

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F509778

KENNY BATY, EMPLOYEE

CLAIMANT

HELENA CHEMICAL CO., EMPLOYER

RESPONDENT

HARTFORD UNDERWRITERS INS. CO., CARRIER

RESPONDENT

OPINION FILED APRIL 19, 2007

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on March 16, 2007, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE JIM R. BURTON, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by the HONORABLE WILLIAM C. FRYE, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above style claim to determine the claimant's workers' compensation benefits.

On January 30, 2007, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order of the same date was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' contentions relative to the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1. The testimony of Kenny Baty, the claimant, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Kenny Wayne Baty, with a date of birth of September 10, 1957, is a high school graduate, commenced his employment with respondent-employer on February 28, 2005, as a loader operator. Prior to his employment by respondent, the claimant's work history consisted of 8-9 years as a brick layer, and approximately 7 years as a truck driver for BJ Plant Food Company. Claimant was also self-employed as a carpenter.

The testimony of the claimant reflects that while working for farm service, he fell while putting a tarp on a truck and was sent to the doctor. Claimant did not undergo surgery relative to the accident nor did he miss any time from work.

Claimant suffered an accidental injury in the employment of respondent on August 11, 2005. In describing the mechanics of the accident, the testimony of the claimant reflects:

What kind of work I was doing was I was driving a logger loading trucks - - fertilizer. Also, you know, I was loading fertilizer. We'd mix seed - - it comes in 60 pound bags and, you know, 100 and 150 bags at a time sometimes, you know, to be opened up. The day that I got hurt, somebody broke into our back lot there and we needed a roll of chain link fence, so I went and got it.

* * *

Well, I knew where a roll of fence was, and they sent me out in my vehicle, and have a SUV, and when I loaded it up, nobody was with me, and I hurt myself, you know. When we got back that evening about 3:00 o'clock, close to 5:00, and I unloaded it. I had to get in my truck to lift one end of it up, and the rest of the guys were there, all of us, and I felt something pop. Immediately it was hurting in my back, and seemed like it was just - - (T. 9-10).

Claimant estimates the weight of roll of fence at 200-300 pounds or more. The claimant testified that routinely in his job with respondent he lifted up to 65 pounds. In describing the manner in

which he sustained his back injury, claimant continued:

Well, when we unloaded it, there was about eight of us out there, you know. It was getting about quitting time. We decided we'd go ahead and get it put up. When I got back to my truck, you know, there were these other guys there, you know, going to help unload it. When I was unloading it to them, they were getting it, and I felt something to pop in my back, which was strained from earlier when I loaded it and I felt something pop in my back. At that time, somebody brought me a loader around, and there was a bunch of trees there, and I had to get my loader and knock some of the trees down, but they - - then they didn't want me to help pull on the fence or do anything, you know, from then on. (T. 11).

Claimant did not get medical treatment on the day of the incident. While the claimant maintains that his wife observed a "big knot" on his back after he arrived home on the date of accident, he continued to work for a week or two thereafter. Claimant explained that he did do anything and he was allowed to stay in the office while at work. Claimant testified that he had a hard time just walking and getting around.

The claimant is uncertain how much time elapsed between the date of his injury and when he first sought medical treatment. The first doctor that the claimant saw in connection with his injury was Dr. Bill Ball on August 24, 2005. Regarding the date of his injury, the claimant testified:

Well, it was before the 11th when I got hurt. It was before the 11th when I got hurt.

But we didn't know the extent of damage or anything. We thought maybe it would go away or something, you know, and that's why nobody sent me to the doctor, and that's why he didn't have me going back out there to work on the loader. (T. 12).

The testimony of the claimant reflects that Dr. Ball ordered an MRI of his low back, and referred him to Dr. Patrick Chan in Searcy. Ultimately, the claimant came under the care of Dr.

Wayne Bruffett, a Little Rock orthopedic surgeon. Claimant asserts that while he underwent a myelogram and a post-myelogram CT with Dr. Bruffett he did not receive any medical treatment with him. The claimant's testimony reflects that between late 2005 and early 2006 he did not receive any medical treatment on his back.

The testimony of the claimant reflects that after being seen by Dr. Bruffett for a period of time he requested and was granted a change of treating physician to Dr. Thomas Hart.

