

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F303102

ELIZABETH RODEN VINSON

CLAIMANT

DOLLAR GENERAL CORPORATION
SELF INSURED

RESPONDENT

OPINION FILED OCTOBER 31, 2005

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Fort Smith, Sebastian County, Arkansas.

Claimant represented by GUNNER DeLAY, Attorney, Fort Smith, Arkansas.

Respondents represented by BETTY DEMORY, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held in the above styled claim on August 9, 2005, in Fort Smith, Arkansas. A pre-hearing order was entered in this case on May 26, 2005. This pre-hearing order set out the stipulations offered by the parties and outlined the issues to be litigated and resolved at the present time. Prior to the commencement of the hearing, certain amendments were made in regard to the stipulations and issues and two of the issues were withdrawn by agreement of the parties. A copy of the pre-hearing order with these amendments noted thereon, was made Commission's Exhibit No. 1 to the hearing.

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

1. On March 13, 2003, the relationship of employee-self insured employer-third party administrator existed between the parties.

2. The weekly compensation rates are \$320.00 for total disability and \$240.00 for permanent partial disability.
3. On March 13, 2003, the claimant sustained a compensable injury to her low back.
4. There is no dispute over the payment of medical expenses incurred prior to April of 2005.
5. There is no dispute over the payment of temporary total disability at the present time.

By agreement of the parties the issue to be litigated and resolved at the present time was limited to the following:

1. The claimant's entitlement to additional medical services, during and after April of 2005.

In regard to these issues, the claimant contends:

"The claimant contends that she sustained a compensable low back injury on March 13, 2003 and she is entitled to additional medical expenses."

In regard to these issues, the respondents contend:

"It is the contention of the respondent that the claimant has been provided all appropriate benefits to which she is entitled. Specifically the respondent asserts that any additional benefits sought by the claimant are not reasonably necessary nor are they causally related to the March 13, 2003 work related injury."

DISCUSSION

_____The sole issue presented for resolution, at the present time, concerns the claimant's entitlement to additional medical services during and after April of 2005. The burden rests upon the claimant to prove that these medical services represent "reasonably

necessary medical services” within the meaning of Ark. Code Ann. §11-9-508.

Medical services are “reasonably necessary” when they are connected to or necessitated by the compensable injury. Further, these medical services must have a reasonable expectation of accomplishing the purpose or goal for which they are intended. However, there is no requirement that the medical services must actually accomplish their intended purpose nor is there a requirement that the compensable injury be the sole or even major cause of the need for the services.

The evidence shows that the claimant was initially injured on March 13, 2003. She initially complained of a “pop” in her right lower back with immediate numbness of both legs. Initial x-rays showed mild degenerative end-plate changes and some minimal disc narrowing at L5-S1. The claimant’s subsequent complaints involved right lower back pain with radiation down the outer part of her right thigh and tingling in her right great toe. An MRI performed on March 19, 2003, revealed a small focal disc protrusion or herniation at L4-5 that was “left paracentral” and which could be compromising the exiting left L4 nerve root. However, as the claimant’s lower extremity complaints involved her right lower extremity, the diagnosis of the etiology of her complaints remain that of a lumbar strain, as opposed to a disc herniation.

By April 15, 2003, the claimant was noted to have gradually improved and was quite a lot better by that time. Her only complaints involved a little bit of pain in the upper sacral area.

By May 1, 2003, the claimant was noted to be 100% recovered. She was released to return to work without restrictions and discharged from further medical treatment.

The claimant apparently returned to regular employment with this respondent and performed such employment without difficulty until August 14, 2003. There is no indication that the claimant required or even sought any medical treatment between May 1, 2003 and August 14, 2003.

On August 14, 2003, the claimant was once again sought medical treatment for difficulties with her low back and this time her left leg. The claimant gave a history that after she had helped unload a truck, she was putting something on a lower shelf and when she raised up, she felt her back "pop" with severe pain in the lower back and some radiation into the left leg. Following this new incident, another MRI was performed which was interpreted as unchanged from the prior study in March of 2003. However, this time the claimant's difficulties were diagnosed as being attributable to a lumbar strain with a L5- radiculopathy secondary to her disc protrusion or bulge at L4-5. The claimant was treated for these diagnosed difficulties through February 3, 2004. On February 3, 2004, the claimant was noted to be "pain free," except for some complaints of muscle pain in her low back on the left side. These residual muscle pain complaints were attributed to the residuals of the series of epidural steroid injections made into this area. On February 6, 2004, the claimant was released to return to work with permanent restrictions against lifting in excess of 30

pounds, repetitive bending, repetitive twisting, and repetitive lifting. She was discharged from further treatment, to return only on an as needed basis.

Again, there is no evidence that the claimant required or even sought any further medical treatment for any difficulties involving her back or lower extremities until September 20, 2004. At that time, she again sought medical treatment for low back pain and left leg pain. The onset of this episode of difficulties was again attributed to another specific employment related incident that occurred on September 19, 2004. The claimant stated that her difficulties reappeared while she was lifting cases of 2 liter bottles on that date.

Again, the claimant's difficulties were diagnosed as being due to a lumbar strain. A third MRI study, which was performed on September 30, 2004, continued to show no change from the prior two studies. The claimant's physical examination also showed no evidence of radiculopathy, such as sensory or motor function changes, atrophy, reflex changes, or positive straight leg raising.

On October 22, 2004, the claimant was noted to have only minimal discomfort. She was released by Dr. Cheyne (her treating physician) to return to work under her previous permanent restrictions. He opined that the claimant had reached maximum medical improvement and discharged her from further care.

There is no evidence that the claimant required or even sought any further medical services until April 27, 2005. At that time, she returned to Dr. Cheyne. This time she gave a history that she

was doing well until recently, when she unexplicably experienced a pain in her back and down her leg. This was the first time that the reappearance of her symptoms did not coincide with a particular lifting incident.

It further appears that the purpose of her return was not particularly to seek medical services from Dr. Cheyne, but to obtain a referral to Dr. Capocelli (a neurosurgeon). She advised Dr. Cheyne that she was requesting this referral because "her attorney told her that is what she needed to do."

In his report of April 27, 2005, Dr. Cheyne indicates that he was going to order a new MRI scan. However, if this test was ever actually performed, the results of this most recent study have not been introduced, nor have any results of such a study been mentioned in the subsequent medical records.

The claimant was seen by Dr. Capocelli on May 10, 2005. Curiously, Dr. Capocelli recorded a history of an injury at work some 4 years prior with the claimant's back difficulties going back to that time. He also noted that the claimant "has been doing reasonably well" for the past 4 years. Obviously, this is a mistake in Dr. Capocelli's dictation or its transcription. In spite of this error in the time frame, it is apparent from Dr. Capocelli's report that he recorded a history of a relatively recent onset or recurrence of the claimant's symptoms, which involved both her low back and her left lower extremity. He also noted that the claimant's current symptomology was similar to that which she had previously experienced, but was merely not as severe. However,

unlike the claimant's prior episodes of difficulties, he recorded no history of any precipitating event or incident that brought on this most recent new episode of symptoms. While he recognized that surgical intervention could ultimately be a possible option, it was obvious his opinion that conservative measures should again be tried.

On May 31, 2005, the claimant apparently returned to Dr. John Swicegood for another series of epidural steroid injections. From his records, it appears that these injections are again accomplishing the intended purpose of alleviating the claimant's current episode of difficulties.

The claimant appears a credible witness. At the hearing, she testified that she had never experienced any difficulties with her back sufficient to cause her to seek or receive any medical or chiropractic treatment prior to the employment related incident and injury of March 13, 2003. Following this incident, she was objectively shown to have a lumbar defect in the form of a small disc protrusion or herniation at L4-5 that was restricting or compromising the left neural foramina and possibly impinging on the exiting L5 nerve root. Clearly, the incident of March 13, 2003, as described by the claimant could have reasonably produced this disc protrusion or herniation. The claimant's symptoms indicative of an injury to this portion of the anatomy occurred within a reasonable period of time after the described incident. Finally, there is no evidence of any other traumatic event that would explain the existence of this defect. Thus, I find that the greater weight of

the credible evidence establishes that the claimant's compensable injury of March 13, 2003, likely resulted in the small left paracentral disc protrusion or herniation at L4-5.

Once such a discal defect occurs, the actual damage to the disc, itself, is essentially permanent. Appropriate conservative treatment may alleviate the symptoms, but the actual damage to the disc remains. This fact is clearly recognized by Dr. Cheyne when he previously placed permanent restrictions on the claimant's potential physical activities. The obvious purpose of these restrictions was to prevent further damage to the disc and to also prevent it from again becoming symptomatic.

The evidence shows that following the resolution of her symptoms after her initial injury, the claimant experienced periodic exacerbations (i.e. recurrences or increases in her symptoms) with activities that placed particular stress on her lower back. However, the repeated MRI studies shows that these subsequent incidents did not produce any additional physical damage to the claimant's back, particularly the L4-5 intervertebral disc.

The most recent flare up or episode of an increased symptomology, unlike the prior episodes, does not appear to have had any particular precipitating event or activity. Although it is unusual for the reappearance of symptoms without some type of aggravating event or activity, the event or activity need not involve unusual stress or exertion or even noticeable stress or exertion. Sufficient stress can occur by merely getting out of a chair, bending over and picking something up from the floor, or

turning over in bed. The precipitating event for the claimant's current episode of difficulties could have easily gone unnoticed.

However, after consideration of all the evidence presented, it is my opinion that the claimant's current difficulties with her lower back and lower extremity, that necessitated the medical services beginning in April of 2005, were still at least in part causally related to the claimant's initial compensable injury of March 13, 2003. If this initial injury had not produced the permanent damage to the claimant's L4-5 intervertebral disc, there would be no condition to be aggravated by subsequent physical activities, so as to bring about periodic episodes of symptoms. Thus, the claimant's current need for medical services, beginning in April of 2005, is still in part connected with her initial compensable lumbar injury.

The medical services provided to the claimant by Dr. Cheyne, Dr. Capocelli, and Dr. Swicegood, beginning in April of 2005, were clearly intended to develop an appropriate program of treatment to resolve or decrease the episode of symptoms which the claimant was experiencing with her lower back and lower extremity, at that time. The medical services provided by these physicians were of a type and nature generally excepted by the medical community as being appropriate for this purpose. In fact, the evidence shows that the services provided by Dr. Swicegood were of the same type and nature as had previously been successful in resolving an earlier episode of symptoms with the claimant's lower back and lower extremity. The reports and records of Dr. Swicegood go on to show that the

services he was providing appear to have actually been accomplishing their intended purpose.

In summary, it is my opinion that the greater weight of the credible evidence establishes that the medical services provided and recommended to the claimant by Dr. Cheyne, Dr. Capocelli, and Dr. Swicegood for her lower back and lower extremity difficulties on and after April 27, 2005, represent "reasonably necessary medical services" for the claimant's compensable injury to her lumbar spine that occurred on March 13, 2003, and that was in the form of a protruding or herniated lumbar disc at L4-5. Specifically the evidence shows that the medical services provided these physicians was necessitated by or connected with this particular injury and had a reasonable expectation of accomplishing the purpose or goal for which they were intended. Thus, under Ark. Code Ann. §11-9-508 the respondents are liable for the expenses of these services, subject to the medical fee schedule established by this Commission.

FINDINGS OF FACT & CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 13, 2003, the relationship of employee-self insured employer-third party administrator existed between the parties.
3. On March 13, 2003, the claimant earned wages sufficient to entitle her to weekly compensation benefits of \$320.00 for total disability and \$240.00 for permanent partial

disability, when and if such benefits should become appropriate.

4. On March 13, 2003, the claimant sustained a compensable injury to her low back that was in the form of a protruding or herniated disc at L4-5.
5. There is no dispute over the payment of medical expenses incurred prior to March 13, 2005, and all such expenses have or will be paid.
6. There is no dispute, at the present time, over the payment of temporary total disability benefits.
7. The medical services provided to the claimant by and at the direction of Dr. Cheyne, Dr. Capocelli, and Dr. Swicegood, on and after April 27, 2005, represents reasonably necessary medical services for her compensable lumbar spine injury of March 13, 2003. Specifically, these medical services were necessitated by or connected with this compensable injury and have a reasonable expectation of accomplishing the purpose or goal for which they are intended. Pursuant to Ark. Code Ann. §11-9-508, the respondents are liable for the expense of these services, subject to the medical fee schedule established by this Commission.
8. The respondents have controverted the claimant's entitlement to any additional medical services during and after April of 2005.
9. As no controverted benefits have been awarded directly to

the claimant, no controverted attorney's fee can be awarded to her attorney.

ORDER

The respondents shall be liable for the expenses incurred to the claimant as a result of medical services rendered her for her lower back difficulties during and after April of 2004, by and at the direction of Dr. Thomas Cheyne, Dr. Anthony Capocelli, and Dr. John Swicegood. This liability is subject to the medical fee schedule established by this Commission.

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.

MICHAEL L. ELLIG
Administrative Law Judge