

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F104783

JUDITH A. HENDRIX

CLAIMANT

LOWE'S HOME CENTERS, INC.

RESPONDENT EMPLOYER

SPECIALTY RISK SERVICES, INC.

RESPONDENT CARRIER

ORDER AND OPINION FILED JULY 1, 2003

Hearing before Administrative Law JUDGE LINDA K. MARSHALL.

Claimant represented by the HONORABLE R. THEODOR STRICKER, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by the HONORABLE RANDY P. MURPHY, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

The above claim came on for a hearing on May 12, 2003, in Jonesboro, Arkansas. A prehearing conference was held on February 5, 2003 and a prehearing order was filed the same date. A copy of the prehearing order was marked as Commission Exhibit No. 1 and made a part of the record without objection.

At the prehearing conference, the parties agreed to the following stipulations:

1. There was a compensable injury on April 16, 2001.
2. The compensation rates are \$191/154.

The claimant contends that she is entitled to additional medical benefits and temporary total disability benefits from November 9, 2001, to the present. Permanency is reserved.

The respondents acknowledge the claimant sustained a compensable low back injury on April 16, 2001. The respondents paid medical and temporary total disability benefits until the claimant was released by Dr. Jerry Engelberg to full duty with zero impairment on November 9, 2001. The respondents contend that the claimant experienced and sought treatment for neck problems subsequent to the reported low back injury and those problems have been controverted in their entirety. All benefits were controverted after November 9, 2001.

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

**FINDINGS OF FACT
AND
CONCLUSIONS OF LAW**

1. There was a compensable injury on April 16, 2001.
2. The compensation rates are \$191/154.
3. The claimant has failed to prove by a preponderance of the evidence that additional medical treatment after November 9, 2001, for her low back was reasonable and necessary and related to the April 16, 2001, incident.
4. The claimant has failed to prove by a preponderance of the evidence that her cervical problems were related to the April 16, 2001, incident.

5. The claimant has failed to prove by a preponderance of the evidence that she remained in her healing period and was unable to earn wages because of her April 16, 2001, work injury after September 2001.

DISCUSSION

The claimant, 56 years old, began her employment with respondent in February 2000. According to the claimant, on April 16, 2001, she was cleaning up the front of the store near closing time, when she picked up a bag of fertilizer and threw it over her shoulder. The claimant testified that pain shot from her head to her feet and she continued to have pain that progressively got worse. The claimant reported the incident to Susan, the manager, and later reported the incident to Ada, the boss. The employer sent the claimant initially to Dr. Michael Lack who prescribed muscle relaxers and pain medication and suggested physical therapy. Dr. Lack referred the claimant to Dr. Jeffrey Kornblum and a MRI was performed. Dr. Kornblum referred the claimant to Dr. Mihaela Savu, a pain management specialist. According to the claimant, Dr. Savu wanted to do some back injections to kill the nerves in her back and she declined that treatment. The claimant asked for another doctor and the insurance company sent her to Dr. Engelberg. Dr. Engelberg ordered a nerve conduction study but no treatment was pursued by the doctor, according to the claimant. According to the claimant, she found out at her deposition that Dr. Engelberg had released her to return to work in November 2001.

After a period of receiving no further benefits, the claimant testified that she contacted the insurance company about seeing another doctor and was advised that the claim was being controverted. The claimant sought medical treatment with her

family physician and was referred to Dr. Roy Tyrer. Dr. Tyrer sent the claimant for a myelogram in Memphis. The claimant advised her family doctor that she was unable to travel as far as Memphis for treatment so she was referred to Dr. Edward Cooper for treatment. Dr. Cooper ordered a myelogram and MRI and performed neck surgery. Dr. Cooper referred the claimant to Dr. Sunil Gera for pain management treatment, consisting of a series of shots in the low back. When the problems did not subside, Dr. Cooper performed back surgery in September 2002 and a second back surgery in December 2002. The claimant testified that her neck and back are both improved, although she does still have some back pain that goes into her leg. The claimant has continued to see Dr. Gera for pain management and he has given her some injections which seem to help.

Under cross examination, the claimant testified that her husband's health insurance paid some of her medical and she and her husband paid some out-of-pocket expenses. The claimant also testified that she had been involved in four motor vehicle accidents, 1980, 1988, 1992 and 1994. The claimant sought chiropractic treatments following the 1994 motor vehicle accident and ultimately settled the case for \$20,000.

The claimant testified that she changed doctors from Dr. Kornblum to Dr. Engelberg and that was approved through the Arkansas Workers' Compensation Commission. The claimant also confirmed that Dr. Engelberg released her to return to work in September 2001. The claimant confirmed that her employer provided her a door greeter position in September 2001 and she was provided a stool where she could sit or stand, as needed.

Ada Butler, Lowe's personnel training coordinator, testified that the claimant reported a low back problem with leg pain in April 2001. Ms. Butler testified that the claimant did not report a neck injury and she was unaware of neck surgery until today. Ms. Butler confirmed that light duty was made available to the claimant in September 2001 and the claimant worked three days.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. §11-9-508(a)(Repl. 1996). However, injured employees have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary for treatment of the compensable injury. *Norma Beatty v. Ben Pearson, Inc.*, Full Workers' Compensation Commission Opinion filed February 17, 1989 (Claim No. D612291). In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, we analyze both the proposed procedure and the condition it is sought to remedy. *Deborah Jones v. Seba, Inc.*, Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D511255). Also, respondents are only responsible for medical services which are causally related to the compensable injury.

The respondents accepted the claimant's low back complaints as a compensable injury and paid for medical care and temporary total disability benefits. The claim was controverted November 9, 2001. The claimant initially presented to Dr. Michael Lack with lower back pain and numbness to the knee with the left foot beginning to hurt if she is on her feet too long. Dr. Lack prescribed medication and physical therapy. A lumbar MRI was performed on April 27, 2003 and Dr. Lack's April

30, 2003, office notes reflect that the MRI shows multiple degenerative changes with multiple bulges without any nerve compromise. Dr. Lack then referred the claimant to Dr. Savu or Dr. Gibson for diagnostic therapeutic injections. Dr. Lack referred the claimant to Dr. Jeffrey Kornblum, an orthopedic surgeon, and on May 7, 2001, the claimant was evaluated by Dr. Kornblum. At that time, Dr. Kornblum prescribed medication and recommended physical therapy and returned the claimant back to work on May 22, 2001. On May 21, 2001, Dr. Kornblum recommended two caudal blocks for the claimant and released her to light-duty work only. By May 25, 2001, Dr. Kornblum took the claimant off work again. When Dr. Kornblum saw the claimant on June 11, 2001, she had decided against the blocks at Dr. Savu's clinic. Dr. Kornblum ordered an EMG nerve conduction study and additional physical therapy was discussed. The claimant was going to pursue blocks in Memphis and Dr. Kornblum's note indicates he will see her after that. Dr. Kornblum's notes indicate that he discussed with the claimant that he was "most suspicious her degenerative disc disease is the source of the pain, though cannot be positive." Cl. Exh. No. 1, p. 41.

The medical records reflect the claimant went to her family doctor, Dr. Robert Lawrence, and, on June 13, 2001, she underwent a cervical spine MRI without contrast and a MRI of the head without contrast for complaints of neck pain and headaches. On June 26, 2001, the claimant returned to Dr. Kornblum with complaints of low back and left leg pain and severe headaches, neck pain and left arm pain. Dr. Kornblum's notes reveal that the claimant stated that she had been having this difficulty since her injury in April. Dr. Kornblum opined:

IMPRESSION: Ms. Hendrix has a complex picture of extensive pain along the spinal axis, left arm and left leg. To this time, for various reasons, she has not pursued any of the therapeutic interventions I have recommended. At this junction, I believe her neck and left arm symptoms are most consistent with a C6 disc herniation and her low back and left leg symptoms are likely caused predominantly by the L5 degenerative disc problem. However, there are other factors and diagnostic differential is certainly not clearcut. I reviewed this with her and her husband. (Cl. Exh. No. 1, p. 46.)

The claimant next was referred to Dr. Roy Tyrer by the claimant's family doctor, Dr. Robert Lawrence. Dr. Tyrer ordered a complete myelogram correlated with a post myelogram CAT scan in both the cervical and lumbar areas. Dr. Tyrer's August 20, 2001, report reveals:

Minor cervical spondylosis is present but no significant cervical disc herniation is identified. There is the very slightest left paracentral C6 disc prominence, which is not considered clinically significant.

A good lumbar study also was obtained and no significant abnormality identified. At L5-S1 disc level, on the right there is a small bubble of air which might represent a small annular tear, but I don't consider it clinically significant.

Clearly there is nothing in either the cervical or lumbar area to suggest a surgical disc problem. (Cl. Exh. No. 1, p. 51.)

As of August 22, 2001, Dr. Kornblum did not feel surgical intervention was needed for the claimant. He again recommended a pain clinic. On August 23, 2001, the claimant underwent a functional capacity evaluation. Richard DeKok, PT, MTC, wrote in his report that, "Due to Mrs. Hendrix's lack of full physical effort and significant degree of symptom magnification, I am unable to provide an accurate estimate of her physical abilities and limitations at this point." (Cl. Exh. No. 1, p. 55.)

On September 7, 2001, Dr. Michael Lack returned the claimant to work with restrictions. Dr. Lack's notes indicated the claimant already had an appointment with Dr. Edward Cooper at the referral of Dr. Robert Lawrence, family doctor. On September 24, 2001, Dr. Cooper ordered a CT myelogram of the cervical spine. On September 27, 2001, Dr. Cooper's notes reveal that the CT myelogram was performed and this revealed a HNP on the left at C5-C6 and C6-C7 with left C6 and C7 nerve root compromise with no change in her physical findings.

On October 12, 2002, the claimant saw Dr. Jerry Engelberg, neurosurgeon. Dr. Engelberg is the claimant's change of physician doctor from Dr. Kornblum. Dr. Engelberg ordered an EMG looking for denervation left L5-S1 nerve root distribution. The claimant returned to see Dr. Edward Cooper on October 17, 2001 and cervical surgery was scheduled. Dr. Edward Cooper performed anterior cervical decompression fusion C5-C6 and C6-C7 with left anterior iliac crest bone autograft and anterior cervical plate internal fixation on October 23, 2001.

On November 9, 2001, Dr. Engelberg saw the claimant again and after a review of the EMG, he opined that there was no denervation in the left L5-S1 nerve roots. He opined that the MRI showed a little disc abnormality at lumbar 5, but it did not seem to be compressing the cauda equina of the nerve roots. He encouraged a walking program. Dr. Engelberg examined the claimant again on November 9, 2001 and cleared her to work with no impairment from the lumbar and this was documented on December 11, 2001.

On January 11, 2002, Dr. Edward Cooper opined in a letter that he was caring for the claimant for HNP C6-C7 and in his opinion this injury occurred when the

claimant was picking up a 50-pound box of fertilizer on April 16, 2001. Dr. Cooper began treating the claimant on September 12, 2001. By April 29, 2002, when Dr. Cooper saw her again, her neck, arm and headaches had subsided, but she continued to complain of low back pain with bilateral lower extremity pain. Dr. Cooper ordered a CT scan of the “LS to R/O herniation or stenosis.” Cl. Exh. No. 2, p. 113. On May 6, 2002, Dr. Cooper’s notes reveal:

.... The CT scan was reviewed. This does show lumbar spondylosis at multiple levels with multi-level facet joint arthritis, hypertrophy of the ligamentum flavum and there is also significant disc bulging especially at L4-L5 and L5-S1. At L4-L5 there is large osteophytosis off the facet joint. This is worse on the left than on the right with moderate to severe left lateral recess stenosis. At L5-S1 there is disc bulging centrally with some narrowing of the lateral recesses bilaterally.... (Cl. Exh. No. 1, p. 113.)

On September 17, 2001, Dr. Cooper performed the bilateral decompressive laminectomies L4-L5 and L5-S1. On December 10, 2002, Dr. Cooper performed a repeat bilateral decompression laminectomy at L4-L5 and L5-S1.

As the medical evidence indicates, the claimant has seen a myriad of doctors. The respondents sent the claimant to Dr. Michael Lack. Dr. Kornblum was the first specialist the claimant saw at respondents’ expense. Dr. Savu, a pain management specialist, was also made available to the claimant and the claimant asked to change specialists. The respondents next paid for the claimant to treat with Dr. Jeffrey Engelberg.

Dr. Kornblum, in his April 2, 2003, deposition, testified that the diagnostic testing he had reviewed did not indicate surgery was necessary. Dr. Kornblum also reviewed his notes of the claimant’s office visits and found that June 26, 2001, was the first

mention of neck pain. Dr. Kornblum was questioned about the claimant's subsequent surgeries.

Q. [Mr. Stricker] You wouldn't be critical of the surgery necessarily?

A. [Dr. Kornblum] Well, it depends on the circumstances. Any patient that sees enough doctors will end up with an operation. If you keep complaining – personally if I keep seeing someone back, what I might not have recommended a surgery for because I thought the risk/benefit ratio was poor, by the time I have seen someone for six months, if they're still complaining, I think, well, maybe we ought to take our chances and do it.

Well, if they have a bad result, probably, you know, you look back and say, well, I shouldn't have done that. But what else are we going to do? We tried this and this and this. And so by the time enough months pass, she ends up with the surgery, I don't find that as a surprise. (Resp. Exh. No. 2, p. 34, lines 3-19.)

The next neurosurgeon, Dr. Engelberg, saw the claimant on three occasions. As Dr. Engelberg opined in his April 1, 2003, deposition, he ordered an EMG study. He further explained:

She returned on November the 7th, 2001 and the EMG study was not complete. It was complete a day or two later and it showed no denervation in the left L-5, S-1 nerve roots. So I discussed with Mrs. Hendrix that the MRI showed a disc bulge at lumbar five, but I didn't feel it was compressing the the [sic] nerve roots. I encouraged her in a walking program, went over some back exercises and told her we'd be glad to see her as needed and let her resume her work activities. (Resp. Exh. No. 3, p. 7, lines 10-18.)

Dr. Engelberg stated that when he released the claimant to full duty on December 11, 2001, he did not find any need for surgery. Dr. Engelberg testified that the claimant did not complain to him of neck problems between October and November

2001. Dr. Engelberg reviewed Dr. Cooper's operative report of the claimant's lumbar surgery and verified the report says no acute disc herniations were noted.

Dr. Roy Tyrer was deposed on April 29, 2003 and he testified he saw the claimant three times between August 13, 2001 and August 27, 2001. Dr. Tyrer testified he reviewed the prior studies of the claimant and he ordered the lumbar and cervical myelogram. Dr. Tyrer opined the tests revealed cervical spondylosis and no low back significant abnormalities. He did recommend epidural blocks in the neck and low back. Dr. Tyrer testified he did not recommend surgery.

Dr. Edward Cooper was deposed on April 21, 2003 and he testified he first saw the claimant on September 12, 2002 and last saw her March 10, 2003. Dr. Cooper testified that on his last visit with the claimant she was still having back pain and he recommended some pain management with Dr. Gera. Dr. Cooper testified the claimant's neck seems to be doing fine. Dr. Cooper also testified he was unaware of the claimant's initial complaints following the April 2001 incident. Dr. Cooper initially recommended conservative treatment but ultimately performed cervical surgery with good results. On April 29, 2002, the claimant began to complain of low back pain. Dr. Cooper ordered a CT scan of the lumbar spine to evaluate for herniation or stenosis.

According to Dr. Cooper, that evaluation revealed:

Let's check that. Showed lumbar spondylosis multiple levels. That's arthritis with degeneration of the disk and, you know, osteophyte or spur formation. Kind of the predecessor of stenosis. (Resp. Exh. No. 5, p. 20, lines 20-23.)

Dr. Cooper obtained a CT myelogram on May 13, 2002 and was asked about that test:

Q. [Mr. Murphy] Did it confirm the degenerative changes, the spondylosis, stenosis, the osteophyte formation, the other things that you had seen on the CT scan, the lumbar CT scan.

A. [Dr. Cooper] Yes, it did.

Q. Okay.

A. It showed bilateral L-5 nerve root compression at L5-S1 and some significant foraminal stenosis, and at L4-L5 he didn't think it was as significant as I did. (Resp. Exh. No. 5, p. 22, lines 11-19.)

Dr. Cooper was finally asked his opinion regarding the claimant's back and he stated:

Okay. Well, yes. My opinion is that she had a degenerative process going on for a period of time, and then at some point the disk bulged back and irritated the nerve and got it started, and that's basically it. (Resp. Exh. No. 5, p. 54, lines 20-23.)

The claimant sought treatment at her own expense with Dr. Lawrence, her family doctor; Dr. Roy Tyrer, a neurosurgeon; and, finally, Dr. Edward Cooper, a neurosurgeon.

After considering all the credible evidence, to include the vast medical packet and the claimant's testimony, I find the claimant has failed to prove that additional medical treatment after November 9, 2001, for her low back was reasonable and necessary and related to her compensable April 16, 2001, incident. I give great weight to the opinions of Dr. Kornblum, Dr. Engelberg and Dr. Tyrer who recommended conservative care and did not recommend back surgery. Dr. Kornblum discussed with the claimant her degenerative disc problems causing her pain. Further, the claimant's medical history documents complaints of back pain to March 1995, as well as disc

herniation. I further find the claimant has failed to prove by a preponderance of the evidence that her cervical problems arose out of the April 16, 2001, incident. The claimant's testimony about immediate neck pain and severe headaches did not correspond with the contemporaneous medical evidence. The medical evidence does not make mention of headaches and neck pain until late June 2001. I was not persuaded by the claimant's testimony that she developed the neck problems on April 16, 2001. The neck problems were not reported to the supervisor nor were they identified in her initial medical visits. Also, the claimant had complained of neck pain and numbness in her fingers in March 1995.

In order to be entitled to TTD benefits, the claimant must remain in his healing period and be unable to earn wages. *Ark. State Hwy. & Transp. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981).

In the present case, the medical records and the claimant's testimony indicate the claimant was released to light-duty work in September 2001. The testimony was that light-duty work was provided, although the claimant only worked a few days. I find the claimant has failed to prove by a preponderance of the evidence that she remained in her healing period and was unable to earn wages after September 2001.

ORDER

The claimant has failed to prove by a preponderance of the evidence that additional medical treatment for her low back after November 9, 2001, was reasonable and necessary and related to the April 16, 2001, incident. The claimant has failed to prove by a preponderance of the evidence that her cervical problems were related to

the April 16, 2001, incident. The claimant has failed to prove by a preponderance of the evidence that she remained in her healing period and was unable to earn wages because of her April 16, 2001, work injury after September 2001. The claim for benefits is respectfully denied and dismissed.

IT IS SO ORDERED.

**LINDA K. MARSHALL
ADMINISTRATIVE LAW JUDGE**