

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NUMBER F202214

**WILLIAM A. DEMPSEY,
EMPLOYEE**

CLAIMANT

**ARKANSAS CO-OP CORPORATION,
SELF-INSURED EMPLOYER**

RESPONDENT

**ARKANSAS RURAL ELECTRIC
SELF-INSURED TRUST;
CROCKETT ADJUSTMENT,
BENEFITS ADMINISTRATORS**

RESPONDENT

OPINION FILED SEPTEMBER 22, 2003

Hearing conducted June 24, 2003, before Administrative Law Judge Richard B. Calaway in Little Rock, Pulaski County, Arkansas, with

Mr. J. Gary Davis, Attorney at Law, Little Rock, Arkansas, appearing for the claimant, and

Ms. Betty J. Demory, Attorney at Law, Little Rock, Arkansas, appearing for the respondents.

STATEMENT OF THE CASE

This is a dispute over the claimant's request for additional medical and indemnity benefits for his admittedly compensable low back injury of February 4, 2002.

Specifically, he requested additional temporary total disability benefits from the date they were terminated, June 30, 2002, until November 4, 2002; unpaid medical expenses, including the expenses of injection therapy, incurred at the direction of Dr. Sunder Krishnan; and benefits for permanent anatomical impairment of 6% to the body as a whole, as assessed by Dr. Krishnan. An attorney's fee for controversion was also requested. Other possible issues were reserved.

The respondents contended that the claimant is not entitled to additional temporary total disability benefits because his healing period ended June 30, 2002, when he was released to full duty work without impairment. They further contended that the requested medical expenses were neither

authorized nor reasonably necessary in connection with his compensable injury. Finally, they contended that the claimant has not sustained compensable anatomical impairment, according to the opinions of Dr. Steven Cathey and Dr. Meador and, further, that his impairment rating is not compensable because its major cause was pre-existing degenerative problems, rather than his compensable injury.

Based upon the record as a whole, and without giving the benefit of the doubt to any party, as required by the Act, the following findings of fact and conclusions of law are hereby made:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction of the parties and subject matter of this claim.

2. Pursuant to the stipulations of the parties and the record, the employment relationship existed at all pertinent times; the claimant sustained a compensable injury February 4, 2002; his average weekly wage was \$300.65; temporary total disability benefits and medical expenses had been paid through June 30, 2002; and the claimant first sought treatment from Dr. Krishnan July 10, 2002.

3. The preponderance of the evidence fails to show that the claimant is entitled to additional benefits for temporary total disability after June 30, 2002, because he was no longer in his healing period and totally incapacitated to earn wages at that time.

4. The preponderance of the evidence fails to show that the requested medical expenses were reasonably necessary in connection with the claimant's compensable injury.

5. The preponderance of the evidence fails to show that the claimant is entitled to benefits for permanent anatomical impairment because it fails to show that his compensable injury was the major cause of his permanent impairment.

DISCUSSION

The claimant, now 44 years of age, was employed to trim brush and trees around power lines. On February 4, 2002, he injured his back when he picked up a heavy log and started to throw it over into the back of a chipper truck and felt pain run through his back. He stated that it was a sharp pain, kind of like a knife sticking in his back.

He first received medical care from Dr. Chrysti Williams who recommended an MRI scan that was conducted February 18, 2002. That scan was read by Dr. Donald Harper as showing mild lumbosacral spondylosis and possible minimal superimposed central posterior disc protrusion at L5-S1. On February 20, 2002, Dr. Chrysti Williams' note indicated that the claimant had a positive straight leg raise on the left and suffered from chronic low back pain, acute exacerbation. She recommended medication and a referral to a neurosurgeon in light of the MRI. On March 8, 2002, she indicated that the claimant's appointment with neurosurgeon Dr. Zachary Mason had been delayed because the claimant had decided to file this on worker's compensation and had an appointment but does not know whether to keep it or not.

A Baptist Medical Center Emergency Room Report dated March 26, 2002, stated that the claimant reported that he was under the care of his primary physician for lumbar upper thoracic pain after injury while at work a month ago and now has a radicular component to the pain into both bilateral lower extremities with some numbness and paresthesias. The emergency room note also

stated that the claimant does have an MRI which does show some canal stenosis, the significance of which is not noted at this time, and also some small lumbar disc degenerative changes.

On April 15, 2002, the claimant was examined by neurosurgeon Dr. Steven L. Cathey of North Little Rock who wrote that the claimant's neurological examination was negative and he had no sign of lumbar radiculopathy. He also stated that the MRI scan was negative to his review and, even though the radiologist mentioned degenerative disc disease as well as a possible disc protrusion at L5-S1, Dr. Cathey believed the study to be unremarkable for a patient 42 years old. He also stated that he saw no evidence of disc herniation, spinal stenosis, nerve root impingement, etc. He recommended the claimant consult Dr. Chrysti Williams so that physical therapy and other measures could be arranged. He wrote that he believed the claimant could return to work at regular duty whenever he feels he can handle himself there and that he did not believe the claimant had sustained any impairment as a result of his industrial injury of February 4, 2002. Dr. Cathey's deposition testimony is generally consistent with his report.

On April 17, 2002, the claimant was examined by Dr. Williams who wrote that he stood, could not sit, and could not do a full examination because he could not sit. She also noted that there were no palpable spasms in the lumbar lower musculature. She prescribed medication and arranged for physical therapy, pursuant to the recommendation of Dr. Cathey. On May 7, 2002, Dr. Williams wrote that the claimant had negative straight leg raise, normal deep tendon reflexes, and that physical therapy reports showed no improvement in agreement with patient, also complaining he has not improved. She wrote that Dr. Cathey did not want to see the claimant again and that she was going to contact workers' compensation to get approval for a second opinion from a neurosurgeon or a pain management referral or something because she was not sure what else to do with Mr. Dempsey.

On June 10, 2002, the claimant was examined by Dr. Annette P. Meador. She noted that the claimant located his pain from the lower ribs down to the iliac crest area and, while he says he has pain down both extremities on his questionnaire, he does not mention this during the evaluation. There was no indication that the claimant had palpable muscle spasms. She stated that he initially stated he spent all of his time on his couch in his home but when she remarked about the depth of his suntan, his wife added that he stands in the yard a lot. She wrote that the claimant had been instructed in stretching exercises but had quit doing those. She also noted his drug list and that the claimant was not really sure about his dosage schedule, as his wife just hands him a handful of pills every morning. It was her impression that the claimant had myofascial pain syndrome for which she administered trigger point injections; instructed him in stretching exercises; recommended walking and a liver profile considering the amount of medication he has been taking; advised him she would rather rely on stretching exercises and trigger point injections instead of narcotic-containing medicines; and also recommended Robaxin for pain. She also stated that she explained that the claimant's recovery would be largely dependent on his motivation and that she did not see any spinal root impingement, although the claimant and his wife are convinced that he has a herniated disc for which she could see no physical finding. In a letter to the insurance adjuster on June 10, 2002, Dr. Meador wrote that she saw no reason why the claimant could not return to work in the near future and that she would discuss that with him the next visit.

On June 12, 2002, the claimant was seen by Dr. Williams who wrote that he stood during the entire examination, had no palpable spasms, was unable to cooperate with deep tendon reflexes or straight leg raise and suffered from severe chronic back pain. She recommended medication and a referral to a different pain management doctor.

On June 28, 2002, the claimant was again seen by Dr. Meador who wrote that the examination was “completely within normal limits with bilaterally symmetrical reflexes, excellent strength in his upper and lower extremities, negative straight-leg raise, and negative Patrick’s testing.” She released the claimant from her care and released him to work full duty. She remarked, again, about the claimant’s tan which was even deeper than when she first noticed it on June 10 and noted a burn on his forearm from grilling in the yard.

On July 10, 2002, the claimant was seen by Dr. Sunder Krishnan who believed the claimant to suffer from bulging lumbar disc and lower extremity radicular pain. He recommended treatment at Baptist Health Medical Center and that the claimant should try to utilize his narcotics as limited as possible. He noted that claimant reported that Dr. Meador said he had muscle spasms, although Dr. Krishnan’s own examination revealed tenderness and diminished range of motion of the LS spine with normal range of motion for the hips but without mention of muscle spasms. Similarly, the reports of Dr. Meador do not mention muscle spasms. Dr. Krishnan continued to treat the claimant relying to some extent on the accuracy of his subjective complaints of pain and muscle spasm, as well as his history.

In that regard, on cross-examination, counsel for respondents demonstrated that the claimant had been at least careless in relating his history from time to time. For example, in his deposition, before the hearing, he had stated that he had not seen doctors for reasons other than his back which started in February, 2002, even though there is a record of him being treated for lung and back problems in 2001. The claimant then admitted that he had testified earlier that he had not seen a doctor in 15 to 20 years. He had also previously testified that he had never been to see Dr. Chrysti Williams although he had, indeed, consulted Dr. Williams on several occasions before February,

2002. The record also shows that the claimant represented to Dr. Cathey and Dr. Meador that he had no prior back trouble even though he had received care for his back in July, 2001, at the emergency room, albeit not for his low back.

Here, the claimant relies primarily on Dr. Krishnan's opinions concerning his condition while the respondents prefer the opinions of Dr. Cathey and Dr. Meador. In the area under consideration, the opinions of the neurosurgeon, Dr. Cathey, are generally entitled to considerable weight. Both he and Dr. Meador believed the claimant was able to return to work and Dr. Meador's reports suggest some skepticism about the claimant's veracity. In short, the preponderance of the evidence indicates that the claimant had pre-existing degenerative pathology in his low back, as well as prior problems higher on his spine, but reached the end of his healing period for his work-related injury in June, 2002, consistent with the opinions of Dr. Cathey and Dr. Meador, and is not entitled to additional benefits for temporary total disability thereafter.

Similarly, the opinion of Dr. Cathey that the claimant's objective pathology in his low back is not sufficient to form the basis of an impairment rating is entitled to greater weight than the opinion of Dr. Krishnan in this area. Dr. Cathey emphasized that the claimant's MRI scan was normal for a 42 year old; that his examination was normal; that the degenerative changes on the MRI scan were not related to the claimant's pain; and that 8 to 12 weeks was a reasonable time for a musculoskeletal injury to heal.

Dr. Krishnan's notes and deposition testimony show that he is an anesthesiologist whose practice is entirely pain management. His initial examination of the claimant was negative except for paraspinal muscle tenderness and a decreased range of motion of the claimant's lumbar spine, neither of which are considered objective findings under the Act. The claimant's sacroiliac joints

were non-tender; range of motion of his hips was normal and non-painful; there was no trochanter bursa tenderness; he was able to heel and toe walk without difficulty; his patellar and Achilles reflexes were normal; his sensory evaluation was intact; his muscle mass and motor strength were normal; straight-leg raising was negative bilaterally; Babinski and clonus were negative; and x-rays taken that day were normal. The claimant was counseled about reducing his use of narcotics and Dr. Krishnan recommended that he undergo epidural steroid injections. Later, Dr. Krishnan was able to review the claimant's February, 2002, MRI scan which he thought indicated minimal disc bulging without nerve root impingement. He also testified that the MRI showed evidence of lumbar spondylolisthesis and arthritis in the facet areas which probably pre-existed his injury and could cause him to have pain or problems. He stated that he was not able to determine whether the claimant's alleged pain or problems were coming from his arthritis or the minimal disc bulge. Dep. at 11. He also testified that the claimant received no benefit from two courses of injection therapy, one in July and one in August, 2002.

In August, 2002, Dr. Krishnan had the claimant undergo an additional MRI scan with contrast enhancement because the claimant had just received an injection several days earlier and he wanted to rule out any sort of infectious process or worsening. However, the MRI still showed the same changes as before.

Dr. Krishnan saw the claimant again September 23, 2002, and again noted a normal neurologic examination and discussed a provocative diskogram, about which the claimant was hesitant. From September through January, 2003, the claimant was cared for by Dr. Williams, and when Dr. Krishnan saw him January 13, 2003, his neurological examination was unchanged. Dr. Krishnan discussed the claimant's narcotic medication including Demoral shots, which the

claimant indicated did not help him, and Dr. Krishnan suggested that he would be better off not taking them.

In November, 2002, Dr. Krishnan completed a form provided by claimant's counsel which indicated that the claimant had 8% anatomical impairment, which he adjusted to 6% during his deposition testimony. He also agreed that it could not be stated within a reasonable degree of medical certainty when the minimal disc bulges were present. Dep. at 23. Even though he stated that the claimant did have severe spasms, Dep. at 23, he also stated that he did not actually palpate any muscle spasms when he examined the claimant, although the claimant was quite tender and tense. Dep. at 25. He also stated that on September 23, 2002, the claimant was not going to proceed with the diskogram, he would have reached maximum medical recovery and a functional capacity evaluation would be recommended to determine his restrictions.

To be entitled to temporary total disability benefits, the claimant must show that he remained in his healing period and was totally incapacitated to earn wages as the result of his compensable injury. Here, both Dr. Cathey and Dr. Meador felt that the claimant was not incapacitated as a result of his compensable injury and that he had reached the end of his healing period. Indeed, even Dr. Krishnan felt that by September, 2002, the claimant would have reached maximum medical recovery if he was not going to proceed with the diskogram.

The continuing medical care provided primarily by Dr. Krishnan was based substantially on the claimant's subjective complaints. Dr. Krishnan testified frankly that he was not able to determine whether the claimant's problems were coming from arthritis or the minimal disc bulge. He also testified that he was unable to determine when disc bulge had occurred, other than by relying on the claimant's history. The record has demonstrated that the claimant has been less than an

accurate historian concerning his health. Even at the hearing, on direct examination, the claimant testified that he had never even been to a doctor before his injury. Additionally, some of Dr. Krishnan's treatment, epidural steroid injections which were of no benefit to the claimant, was very much like the treatment he previously received, also without benefit. Thus, Dr. Krishnan's reliance on the claimant's recollection to connect his condition to the job-related injury, rather than pre-existing pathology, was somewhat misplaced.

The Act also requires that permanent benefits be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment. Here, Dr. Cathey, a neurosurgeon, and Dr. Meador have not attributed any permanent impairment to the claimant's compensable injury and Dr. Krishnan in his deposition stated that he could not tell when the bulging disc had occurred or whether the claimant's symptoms should be attributed to pre-existing arthritis or the bulging disc, even assuming that the disc was related to his compensable injury. Thus, the requirement of showing that the compensable injury was the major cause of the claimant's impairment has not been met.

For the foregoing reasons, this request for benefits should be, and it is hereby, respectfully denied and dismissed.

IT IS SO ORDERED.

RICHARD B. CALAWAY
Administrative Law Judge