Claimant's testimony reflects that Dr. Hart performed two separate injections in his back which did not afford any pain relief. The controversy in the present claim centers of a difference of opinion between Dr. Hart and Dr. Bruffett regarding a procedure, discogram, recommended by Dr. Hart.

The testimony of the claimant reflects that the discogram was performed on November 15, 2006, using his health insurance. Claimant testified that Dr. Hart reviewed and discussed the results of the discogram with him. Claimant has not been seen by Dr. Hart since the discogram was performed. Claimant has not been seen by Dr. Bruffett since the discogram was performed. Claimant is seeing his family physician, Dr. Barden, for pain medication.

Claimant describes the condition of his back as painful and hurting. Regarding his current medication, the testimony of the claimant reflects:

I'm taking Soma. I'm taking Xanax, Lorcet 10, blood pressure pills and patches I take, can't remember the name of them, but he upped them from 25 to 50 milligrams after I had the discogram. (T. 17).

Claimant asserts that while the medicine helps, it does not relieve him from all of his pain. The testimony of the claimant reflects, with respect to his symptoms:

Not numbness. In fact, I did before, you know, when it first

happened. I had numbness, and I had shooting pains through my toes and stuff, but it seems like my leg just gets heavy.

My right leg, and my hip gets to hurting, you know, if I walk too much and feels like my leg is heavy. (T. 17-18).

Claimant acknowledged undergoing a Functional Capacity examination. Claimant explained that he had difficulty performing the evaluation due to “very bad pain”. Claimant asserts the he had been advised to refrain from lifting by Dr. Barden. As a consequence of his symptoms claimant maintains that he was unable to complete the FCE.

Claimant is not presently working. Claimant testified that he spends most of his time during the day in his house. Claimant’s testimony reflects that he has not had any other opportunities to go back to work anywhere. Claimant noted that he has not sought work because he has not feel that he is physically able to do anything. Claimant testified that he has not received unemployment benefits. Claimant has not filed for social security disability benefits.

Claimant was initially seen by Dr. Hart in July 2006, at which time he relayed that he was having symptoms of low back pain and right and left leg pain. Claimant testified the his left leg pain had its onset at the time of his injury, however it did not go down into his foot at the time. Claimant noted that he no longer has the stinging sensation in his leg and foot.

Claimant confirmed that during the discogram he relayed to Dr. Hart that he was having pain at L3-4, L4-5, and at L5. Claimant testified that the steroid injections performed by Dr. Chan did not help any, nor did the physical therapy that he underwent. Claimant asserts that while he was not told to do any back exercises, he has been doing some walking on his own.

Claimant is a one pack per day cigarette smoker. Claimant suffers from high blood pressure and had breathing problems during the winter. Claimant denies that he has been

encouraged to quit smoking by his doctors.

Claimant concedes that he was unable to perform the recommended tests of Dr. Bruffett initially because of concerns regarding suspected heart problems, which resulted in an evaluation before the myelogram was performed. At the time the claimant starting seeing Dr. Bruffett on January 13, 2006, he relayed complaints of low back and right leg pain. Claimant has no explanation for the absence of his left leg complaint from the history provided to Dr. Bruffett. Regarding the extent of Dr. Bruffett's review of the diagnostic studies with him, claimant testified:

No, the only thing he said was - - I went there after I had the test, and he put some x-rays on there, and he said, "Here's your back. Here's where the dye went through." Clicked it off, and that's all he said. (T. 24).

The claimant under went the Functional Capacity Evaluation on March 20, 2006. The testimony of the claimant reflects that his physical condition is about the same now as it was at the time of the March 20, 2006, FCE, except he is not experiencing the pin/needle sensation in his feet as he was at the time of the FCE. Claimant estimates the duration of the FCE at two (2) hours or longer. Claimant is aware that the FCE examiner indicated that he gave unreliable effort during the testing. While the claimant testified that he did not recall telling the examiner that his right leg was totally numb, during that period his leg was in fact getting numb and he was experiencing shooting pains. Claimant testified that he did not recall telling the examiner that he was unable to stand on his right leg for even a second or that he was unable to fully extend the leg. Claimant added, however:

No, if I wasn't being able to extend my leg, I can't and stand on it. I can't walk very long because like I said, it just feels like it is heavy and hurts in my back. (T. 26).

