

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NUMBER F410166

RONALD K. BALLARD, EMPLOYEE

CLAIMANT

DUNCAN PARKING TECHNOLOGIES, INC., EMPLOYER

RESPONDENT

**FEDERAL INSURANCE COMPANY,
ESIS, CARRIER/TPA**

RESPONDENT

OPINION FILED MARCH 10, 2006

A hearing in this case was conducted on October 6, 2005, before ADMINISTRATIVE LAW JUDGE D. FRANKLIN AREY, III, at Harrison, Boone County, Arkansas.

Claimant was represented by Evelyn E. Brooks, Attorney at Law, Fayetteville, Arkansas.

Respondents were represented by Melissa Ross-Criner, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A prehearing telephone conference was held on this claim on June 13, 2005. A Prehearing Order was filed on that same date. A copy of the Prehearing Order was admitted into the record as Commission Exhibit #1.

The parties agreed to two stipulations. These stipulations were listed in the Prehearing Order, were confirmed at the hearing, and are hereby accepted.

1. The employee-employer-carrier relationship existed on May 13, 2004 and at all other relevant times.

2. Claimant sustained a compensable low back injury on May 13, 2004.

At the October 6, 2005 hearing, the parties discussed the issue set forth in the Prehearing Order. The parties agreed that the issue to be litigated and resolved is limited

to the following:

1. Whether Claimant is entitled to additional reasonably necessary medical treatment, including fusion surgery.

Claimant asked that this issue be amended to specify that Claimant could return to Dr. James Blankenship for additional treatment. Respondents objected, claiming lack of notice that this was an issue. In light of Respondents' objection, the issue will remain as stated in the Prehearing Order and otherwise agreed to by the parties at the hearing.

Claimant seeks additional reasonably necessary medical treatment, particularly the fusion surgery recommended by Dr. Blankenship. Respondents contend that such surgery is not reasonably necessary and that Claimant instead should be offered conservative care.

DISCUSSION

_____ Claimant began working for the Respondent employer in 1979. On May 13, 2004, he was working in the unit where parking meters and other items are assembled.

Q. And, what were you doing when you were injured?

A. I picked up a pan of parts and I just kind of twisted and set them down on the opposite side of me.

Q. How heavy was the pan of parts, would you guess?

A. It wasn't a full pan; it was probably half. It weighed probably thirty pounds, thirty-five pounds.

Q. What happened when you set the parts down?

A. Oh, gee. It was just like a bolt of lightening went up and down my back. It went down to my tail, you know. Boy it made me sick at my stomach.

As noted, the parties stipulated that Claimant suffered a compensable low back injury on

May 13, 2004.

Claimant then began a course of treatment for his compensable injury. Dr. Ken Collins initially examined Claimant; he ordered studies and physical therapy and ultimately referred Claimant to Dr. Blankenship. Claimant testified that Dr. Blankenship “gave me a shot because I was in pain, pretty severe pain in my hips and my back and stuff.” This injection failed to provide long-term relief, nor did Claimant obtain any relief from two additional sessions of physical therapy. Claimant last worked in September of 2004.

At some point Claimant presented to Dr. Scott Schlesinger for an independent medical evaluation. Claimant was then directed to present to Dr. Luke Knox. He has also been seen by a Dr. Cannon, who “gives me shots,” as does a Dr. Grace.

Q. Have those shots helped you?

A. Sometimes. Usually they last about two weeks and then there's lots of side effects.

Q. What kind of side effects do you have from the shots?

A. Well, if you've ever had a charlie horse or something along that line -- that would just wake me up and jerk me right off the bed, you know. I have had some -- they had give me some relief, you know. I kind of think this last one has stayed in part of my bowel.

Q. How many shots have you had?

A. Well, Dr. Grace has give me one, maybe two. It's been a while. Dr. Cannon has given me three.

...

Q. Has these shots improved you to the point to where you can go back to work?

A. Oh, no.

Q. Do you have any problems doing basic daily activities at home?

A. It's just a total life change, you know, when you get your back hurt. I can't do no lifting or I'm just not able to do many things.

Claimant is aware that, contrary to Dr. Blankenship, at least a couple of doctors don't think surgery is a good idea.

Dr. Blankenship first examined Claimant on September 24, 2004. The doctor recorded the following history in his clinic note:

[Claimant] has had ambulatory leg pain for the past four months after an acute injury on the job in mid May. The patient was lifting a pan of frames and twisted and had acute stabbing pain in his lower back with radiation in to both thighs. The patient has been treated conservatively with antiinflammatory medications and has had course of physical therapy with no relief. The patient states that his leg pain may be slightly better than it was with the onset of injury in mid May, but he is having a significantly amount of ambulatory leg pain that he describes as equal in both legs.

With regard to Claimant's low back pain, Dr. Blankenship noted that Claimant "has a disc herniation in the midline with marked lateral recess stenosis. This results in rather significant spinal canal stenosis at this level and I am also positive this is the etiology of his pain." Dr. Blankenship also noted disc bulging with protrusion at L5-S1. Concerning treatment, Dr. Blankenship opined:

The gentleman has a five month history of pain and an adequate conservative trial. I have told him the two options we have are to give him an IM injection of Decadron LA and get him back in to a course of physical therapy or to consider surgical intervention. I told him that based on the retrolisthesis, it is my medical opinion that anything less than an L4/5 reconstruction would not be of any benefit to him in the long run. Obviously, if L4/5 is addressed, L5/S1 will have to be addressed also.

After discussing the options, Claimant elected to proceed with another month of conservative treatment. The doctor opined that "this is unlikely to afford him any significant benefit...."

Claimant again presented to Dr. Blankenship on November 2, 2004. He reported

that his pain, after aggressive physical therapy, “is somewhat less intense than it was and has centralized somewhat to his lower back and his deep buttocks bilaterally.... He states his pain is worse with ambulation.” Dr. Blankenship ordered a new MRI.

Claimant underwent an MRI of his lumbar spine on November 2, 2004. Among other findings, the radiologist noted the following:

L3-4: A broad based disc bulge minimally flattens the anterior aspect of the thecal sac. The neural foramina are unremarkable.

L4-5: A broad based disc bulge with lateral components along with posterior facet hypertrophy mild to moderately narrow the canal. The neural foramina are mild to moderately narrowed, left greater than right. I suspect the left lateral aspect of the disc abuts the extra-foraminal portion of the nerve.

L5-S1: A broad based disc bulge along with posterior facet hypertrophy moderately narrow the canal. A small focus of increased signal along the posterior annulus may represent a radial tear. The neural foramina are moderately narrowed.

The radiologist did not find evidence of high grade canal stenosis or free disc fragments.

Dr. Blankenship interpreted Claimant’s November 2, 2004 MRI on the following day.

He reported the following impressions:

1. L4/5 and L5/S1 disc protrusions with high intensity zone areas indicative of annular tearing consistent with acute to subacute disc disruption.
2. Segmental spinal canal stenosis at both levels, L4/5 and L5/S1.
3. Disc space changes at L4/5 and L5/S1, more significant at L5/S1 with significant disc space settling, however, at the L4/5 level.

On November 18, 2004, Claimant underwent lumbar diskography injections at L3-4, L4-5, and L5-S1. Following this procedure, Dr. Blankenship summarized his impression: “[I]t is felt like the L4-5 and L5-S1 disk spaces are pain generators with mechanically positive disk injections....” A CT study of Claimant’s lumbar spine taken that same date

produced the following impression:

Central and right paracentral disc herniation at L5-S1, left-sided extruded disc at L4-5, broad-based disc protrusion at L3-4. All of the above encroaching on a diminutive spinal canal with marked central canal stenosis at the lower two levels.

Claimant returned to Dr. Blankenship on November 30, 2004. Claimant denied any significant leg pain. Dr. Blankenship offered Claimant fusion surgery at the L4-5 and L5-S1 levels for treatment. Since Claimant was not experiencing leg pain, Dr. Blankenship recommended an anterior approach at these levels with discectomy and osteotomy and anterior instrumentation.

As noted above, Claimant presented to Dr. Schlesinger for an independent medical evaluation on January 17, 2005. Dr. Schlesinger recorded the following history:

[Claimant] says his problems began in April 2004 with an injury at work and back pain. He again hurt himself in May 2004.... His main pain is in the lower back. He has had bouts of pain down his legs, particularly when it first hit him, but most of his pain is back pain. He has had one epidural steroid injection and has not had many episodes of pain down his legs since. His back pain was also significantly improved for about three weeks afterwards.

Following an examination of Claimant and review of the available studies, Dr. Schlesinger recommended, in part, that Claimant “have one to two more epidural steroid injections to complete conservative care.” He opined that Claimant has symptomatic lumbar degenerative disc disease and that lumbar fusion did not have “a very significant chance of helping resolve this back pain.” If Claimant continued to experience pain after the recommended epidural injections, Dr. Schlesinger thought an FCE might be appropriate. Dr. Schlesinger also recommended weight loss and an extensive fitness program for spinal conditioning. Dr. Schlesinger didn’t “believe the chances of his benefitting from a fusion are justifiable in the face of the risks and the low percentage outcome, particularly in

somebody who has had a workmen's comp source as certainly these findings are long-standing degenerative arthritis aggravated by a work injury with no acute disc herniations, etc."

On January 25, 2005, Dr. Blankenship authored a "To Whom It May Concern" letter, recommending a sequential stimulator for Claimant's use. Dr. Blankenship noted that Claimant had been using the stimulator "with excellent results in decreasing pain and muscle spasms, as well as improving over-all muscle condition."

On February 15, 2005, Dr. Blankenship responded to Dr. Schlesinger's independent medical evaluation. He noted that Dr. Schlesinger did not refute Claimant's diskography findings. Dr. Blankenship opined in part:

The current thought in the pain management community is that a series of epidural steroid injections really is of no benefit. This has been my clinical experience over the past 20 years, also. I would agree to perform, or have performed, an epidural steroid injection of this gentleman as long as it was done with a more modern transforaminal approach where the steroid medication is actually back in the region of the annular fibers.... I would feel that one ESI that did not show any significant benefit would be confirmatory that this has failed. I also would not recommend this to the gentleman if the intent was not to see if this fails or not and then plan surgical intervention afterwards.... I do take great exception to the statement that Dr. Schlesinger made that he did not believe the chances of benefiting him with a fusion are justifiable in the face of the risks and the lower percentage of outcome. The current outcome studies indicate a successful outcome in patient's that have provocatively positive discography with mechanical low back pain, such as Mr. Ballard, to be greater than 75-80%. The risks are also minimal and have been gone over with Mr. Ballard prior to even proceeding down this road.

Dr. Blankenship notified that he is board certified by the American Board of Spine Surgeons and the American Board of Pain Medicine; is a member of the spine section of the American Association of Neurological Surgeons; and is a Spine Fellow in the American College of Spine Surgeons.

Dr. Ray Jouett performed a file review on Claimant's file on February 23, 2005. After noting Dr. Blankenship's desire to perform fusion surgery, Dr. Jouett summarized Dr. Schlesinger's independent medical evaluation report. Dr. Jouett, in light of the information in the chart and Dr. Schlesinger's opinion, recommended that Claimant's request for a spinal fusion be denied and that Claimant continue to receive conservative treatment.

Dr. Knox examined Claimant on April 28, 2005. He noted that Claimant's "pain extends to his hips and posterior aspects of his legs bilaterally to his calves, right equal to the left.... It worsens with walking and is improved with lying. His leg pain is rather severe...." Dr. Knox examined Claimant and reviewed Dr. Blankenship's diskogram report as well as Claimant's MRI scan report. Dr. Knox offered the following impression:

It appears that Mr. Ballard's primary complaints are probably related to a facet syndrome secondary to the degenerative disc changes and the disc injury occurring last year at work. I would be hesitant to recommend that he consider surgical options at this point. I would like him to redo his MRI scan as his last MRI scan is over six months old and compare the two to make certain that there has been no significant change. He should undergo a lumbar SPECT scan to rule out the possibility of overt increased uptake of the facet joints. At this point, I am primarily impressed with the facet syndrome nature of his complaints.

Dr. Knox also reviewed an x-ray study performed that day. He noted "significant degenerative disc changes... throughout the lumbar spine" and the appearance of a transitional level, but found an "[o]therwise unremarkable spine without evidence of pathologic motion on flexion and extension views."

Claimant underwent an MR of his lumbar spine without contrast on May 4, 2005.

The radiologist noted the following findings:

There are mild diffuse degenerative changes in the intervertebral discs with disc desiccation throughout the lumbar spine. At L4-5, there is mild posterior disc protrusion which narrows both neuroforamina somewhat, more so on

the left. There is no evidence of focal disc herniation or significant neural encroachment elsewhere.

The radiologist did note the presence of moderate lumbar facet hypertrophy.

An employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). Reasonably necessary medical services “may include that necessary to accurately diagnose the nature and extent of the compensable injury; to reduce or alleviate symptoms resulting from the compensable injury; to maintain the level of healing achieved; or to prevent further deterioration of the damage produced by the compensable injury.” Greer v. Phillip Mitchell Construction, Full Workers’ Compensation Commission Opinion filed February 14, 2003 (E906565) (citations omitted). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, the Commission analyzes both the proposed procedure and the condition it is sought to remedy. Gardner v. Area Agency on Aging, Full Workers’ Compensation Commission Opinion filed January 4, 2006 (F302438).

The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. Hamilton v. Gregory Trucking, ___ Ark. App. ___, ___ S.W.3d ___ (March 16, 2005). “Preponderance of the evidence” means evidence of greater convincing force; the term does not mean preponderance in amount, but implies an overbalancing in weight. Smith v. Magnet Cove Barium Corp., 212 Ark. 491, 496-97, 206 S.W.2d 442, ___ (1947). The Commission is entitled to examine the basis for a physician’s opinion, like that of any other expert, in deciding the weight to which that opinion is entitled. Palasota v. Chandler Interiors, Full Workers’ Compensation

Commission Opinion filed February 8, 2006 (F100218, F400082, F400083).

I find that Claimant has sustained his burden of proving by a preponderance of the evidence that he is entitled to additional reasonably necessary medical treatment, including fusion surgery. In January and February of 2005, Dr. Schlesinger and Dr. Jouett recommended continued conservative care. At the October 2005 hearing Claimant's testimony revealed that, subsequent to these opinions, Claimant did receive such care in the form of further injections. Claimant testified that these injections "sometimes" provide temporary relief, but they have not made it possible for him to return to work: "I can't do no lifting or I'm just not able to do many things." Of course, Claimant's testimony validates Dr. Blankenship's September 24, 2004 opinion that conservative treatment "is unlikely to afford him any significant benefit...." Dr. Blankenship's opinion is entitled to weight for additional reasons: he was Claimant's treating physician and he has credentials applicable to this field. In light of Dr. Blankenship's opinion concerning the necessity for fusion surgery and the weight to which that opinion is entitled, and in light of Claimant's failure to gain significant relief after receiving the additional recommended conservative care, additional medical treatment in the form of fusion surgery is reasonably necessary.

The foregoing considerations address Dr. Knox's April 28, 2005 opinion. At that time, he was "hesitant" to recommend surgery. However, as Claimant testified, subsequent conservative treatment in the form of multiple injections failed to provide relief. Further, based on notes in the record, it appears that Dr. Blankenship has greater familiarity with Claimant's condition - he appears to have examined and treated Claimant more frequently than Dr. Knox.

_____ I acknowledge Claimant's May 4, 2005 MRI. However, its findings are contradicted

by Claimant's November 2, 2004 MRI; his November 18, 2004 diskography procedures; and his November 18, 2004 CT study of his lumbar spine. Further, Claimant testified to continuing problems with his back after the date of this MRI. Thus, I believe the other studies and Dr. Blankenship's opinion are all entitled to greater weight.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The stipulations agreed upon by the parties are reasonable and are approved.
2. The employee-employer-carrier relationship existed on May 13, 2004 and at all other relevant times.
3. Claimant sustained a compensable low back injury on May 13, 2004.
- _____4. Claimant is entitled to additional reasonably necessary medical treatment, including fusion surgery. While two physicians did recommend conservative care, Claimant testified that he subsequently received this conservative treatment in the form of injections and that these have not provided relief. Dr. Blankenship's recommendation concerning fusion surgery is entitled to greater weight: his opinion is validated by the failure of conservative treatment; his credentials in this field are evident; and he appears to have rendered the most treatment to Claimant.

AWARD

Respondents are directed to provide benefits in accordance with the Findings of Fact and Conclusions of Law as set forth herein.

IT IS SO ORDERED.

D. FRANKLIN AREY, III,
Administrative Law Judge

DFA/ml