

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F402644**

<b>JERRY D. SWINK, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>RICELAND FOODS, INC., EMPLOYER</b>	<b>RESPONDENT</b>
<b>LIBERTY MUTUAL INSURANCE, CARRIER</b>	<b>RESPONDENT</b>

**OPINION FILED FEBRUARY 17, 2006**

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH W. HOGAN, on November 22, 2005, at Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE GARY DAVIS, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE MICHAEL E. RYBURN, Attorney at Law, Little Rock, Arkansas.

**ISSUES**

A hearing was conducted to determine the claimant's entitlement to payment of additional medical treatment, temporary total disability benefits and attorney's fees.

At issue is whether or not the medical treatment is reasonable and necessary and causally related to the compensable injury pursuant to Ark. Code Ann. §11-9-508. All other issues are reserved.

After reviewing the evidence impartially without giving the benefit of the doubt to either party, Ark. Code Ann. §11-9-704, I find the evidence preponderates in favor of the claimant.

**STATEMENT OF THE CASE**

The parties stipulated to an employee-employer-carrier relationship on September 16, 2003 at which time the claimant sustained a compensable injury at a compensation rate of \$424.00. Medical expenses were paid before this claim was

controverted on September 15, 2004.

The claimant contends he remained symptomatic as a result of the compensable injury and needed surgery (cervical fusion) as recommended by his treating physician, Dr. Reza Shahim. The claimant seeks payment of medical expenses, temporary total disability benefits from July 28, 2005 to a date yet to be determined and attorney's fees.

The respondents contend this claim was accepted as a temporary aggravation of a previous condition (2002 cervical fusion). The claimant was treated and released for the 2003 injury with no impairment. Any additional treatment is unrelated, unreasonable and unnecessary.

The following were submitted without objection and comprise the evidence of record: the parties' prehearing questionnaires and exhibits contained in the hearing transcript.

The claimant was the only witness to testify at the hearing. He had trouble expressing himself, however, he appeared to be sincere in his testimony. It is also noted that the claimant has been cooperative with his physicians, efforts to return to work, and the Functional Capacity Evaluation.

The claimant, age 54 (D.O.B. October 4, 1951) has a high school education and experience in the Army. His health history includes surgery for a thyroid cyst (2004), an ulnar nerve transposition (May 2002) and cervical fusion (April 2002), for a non-work related condition.

The claimant was employed by the respondent as a machine maintenance crewman. On September 16, 2003 he injured his neck when he fell and hit his neck against a guardrail. (Tr. p. 6-9, 45). Co-worker, Jerry Walker witnessed the

accident. The claimant reported the injury to his foreman, Rex Williams.

The carrier provided medical treatment at the Stuttgart Hospital and with Dr. Charles Pearce. Dr. Pearce referred the claimant to Dr. Shahim who had treated the claimant for a prior non-work related neck problem in 2002. Dr. Shahim referred the claimant to Dr. Covey for injections. In April, 2004, Dr. Shahim proposed surgery. The carrier obtained a second opinion in June from Dr. Bruffett, who recommended conservative treatment. In turn, Dr. Bruffett referred the claimant to his partner, Dr. Sprinkle for more injection therapy.

In September, 2004, Dr. Sprinkle released the claimant with the understanding that he could obtain prescription refills at a local clinic. The claimant returned to work but the clinic would not prescribe his medication. The nurse case manager, assigned by the carrier, informed the claimant that the claim would be controverted.

In December, 2004 the claimant returned to Dr. Shahim to discuss surgery in the hopes that it would alleviate the need for medication. The neck surgery was delayed because a cyst was found on the claimant's thyroid gland. Surgery was necessary to rule out cancer. After recovery, Dr. Shahim performed cervical fusion surgery on July 26, 2005, at C6-7. The claimant has not been able to return to work but the surgery did help his symptoms and he no longer needs as much medication as he did prior to the operation.

The claimant stated that his prior neck problem in 2002 caused cramping in both arms (worse on the right) but he does not recall any specific injury. He was treated by a chiropractor and Dr. Shahim. The cervical surgery relieved the arm cramps while the ulnar nerve transposition surgery relieved the tingling sensation in his right hand, (Tr. p. 11-14, 29-30). He took pain medication and was off work for

about a month following the surgery. The claimant returned to work and experienced some headaches but he was able to perform his job with no restrictions.