Claimant testified that because of the passage of time he is uncertain what he told the FCE examiner. Claimant confirmed, as reflected in the FCE report, that at home he uses a cane and a walker. Claimant concedes that neither of the afore was prescribed by a physician. While testifying that if he goes longer distances he would probably need a cane, claimant acknowledged that he did not have one with him at the hearing.

Claimant acknowledged being directed to walk during the FCE. While the FCE reflects that the claimant was able to walk a straight line and heel and toe walk without difficulty, claimant asserts that at the time his right leg had a sensation of heaviness and that he had pain in hip. Claimant maintains that he was unable to bend over and had been directed not to do so by his doctor, or to lift. As a consequence of the afore claimant informed the FCE examiner that he was unable to perform a stooping test or to bend over. The claimant was questioned regarding the inconsistencies in the FCE. (T. 27-30).

Claimant returned to Dr. Bruffett following the March 20, 2006, FCE. During his deposition claimant expressed the opinion of collusion among Dr. Bruffett and the FCE examiner, and medical management personnel at Corvelle. Claimant's testimony reflects:

I believe that they wanted to get me back to work because we didn't have no light duty work, and I was still off about three months, and I believe they wanted to speed it up. (T. 30-31).

Claimant maintains that Dr. Bruffett did not review the FCE results with him, contrary to the April 7, 2006, report to that effect. Claimant acknowledged that Dr. Bruffett informed him that he did not need surgery and released him to return to work during the April 7, 2006, visit. Claimant explained the rational for not attempting to return to work per the release of Dr. Bruffett:

No, because I was still off by Dr. Barden. He told me not to go back to work, that I couldn't be lifting anything, and that's when we had change in doctors and stuff, and he's still got on there to date no lifting, no bending, or anything. (T. 31).

Claimant's testimony reflects that his physical condition relative to the August 11, 2005, accident was the same at the time of the discogram by Dr. Hart as it was at the time of the FCE. Claimant testified that he continues to experience "terrible pain". (T. 35).

The claimant acknowledged that his treatment in connection with the August 11, 2005, compensable injury under the care of Dr. Greg Barden, his family physician, was not pursuant to the directions of the respondents or the Commission. Any bills incurred in his treatment with Dr. Barden have been submitted and/or paid by the claimant's health insurance carrier.

Claimant maintains that his reasons for not returning to work at the time of the April 7, 2006, release by Dr. Bruffett was because he did not feel that he could work and Dr. Barden had directed that he remain off work. In describing the status of his physical condition at the time of the April 7, 2006, release by Dr. Bruffett, claimant testified:

I was in terrible pain and just my right leg and numbness and feels like needles in my feet and I couldn't bend and was still happening at that time. (T. 43).

There are no medical records authored by Dr. Barden contained in the hearing record.

The testimony in the record reflects that the claimant was seen by Dr. Hart on three (3) occasions, one of which was pursuant to the Change of Physician Order entered in July 2006. Claimant maintains that he treated with Dr. Barden during the period between the July 2006, Change of Physician Order, and the November 2006, discogram by Dr. Hart.

The medical in the record reflects a March 6, 2006, office visit of the claimant to Dr.

Bruffett. The office note relative to the afore visit reflects, in pertinent part:

Mr. Baty returns for a followup after having obtained a myelogram and post myelogram CT. He had a work related accident that occurred in August. He has had nonsurgical treatment in the form of injections, therapy, and medications, etc.

PHYSICAL EXAMINATION:

There is no change in his exam.

RADIOGRAPHIC REPORT:

His myelogram and post myelogram CT were reviewed. He has degenerative changes, but I do not see any evidence of high grade stenosis or nerve impingement. There is no evidence of any nerve compression.

IMPRESSION:

Bulging disc with degenerative disc disease.

DISCUSSION:

I told Mr. Baty that I do not see a surgical problem in his spine. I think nonsurgical things have been exhausted. He agrees with this. I would say that he is at a point of MMI. To determine his capabilities, as far as returning to work, I would recommend an FCE for objective data. (RX. #1, p. 11).

On March 20, 2006, claimant underwent the recommended functional capacity evaluation, however demonstrated numerous inconsistencies and yielded unreliable results. (RX. #1, p. 12-24).

The April 7, 2006, office note of Dr. Bruffett relative to an office visit of the claimant of the same date, reflects, in pertinent part:

His FCE is reviewed with him and his wife in detail. It appears that he gave unreliable effort with 21 of 44 consistency measures within expected limits. It is stated the Mr. Baty put forth very inconsistent effort and exhibits inappropriate illness behavior.

* * *

DISCUSSION:

I told Mr. Baty that I really can not put restrictions on him or limitations

because these are not measurable. I would say he has no restrictions. He probably has limitations based on his pain, but I can not say that he should not be allowed to do this or that. I am going to release him back to work on Monday with no restrictions. I really do not see an objective injury here to assign a specific impairment rating. Therefore, I do not think he has a rateable injury. (RX. #1, p. 25).

Dr. Bruffett authored a release noting that the claimant could return to work on April 10, 2006, without restrictions. (RX. #1, p. 26).

The evidence reflects that the claimant was seen by Dr. Patrick Chan, a Searcy neurosurgeon, on May 3, 2006. The report of the same date generated as a result of the visit reflect, in pertinent part:

Hx of present illness:

Work injury 8/11/2005, persistent low back pain radiating to right leg/foot. Positive for numbness and paresthesia right leg, occ sx right leg, saw Dr. Bruffett per work comp-pt not satisfied. Still not returned to work. Had physical therapy, NSAIDS, lumbar epidural steroid injection.

* * *

Diagnosis and recommendation:

Work injury, persistent low back pain and right leg pain, not better. Plan - Need new MRI lumbar spine. May need L34 L45 L5S1 discogram/nucleoplasty. (RX. #1, p. 27).

On July 10, 2006, the claimant was initially seen by Dr. Thomas M. Hart, a pain management physician, pursuant to the entry of a Change of Physician Order. At the time of the initial visit, a review of the July 10, 2006, report of Dr. Hart reflects that he did not have all of the claimant's prior pertinent medical records, to include the March 20, 2006, Functional Capacity Evaluation which was performed at Functional Testing Centers, Inc. The July 10, 2006, report reflects, in pertinent part:

PHYSICAL EXAMINATION: This is a 48 year old male who appears slightly older than his stated age. He is alert and oriented. He carries on a regular conversation. He does appear to be in moderate distress. I observed him walking from the reception area to the examination room. He had a slow, slightly left antalgic gait with a stooped posture. In the examination room he appeared to move about. He could not sit still for any period of time because of his back pain complaints.

* * *

BACK: Further evaluation of the lower back in the sitting position where I performed straight with distraction he did demonstrate pain in which he grimaced and verbalized when I raised his leg to 60 degrees. It was worse with dorsiflexion with pain in the anterior lateral thigh to the mid calf on the right side only. The left side was negative.

IMAGING STUDIES: MRI, I did have the opportunity to review with him the MRI dated 9/1/05. I showed them the T1, as well as the T2 weighted images. It clearly demonstrated that the 3-4 level he had mild to possible moderate disc protrusion into the anterior epidural space as seen in the axial view, a minor bulge at the 4-5 level. In the parasagittal view one could see that he did have some compromise of the foramen, most notably at 3-4 and 4-5 which may explain the nerve irritation to the L4. This was not a normal MRI. Myelogram reports again showed some disc bulging, but again, no strong nerve compression signs were identified there.

PLAN: At this point I had a long discussion with Mr. Baty and his wife as to etiologies of back pain. First of all as I discussed with him it has been well established in the medical literature that one does not need a herniated nucleus pulposus in order to have back and lower extremity pain complaints. The number one cause of back pain is the disc. The disc in itself is a very painful, highly innervated structure for multiple innervations. Again, this can be found in any recent literature, research, etc. as to discogenic back pain. Also it has been clearly demonstrated that the disc in itself, besides being very painful has its own nondermatomal referred pain pattern to the back, to the lower extremities, to the groin, etc. It is a significant source of pain. So it has been well described about a possible leaking disc. The contents of the nucleus pulposus, i.e., the center of the disc contain highly inflammatory chemicals. There is no pain inside the disc but the outside, again, is highly innervated and very painful. If one has a leakage of the disc, the contents that can cause a chemical radiculitis in which neurologically one could be intact, which he basically is. EMG's and nerve conductions can be perfectly normal. That does not mean that one does not hurt. So far he has had 2

epidural injections performed by a neurosurgeon. Whether or not these were performed properly, whether or not these were per interlaminar or transforaminal approach I am not sure. Unfortunately surgeons performing interventional spine procedures they do the very basis of epidural injections. Usually most are nonselective. My greatest concern, as I discussed with Mr. Baty that if he were to have surgical intervention what levels were going to be operated on? According to the North American Spine Society's Protocol the most appropriate study at this point, since he has already had an MRI, he has already had a CT myelogram, would be discography. Why? It is a more sensitive study that either of the 2 above. It allows us to compare the objective, i.e., the morphological appearance of the disc, as well as pressure volumes to the subjective. Is that the area of concordant pain? This has not been performed. I think that before anything else is done in his situation, that would be the appropriate study. I state to a degree of medical certainty and probability. . .

PLAN: As discussed with Mr. Baty, I think that he is an appropriate candidate for provocative discography at the 2-3 (control level), 3-4, 4-5 (suspect levels), 5-S1 possible control level. If positive both objectively and subjectively then he would require post CT imaging to identify the extent of the disruption. At that point in the algorithm whether or not he is to require surgery surgical evaluation. As to his narcotic analgesic medications, at this time I think that it is appropriate for continuation of his medications since I do think that he has legitimate pain but this will be under the responsibility of his primary care physician, Greg Barton, M.D. in Searcy, Arkansas. (RX.#1, p. 30-33).

Following the July 10, 2006, recommendations of Dr. Hart, the claimant's medical records, to include the report of Dr. Hart, were reviewed by Dr. Bruffett at the request of respondents. In his August 30, 2006, response, Dr. Bruffett noted:

Mr. Baty underwent a functional capacity evaluation on March 20, 2006, which showed that he gave unreliable effort with 21 of 44 consistency measures within expected limits. Therefore, more than half the time, he gave an inconsistent effort with this testing. Therefore, his capabilities were unable to be adequately assessed.

I think this speaks volumes towards his response to treatment in the future. In reviewing Dr. Hart's note, he is recommending diskography. I use diskography quite a bit in my practice, but I feel the only reason to obtain this would be if we were going to make further treatment recommendations

base on this. After a patient basically “fails” a functional capacity evaluation, I would say that the chances of having successful treatment and good outcomes is very limited at best.

Certainly, Mr. Baty is not a candidate for any spinal surgery based on the results of diskography. Also, I really do not feel that doing a percutaneous nucleoplasty or taking out part of a damaged disk would yield any significant improvement unless there is evidence of specific nerve compression from the disk. The myelogram has ruled that out. Therefore, I really do not feel that diskography is indicated or necessary, because I do not think it changes our treatment. (RX. #1, p. 34).

The claimant was again seen by Dr. Hart on November 2, 2006. In addition to reciting the history of the claimant’s August 11, 2005, injury, treatment received relative to same, and the results and recommendations as growing out of the one time visit pursuant to July 10, 2006, referral of the Commission, the clinic note generated during the visit reflects, in pertinent part:

. . . . But since that period of time, again almost 4 months ago, I have not heard anything from Mr. Baty. On his presentation today he is requesting an updated evaluation since several weeks ago when helping his wife he aggravated his back. It is the same pain as before but made much worse. “I couldn’t get out of bed for almost 3 weeks.”

* * *

PLAN: At this point again I discussed with Mr. Baty that I think that this is almost absolutely ridiculous that 4 months ago Mr. Baty present after failure of conservative care as a referral from the Work Comp Commission. Nothing has happened in the last 4 months whatsoever. His wife made mention that they had no income coming in and he still has significant pain which was recently aggravated and they really don’t know what to do. To a degree of medical certainty and probability, I still stat to the Baty’s, that I think the discography is the most appropriate study performed properly according to national standards. (CX. #1, p. 1).

On November 15, 2006, the claimant underwent the diskography under the care of Dr. Hart. The operative report reflects, in pertinent part:

DISCOGRAPHIC ANALYSIS:

In summary, the 2-3 was perfectly normal disc, normal appearance with normal pressure volumes and no pain. The 3-4 was very painful; the most painful, with marked complete circumferential disruption, abnormal pressure volumes, and again subjectively very painful right greater than left back, buttock, and lateral thigh pain complaints. L4-5 also demonstrated complete circumferential disruption immediately, also abnormal pressure volumes, as well as reproduction of concordant pain, right greater than left back, buttock, posterolateral thigh to the knee. Also, 5-1 demonstrated a posterior disruption, but no annular tear outside of the disc and reproduced moderate back pain, but not as painful as 4-5 and 3-4 and right greater than left back and buttock pain complaints. . . .

. . . . Sony permanent prints were placed in the chart, demonstrating documenting today's procedure which is medically necessary to a degree of medical certainty and probability. A copy was sent to the radiologist for post CT comparison, part of his permanent x-ray file. A copy was sent to Dr. Wayne Bruffett, his orthopedic spinal specialist, giving him further information to legitimize Mr. Baty's back pain complaints since it has been a little over a year now since his back has continued to hurt. . . .

PLAN:

I will get him back in the office in the next 1 to 2 weeks to review the post CT. I think it is also very appropriate and medically necessary to get him back to Dr. Wayne Bruffett for a reevaluation since he has basically failed conservative care. This is our current plan. (CX. #1, p. 5-6).

After a thorough consideration of all of the evidence in this record, to include the testimony of the claimant, review of the medical reports and other documentary evidence, application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On August 11, 2005, the relationship of employee-employer-carrier existed among the parties.
3. On August 11, 2005, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$367.00/\$275.00, for temporary total/permanent partial disability.

4. On August 11, 2005, the claimant sustained an injury to his low back arising out of and in the course of his employment.

5. On June 12, 2006, a Change of Physician Order was entered by the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission designating Dr. Thomas M. Hart as the claimant's authorized treating physician relative to the August 11, 2005, compensable injury.

6. The provocative discography recommended by Dr. Thomas M. Hart is a reasonably necessary medical procedure in connection with the treatment of the claimant's August 11, 2005, compensable injury, pursuant to Ark. Code Ann. §11-9-508 (a).

7. The respondent shall pay all reasonable hospital and medical expenses arising out of the injury of August 11, 2005.

8. The respondents have controverted the payment of medical benefits in this claim subsequent to July 10, 2006, to include the treatment recommendations of Dr. Thomas M. Hart.

CONCLUSIONS

On August 11, 2005, the claimant suffered an injury to his low back within the course and scope of his employment with respondents. After a period of treatment under the care of physicians selected by respondents claimant requested and was granted a change of treating physician to Dr. Thomas M. Hart, a Little Rock pain management specialist, who recommended a provocative discography. Claimant asserts that the recommendation of Dr. Hart represented reasonably necessary medical treatment and that respondents should be liable for the cost of same. Respondents take the position that further medical treatment, to include the procedure recommended by Dr. Hart, is not reasonable or necessary.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

The compensability of the claimant's August 11, 2005, compensable low back injury is not disputed. There is no evidence in the record to reflect that the claimant required medical treatment relative to his back prior to his August 11, 2005, injury in the employment of respondents. Neither is there any evidence in the record to reflect that the claimant experienced limitations or physical restrictions relative to his back prior to the August 11, 2005, compensable injury in the employments. The evidence in the record reflects that the claimant successfully discharged his assigned job duties in the employment of respondents prior to his August 11, 2005, compensable injury.

The claimant was initially seen by Dr. Bill Ball relative to the August 11, 2005, compensable injury. In an October 18, 2005, correspondence to respondents, Dr. Ball recited the course of the claimant's medical treatment to date, to include the results of diagnostic studies.

The correspondence reflects, in pertinent part:

Enclosed you will find a copy of the MRI report of his lumbar spine that demonstrates herniations at L3-4 and L4-5. He does have neural foramina narrowing at these levels of his left lumbar spine.

Mr. Baty has seen Dr. Patrick Chan, Neurosurgeon in Searcy for evaluation. He saw him initially on September 13, 2005. Dr. Chan has performed epidural steroid injections of his lower back once and he is to have another injection in October. I think surgery will be contemplated if Mr. Baty does not respond favorably to the injections. After the first set of injections, he is still having considerable pain in his lower back.

His pain is requiring a high dose of Hydrocodone three times a day, as well as Soma, a muscle relaxant three times a day. . .

Of course, he had not been able to work due to the debility that the injury and its consequences have brought. (RX. #1, p. 3-4).

On or about January 13, 2006, the claimant came under the care and treatment of Dr. Wayne L. Bruffett, a Little Rock orthopedic surgeon. Claimant underwent additional diagnostic studies while under Dr. Bruffett's care, to include a myelogram and post myelogram CT. Dr. Bruffett concluded, based on the results of the myelogram and post myelogram CT, that the claimant did not have a surgical problem in his spine and that "nonsurgical things" had been exhausted as of March 6, 2006. The claimant was then referred by Dr. Bruffett for a functional capacity evaluation to determine his capabilities relative to returning to work.

