid a 13% impairment rating to the body as a whole. Respondents contend that the spinal fusion performed by Dr. Peek was not a reasonable and necessary medical procedure. Respondents requested a psychological evaluation prior to a determination on the necessity of any proposed procedure, which evaluation was ordered by the Commission on November 26, 2003, to take place on December 5, 2002. Respondents contend that the surgery was not reasonable and necessary and that it was not causally related to the claimant's compensable injury.

From a review of the record as a whole, to include the medical reports, documents, Prehearing Order filed January 27, 2003, Dr. Richard Peek's deposition taken on May 21, 2003, Dr. Jim J. Moore's deposition taken on March 17, 2003, the November 26<sup>th</sup> Order, the transcript from the Hearing on Motions held December 4, 2002, and all other matters properly before the Commission, and having had an opportunity to hear the testimony of the claimant and 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 prehearing telephone conference conducted on January 27, 2003, and contained in the Prehearing Order filed that same date are hereby accepted as fact.

2.      Claimant earned an average weekly wage of \$500.00, which computes to a temporary total disability rate of \$334.00 per week.

3.      Claimant has proven by preponderance of the evidence that the medical treatment she has received from Dr. Richard Peek and through his referrals has been reasonable and necessary in connection with her compensable injury.

4.      Claimant has proven by a preponderance of the evidence that Dr. Peek was her authorized treating physician upon Dr. Yeshwant Reddy's departure from practice in Arkansas.

5.      Claimant was ordered to undergo a psychological evaluation by Dr. Winston Wilson on December 5, 2002, pursuant to an Order dated November 26, 2002.

6.      The November 26, 2002, Order specifically stated: "It is further **ORDERED** that no further medical procedures shall be considered "authorized" until such time as claimant presents for the examination as ordered herein."

7.      Claimant underwent a spinal fusion performed by Dr. Richard Peek on December 3, 2002.

8. Pursuant to the November 26, 2002, Order, the spinal fusion performed by Dr. Peek was unauthorized medical treatment and in violation of the November 26, 2002, Order.

9. Claimant has failed to prove by a preponderance of the evidence that she is entitled to medical benefits for the medical treatment she received from November 26, 2002, through the December 5, 2002.

10. Claimant has proven by a preponderance of the evidence that she remains within her healing period and totally incapacitated from earning wages from the date such benefits ceased and continuing through a date yet to be determined.

11. Claimant has proven by preponderance of the evidence entitlement to temporary total disability benefits from the date such benefits ceased and continuing through the end of her healing period, a date which is yet to be determined. Respondents are given a credit for any permanent partial disability benefits paid.

12. Respondents have controverted claimant's entitlement to additional medical benefits and temporary total disability benefits.

13. Claimant is entitled to the maximum attorney's fee on the benefits awarded herein, one-half to be paid by the respondents and one-half to be withheld from the claimant's award of benefits.

## DISCUSSION

### Facts

Claimant sustained an admittedly compensable injury in January of 2001, when she lifted boxes at work. Claimant was employed by respondent-employer as a Loan Funding Coordinator. After her injury, claimant continued to work until May of 2001.

Claimant was diagnosed with a herniated nucleus pulposus at L4/L5 and L5/S1 for which she underwent a bilateral discectomy performed by Dr. Richard Peek on or about May 17, 2001. In the first post-operative follow-up report dated June 15, 2001, Dr. Peek noted; "She is making satisfactory progress at the current time. She does have some residual symptoms in the left leg but has improved significantly from her preoperative state." Dr. Peek ordered physical therapy and advised that the claimant could return to work in two weeks with restrictions.

On July 17, 2001, claimant called Dr. Peek's office to advise that she was having "increased pain in her back and down her leg as she did prior to surgery." This report prompted Dr. Peek to order a lumbar MRI. The MRI performed on July 18, 2001, revealed evidence of epidural scar or granulation tissue at L4/L5, and a persistent diffuse bulge of the disc material at this same level. A mild diffuse bulge was also observed at the L5/S1 level. Dr. Peek described these MRI findings as evidence of degenerative disc disease. Dr. Peek ordered additional physical therapy and a caudal lumbar epidural injection on July 19, 2001. After being

advised of the risks for this procedure, Dr. Randall Middaugh administered a lumbar epidural injection on July 26, 2001. The third in the series of three such injections was performed on August 2, 2001. In his August 31, 2001, office report, Dr. Peek stated that the claimant was making progress, but that she still had some symptoms in her legs. Accordingly, Dr. Peek ordered more physical therapy and prescribed Neurontin.

On October 1, 2001, claimant had a Nerve Conduction Study/EMG. These diagnostic studies revealed a normal nerve conduction study with no evidence of peripheral neuropathy, but an abnormal EMG in both lower extremities. In his office report dated October 12, 2001, Dr. Peek made note of the abnormal EMG report and noted that claimant's symptoms correlate with these findings. Dr. Peek further noted; "The patient is going to have a prolonged rehabilitation, so we got our rehab doctor, Dr. Reddy, involved with her to do a follow-up epidural and get her in some type of treatment for post laminectomy syndrome." Dr. Peek removed the claimant from the Neurontin as it was making claimant's hair fall out, and he placed her on Xanax for sleep.

Pursuant to Dr. Peek's recommendation, claimant was seen by Dr. Yeshwant Reddy on October 25, 2001 for a left L4-5 transforaminal epidural steroid injection and an L5-S1 lumbar epidural steroid injection. Claimant returned to Dr. Reddy for repeat injections on November 7, 2001.

Dr. Peek ordered additional MRI studies of claimant's lumbar spine which were performed on November 7, 2001. In his report dated November 30, 2001, Dr. Peek stated that the MRI scan did not show a recurrence so the claimant was not a candidate for additional surgery despite her continued complaints of bilateral leg pain. Dr. Peek described the claimant as despondent at that time. Claimant advised Dr. Peek that "sitting at work is causing problems. She says she feels like she is sitting on a nerve." Accordingly, Dr. Peek removed claimant from work and referred her to Dr. Reddy for a more active role in the treatment of claimant's pain.

Following his examination of the claimant on December 20, 2001, Dr. Reddy described the claimant as being in a pain cycle. Dr. Reddy outlined his course of treatment for the claimant to include a course of range of motion, body mechanics, as well as low-level lumbar stabilization program, and pain medications. Dr. Reddy confirmed that the claimant was to remain off work until "she has completely rehabilitated her back at least for four weeks." Dr. Reddy further noted that the claimant was not a candidate for the IDET procedure but that a discography would be helpful to identify the claimant's pain generator.

On January 24, 2002, claimant returned to Dr. Reddy and he noted that claimant's condition had not changed. Dr. Reddy specifically stated in his report:

This is a very difficult situation. Mrs. Ashcraft does have a very difficult lumbar spine problem. She is seven months following discectomy at L4-5 and L5-S1. She continues to experience back and variable bilateral leg symptoms, including numbness. Her back pain may be discogenic, and leg symptoms may be secondary to

epidural scarring. Her situation is further complicated by the poor coping skills she has shown thus far and her minimal tolerance to pain. In addition, she has an attitude for getting fixed and being pain free. Today, I have taken an extended period of time in explaining to her that the causes of her back and bilateral leg symptoms are not entirely clear. Today, I have tried to answer all the questions Mr. & Mrs. Ashcraft had to the best of my medical knowledge.

At respondents' request, claimant was examined by Dr. Reginald Rutherford, a neurologist, on January 15, 2002. After reviewing the claimant's medical records and diagnostic studies, as well as, conducting a physical examination of the claimant, Dr. Rutherford stated:

Ms. Ashcraft's history and medical documentation are indicative of a large disc herniation at the L4/5 level with attendant bilateral lumbar nerve root as defined by her persisting symptom complex and electromyography study from early October, 2001. Follow up post-operative imaging is negative for evidence of recurrent disk herniation or other structural abnormality which would clearly lend itself to further surgery. Follow up EMG/Nerve Conduction Study is recommended to ascertain whether or not any healing has transpired from the prior study. Anticipated further treatment in Ms. Ashcraft's case comprises use of medication for neuropathy and nociceptive pain and a TENS which to date has not been used in her case. This will be addressed pending completion of the electrodiagnostic study and clinical follow up.

There is no indication in the record that the claimant returned to Dr. Rutherford for a clinical follow up. However, claimant had a limited EMG study on January 22, 2002, which revealed mild active denervation from the S1 supplied

myotomes bilaterally, but that the claimant did display some improvement since her last EMG study.

Claimant returned to Dr. Reddy on January 24, 2002, at which time he adjusted claimant's pain medication and instituted a TENS unit as advised by Dr. Rutherford. Moreover, Dr. Reddy stated:

...Further anticipated treatments may include working her up for discogenic pain. This may involve discography. I am reluctant to proceed with this test at the present time. Discography will evaluate back pain but will not give her any clue about her bilateral lower extremity symptomatology. Once we subject her to discography, we do have to act upon the results. In postsurgical situations minimally invasive surgery will not be effective. The only alternative would be surgery, and that would be fusion. If discography is positive. At this time, I do not think Mrs. Ashcraft is in a situation to cope with another extensive surgery and come out as a winner.

As regards to her bilateral lower extremity symptoms, it could be because of epidural scarring and fibrosis. It is only 7 months following surgery. It may be worthwhile at some point to consider epidural lysis using Racz method.

I also think that prior to subjecting her to further investigations and treatment we need to have a psychological evaluation so that her coping skills could be improved....

Dr. Reddy also requested a neurosurgical consultation to determine if there was a need for discography, epidural lysis, and possible further surgery.

Claimant returned to Dr. Peek on January 31, 2002. In his office note of that date, Dr. Peek stated; "She asked about further surgery, including fusion, and I did discuss surgery is of benefit if there is nerve root impingement, which MRI did not show. Will get a myelogram and maybe it will show on this." Dr. Peek further noted that claimant's healing period and date of maximum medical improvement would be deferred or a few more months while the claimant continues under Dr. Reddy's treatment.

The lumbar myelogram was performed on February 11, 2002. This test revealed findings of a ventral defect of the thecal sac at the L4-5 level which is consistent with findings of a posterior disc bulges at L4-5 and L5-S1. The test also revealed a vacuum disc at L5-S1.

Following her examinations by Dr. Reddy on February 28, 2002, and March 21, 2002, Dr. Reddy noted that the claimant was making some progress and that she did not appear to be as despondent. Dr. Reddy further noted that the TENS unit provided claimant with extended periods of pain relief which caused him to consider whether claimant might be a candidate for a spinal cord stimulator. On her return visit on April 4, 2002, Dr. Reddy noted that the claimant was again quite tearful. Dr. Reddy further stated that he wanted to increase the claimant's therapy to three times a week, he wanted to include work-hardening in the therapy, and he ordered a Functional Capacity Evaluation. The Functional Capacity Evaluation was performed on May 7, 2002. The Functional Capacity evaluator concluded that the

claimant was physically capable of performing work in the sedentary category as defined by the US Department of Labor for eight hours per day.

Claimant returned to Dr. Reddy on May 9, 2002, at which time he stated that the claimant's clinical situation had not changed and that he had nothing further to offer the claimant to improve her condition. Dr. Reddy further stated; " She is at MMI pending another neurosurgical opinion if she needs to...." Dr. Reddy assigned claimant a 13% physical anatomical impairment to the body as whole pursuant to the DRE Category III of the AMA Guides to the Evaluation of Permanent Impairment. In addition, Dr. Reddy stated:

She does require future treatments. This will include chronic pain management, intermittent spinal injections, physical therapy, possibly psychotherapy, and I cannot rule out future surgery.

I will be able to see her, as she has a lot of confidence in me, once she has her neurosurgical consultation. At that point we will find a physician who will be able to care for her long term.

Duragesic 25 mcg is not helping her. We will try increasing it to 50 mcg and see how she does.

As regards to depression, I would like for her to see a psychiatrist.

In his June 11, 2002, report, Dr. Reddy stated that the claimant had been unsuccessful in getting into a neurosurgical clinic due to her previous lumbar surgery, therefore, he was now placing the claimant at maximum medical improvement.

On July 30, 2002, claimant was evaluated by Dr. Jim J. Moore, a neurosurgeon. Dr. Moore reviewed the claimant's medical records and diagnostic studies prior to examining the claimant. Dr. Moore confirmed the 13% impairment rating assigned by Dr. Reddy, and concurred that the claimant required ongoing support, but he did not find the claimant to be a surgical candidate.

Claimant returned to Dr. Peek on September 16, 2002, after Dr. Reddy advised the claimant that he was moving out of state. Dr. Peek noted that the claimant had not improved any since his last examination. Moreover, Dr. Peek stated:

She asked me some questions about the long-term use of Duragesic patches. Since this is not a part of my practice, we will need pain management experts to help in managing this. Since the Celebrex is not helping, I will increase this to b.i.d. dosage. The question is how to treat this. The treatment options for failed back syndrome are a lumbar fusion and chronic pain medication, which she is currently on. We will need someone who specializes in chronic pain management or a medical provider to help with this, including a pain pump or spinal cord stimulator. I would also recommend massage and therapy exercises to manage her condition. We will have to see about who we are going to get her in with to do the discogram and further pain management evaluation. We will see if Dr. Hart or one of the other doctors can start working with her. Tentatively, I did ask, when I found out that Dr. Reddy was leaving the state, a consult for another pain management doctor, and this was initially denied, but hopefully we will be able to find somebody else to help, since there are still a number still present in the state in Little Rock and North Little Rock in her locale, as long as we can get approval from workers' comp to allow us

proper treatment. Discography will be necessary to determine whether fusion is an option....

She is disabled from employment and will not be able to return to her previous employment due to failed back syndrome and arachnoiditis.

Dr. Peek authored a letter dated September 16, 2002, stating that the claimant was unable to return to work due to her condition of failed back syndrome and severe degeneration. On September 19, 2002, Dr. Peek wrote the claimant a letter stating that the workers' compensation carrier had refused any further treatment from his office and that she needed to contact the carrier and seek a referral for a new doctor.

On November 11, 2002, claimant was examined by Dr. Thomas Hart, a pain management specialist, upon referral from Dr. Peek. After conducting his examination, Dr. Hart noted:

...I do agree with Dr. Peek. I think that the gold standard once and for all to determine does she or does she not have continued discogenic pain is discography, not an MRI and not a CT myelogram. According to the North American Spine Society's Protocol/Commission, as well as International Spinal Injection Society's Protocol discography would be the gold standard. This will help to subjectively and objectively delineate does she have continuing discogenic pain. If so, she may be an appropriate candidate at this time for decompression and infusion [sic] of these levels to have a significant relief in her back pain complaints. As to the arachnoiditis, whether or not this will be benefitted? That may be an issue if it continues to cause pain for other modalities including possible spinal cord stimulation. To say that she has reached MMI, I do not

agree with and she did not have the appropriate studies performed. The arachnoiditis has not been addressed. So to simply tell Ms. Ashcraft to get up and go back to work without these issues being resolved was not medically appropriate....

Dr. Hart performed the discogram on November 13, 2002. During this procedure dye entered and exited around the nucleus pulposus at L4/5 and L5/S1 and produced extreme pain complaints. Dye introduced into the L3/4 disc space did not extend beyond the disc and did not produce complaints of pain.

Claimant followed up with Dr. Peek on November 18, 2002. Dr. Peek discussed a spinal cord stimulator and a morphine pump with the claimant, as well as, the pros and cons of a spinal fusion. Upon conclusion of this visit claimant agreed to proceed with a fusion. Arrangement were made at that time to schedule surgery.

On November 19, 2002, counsel for respondent wrote to counsel for claimant advising that an agreed upon evaluation by Dr. Winston Wilson was scheduled for Wednesday, December 5, 2002. Claimant testified that when she learned of this appointment, she contacted her attorney's office and advised that she had surgery scheduled for December 3, 2002. Counsel for claimant made arrangements to reschedule the appointment with Dr. Wilson. Counsel for respondent objected to the cancellation of the December 5<sup>th</sup> appointment and stated in his letter to the undersigned which is inadvertently dated November 15, 2003, but which bears a fax date of November 26, 2002:

It is the Respondents position that, before any spinal cord stimulator could be authorized, the claimant must undergo a psychological evaluation. In fact, Dr. Moore recommended an evaluation in his report.

As November 26, 2002, was the Tuesday before Thanksgiving, counsel for respondent suggested a pre-hearing conference for the following week. The undersigned was on vacation leave on November 26<sup>th</sup>, however, prior to leaving town for the holidays, attempts were made to contact both attorneys on Tuesday morning, November 26, 2002. Counsel for respondent was available, however counsel for claimant was not. Messages were left for counsel for claimant or his paralegal to contact the Commission as soon as possible regarding this matter. With the Commission closed on November 28<sup>th</sup> and 29<sup>th</sup>, there remained only four business days between November 26, 2002, and the scheduled evaluation by Dr. Wilson. The undersigned postponed her departure time, and returned to the office on the morning of November 26<sup>th</sup>, when the initial attempts to conference with the parties had failed. Given that the parties had previously agreed to an evaluation by Dr. Wilson, the numerous comments in the claimant's medical records regarding the need for a psychological evaluation, and the knowledge gleaned from respondent's November 26, 2002, fax that claimant's attorney indicated that the claimant would be "undergoing a medical procedure" good cause was found for the psychological evaluation to proceed as scheduled. An Order so stating was faxed

to the parties around 11:00 a.m. approximately three hours after the first failed attempt for a conference call between the parties. This ordered further stated:

It is further **ORDERED** that no further medical procedures shall be considered "authorized" until such time as the claimant presents for the examination as ordered herein.

Upon receipt of this order, counsel for claimant called the Commission, and advised that he intended to file several motions regarding the November 26, 2002, Order. Not having received any such motions prior to December 4, 2002, a hearing was held on December 4, 2002, to allow claimant the opportunity to make an oral motion and obtain a record of the proceeding prior to the scheduled evaluation by Dr. Wilson on December 5, 2002. Until this hearing it was not known that the claimant underwent a spinal fusion on Tuesday, December 3, 2002. At the conclusion of the December 4, 2002, hearing, claimant's motions were denied. The motions and denials are made a part of this record through the transcript from the December 4, 2002, hearing. Counsel for claimant advised at the conclusion of the December 4, 2002, hearing that his client would be available for examination by Dr. Wilson in her hospital room as she had just undergone a fusion performed by Dr. Peek.

Dr. Wilson attempted to evaluate the claimant on December 5, 2002. As claimant's energy level and stamina were low due to her recent surgery, Dr. Wilson conducted an abbreviated evaluation. Dr. Wilson was "reluctant to conclude any

definite impressions” at that time and stated in his report that he was hopeful that the evaluation “will be conducted in its entirety on January 16, 2003.” Accordingly, having presented herself for an evaluation on December 5, 2002, claimant complied, in essence, with the November 26, 2002, Order. Claimant testified at the hearing that she was not advised by her attorney that Dr. Wilson’s evaluation was to resume on January 16, 2003, until several days prior to the scheduled appointment. Since claimant’s husband was out of town at that time, the claimant did not have a means to dress herself and to drive to a doctor’s appointment. Therefore, she requested that the appointment be rescheduled. Claimant testified that she did not refuse to continue with Dr. Wilson’s examination.

With regard to the fusion surgery, claimant testified that she has improved a great deal. Dr. Peek’s medical record dated January 27, 2003, indicated that the claimant had improved, while the March 7, 2003, report indicated that she was doing better than before surgery, but not as good as she was doing on her January 27, 2003, visit. Claimant described herself as having good days and bad days, but that overall she has improved with the fusion surgery. In this regard, claimant testified:

I know it helped. There’s no doubt in my mind that this surgery helped me. I had severe nerve pain before the surgery, due to I guess, you know, the empty disk, the one that didn’t have - - or the empty vertebra that didn’t have any cushioning in it at all. I had severe pain, couldn’t function....I was on morphine, I was on 25 milligrams, didn’t help; he increased my morphine patches to 50 milligrams, I couldn’t tolerate 50

milligrams so he backed it back down and had me to change out the morphine patches every 48 hours instead of 72 hours to try it that way. And, no matter what I took, nothing, nothing at all helped the pain, or it might help it some but it didn't take the pain away. I was always, always in severe pain and couldn't function....

When asked to describe her condition following surgery, claimant testified:

I no longer have that stabbing pain in my thighs, and the right and the left, both legs, were severely involved, and the right leg is much, much better - -.. - - and my back feels a lot better. So, yes I can actually function. I'm still having to pace myself, but I can function.

When asked if she was glad she underwent the fusion surgery, claimant testified; "Absolutely."

Claimant's husband also testified on behalf of the claimant. Mr. Ashcraft testified that prior to the fusion his wife was very dysfunctional. He further testified that the second surgery has been "great." Mr. Ashcraft acknowledged that the claimant has had a few complications since the second surgery, but that she is still greatly improved.

The parties deposed Dr. Peek and Dr. Moore regarding the necessity of the fusion surgery. Dr. Peek outlined the course of treatment he administered to the claimant following her initial injury and stated that after her relapse following the discectomy, and a year and a half of pain management, claimant's reliance on a strong scheduled two narcotics for pain relief, the claimant's options came down to

continuing chronic narcotic medications for the rest of her life, a spinal cord stimulator, a morphine pump, or a fusion. After the discogram revealed discogenic problems at the L4/5, and L5/S1 level, claimant wanted to have a fusion. In this regard, Dr. Peek testified; "So, that's how we ended up with the fusion because she had a failed back syndrome which was caused by severe degeneration and discogenic pain." When asked if the claimant's compensable injury and initial surgery were related to the claimant's segmental collapse and discogenic pain, Dr. Peek unequivocally replied, "Yes."

Dr. Peek stated that the claimant was still in her healing period from the fusion as it takes approximately one year for a fusion to fully heal. Dr. Peek further stated:

Yeah, I saw her on April 18<sup>th</sup>. She had some burning in her back. Her fusion was still solid...she had was better, better and then she had a little bit of relapse and we gave her a shot and now she's doing somewhat better. She's still waxing and waning some but not quite as well as the March 7<sup>th</sup>, visit. But, she's had some leg and neuritis in her legs and some burning in her back but she's off the Duragesic patches. She's down to a pain pill or two a day, which is a lot better than around the clock narcotics. She's not well by any means but she's better than she was and it's early on in the fusion process even though it seems like a long time. So, I feel confident we've helped her with this operation. But, we also started some B-12 shots to help the legs and Neuortotin [sic] but we just have to see how she comes out. She's not well but she's better than she was.

Dr. Peek testified that since the claimant's fusion surgery was based upon organic pathology, as opposed to a spinal cord stimulator or morphine pump which is recommended for pain complaints, a psychological evaluation was not necessary prior to surgery.

Dr. Peek was asked during cross-examination if he had read Dr. Jim J. Moore's deposition and whether he agreed with Dr. Moore's findings. In this regard, Dr. Peek testified in part:

"Q. [Mr. Frye] She indicated from her first surgery, technically she was better because the MRIs indicated that you have removed the disc herniation, would you agree with that?

"A. [Dr. Peek] Yes.

"Q. And, I think you both agree that neurologically she was improved as far as the findings from when you first saw her and did the surgery?

"A. Oh, yeah.

"Q. From what I understand subjectively she wasn't any better. In fact she kept telling you she was getting worse and worse?

"A. Well, subjectively and objectively she had a collapse of the disc space, positive EMG. I'm not so egotistical to say that if I've operated on somebody it fixes them. Most people do well with discectomy for a large herniation. She didn't. She developed all the things of a failed back, post laminectomy syndrome. Basically, it's a type of discogenic pain from where the disc space collapses and you've got chronic back pain and it does progress over time." [D28-29]

With regard to Dr. Moore's testimony that a fusion is only necessary for instability, Dr. Peek testified:

"Q.    [Mr. Frye] You x-rayed the patient. Was there instability, is what Dr. Moore said you were looking for as far as a fusion.

"A.    [Dr. Peek] They showed segmental collapse of L4-5, L5-S1.

"Q.    Do you have a report that shows that, a radiology report?

"A.    Radiographics have not shown degenerative disc disease increased without spondylolisthesis at L4-5 and L5-S1 so both the disc and narrowing together was spondylolisthesis, that's the slippage. [D31]

Finally, with regard to the claimant's degenerative disc disease, Dr. Peek testified in his deposition:

"Q.    [Mr. Davis] . . . When we talk about degenerative disc disease in this case, we're talking about collapsed segments. Collapsed discs that come directly from the injury of January 25, '01 and the resulting huge herniations and surgery fro those herniations, is that correct, Doctor?

"A.    [Dr. Peek] That's correct. You know, there is a whole week's seminar and a lifetime of study in that. That's what makes a disc painful or not but a person that has gradual degeneration in the disc, the boy has stopped, settled down and tightened up. It kind of cinches down. And I see some people who have a horrible disc but it happened so gradually that never had any pain from it but people that develop tears or herniations, they have a sudden onset and the disc collapses and it is a factor that goes through that. This article goes into some of that but degeneration itself you, a lot of us have, even

bulging discs on MRI scans that are asymptomatic then. I wouldn't - - probably everybody at this table has a disc that has some degeneration. But there is a difference in the aging process and everything that causes the disc to be painfully degenerated.

"Q. And it's not the aging process we are talking about in this case, when we see degenerated disc disease in your reports, is that correct, Doctor?

"A. That is correct.

"Q. Okay. This is traumatic degenerative disc disease?

"A. Right. Post laminectomy syndrome, degenerative disc disease.

"Q. Because radiologists, some doctors throw that term around rather loosely to mean a slow degenerative process due to the aging versus traumatic degenerative disc. And, what some workers' comp insurance people like to argue is that anytime you see degenerative disc disease, you're talking about a non-work-related preexisting condition and what I am trying to do with this questions is to dispel that idea in this particular case.

"A. That's correct. I think I've stated my opinion. That her collapse and disc was related to herniation. She probably did have some preexisting degeneration and spurs, as most people do when they get to be 40 but this was rapidly, rapidly accelerated. And we did see the - - there was a time the disc collapsed, over that period of time after her surgery." [D40-42]

Respondents offered the deposition of Dr. Jim J. Moore into evidence.

Dr. Moore testified that his neurological examination of the claimant was normal.

Dr. Moore further testified:

Subjectively, she probably would be in a failed back syndrome. Objectively, she checked out really very good, but I think that there would - - it would not be appropriate to attempt to separate objectivity and subjectivity.

Dr. Moore explained in his deposition why he felt that a discogram would be dangerous for the claimant. In this regard, Dr. Moore testified that if the claimant had a free fragment in the disc, the dye from the procedure could cause the fragment to extrude creating additional problems. When asked if he would have recommended surgery after a positive discogram, Dr. Moore testified that he did not see anything in his examination that would suggest that the claimant would benefit from surgery. Dr. Moore testified that he did not find anything during his examination that would account for the claimant's bilateral leg pain. Dr. Moore diagnosed the claimant with arachnoiditis, which can cause leg pain.

On cross-examination Dr. Moore acknowledged that when he examined the claimant he did not have the studies available to him that would allow him to make a determination of whether the claimant required a fusion. Dr. Moore testified at length in his deposition on both direct and cross examination regarding the potential placebo effect of a surgery when the surgery is performed when it is not indicated by objective findings.

#### **Reasonable and Necessary Medical Treatment**

Claimant contends that the medical treatment she has received since Dr. Reddy's treatment ended through Dr. Peek and his referrals is reasonable and

necessary medical treatment related to her compensable injury. Respondents contend that all of the treatment administered by Dr. Peek and through his referral to Dr. Hart is not reasonably necessary medical treatment in connection with claimant's compensable injury. In this regard, respondent's contend that Dr. Reddy opined that he did not have anything further to offer the claimant, he released her to return to work within the guidelines of the Functional Capacity Evaluation, and assessed the claimant with a 13% permanent anatomical impairment rating.

An employer must promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. A.C.A. § 11-9-508(a). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W.2d 857 (1987). Claimant has the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary. Norma Beatty v. Ben Pearson, Inc., Full Commission Opinion, Feb. 17, 1989 (D612291); B.R. Hollingshead v. Colson Caster, Full Commission Opinion, Aug. 27, 1993 (D703346). Employers are only liable for medical treatment and services which are deemed reasonably necessary for the treatment of employees' injuries. DeBoard v. Colson Co., 20 Ark. App. 166, 725 S.W.2d 857 (1987). In workers' compensation cases, the burden rests upon the claimant to establish her claim for compensation by a preponderance of the evidence. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999).

Kuhn v. Majestic Hotel, 50 Ark. App. 23, 899 S.W.2d 845 (1995); Bartlett v. Mead Container Board, 47 Ark. App. 181, 888 S.W.2d 314 (1994). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, the Commission must analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Commission Opinion, Dec. 13, 1989 (D512553).

The record indicates that the claimant's back and leg pain resumed shortly after her first surgery. Initially, claimant's treating physician, Dr. Peek, opined that the claimant was not a candidate for surgery since she did not have a herniated disc after this first surgery. Accordingly, Dr. Peek referred claimant to Dr. Yeshwant Reddy on November 30, 2001, for pain management. While treating with Dr. Reddy, claimant was occasionally seen by Dr. Peek as both physicians were in the same office complex. In his report dated January 24, 2002, Dr. Reddy opined that the claimant may require a discogram to evaluate her back pain, however he was reluctant to recommend the procedure at that time since a positive finding would prompt additional surgery and he did not believe that she was in a situation to cope with another extensive surgery at that time. On February 28, 2002, Dr. Reddy even suggested the possibility of a spinal cord stimulator. Dr. Reddy requested a neurosurgical work-up to determine whether a discogram, an epidural lysis or possible surgery were needed. After a year of pain management, claimant's pain was not improved. Claimant required narcotic pain medications to manage her

pain, but she continued to describe her pain as unimproved. On May 9, 2002, Dr. Reddy stated in his report that he did not have anything else to offer the claimant. Despite this comment, it is noted that Dr. Reddy had previously recommended a discogram and possibly a spinal cord stimulator., which had not taken place. Dr. Reddy did not mention why these tests or procedures were no longer recommended. Dr. Reddy again recommended a neurosurgical evaluation of the claimant. Upon his conditional release of the claimant in May of 2002, Dr. Reddy opined that the claimant would continue to require chronic pain management, intermittent spinal injections, physical therapy, possible psychotherapy, and possibly surgery.

Respondents had claimant examined by Dr. Jim J. Moore, a neurosurgeon, on or about July 30, 2002. Dr. Moore did not recommend additional surgery, but concurred that the claimant would require ongoing “support.”

Dr. Reddy advised the claimant that he was leaving the state to open a practice up north and that she needed to acquire another treating physician. Accordingly, claimant returned to Dr. Peek, her previous treating physician. Since Dr. Peek is an authorized treating physician within the chain of referral, a formal change of physician petition or request was not necessary. Contrary to respondent’s contentions, I find that Dr. Peek was an authorized treating physician within the authorized chain of referrals. See Porter v. Aalf’s Manufacturing Co., Full

Commission Opinion filed May 8, 2003, (E902622); and Mickey v. Arkansas Methodist Hospital, Full Commission Opinion filed July 22, 2003 (F002633).

In his report dated September 16, 2002, Dr. Peek stated for the first time that a lumbar fusion was an option for “failed back syndrome.” Dr. Peek referred claimant to Dr. Thomas Hart, a pain specialist, to determine the source of claimant’s lumbar pain. Dr. Hart performed a discogram on November 13, 2002, and concluded that claimant suffered from discogenic pain at L4/5 and L5/S1. In reliance, in part, upon this diagnostic test, Dr. Peek performed a lumbar fusion on December 3, 2002. Dr. Peek testified in his deposition that claimant was a candidate for a lumbar fusion because of her failed back syndrome and severe degeneration. Dr. Peek unequivocally testified that the claimant’s severe disc degeneration was caused by her work related injury and first back surgery. In this regard, Dr. Peek explained that claimant’s discogenic pain was caused from the disc space collapse and rapidly accelerated degeneration brought on by the injury and first surgery. Dr. Moore testified in his deposition that he did not adhere to the philosophy of performing a lumbar fusion for a failed back syndrome after only one lumbar surgery. According to Dr. Moore a fusion would only be appropriate for lumbar instability, a finding he did not make during his examination of the claimant. However, Dr. Moore acknowledged that he did not have the proper diagnostic tests before him to make a finding of lumbar instability. The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has

the force and effect of a jury verdict. McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989). In assessing the weight to be accorded Dr. Moore's deposition testimony, I note that Dr. Moore only examined the claimant on one occasion. Dr. Peek, on the other hand, was claimant's treating physician who performed the original surgery on the claimant and treated her for a period of time prior to referring the claimant for pain management. Dr. Peek supported his decision to operate on the claimant with learned articles on the subject of failed back syndrome and lumbar fusion. Dr. Peek explained how the claimant developed the segmental collapse and how the x-rays demonstrated spondylolisthesis or slippage in claimant's spine.

At the hearing, claimant testified that the lumbar fusion has improved her condition. In this regard, claimant testified that she can function now that she has had the surgery, and that she is no longer dependent upon narcotic pain medication to control her pain. Likewise, Dr. Peek testified that the claimant is "not well by any means but she's better than she was and it's early on in the fusion process even though it seems like a long time. So I feel confident we've helped her with this operation." Post-surgical recovery is a relevant consideration in determining whether treatment was reasonably necessary. Winslow v. D&B Mech. Contractors, 69 Ark. App. 285, 13 S.W.3d 180 (2000).

Although Dr. Reddy indicated that he did not have any additional treatment to offer the claimant, he indicated that further treatment and monitoring of the claimant's condition was required. Dr. Reddy even acknowledged that additional

surgery may be necessary. Dr. Reddy had previously recommended or pondered several diagnostic and treatment options such as a discogram and a spinal cord stimulator. However, upon his release of the claimant in May of 2002, Dr. Reddy did not indicate why these procedures were no longer an option he had to offer the claimant. Dr. Reddy wanted claimant to undergo a neurosurgical examination prior to fully releasing the claimant. This did not happen before Dr. Reddy's move. Upon resuming treatment with Dr. Peek, he recommended several treatment options, including a lumbar fusion, a spinal cord stimulator and a morphine pump. Dr. Peek referred claimant to Dr. Hart who concluded that additional procedures to improve the claimant's condition should be tried. Dr. Peek ordered a discogram to delineate the source of claimant's lumbar pain. Dr. Peek has credibly explained how this discogenic pain is related to claimant's compensable injury. Upon determining that claimant suffered from discogenic pain at two levels in her lumbar spine, Dr. Peek offered spinal fusion surgery to the claimant. I find that the treatment, referral, and surgery performed by Dr. Peek are reasonable and necessary medical procedures in connection with claimant's compensable injury. Dr. Peek provided treatment and surgery to address claimant's discogenic pain. Claimant has improved with this treatment. While the claimant continues to have some complaints of pain, the record clearly indicates that claimant's pain has dramatically decreased from its intensity prior to the fusion. Accordingly, I find that the claimant has established by

a preponderance of the evidence that the course of treatment she has received from Dr. Peek was and is reasonably necessary.

**Authorized Medical Treatment**

As noted above, I find that Dr. Peek was an authorized treating physician. Claimant's treating physician, Dr. Reddy, was leaving the state, therefore claimant returned to the physician who referred her to Dr. Reddy. Dr. Peek is an authorized treating physician within the chain of referral. See Porter v. Aalf's Manufacturing Co., Full Commission Opinion filed May 8, 2003, (E902622); and Mickey v. Arkansas Methodist Hospital, Full Commission Opinion filed July 22, 2003 (F002633).

The Order filed November 26, 2002, ordered claimant to undergo an evaluation by Dr. Winston Wilson. This Order further ordered that "no further medical procedures shall be considered 'authorized' until such time as the claimant presents for the examination as ordered herein." This provision is, in essence, a temporary restraining order on additional medical treatment until the parties have had the benefit of a psychological evaluation of the claimant. Subsequent to the entry of the November 26, 2002, Order, but prior to the examination by Dr. Wilson on December 5, 2002, claimant underwent surgery on December 3, 2002. In accordance with the November 26, 2002, Order I find that the treatment received

by the claimant, between November 26, 2002, and December 5, 2002, including the fusion surgery, was in contradiction with the Order and was not authorized medical treatment. Therefore, I find that respondents are not liable for the medical treatment claimant received between November 26, 2002, and December 5, 2002, including the fusion surgery.

**Temporary Total Disability Benefits**

The period of temporary total disability is that period within the healing period in which an employee suffers a total incapacity to earn wages. Ark. State Highway & Trans. Dept. v. Breshears, 272 Ark. 244, 613 S.W.2d 392 (1981). Temporary disability is determined by the extent to which a compensable injury has affected the claimant's ability to earn a livelihood. An injured employee is entitled to temporary total disability compensation not simply because she has a compensable injury, but rather during the period of time that she is within her healing period for the compensable injury **and** while she is totally incapacitated to earn wages as a result of that injury. Arkansas State Highway & Transportation Dept. V. Breshears, 272 Ark. 244, 613 S.W.2d (1981). Accordingly, to be entitled to temporary total disability benefits, an injured employee must satisfy this two-pronged test.

The "healing period" is defined as the period necessary for the healing of an injury resulting from an accident. Ark. Code Ann. § 11-9-102(13)(Supp. 1997). The healing period continues until the employee is as far restored as the permanent character of her injury will permit. When the underlying condition causing the disability becomes stable and when nothing further will improve that condition, the healing period has ended, and the claimant is no longer entitled to receive

temporary total disability compensation or temporary partial disability compensation, regardless of her physical capabilities. Moreover, the persistence of pain is not sufficient in itself to extend the healing period or to find that the claimant is totally incapacitated from earning wages. Mad Butcher, Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982).

Claimant returned to work following her first surgery for a short period of time. In November of 2001, Dr. Peek removed the claimant from work. Likewise, Dr. Reddy noted in his December 20, 2001, report that the claimant should remain off work until “she has completely rehabilitated her back...” Temporary total disability benefits resumed until Dr. Reddy declared that the claimant had reached maximum medical improvement and assigned her a 13% impairment rating. Claimant contends that she is entitled to additional temporary total disability benefits from the period such benefits ceased until the end of her healing period, a date which is yet to be determined. In my opinion, Dr. Reddy’s placement of the claimant at maximum medical improvement in June of 2002, was premature. Dr. Reddy had previously ordered a Functional Capacity Evaluation that determined that the claimant was capable of working 8 hours a day in a sedentary position. Dr. Reddy noted this finding, but never stated in his medical reports that he found the claimant capable of returning to gainful employment, nor did he release the claimant from his care to return to work. Having observed the testimony of the claimant and her husband, both credible witnesses, I find that, despite the Functional Capacity Evaluation, the claimant was not capable of earning wages during this period of time. The claimant required extensive doses of narcotic medication to help control her pain. Claimant’s husband described the claimant as having slept through many

family functions during this period of time. With the claimant under such heavy medication, I find that she was totally incapacitated from earning wages.

In his May 9, 2002, report in which he stated that the claimant was at maximum medical improvement pending a neurosurgical evaluation, Dr. Reddy specifically outlined additional medical treatment, including a possible surgery, which the claimant continued to require. In his report dated November 11, 2002, Dr. Hart specifically stated that he disagreed with Dr. Reddy's assessment of maximum medical improvement. In addition to the treatment outlined by Dr. Reddy, Dr. Hart stated that the claimant's arachnoiditis has not been addressed, and additional appropriate studies were necessary. Dr. Hart further stated; "So to simply tell Ms. Ashcraft to get up and go back to work without these issues being resolved was not medically appropriate...."

Under the care of Dr. Peek, claimant underwent additional diagnostic testing and a lumbar fusion. I have previously found that this treatment was reasonable and necessary. Accordingly, I find that the claimant was still within her healing period as claimant was seeking additional medical treatment which was available to improve her condition and she was totally incapacitated from earning wages. Therefore, I find that the claimant is entitled to temporary total disability benefits from the date such benefits ceased until the claimant reaches the end of her healing period, a date which is yet to be determined, including the period of time that the claimant received the unauthorized medical treatment in violation of the November 26, 2002, Order. See Byars. Const. Co. v. Byars, 72 Ark. App. 158, 34 S.W.3d 797 (2000).

**AWARD**

Claimant has proven by a preponderance of the evidence that the medical treatment she received through Dr. Peek and his referrals was reasonably necessary in connection with her compensable injury. Likewise, claimant has proven that Dr. Peek was an authorized treating physician. Pursuant to the November 26, 2002, Order, the medical treatment claimant received between November 26, 2002, and December 5, 2002, was unauthorized. Respondents are hereby ordered to pay medical benefits to or on behalf of the claimant for all the authorized, reasonable and necessary medical treatment found herein. Claimant has proven by a preponderance of the evidence that she remained within her healing period and totally incapacitated from earning wages from the date such benefits ceased and continuing through the end of her healing period, a date which is yet to be determined. Respondents are hereby ordered to paid claimant temporary total disability benefits from the date such benefits ceased through the end of claimant's healing period, a date which is yet to be determined. Respondents have controverted claimant's entitlement to the benefits awarded herein. Accordingly, claimant's attorney is entitled to the maximum statutory fee on all benefits awarded, one-half (1/2) to be paid by the claimant and one-half (1/2) to be paid by respondents. Respondents are ordered to withhold claimant's portion of the attorney's fees from the claimant's award and to pay the attorney's fees directly to claimant's attorney.

All sums herein accrued are payable in a lump sum without discount and this award shall draw interest at the maximum legal rate until paid.

**IT IS SO ORDERED.**

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KAREN ASHCRAFT  
VS. ARVEST BANK

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**HON. KAREN McKINNEY**  
Administrative Law Judge