The claimant's symptoms changed after the 2003 injury with the respondents. The claimant stated he could barely raise his left arm due to weakness. The claimant also experienced sleep disturbance after the 2003 injury but he continued to work until the second neck surgery in 2005.

### **MEDICAL EVIDENCE**

The claimant gave his physicians a history of injury consistent with his testimony. In a report dated October 9, 2003, the claimant explained to Dr. Pearce that his neck surgery in 2002 addressed radicular pain in his right arm while the 2003 injury at Riceland affected his left arm, neck and shoulder. Dr. Pearce referred the claimant back to his operating surgeon, Dr. Shahim.

Diagnostic testing on October 20, 2003 revealed mild multilevel disc bulging at C3-4, C4-5, and C6-7 and foraminal stenosis at C6-7 due to spurring. There was also evidence of cervical fusion at C5 and C6.

Dr. Shahim prescribed physical therapy for three weeks. The claimant was released to return to work on December 11, 2003 at full duty.

On January 8, 2004 a CT scan and myelogram were performed which revealed osteophytes at C6 and C7 with "moderate impression" on the thecal sac, degenerative changes, and a partial solid bony union at C5-C6.

In a report dated January 12, 2004, Dr. Shahim noted the claimant developed neck and shoulder pain after a ladder fell on him at work in 2003. The doctor stated the injury caused the claimant's symptoms which emanated from ligamentous hypertrophy and disc herniation at C6-7, below the diskectomy site at C5-6. Dr.

Covey administered epidural steroid injections.

It should be noted that Dr. Shahim refers to the C6-7 site as a “herniation”, suggesting a new specific injury, while other reports refer to “osteophytes” or “spurring” at C6-7, suggesting a gradual progression of the preexisting condition or degeneration.

The claimant remained symptomatic and in a report dated April 14, 2004, Dr. Shahim recommended a cervical discectomy and fusion for a disc at C6-7 with nerve root compression.

The claimant saw Dr. Bruffett on June 2, 2004 at the request of the carrier. Dr. Bruffett felt the surgery would be appropriate if the claimant demonstrated radicular arm pain, but that was not one of his symptoms. Dr. Bruffett thought the risks involved in the surgery out-weighed any possible benefits to the claimant’s neck and thoracic pain. He referred the claimant to Dr. Sprinkle for conservative care.

In his report of June 22, 2004, Dr. Sprinkle prescribed medications, an EMG/NCV study, and trigger point injections. Dr. Sprinkle returned the claimant to light duty.

The patient is a 52-year old male with neck pain. He does not really describe any radicular pain. This has been going on since September 2003. He was in some type of bucket or buggy that was being lifted up and then some type of guidewire or something broke and slammed him into the guard rail and hit his neck.

He also has preexisting history of neck surgery with degenerative disc disease per Dr. Bruffett, and I think there is no significant interval change. He does have a C5-6 disc bulge, but it is not clear that surgery would resolve this, because he does not have clear radicular symptoms.

Dr. Sprinkle saw the claimant again on June 30, 2004:

I do not see evidence of cervical radiculopathy on the EMG. There is evidence of median and ulnar nerve entrapment bilaterally, and those could explain the sensory hand complaints. However, that would not have been caused by his work-related injury.

The claimant saw Dr. Sprinkle in follow-up on several occasions (July 14, 2004, August 4, 2004, August 25, 2004) but the claimant remained symptomatic. Dr. Sprinkle commented, "he may ultimately have to go back to Dr. Bruffett to discuss surgery since he has not responded to any other measures." Dr. Ackerman performed facet joint injection therapy on September 3, 2004.

The claimant returned to Dr. Sprinkle on September 14, 2004:

I just do not know what else to offer him to try to reduce his symptoms. Dr. Bruffett's previous note has indicated that without any clear radicular pain he did not feel confident that a surgery at C6-7 would reduce his symptoms. I would concur with that, but he did leave the decision ultimately to the patient.

As far as an impairment rating, I would not anticipate an impairment rating because of the similar findings on the pre and post-injury CT myelogram. I think this could be an exacerbation of previous degenerative disc disease.

A Functional Capacity Evaluation was conducted on October 12, 2004. The results were considered valid and the claimant demonstrated an ability to perform work in the "Heavy" Physical Demand Classification. The claimant told the evaluator, "I can do all the things tested but I will pay for it tomorrow."

The claimant returned to Dr. Shahim on December 6, 2004. The doctor ordered diagnostic testing to evaluate the claimant for surgery:

X-rays of the cervical spine shows cervical spondylosis above the fusion at C4-5 and also below the fusion at C6-

7. There is solid fusion at the C5-6 level. I still think Mr. Swink has symptoms due to progression of the adjacent level disease and may benefit from an anterior fusion at the C6-7 level.

The MRI scan noted changes between a study conducted on October 23, 2001, (prior to the 2002 cervical fusion at C5-6) and the 2004 study (after the Riceland injury):

- a right paracentral protrusion at C4-5
- foraminal narrowing at C3-4 due to osteophytes and spurring
- a cystic mass in the thyroid
- a "cyst" at C5-6 (this is the same level that Dr Sprinkle diagnosed a disc bulge)

These changes, specifically the bulge at C4-5, could be considered objective evidence of a new injury. However, Dr. Shahim's treatment plan did not target any of these changes. Dr. Shahim recommended surgery for a C6-7 disc herniation and spondylosis with left arm pain but the plan was interrupted while the claimant was being evaluated for possible thyroid cancer.

In June, 2005, Dr. Shahim ordered a CT scan and myelogram which showed stenosis at C6-7 due to an osteophyte, and progression of disc disease at C6-7. Surgery was performed on July 26, 2005 for fusion at C6-7. The claimant was released to light duty on October 17, 2005. The operative report shows a diagnosis of stenosis at C6-7. Dr. Shahim commented, "Mr. Swink is status-post anterior fusion of C5-6 who presents with progressive neck pain and radiculopathy. He has developed transitional level syndrome at C6-7. He has failed conservative management."

With regard to causation, Dr. Sprinkle authored a report dated September 27, 2005 opining that the claimant did not suffer a new injury in his accident with the

respondent-employer. However, Dr. Sprinkle also indicated the injury could have exacerbated or aggravated the preexisting degenerative disc disease. This was a temporary aggravation that would have resolved as of September 14, 2004. Any further treatment, including Dr. Shahim's surgery, would be related to the preexisting condition.

Dr. Sprinkle's determination of the end of the healing period seems rather arbitrary. The medical records indicate Dr Sprinkle simply ran out of conservative treatment options in September 2004. The claimant's symptoms never changed from the time of the accident in September 2003 until the second neck surgery in July, 2005. Furthermore, it is clear from the medical records that during the course of treatment, Dr. Sprinkle considered returning the claimant to Dr. Bruffett to discuss surgical options.

### **FINDINGS AND CONCLUSIONS**

Act 796 of 1993, did not abolish compensation for a preexisting condition. Atkins Nursing Home v. Gray, 54 Ark. App. 125, 923 S.W.2d 897 (1996). The employer "takes the employee as he finds him" and employment circumstances that aggravate preexisting conditions are compensable. St. Vincent Infirmary v. Brown, 53 Ark. App. 30, 917 S.W.2d 550 (1996). Public Employee Claims Division v. Tiner, 37 Ark. App. 23, 822 S.W.2d 400 (1992).

A preexisting disease or infirmity does not disqualify a claim if the employment aggravated, accelerated, or combined with the disease or infirmity to produce the disability for which compensation is sought. Nashville Livestock Commission v. Cox, 302 Ark. 69, 787 S.W.2d 664 (1990); Minor v. Poinsett Lumber & Mfg. Co., 235 Ark. 195, 357 S.W.2d 504 (1962); Conway Convalescent Center v. Murphree, 266 Ark. 985, 588 S.W.2d (Ark. App. 1979).

An aggravation is a new injury resulting from an independent incident, which must meet the definition of a compensable injury, pursuant to Ark. Code Ann. §11-9-102, Williams v. L & W Janitorial, Inc., 85 Ark. App. 1, 145 S.W.3d 383 (2004).

A compensable injury is established by an accident causing internal harm, arising out of and in the course of employment and requiring medical services. The injury must be proven by objective medical findings which are not under the voluntary control of the claimant. The claimant also has the burden of proving a causal relationship between his employment and the injury, which is a question of fact for The Commission. Crawford v. Single Source Transp. Fidelity & Casualty Ins. Co., \_\_\_ Ark. App. \_\_\_, \_\_\_ S.W.3d \_\_\_ (June 30, 2004); Jeter v. B. R. McGinty Mech., 62 Ark. App. 53, 968 S.W.2d 645 (1998).

The evidence of record shows the claimant had cervical fusion at C5-6 in April, 2002, for a non-work related condition. He was able to return to work at full duty.

On September 16, 2003, the claimant injured his neck in an violent accident at work resulting in a cervical disc bulge, aggravation of a preexisting condition and a change in his symptoms. His treating physician recommended surgery while the carrier's physician offered conservative care. The conservative treatment did not restore the claimant to his pre-injury status.

The claimant remained symptomatic from September, 2003 to July 26, 2005, when the claimant's treating physician performed surgery at the C6-7 level. The surgery did not completely relieve his pain but he does not require as much medication as before. The claimant was a credible witness.

Accordingly, I find the September 2003 compensable neck injury combined with the claimant's preexisting neck condition (disc fusion and degeneration) to

produce a compensable injury.

Employers must promptly provide medical services which are “reasonably necessary in connection with” the compensable injuries. Ark. Code Ann. §11-9-508(a). However, injured employees have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary. Patchell v. Wal-Mart Stores, Inc., \_\_\_ Ark. App. \_\_\_, \_\_\_ S.W.3d \_\_\_ (2004). What constitutes reasonable and necessary medical treatment is a fact question for the Commission, and the resolution of this issue depends upon the sufficiency of the evidence. Gansky v. Hi-Tech Engineering, 325 Ark. 163, 924 S.W.2d 790 (1996). Reasonably necessary medical services “may include that necessary to accurately diagnose the nature and extent of 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 Commission opinion February 14, 2003 (E906565). In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, it is necessary to analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Workers’ Compensation Commission, December 13, 1989 (Claim No. D511255).

The carrier’s physician, Dr. Bruffett, did consider the possibility of surgery for pain management, however, he thought the risks out weighed the benefits. The decision was left to the claimant to decide between surgery and conservative treatment. Ultimately, Dr. Bruffett convinced the claimant to try conservative care with Dr. Sprinkle. The claimant was cooperative and tried medications, therapy and injections from 2003 to 2005 with no improvement. Even Dr. Sprinkle considered

returning the claimant to Dr. Bruffett to reconsider his surgical options. Once the claim was controverted, the claimant returned to Dr. Shahim for surgery which improved his condition.

Therefore, I find the second fusion surgery was reasonable and necessary for treatment of the compensable injury.

1. The Workers' Compensation Commission has jurisdiction of this claim in which the relationship of employer-employee-carrier existed among the parties on September 16, 2003 at which time the claimant sustained a compensable neck injury at a compensation rate of \$424.00. Medical expenses were paid before this claim was controverted on September 15, 2004.
2. The claimant has proven by a preponderance of the credible evidence of record that he sustained a compensable aggravation of a preexisting condition.
3. The claimant has proven by a preponderance of the credible evidence of record that Dr. Shahim's treatment was reasonable, necessary and related to the compensable injury.
4. The respondents are directed to pay Dr. Shahim's medical expenses within thirty days pursuant to WCC Rule 30.
5. The claimant is entitled to temporary total disability benefits from July 28, 2005 to a date yet to be determined as he remained in a healing period, unable to work.
6. This claim has been controverted and the claimant's counsel is entitled to the maximum attorney's fees to be paid in accordance with A.C.A. §11-9-715, §11-9-801, and WCC Rule 10.

Pursuant to the Full Commission decisions of Coleman v. Holiday Inn, (November 21, 1990)

(D708577), and Chamness v. Superior Industries, (March 5, 1992)(E019760), the claimant's portion of the controverted attorney's fee is to be withheld from, and paid out of, indemnity benefits, and remitted by the respondent, directly to the claimant's attorney.

As a reminder, Ark. Code Ann. §11-9-715 was amended by Act 1281 of 2001, limiting attorney's fees on medical benefits and services for injuries after July 1, 2001.

7. If the respondents have not all ready done so, they are directed to pay the court reporter's fees within thirty days.

### **AWARD**

Respondents are directed to pay benefits in accordance with the Findings of Fact above along with their proportionate share of attorney's fees. All accrued sums shall be paid in a lump sum without discount and this award shall earn interest at the legal rate until paid, pursuant to A.C.A. §11-9-809, and Couch v. First State Bank of Newport, 49 Ark. App. 102, 898 S.W.2d 57 (Ark. Ct. App. 1995), and Burlington Industries, et al v. Pickett, 64 Ark. App 67, 983 S.W.2d 126 (1998), 336 S.W. 515, 988 S.W.2d 3 (1999).

IT IS SO ORDERED.

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ELIZABETH W. HOGAN  
Administrative Law Judge