Regardless of the results of the FCE, as of the March 6, 2006, visit, Dr. Bruffett was of the opinion that the claimant was not a surgical candidate and that nonsurgical treatment had been exhausted. Upon receipt of the results of the March 20, 2006, functional capacity evaluation Dr. Bruffett released the claimant from his care and returned him to work without restriction effective April 10, 2006. In his April 7, 2006, report Dr. Bruffett conceded that the claimant "probably has limitations based on his pain". (RX. #1, p. 25).

On June 12, 2006, a Change of Physician Order was entered by the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission in accordance with Ark. Code Ann. §11-9-514 and *Collins v. Lennox Industries, Inc.*, 77 Ark. App. 303, 75 S.W.3d 204 (2002). The Change of Physician Order designated Dr. Thomas M. Hart, a pain management specialist, as the claimant's authorized treating physician relative to the compensable August 11, 2005, injury. The claimant was seen by Dr. Hart on July 10, 2006, pursuant to the Change of Physician Order. In his detailed and exhaustive report of July 10, 2006, relative to his

examination of the claimant Dr. Hart recommended a provocative discography and clearly enumerated the basis for the recommendation. (RX. #1, p. 29-33).

Respondents refused to authorize the discogram, but rather, provided the results of the July 10, 2006, examination of the claimant, as contained in Dr. Hart's report to Dr. Bruffett and solicited his opinion. Dr. Bruffett concluded that diskography was not indicated or necessary "because I do not think it changes our treatments". (RX. #1, 34).

Using his health insurance the claimant ultimately underwent the discogram under the care of Dr. Hart on November 15, 2006. In his November 2, 2006, report, Dr. Hart again detailed the medical necessity of the discogram. The November 15, 2006, procedure yield results which warranted further medial treatment, as outlined in Dr. Hart's plan to refer the claimant back to Dr. Bruffett.

Ark. Code Ann. §11-9-508 (a) mandates that the employer provide such medical services as may be reasonably necessary in connection with the work related injury received by an employee. Whether a medial procedure or device is reasonable and necessary is a question of fact. *Air Compressor Equipment v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000).

The evidence preponderates that the claimant continued to experience residuals of his August 11, 2005, compensable injury. While his prior treating physician, Dr. Bruffett, conceded that the claimant probably had limitations on his employment activities based on pain, at the time he discharged him to return to work effective April 10, 2006, it was without limitations.

The simple truth of the matter is the claimant's authorized treating physician relative to his August 11, 2005, compensable injury is Dr. Thomas M. Hart, a pain medicine specialist, pursuant to the June 12, 2006, Change of Physician Order entered by the Medical Cost

Containment Division of the Arkansas Workers' Compensation Commission. The discogram is a recognized and approved test by the American Medical Association. *Smith v. County Market/Southeast Foods*, 737 Ark. App. 333, 44 S.W.3d 1 (2001). Dr. Hart emphasized that the discography is a more sensitive study than either an MRI or CT myelogram and provides valuable information, as evident by November 15, 2006, results. As a aside, it is clear that the claimant has failed conservative care relative to the treatment of his injury. The discography recommended by Dr. Hart was reasonably necessary in connection with the August 11, 2005, compensable injury of the claimant.

The claimant has continued to receive medial treatment relative to his compensable injury of August 11, 2005, subsequent to July 10, 2006, when respondents refused to authorize same under the care of the authorized treating physician or any other provider. The medical treatment subsequent to the claimant's one time visit to his authorized treating physician was provided by the claimant's primary care physician. Indeed , there is credible testimony in the record to reflect that physical restrictions were placed on the clamant by his primary care physician subsequent to the April 7, 2006, visit to Dr. Bruffett. The respondents have controverted the claimant's entitlement to reasonably necessary medical treatment subsequent to July 10, 2006.

AWARD

Respondents are herein ordered and directed to pay all reasonably necessary medical treatment in connection with the claimant's compensable injury of August 11, 2005, to include the discogram recommended by Dr. Thomas M. Hart, as well as all reasonable and related medical, hospital, nursing and other apparatus expenses, to include medical related travel.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809,

until paid.

Matter not addressed herein are expressly reserved, to include temporary total/permanent partial disability benefits.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE