BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F105697

MICHAEL THOMPSON	CLAIMANT
DUKE'S WEST OAKS	RESPONDENT
CYPRESS INS. CO. INSURANCE CARRIER	RESPONDENT

OPINION FILED AUGUST 14, 2003

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by STEPHANI JUNGMEYER, Attorney, Fayetteville, Arkansas.

Respondents represented by WILLIAM FRYE, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on June 20, 2003, in Fort Smith, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on May 7, 2003. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

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

2. On all relevant dates, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to his neck on May 10, 2001.

4. Medical expenses have been paid to some point.

5. The claimant is entitled to a compensation rate of $268.00 for temporary total disability.

6. Temporary total disability has been paid to some point.

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

1. Claimant's entitlement to cervical surgery as recommended by Dr. Blankenship.

2. Additional temporary total disability from July 17, 2002, to a date to be determined.

3. Attorney's fees.

In regard to the foregoing issues the claimant contends that he sustained an injury to his head, neck and both arms when he was assaulted on May 10, 2001, while working at Duke's West Oaks Restaurant. The claimant had an MRI performed on May 22, 2001, which indicated severe C5-6 stenosis, moderate/severe C6-7 stenosis and degeneration disc disease. The claimant has received treatment from Dan B. Bell, MC from May 16, 2001, through June 18, 2002, form cervical disc disease with bilateral impingement, severe headaches, depression and uncontrolled pain. Additionally, the claimant has received treatment from D. Luke Knox, MD from August 24, 2001, to December 4, 2001, for neck pain, bilateral arm pain and severe headaches. The claimant has received treatment from James B. Blankenship, MD, FACS from April 3, 2002, through April 23, 2002, for a persistent left upper extremity radicular pain and marked cervical spondylosis with exit foraminal stenosis at C5-6 and C6-7. Dr. Blankenship recommended surgical treatment including a C5-6 and

C6-7 anterior cervical decompression and diskectomy with implants and anterior plating. This surgery was scheduled at Dr. Blankenship’s recommendation, but was cancelled by the workers’ compensation carrier after the carrier sent the claimant to Vincent B. Runnels, MD on June 17, 2002, for an independent medical evaluation. Dr. Runnels stated that the claimant suffered with severe spondylosis at C5-6 and C6-7, decreased range of motion in all directions and depression. Dr. Runnels stated that in his pinion the claimant was not a surgical candidate. The claimant wishes to proceed with the surgery as recommended by Dr. Blankenship, his treating physician.

In regard to the foregoing issues the respondents contend that the claimant has had long-standing low back and neck problems for some time. In fact, he was seen in 1980 for these exact problems. In August 1998, he saw Dr. Danks for neck and low back problems. The diagnosis was failed back syndrome. The claimant was also complaining of numbness of the thumb and arm pain. Dr. Danks ordered a cervical and lumbar MRI scan. The cervical MRI showed defects at C5-6 and C6-7. Since that time, the claimant has been followed for his condition including physical therapy. The claimant was seen some 9 days prior to this injury for his 20 hear history of back problems. After this injury, the claimant was seen by Dr. Morse and Dr. Knox. An MRI was ordered, which indicated no change form the previous study of August 27, 1998. A mylogram and post mylogram CT were also performed and showed only degenerative changes. Subsequent to this, the claimant was seen by Dr. Runnels

for an evaluation. Dr. Runnels noted the claimant had already been seen once by Dr. Danks who did not recommend surgery. He also felt that surgery would not be wise and, in fact, stated the following:

> "This man would not do well with surgery. He is a bad result waiting to happen."

Dr. Runnels further indicated that the claimant had no additional impairment. The respondents contend that the claimant's present problems are due to his long-standing back problems and not due to his compensable injury. Further, the medical treatment recommended by Dr. Blankenship is not reasonable or necessary.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1. The claimant objected to the admission of this document based on timeliness, the respondents' motion was overruled and the document was omitted with the understanding that the respondents had the right to take the deposition of Dr. Bell. The respondents offered documentary evidence which was objected to by the claimant based on surprise since they had not been provided this document. The claimant's motion was granted and the respondents proffered the information and it is marked Respondents' Proffer No. 1. The parties submitted a packet of documentary evidence marked Joint Exhibit No. 1.

DISCUSSION

The claimant testified that he is 51 years old and is currently living in Homer, Alaska. The claimant testified that he worked off and on for the respondent since 1990 starting off as a

dishwasher, then as a cook and then went into management. The claimant testified that in May 2001 he was the kitchen manager but also did other tasks such as payroll and maintenance. The claimant testified that on May 10, 2001, he got into an altercation with a customer who was drunk. The claimant stated that this intoxicated customer punched him and grabbed him by both sides of his head and started yanking his head back and forth trying to smash it into some spindles which went from the bar into the ceiling. The claimant testified that as a result of this altercation, he was first seen at the emergency room by Dr. Beard and then was referred to Dr. Bell. The claimant testified that by the next day when he was able to see Dr. Bell, his arm had gone numb. The claimant stated that Dr. Bell referred him to Dr. Mores and then he was seen by Dr. Knox.

The claimant testified that he has had neck pain in the past but it was not a "big deal." The claimant testified that in 1979 while working in Colorado he injured his low back for which he ultimately had surgery. The claimant testified that he has continued to receive treatment for his low back and that the Colorado workers' compensation is still paying for medication for his low back. The claimant testified that when he has been seen by Dr. Raben and Dr. Knox prior to May 2001, he may have mentioned having pain in his neck but it was nothing like it is now. The claimant testified that he does not remember ever receiving treatment for his neck prior to May 2001 nor has ne ever missed any work as a result of neck problems before that date.

The claimant testified that he was sent by the respondent to Dr. Blankenship and after being seen by the doctor two times, Dr. Blankenship began to set him up for surgery and to take care of all the pre-op preparations. The claimant testified that he had neck surgery scheduled for May 13, 2002, but shortly before the surgery, the respondents cancelled the procedure and denied treatment. The claimant testified that the respondent then sent him to Dr. Runnels who he saw once. The claimant testified that he was not impressed with Dr. Runnels and that they did not particularly get along. The claimant testified that on July 17, 2002, the respondent terminated his temporary total disability.

The claimant testified that he has seen Dr. Kelly Danks for treatment of his low back remembering that this was sometime in 1998. The claimant testified that he may have circled his back to include his neck when he was seen by Dr. Danks but that the treatment he received was for his low back. The claimant did remember that Dr. Danks gave him a prescription for headaches but no treatment was ever given for his neck. The claimant stated that he and Dr. Danks discussed surgery and it was Dr. Danks' recommendation that no surgery was needed at that time.

The claimant testified that he is not working but is drawing social security, explaining that his hands shake quite a bit and that he has severe headaches and neck pain.

On cross examination, the claimant was asked extensively about his 1979 low back injury. The claimant agreed that in his deposition he stated that he did not injury his neck in his 1979

injury. The claimant testified that in 1991 he saw Dr. Raben for his low back and at that time he may have told him that he had a little pain in his neck. The claimant stated that whatever Dr. Raben has in his records he would not disagree with. The claimant testified that whatever neck pain he was experiencing in 1991 when he was seen by Dr. Raben was nothing like it is today. The claimant agreed that at the time he went to the emergency room after the altercation on May 10, 2002, he was already taking medications for his low back. The claimant agreed that he was taking Vicoden, Vioxx and Zoloft and that these medications were for pain, anti-inflammatory as well as depression. The claimant testified that currently he is taking Zoloft and Pamelor for pain, Valium for back spasm and he is taking Bextra which is an anti-inflammatory. The claimant agreed that these are being paid as a result of his low back injury in Colorado. The claimant testified that after his May incident he was referred to a physical therapist for pain in his neck as well as into both of his arms and down into his hands.

The claimant agreed that he has received treatment for his low back and complaints of pain in his head and headaches since his injury in Colorado. The claimant has testified that generally the treatment which he has sought prior to May 10, 2001, has been for his low back although he might have had some complaints about his neck as well. The claimant stated, “I’m not denying that I probably had some neck pain, but after this 260-pound guy tried to rip my head off, as far as I know things have changed in there.”

The claimant testified that for his Colorado low back injury he received a 6 percent disability rating. The claimant agreed that when he filed for social security he listed not only his neck and arms but also his low back as keeping him from working. The claimant agreed that he has been getting approximately $650.00 per month for social security indicating, however, that for the first couple of months he was receiving $62.00 per month. The claimant testified that from the time he saw Dr. Runnels in July of last year until he was seen by Dr. Bell in June of this year, he has been unable to afford any medical treatment. The claimant testified that his neck still gives him fits and he still has headaches as well as his arms still ache and they are numb. The claimant testified that he has some days that are better than others but he still has problems with sleep. The claimant testified that he would like to have an operation in hopes of getting better so he could get back to work.

On redirect examination, the claimant agreed that the pain medications which he is prescribed for his low back are general pain relievers. The claimant further agreed that these pain medications not only help control the pain in his low back but also alleviate the discomfort in his neck as well.

The medical records reflect that the claimant was seen with complaints of neck pain in the emergency room at the Eureka Springs Hospital on May 10, 2001. Dr. Charles Beard notes that the claimant has multiple trigger points in his neck and some visible muscle spasm. It was recommended that the claimant have home rest,

use heating pads, medications were prescribed and he was referred to Dr. Bell. The claimant had been being seen for his low back problems by a physical therapist prior to May 10, 2001. On May 15, 2001, the claimant returned to his physical therapist for his regular low back appointment but his neck or cervical area was addressed as well. The claimant underwent an MRI for his neck on May 22, 2001, which showed severe C5-6 right foraminal stenosis with C6 nerve root compression secondary to eccentric inplate osteophytes and moderate to severe C6-7 left lateral recess stenosis with associated C7 nerve root displacement which is secondary to a combination of eccentric inplate osteophytes and annulus bulging and degenerative disc disease affecting C5-6 and C6-7 and that this test showed no significant change since the test run on August 27, 1998. Dr. Dan Bell writes on May 31, 2001, that he has examined the claimant for his complaints of neck and arm pain as well as reviewed the claimant's MRI. Dr. Bell notes that the MRI shows nerve impingement at two levels, C4-C5 and C5-C6. Dr. Bell assesses the claimant with having marked cervical disc disease with bilateral nerve impingement, acute cervical sprain after an altercation on the job which clearly exacerbated his condition, referred him to a neurosurgeon, continued his physical therapy and prescribed medications. The claimant continued to have physical therapy two to three times a week for his low back as well as neck pain and in June it is noted that he is beginning to develop bilateral carpel tunnel syndrome symptoms which the physical therapist notes as well as Dr. Bell notes in his office

records dated June 29, 2001. The claimant was seen by Dr. Michael Morse on June 22, 2001. Dr. Morse notes that due to the physical altercation which the claimant experienced at work on May 10, 2001, he exacerbated a pre-existing problem with his neck. Dr. Morse writes that the claimant has had cervical spondylitic changes in the past and has had neck pain which had resolved. Dr. Morse writes that the claimant’s neck pain is now worse and radiates down into the medial aspect of his left scapula and down his left arm. The claimant’s headaches are also noted which the doctor associates with his neck pain. Dr. Morse notes that he reviewed the claimant’s MRI of his cervical spine and that he has spondylitic changes at C5-6 and C6-7 on the right at C5-6 and on the left at C6-7. The doctor further notes that he has reviewed the claimant’s nerve conduction test which shows bilateral carpal tunnel syndrome. Dr. Morse assessed the claimant with having significant bilateral carpal tunnel syndrome which he relates to the claimant’s altercation, noting that it is typically an acute carpal tunnel syndrome which should resolve and recommended physical therapy as well as braces for this problem. The doctor notes that the claimant has cervical spine pain which is an exacerbation of a pre-existing condition, noting that the claimant has been given a shot of cortisone and has been to physical therapy. Dr. Morse suggested that if the claimant’s symptoms do not improve, that he be seen by Dr. Knox. Dr. Morse noted that the claimant has chronic low back pain which has not changed since his altercation and that he also

is experiencing tremors in his hands which the doctor relates to the claimant’s overall condition with his neck and hands.

Dr. Luke Knox saw the claimant on August 21, 2001, for consultation for his neck pain and bilateral arm pain. Dr. Knox examined the claimant as well as reviewed his MRI which he notes showed severe degenerative disc changes at 5-6 and 6-7 which the doctor notes “may be the culprit of his current complaints.” Dr. Knox ordered additional testing. Dr. Knox saw the claimant on October 18, 2001, and writes on October 22, 2001, that he has reviewed the claimant’s bone scan which was unrevealing and the CT scan of the claimant’s head was negative. Dr. Knox notes that the claimant continues to have severe headaches and pain in his upper extremity and orders that the claimant undergo a mylogram. Dr. Knox writes again on December 4, 2001, after seeing the claimant on November 29, 2001, noting that he has reviewed the claimant’s mylogram and post mylogram CT scan. Dr. Knox writes that these tests set forth that the claimant had significant spondylitic change which appeared to be degenerative in nature. Dr. Knox writes, “I am quite suspicious that no surgical endeavor would offer significant benefit to his current complaints.” Dr. Knox referred the claimant to a neurologist for his continued complaints of headaches and other symptoms. Dr. Knox also recommended that he arrange to be seen for pain management.

Dr. James Blankenship saw the claimant for an independent medical evaluation at the request of the respondents. After review of the claimant’s old test results and examination of the claimant,

Dr. Blankenship writes that although the claimant does have pre-existing neck and lower back problems, his current clinical complaints of neck and left upper extremity pain originated with an injury last year and the doctor feels as though this is the causative mechanism for the claimant's current pain. Dr. Blankenship recommended that a repeat MRI of the claimant's neck be made. On April 23, 2002, Dr. Blankenship writes that he has reviewed the claimant's new MRI and notes that he has marked cervical spondylosis and that he does have neural exit foraminal stenosis at C5-6 worse than C6-7 and left greater than right. Dr. Blankenship notes that he does feel that the claimant's current problem is related to his on the job injury and that he states this within a reasonable degree of medical certainty. Dr. Blankenship recommended surgery since more conservative treatment had been non-productive, discussing with the claimant the operative procedure of a C5-6 and C6-7 anterior cervical decompression and diskectomy with implants and anterior plating.

The claimant was seen by Dr. Vincent Runnels on June 3, 2002. Dr. Runnels writes to Dr. Bell on June 17, 2002, concerning the claimant. Dr. Runnels notes that he has reviewed the claimant's x-rays which show spondylosis at C5-6, 6-7 and notes that upon examination the claimant was neurologically intact. Dr. Runnels writes that the claimant would not do well with surgery and indicates that Dr. Kelly Danks, who had seen the claimant earlier, had not recommended surgery. Dr. Runnels writes that he thinks that in one months time the claimant can be released and that he

should be over any aggravation of his arthritis as a result of his injury. Dr. Runnels does note that the claimant has psychiatric disease and arthritis.

After a review of this record, I find that the claimant has proven by a preponderance of the evidence that he is in need of additional medical treatment as recommended by Dr. Blankenship. It is not questioned that this claimant had pre-existing cervical degenerative disk disease but this pre-existing problem was not dramatically symptomatic, requiring treatment and hindering the claimant from working, prior to his May 10, 2001, incident where he was beaten by a customer. Dr. Blankenship has had extensive tests run and in light of the conservative treatment which the claimant has received for his compensable injury, Dr. Blankenship, a neurosurgeon, has recommended surgery for this claimant's compensable injury. It is noted that Dr. Runnels does not agree with Dr. Blankenship's recommendation and is adamant in his writing that the claimant would not benefit from such a procedure. Dr. Runnels, however, just reviewed his x-rays and a brief examination when making this determination. It is also noted that Dr. Runnels relies or notes that Dr. Danks is in agreement with his recommendation of no surgery but the records reflect that the claimant was last seen by Dr. Danks in 1998, long before this compensable event occurred. I, therefore, find that this claimant is entitled to the cervical surgery as recommended by Dr. Blankenship at the respondent's expense for treatment of his compensable injury.

I further find, based on the record, that this claimant is entitled to temporary total disability from July 17, 2002, to a date to be determined. Dr. Dan Bell, who has been the claimant's consistent treating physician, has noted several times throughout his records that the claimant is not able to work as a result of his compensable injury. On June 18, 2002, Dr. Bell notes that the claimant is clearly disabled and was assisting him with filling out forms for social security disability. Dr. Bell again writes on June 16, 2003, that the claimant continues to experience dramatic problems as a result of his compensable injury and at that time rated the claimant with being 100 percent disabled. Therefore, the respondents should pay temporary total disability from July 17, 2002, to a date to be determined.

FINDINGS & CONCLUSIONS

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

2. On all relevant dates, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to his neck on May 10, 2001.

4. Medical expenses have been paid to some point.

5. The claimant is entitled to a compensation rate of $268.00 for temporary total disability.

6. Temporary total disability has been paid to some point.

7. The claimant has proven by a preponderance of the evidence that he is entitled to the recommended cervical surgery as recommended by Dr. Blankenship. See discussion above.

8. The claimant has proven by a preponderance of the evidence that he is entitled to temporary total disability from July 17, 2002, to a date to be determined. See discussion above.

9. The respondents have controverted this claimant’s request for additional benefits.

10. The claimant’s attorney is entitled to the maximum statutory attorney’s fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that he is entitled to cervical surgery as recommended by Dr. Blankenship and the respondents should be responsible for the payment of this medical treatment.

The respondents should pay temporary total disability to this claimant from July 17, 2002, to a date to be determined.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

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ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE