

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F012836 (09/14/00)

BARBARA HARPOLE, EMPLOYEE	CLAIMANT
DELAPLAINE SCHOOL DISTRICT, SELF-INSURED EMPLOYER	RESPONDENT #1
RISK MANAGEMENT RESOURCES, TPA	RESPONDENT #1
SECOND INJURY FUND	RESPONDENT #2
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT #3

OPINION FILED AUGUST 20, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on May 30, 2008, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE FREDERICK S. SPENCER, Attorney at Law, Mountain Home, Arkansas.

Respondent #1 represented by the HONORABLE BETTY J. HARDY, Attorney at Law, Little Rock, Arkansas.

Respondent #2 represented by the HONORABLE DAVID L. PAKE, Attorney at Law, Little Rock, Arkansas.

Respondent #3 represented by the HONORABLE JUDY W. RUDD, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above style claim to determine the claimant's entitlement to additional workers' compensation benefits. On April 8, 2008, 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 same. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Barbara Harpole - the claimant, Eddie Harpole, along with the May 15, 2008, deposition testimony of Dr. William Blankenship, couple with medical reports and other documents comprise the record in this claim. Further the transcript of prior hearing of May 6, 2005, in this claim is incorporated

DISCUSSION

_____ Barbara Jean Harpole, the claimant, with a date of birth of March 4, 1950, completed the 9th grade and later obtained her GED in 1985. The claimant was employed by respondent #1 for a period of four to five years, from September 1998 until July 24, 2002, when her employment was terminated. Claimant was employed as a part-time cafeteria worker for respondent #1.

There is not a dispute regarding the compensability of the claimant's September 14, 2000, low back injury in the employment of respondent #1. The mechanics of the September 14, 2000, low back injury was described by the claimant during the previous hearing of May 6, 2005:

Well, I was in the cafeteria in there, and I was fixing to carry the trash out, and it was a standard procedure for us to take one trash bag out of the trash bag and put it over in the other one, and I reached and grabbed and yanked, because I was in such a hurry because they was always pressing me cause I wasn't doing it as fast as they wanted me to do it, and I yanked it an I twisted, and when I did, I heard a pop. (May 6, 2005, hearing, T. 13).

The claimant has undergone two (2) surgeries in connection with the September 14, 2000, compensable low back injury.

The testimony of the claimant reflects that the first surgery, which was performed by Dr. Ricca on May 29, 2001, did not help any. Regarding the second surgery, which was performed

by Dr. Barrett-Tuck on February 2, 2007, claimant testified that the same did not help:

No, sir. When she unpinched the nerve in there, it really went wild - the nerve has.

The - it's been very - the pain has been bad at times. (T. 17).

With regard to the fusion procedure recommended by Dr. Barrett-Tuck and desired by the claimant, the testimony reflects:

Yes, sir, because every time - if I move a certain way, they - it hits or something does, and I don't know - I don't know technical terms, but anyway, I'll - I can reach or I can move a certain way and its' just like somebody hits me with a knife. (T. 17).

Claimant now wears a back brace in an effort to minimize the knife-like sensation. Claimant testified that she wears the back brace daily.

The testimony of the claimant reflects that she wants to undergo the fusion surgery.

Claimant testified regrading her expectations from the surgical procedure:

I think it'll take care of the knife going, you know, hitting me. And, see I've already - the nerve - I've already fell once and broke my wrist because of the nerve pinching.

But that was before I had my surgery [the second surgical procedur] (T. 18-19).

With respect to her current symptoms, attributable to the compensable September 14, 2000, low back injury, the claimant testified:

I have burning, pain that goes all the way down to both my knees. I have - it's like a, oh, like a knife hitting me every so often - it goes down, and it don't never - it don't always go down the same way. Once time, it may go down the left leg, and the next time, it may go down my right leg. And it always hurts down my right leg the most, all across my hip, and down to my ankle on my right leg, and it - and I have a pain now that comes across my stomach and goes down inside of my right leg. (T. 19).

Claimant's testimony reflects that the knife-like sensation in her back is periodic in nature:

Yes, sir. It doesn't happen every day, but if I move a certain way, even - sometimes, even with the back brace on, it will do it. If I reach for something, like reach up in the cabinet it will do it and, a lot of times, I'll reach up in the cabinet and it'll do that, and then I'll have leg cramps all the way down and my leg just stiffens like a - and I can't move it - can't bend it. (T. 19).

Claimant noted that the burning pain that she experiences is constant. Claimant testified regarding the character of the burning pain:

Well, before she - Dr. Tuck had put me on Miritin (phoentic) - it had helped the pain. It hasn't took it away, but it's helped it. But, before I got on Miritin (phonetic), it was like I was almost in tears all the time - it hurt and burned. And it was just like I was sitting with my feet in fire.

And, now then, it's just a mild burning pain. (T. 20).

The testimony of the claimant reflects that prior to the September 14, 2000, compensable low back injury she did not take any medication. Regarding her present medication intake, the claimant testified that she takes Oxaprozin for arthritis that has settled in her back since her injury and surgeries; Seratin (phonetic), which is the same as Zoloff; Omeprozole to prevent ulcers from the medicine that she takes in connection with her injury; Atenolol for when her heart gets to racing away, which is bought on by severe pain from the injury; Methadone, 5 milligrams in the morning and night, for pain; Lyrica, three time a day for the pain and burning sensation, 75 milligrams; Seneca S for constipation bought on by the other medication. Claimant further testified that she takes a Calcium tablet daily for her bones. The claimant has a Nitroglycerin that she keeps with her in case her heart acts up. The testimony of the claimant reflects that she experiences episodes of her heart racing, beating rapidly, two (2) or three (3)

times a week.

Claimant testified that respondent #1 is paying for the Lyrica and Methadone. Further, claimant testified that part of the time respondent #1 pays for her Zoloft and part of the time it will not. Claimant's testimony reflects that because respondent #1 refuses to pay of any of her other medicines Humana is paying for it. Claimant testified that she was informed by the claims adjuster, Ms. Charlotte Flanagan, that the other medicines did not go along with her back problem. The claimant identified Ms. Flanagan's role in the workers' compensation claim:

No, sir, that's the one that's over the workers' comp - where they had - she had to okay my medicine every month - for the - the drugstore has to call every month to have it okayed.

Yes, sir, and last month is the first time that they've paid for the Zoloft. I've been sending the bill in and I have not - no pay on it. (T. 24).

In addition to requesting the surgical procedure as recommended by Dr. Barrett-Tuck, claimant desires respondent to pay cost of her medication, noting that prior to her injury she did not take any. With regards to her desire for the fusion procedure, claimant testified:

Yes. If I could get by without the fusion and I thought I would ever get better, I would not want it. But I don't think - I haven't gotten any better. (T. 25).

The claimant observed that she is comfortable in her patient/physician relationship with Dr. Barrett-Tuck. Claimant testified regarding her understanding of the results of the fusion procedure:

Yes, sir. She [Dr. Barrett-Tuck] told me this was a last-ditch effort to kill the pain. She said she couldn't guarantee it. (T. 25).

The claimant was seen on one occasion by Dr. Blankenship for an evaluation.

During cross-examination, claimant acknowledged that her heart condition developed

after 2000. Claimant treats with her family physician, Dr. Stallcup, for her heart condition. The claimant's first surgery in connection with the September 14, 2000, low back injury was had in 2001 under the care of Dr. Ricca. Claimant maintains that following the 2001 surgery she was trying to go ahead and work, although she was hurting, until respondent #1 refused to re-hire her.

Claimant concedes that the prior hearing of May 6, 2005, was a request to undergo the surgery under the care of Dr. Barrett-Tuck. Further, the claimant acknowledged that the surgery, which was performed in February 2007, seemed to make things worse:

Yes, cause she unpinched the nerve, I guess, is what happened. She said the nerve was pinched, is what she told me. (T. 27).

Claimant testified that the burning pain in her feet has only been present since her February 2007 surgery.

The testimony of the claimant reflects that she does not do any exercises because when she started doing them they made her back hurt worse. Claimant's testimony reflects, regarding the afore:

No, because when you stretch, and it makes it hurt, you don't do it. I went for therapy, and I went - I can't remember if I went three (3) times or four (4) times, and each time, it got worse. And, by the end of the - the last time I went, he told me not to come back until the doctor okayed me for therapy, that my back wasn't - there was something definitely wrong. (T. 28).

The claimant acknowledged that she was referred by Dr. Barrett-Tuck to Dr. Greaser for pain management after complaining of pain following the February 2007 surgery. Claimant has several visits with Dr. Greaser. Claimant testified that Dr. Greaser wanted to put in a stimulator. Regarding the afore, claimant testified:

I - if it - I don't - well, I had - he went ahead and did the

discogram, and in talking with him and Dr. Tuck, I wanted their opinion, whether they thought that it would work, and they told me they didn't think that it . . .

But I wanted their opinion on whether they thought it would work - you know, if the stimulator would work. If it would work, then I would go with that. But, Dr. Tuck didn't think it would stop the pain - from the jabbing pain - from the movement. She said it might stop the other pain, but it still, when I moved a certain way, then I would still have that knife pain. (T. 28-29).

Claimant asserts that while there is never a guarantee with respect to surgical procedures she is of the opinion, based on her communications with Dr. Barrett-Tuck she feels it would help.

Mr. Eddie Harpole, the claimant's husband of forty-two (42) years, provide testimony corroborative of that of the claimant. Mr. Harpole testified regarding his observation of the claimant with respect to her symptoms attributable to the compensable injury and subsequent surgeries growing out of the September 14, 2000, compensable low back injury:

Okay. When we go to church, why, she can't sit very long at a time, and she'll, you know, turn this way and turn that way, and twist, and when we sing - of course, that let's her stand up and gives her some relief. If she sits too long, she has to get up and go to the restroom or something - she can't sit very long. And, last spring, she wanted to do some raking with a little - it's a light leaf rake, and I told her, I said, you should [shouldn't] be doing that. She said, I've got to try to help. So, she went out there and raked a little bit for a little while, and the next day she had to lay on the bed all day long, and that's with all her medicine she's taking. (T. 9).

Mr. Harpole further testified, regarding the evidence of the claimant's pain:

At times, it's worse than others, you know. I can see it on her face, you know, a lot of times, and she can get up and just try to dust the floor, so then she's hurting for thirty (30) minutes. (T. 10-11).

In describing the claimant's daily activities, Mr. Harpole's testimony reflects:

Well, we do watch a lot of TV, to be honest about it.

Cause, you know, she just tries to get to the point where she can sit or lean. A lot of times, she'll lay on the bed, you know, for a couple of hours if she's hurting. (T. 11).

Mr. Harpole noted the claimant will not lay down more than two (2) times during the day, however added that the duration of same could be from one to three hours. Mr. Harpole also noted that the claimant does not sleep well at night, but rather tosses and turns and groans.

Mr. Harpole testified that the claimant walks like her legs are stiff. Mr. Harpole further testified:

And when we ride and go anywhere, why, she has to - about every thirty (30) minutes to an hour, she has to get out and walk. She can't - just like coming up here, we had to stop and let her out and walk. (T. 12).

Mr. Harpole, while acknowledging that continued treatment under the care of Dr. Barrett-Tuck is ultimately the claimant's call, testified that he was pleased with the medical care provided by Dr. Barrett-Tuck, explaining:

She explains things to us. She's thorough with it, and, I mean, I think she's a good doctor. (T. 12).

Mr. Harpole's testimony reflects that while the claimant was prescribed the stimulator by Dr. Greaser respondent #1 refused to authorize it.

The medical reflects that the claimant underwent decompressive partial hemilaminectomy, medial facetectomy and foraminotomy at L4-5 right and through separate incision decompressive partial hemilaminectomy, medial facetectomy, and foraminotomy at L4-5 right procedures on May 29, 2001, under the care of Dr. Gregory Ricca, a Jonesboro neurosurgeon. (CX. #1, p. 6-7). On March 31, 2004, a Change of Physician Order was entered by the Medical Cost Containment Department of the Arkansas Workers' Compensation

Commission designating Dr. Troy Stallcup as the claimant's authorized treating physician relative to the compensable September 14, 2000, low back injury.

The prior hearing of May 6, 2005, centered on the reasonableness and necessity of further diagnostic study, an MRI scan of the lumbar spine as recommended by Dr. Stallcup. The ruling generated as a result of the afore hearing found that the diagnostic study was reasonably necessary in connection with the claimant's compensable injury and respondent #1 was directed to pay the cost of same.

The claimant was later referred by Dr. Stallcup to Dr. Rebecca Barrett-Tuck, a Jonesboro neurosurgeon. Claimant was seen by Dr. Barrett-Tuck on October 25, 2006. The October 25, 2006, report of Dr. Barrett-Tuck reflects, in pertinent part:

She underwent a MRI of the lumbar spine in September 2005. It shows a disc protrusion at L5-S1 on the left that does efface the thecal sac and the left S1 nerve root. She also has mild lateral recess stenosis bilaterally at L4-L5. (CX. #1, p. 13).

Following her examination of the claimant Dr. Barrett-Tuck recommended a myelogram and post myelogram CT scan. The November 17, 2006, radiology report of the afore diagnostic studies reflects the impression of a small left lateral disc extrusion at L5-S1, mildly displacing the left S1 nerve root. (CX. #1, p. 14-15).

The medical in the record reflects that the claimant was seen in follow-up by Dr. Barrett-Tuck on December 20, 2006. The chart note relative to the afore reflects, in pertinent part:

Ms. Harpole returns for follow up and review of her myelogram and post myelogram CT scan. Her pain is most severe on the right even though it has recently worsened on the left with associated numbness going down the posterior aspect of the leg and into the heel on the left. The myelogram and post myelogram CT scan is remarkable for a disc rupture at L5-S1 on the left, it is a fairly small rupture, but there is

obvious effacement of the nerve root. This would be consistent with her complaints of pain and numbness into the heel into the left. She has a lot of residual right leg pain, in fact the right leg pain is worse than the left. On viewing this study, it does not appear that there has been adequate lateral recess decompression at L4-L5 on the right, she does have stenosis at this level as well on the left. At L5-S1 on the right, I think the decompression is very much adequate. I have recommended to Ms. Harpole that we carry out bilateral recess decompressions at L4-L5 and a discectomy on the left at L5-S1. I have discussed with her the possibility that her pain would not improve. I have discussed the risks and possible complications, and in particular her expectations. I have told her clearly that I do not think we are going to relieve her completely of pain, but we may be able to get some relief for her. She seems to understand and indicates that she wishes to proceed with the planned surgery.

Assessment:

1. Lateral recess stenosis L4-L5 bilaterally.
2. Disc rupture L5-S1 on the left.

Plan:

1. Bilateral lateral recess decompression L4 and L5.
2. Discectomy on the left at L5-S1. (CX. #1, p. 16).

On February 2, 2007, the claimant underwent the surgery relative to the above diagnoses under the care of Dr. Barrett-Tuck at the Surgical Hospital of Jonesboro. The report reflects that Dr. Barrett-Tuck performed a redo lateral recess decompression on the right L4-L5; lateral recessed decompression on the left; and partial hemilaminectomy and discectomy L5-S1 on the left. (CX. #1, p. 17-18). On March 5, 2007, the claimant underwent a MRI of the lumbar spine with and without contrast. The report relative to the afore reflects, in pertinent part:

IMPRESSION:

1. Posterior changes are present at L4-5 and L5-S1. Enhancing granulation tissue is seen from bilateral laminectomies at L4-5 along with a left laminotomy at L5-S1.
2. No nonenhancing disc extrusion or disc fragment is seen in the lumbar spine.

3. The granulation tissue at the L4-5 and L5-S1 levels surrounds the proximal bilateral descending L5 and left S1 nerve roots.

4. No focal disc extrusion, canal stenosis, or neural compression is seen in the lumbar spine. (CX. #1, p. 20).

Pursuant to a March 14, 2007, office visit of the claimant Dr. Barrett-Tuck recommended that the claimant undergo a myelogram and post-myelogram CT scan of the lumbar spine. (CX. #1, p. 21-23).

The record reflects the presence of a May 16, 2007, neurosurgery office note of Dr. Barrett-Tuck regarding the claimant:

Barbara Harpole returns today for follow-up. She indicates that her pain has improved considerably since our last visit. She is now taking two pain pills a day and two muscle relaxants a day, which is much better than she had been using previously. She still is having considerable problems. She has to sit down during her daily activities. She must sit before completing cooking a meal. She is not able to walk a complete circuit around Wal-Mart at this time, but in spite of the difficulty she is having, she has improved. She is scheduled to see Dr. Greaser with pain management next week. I am hopeful that his treatments will give her additional relief. I will plan to see her back in 6-8 weeks. We will certainly keep in mind that she may require a fusion if she does not respond to time and further conservative treatment. If so, she would need a diskogram since she has had surgery both at 4-5 and 5-1 levels. (CX #1, p. 24).

A August 17, 2007, report of Dr. Barrett-Tuck reflects, in pertinent part:

Barbara Harpole returns today for follow-up and review of her diskogram. Dr. Greaser completed the diskogram and noted significant correlation with at both L4-L5 and L5-S1. The control level at L3-L4 did not show concordant pain. I discussed these results with Ms. Harpole. She is anxious to proceed with her fusion. It is in my opinion that she will require fusion at both L4-L5 and L5-S1. She does understand that I cannot guarantee complete pain relief yet she has certainly exhausted all conservative treatment. We will plan cage fusion at both of these levels using threaded fusion cage, Vitoss local bone, and bone marrow aspirate. I have discussed with her risks, possible complications, and expectations. She gives her informed consent. I will schedule her surgery for early in September. We will begin

on Workmen's Comp approval today. Ms. Harpole will be following up with Dr. Greaser next week. (CX. #1, p. 25A).

The claimant was again seen by Dr. Barrett-Tuck on October 17, 2007. The office note relative to the afore visit reflects, in pertinent part:

Ms. Harpole returns today for follow-up. She continues to have a tremendous amount of difficulty with back pain. She is wearing her brace, and while her brace is in place she feels some improvement in her back pain. In fact, when she removes her brace, the pain is almost intolerable for her, and she must simply go to bed. She is having a lot of difficulty with constipation. She is on Methadone twice a day now and reports, that she uses stool softeners every day, laxatives, and frequent enemas, and, in fact, despite all this treatment, she still must manually disimpact herself at times. She is also having difficulty with bladder due to the pressure from the brace. Workmen's Comp disallowed or failed to approve request for fusion even though at the time of surgery it was clear that the spaces were unstable at 4-5 and 5-1, and Dr. Greaser's discogram indicated concordant pain at both of these levels. She did have some minor pain at other levels, but it was not concordant. Certainly, on myelogram, the spinal canal is large. Nerve roots fill well. However, we have attempted conservative treatment for a number of months without success, and I truly feel that the fusion is most appropriate at this time. Since this has not been approved, she will follow-up with Dr. Greaser to see if she can get some relief with the use of a spinal cord stimulator. She will ask for a follow-up appoint with him as well as some suggestions regarding the Methadone and the constipation problems. I plan to see Barbara back in six to eight weeks. I know that she is working with Mr. Spencer in attempting to get approval for her surgery. (CX. #1, p. 26).

On February 13, 2008, the claimant was evaluated by Dr. William F. Blankenship, a Little Rock orthopedic surgeon, at the request of respondent #1. Dr. Blankenship authored a detailed report of the same date relative to his evaluation of the claimant. After reciting a history of the claimant's prior medical treatment in relation to the September 14, 2000, compensable injury, the February 13, 2008, report of Dr. Blankenship reflects the results of his physical examination of the claimant, review of prior radiographic studies, and review of the February 2, 2007, operative

report of Dr. Barrett-Tuck.. The report also recites the prior medical records of the claimant that Dr. Blankenship reviewed. The February 13, 2008, report of Dr. Blankenship concludes:

COMMENTS:

- This lady has had two surgical procedures carried out for her subjective complaints of pain in her back and right lower extremity. Neither of these procedures has shown a herniated disc at the L4-L5 level. This is based on two separate explorations of the L4-5 interspace. The last surgical procedure did show a herniated disc only on the LEFT side at L5-S1. Of note, her symptoms, following her injury and before her last surgery were right sided and not left sided. The MRIs before the second surgery did reveal a disc problem on the LEFT side at 5-S1, but nothing was found on the right side except postsurgical changes.

Laminotomies, foraminotomies and medial facetectomies should not result in instability of the lumbar spine. Degenerative disc disease could account for some instability of the lumbar spine. On the films that were reviewed, the only instability seen on the standing flexion/extension, was of L3-4, which is not an involved level.

I am in agreement with the medical reviewer, who commented that no psychological evaluation was conducted, prior to possibly contemplating a third surgical procedure. With the records furnished, I do not see any recent neuropsychiatric evaluation regarding the evaluation of this individual and any possible functional effects it might have on the outcome of the results of a third surgical procedure.

In the letter of 2/12/08 an evaluation was requested, since it appeared another surgery was being recommended. In that letter, your requested comments be made whether additional surgery was necessary and if so, is it related to the February of 2002 work related injury?

In my opinion, after having examined and evaluated this lady and reviewed the records, additional surgical procedure, such as a fusion is not indicated for the following reasons: (1) There is no notation this individual had a psychological functional evaluation being conducted with the possibility of contemplating additional surgical procedure. (2) There is no objective basis for lumbar instability. It should be noted there was motion at L3-4. However, this is not the level of problems this individual has had two surgical procedures on and there is no measured instability, such as angulation or degree of motion noted. In my opinion, noticing loose facet

joints at the time of surgery, does not connote instability of the spine which would require a surgical procedure. (3) there is no objective evidence of neurological progression in this individual's complaints. The complaints this individual elicits at this time are subjective, i.e., pain only.

The herniated disc on the left side at L5-S1 in my opinion is not related to the initial problem this individual had, which appears to have been lumbosacral strain associated with spinal stenosis at the L4-5 level on the right side. there has been no objective evidence that shows a spinal fusion is necessary and the condition that arose out of the work related injury was a lumbosacral strain superimposed on spinal stenosis.

The opinions stated in this report are based on the medical information in the form of medical records provided to me and on physical exam. Should additional medical information or records be provided, it is possible my opinion might be modified or changed. Medicine is an inexact science; however, the opinions stated above are based on a reasonable degree of medical certainty. (CX. #1, p. 34).

On May 15, 2008, the parties obtained the deposition of Dr. Blankenship. During the course of the deposition Dr. Blankenship elaborated on his February 13, 2008, examination of the claim and the resulting findings. Regarding the claimant's failure to receive any relief from her symptoms following the February 2, 2007, surgery by Dr. Barrett-Tuck, Dr. Blankenship testified:

Well, it depends on what you're talking about because first of all, surgeons don't operate on people with the expectations that they're not made better. So not from an egotistical standpoint, but you would expect the patient to be better. So the answer is yes I would be somewhat disappointed that the person didn't do that well. However, if you look at the description of the operation and what went on, I wouldn't be surprised, because this is a degenerative disk disease, not necessarily a traumatic rupture disease, and in those cases, what happens is a lot of times they don't do better because that's part of the whole degenerative process. (JX. #1, p. 13-14).

In describing a fusion surgery in general, the testimony of Dr. Blankenship reflects:

Okay. Well, a fusion surgery by definition is fusion means to make

a joint stiff. The disks in our spine are nothing more than specialized disks, I'm sorry specialized joints. So what you do is you go in and you destroy surgically or you remove the disk, and then you make it stiff, and there's several ways to do that. Some ways, and a lot of neurosurgeons do this, they go through the back and they put some bone plugs in after they destroy the disk space, and some people also, neurosurgeons will sometimes put screws and rods and plates in, and in the present status that they acknowledge today, most people are doing an inner body. In other words, taking the bone out - - I mean, taking the disk out, and doing plates and screws to make it stiff, and so bottom line, that's what a fusion is. (JX. #1, p. 14-15).

Dr. Blankenship is of the opinion that in light of the claimant's failure to realize improvement from the first and second surgical procedures the results from a third procedure would not be any better, explaining:

I think there's several things. First of all, she's never responded to the first one. Secondly, she's got degenerative disk disease, and there's nothing objectively to show that between the first and the second surgery that she has any radiculopathy. Radiculopathy, and maybe I ought to define that, is findings down in the extremity. Pain down the extremity is not radiculopathy. That is call radiculitis, and that's a subjective complaint or can be a subjective complaint. And so when you look at this lady's findings, and I went into this a little bit ago about the reflexes being normal, and you mentioned about the decrease in size, that's the other key thing for radiculopathy is loss of muscle size, which she didn't have. So this lady does not have any objective findings of radiculopathy, fo basically what you get into at this point is you're treating subjective symptoms, and when that happens is usually not going to be made well or better by doing other surgeries. (JX. #1, p. 15-16).

Dr. Blankenship elaborated on his recommendation of a psychological evaluation of the claimant before any further surgery:

Okay. There's a lot of this - - and I'm not a psychiatrist, but I think the correct term is functional overlay, not necessarily in this lady, but also in a lot of people, people who have, say, different types of psychological problems. She did state that she was depressed. That is not a good indicator, if you will, of a person getting better results from a surgery. Also, and I mention this that she's also on methadone, which is another thing that tells

- - there's a real big pain problem there regardless of whatever the cause of it is, and I think if people are not cleared, at least psychologically first, then I think you're kind of hanging yourself out on a limb. Now, I'm not saying that after you have psychological evaluation and the psychologist feels that, "Okay. With psychiatric support, she might do better." But I think when you start looking with a high index or problems with psychological, then I think your results are going to go way down. (JX. #1,p. 16).

Dr. Blankenship testified that he did not find any structural instability in his examination of the claimant. Dr. Blankenship testified that as of the February 13, 2008, examination of the claimant he did not feel that a fusion surgery is reasonable and necessary.

During cross-examination Dr. Blankenship discussed the difference between a neurosurgeon and an orthopedic surgeon:

First of all, neurosurgeons are doctors who specialize in disease, neurological disease such as brain disease, brain injuries, spinal cord injuries, spinal cord tumors, peripheral nerve injuries, ruptured disks, throughout the entire spine.

Orthopedists also - - well, orthopedists also take care of injuries to the spine and also disk problems throughout the spine just like the neurosurgeon does. Now, a difference being in one sense that orthopedic goes into more ligaments, bones, joints, joint stability, instability. Now, lastly, up until probably, I think, historically about World War II and a little after, most disk surgery was done by orthopedic surgeons, and then kind of after all the stuff that came out of that, it kind of fell into a double area of interest both orthopedically, to take care of disk problems as well as neurosurgery taking care of disk problems. I'm sorry to belabor the point, but there is a difference, but there's also a similarity. (JX. #1, p. 22-23).

Dr. Blankenship concedes that Dr. Barrett-Tuck, a Jonesboro neurosurgeon, was able to perform surgery and actually view the low back of the claimant. The testimony of Dr. Blankenship reflects that an observation of interspaces looseness is objective cannot not be faked. Dr. Blankenship testified that the treatment of the claimant by Dr. Greaser at the pain clinic would be more reasonable treatment than a proposed back fusion. Dr. Blankenship

responded that he was in agreement with Dr. Barrett-Tuck that the claimant should try conservative measures before getting into the position of having to do surgery. Further, Dr.

Blankenship testified:

I think also that functional evaluation would be well ordered or done as well as, you know, along with the chronic pain treatment. Yes, sir, I agree with that. (JX. #1, p. 24-25).

The testimony of Dr. Blankenship reflects, regarding the April 22, 2008, report of Dr. Barrett-Tuck:

I don't know if it's objective evidence of it. I think it's just objective when you read the whole body of it, which you handed me, you know, right before we started this disposition, was that he said her MRI looked good, her myelogram, post-myelogram looked otherwise good. She does mention that the joints are exceptionally loose, and she was concerned about trouble in the future, but I think that - - and then I think the real crux of the matter as I read into this, is I think that - - and Dr. Tuck, please forgive me for saying this - - I don't think by reading this that you were convinced that fusion would be in order at this point in time based on that. Not to try to argue, I don't think there's objective findings even Dr. Tuck felt they were subjective findings, that this lady needed back fusion. (JX. #1, p. 25).

Dr. Blankenship acknowledged that Dr. Ricca, a Jonesboro neurosurgeon, performed surgery on the claimant in 2001 and found there was a herniated disk. (JX. #1, p. 29-30). Dr. Blankenship recommends that the claimant have a "good functional evaluation" before a spinal cord stimulator was undertaken.

Dr. Blankenship opined that the claimant's problems on the left side are not related to the September 14, 2000 initial injury in elaborating on his February 13, 2008, report. (JX. #1, p. 38).

Dr. Blankenship testified that while the April 22, 2008, report of Dr. Barrett-Tuck did not specifically identify what level she was referring to regarding being exceptionally loose. With

regard to the afore, the testimony of Dr. Blankenship reflects:

I was trying to - - okay. No, it just said that, "It was noted that the facet joints were relatively loose."

"And the space seemed to be mobile raises concern about a fusion might be in the future." But if she did explore two levels, 4-5 and 5-1, then you're talking about that area involving those two. (JX. #1, p. 39).

In discussing the above, Dr. Blankenship was referencing a February 2007 report of Dr. Barrett-Tuck, when she performed the claimant's second surgical procedure.

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, 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 September 14, 2000, the employment relationship existed between the claimant and respondent #1, when the claimant sustained a low back injury within the course and scope of her employment. The claimant earned wages sufficient to entitle her to workers' compensation benefits at the rate of \$78.00, for temporary total/permanent disability.
3. Further medical treatment under the care of Dr. Rebecca Barrett-Tuck is reasonably necessary in connection with the claimant's September 14, 2000, compensable injury, with any further surgical procedure being preceded by a psychiatric evaluation.
4. Respondent #1 has controverted the claimant's entitlement to the further medical treatment recommended by Dr. Barrett-Tuck.

CONCLUSIONS

The present claim before the Commission is limited to the issue of the claimant's entitlement to additional medical treatment as recommended by her treating neurosurgeon in connection with her September 14, 2000, compensable low back injury. Respondent #1 takes the position that the additional treatment sought by claimant is not reasonable and necessary nor is it causally related to the claimant's workers' compensation claim.

The present claim is one governed by the provisions of Act 796 of 1993 in that the claimant asserts entitlement to additional 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 September 14, 2000, low back injury is not disputed. There is no evidence in the record to reflect that the claimant experienced limitations, restrictions or complaints relative to her low back prior to the compensable injury of September 14, 2000. The credible evidence in the record reflects that the claimant has not been symptom free since sustaining the September 14, 2000, compensable low back injury.

The claimant has undergone two (2) surgical procedures in connection with the September 14, 2000, low back injury under the care of two different Jonesboro neurosurgeons. Following the May 29, 2001, surgery by Dr. Gregory F. Ricca, claimant obtained a change of treating physician from same to her family physician Dr. Troy Stallcup.

While under the care of Dr. Stallcup, pursuant to a Change of Physician Order, additional diagnostic testing was recommended. The refusal of respondent #1 to authorize the afore resulted in a hearing before the Arkansas Workers' Compensation Commission and a ruling finding the same to be reasonably necessary treatment in connection with the injury and directing the payment of same.

Following the diagnostic testing the claimant was ultimately referred by Dr. Stallcup to Dr. Rebecca Barrett-Tuck. While under Dr. Barrett-Tuck's care the claimant underwent a second surgical procedure on February 2, 2007. Dr. Barrett-Tuck observed and recorded during the February 2007, operative procedure movement in the facet joint of the surgical area which might require a fusion procedure in the future. The claimant did not realize improvement in her symptoms following the February 2007 procedure.

The evidence reflects that conservative treatment measures were undertaken to address the claimant's continuing pain complaints, to include a referral to a pain clinic. Dr. Greaser, the pain management specialist, recommended the placement of a spinal cord stimulator to address the claimant's pain complaint. Respondent #1 refused to approve the afore procedure.

Dr. Barrett-Tuck has document findings which she opines warrants a surgical fusion as the most appropriate treatment of the claimant's injury at this time. The credible testimony of the claimant reflects that she has been informed of the risks entailed in the procedure as well as the results of the procedure. The claimant does not have unrealistic expectations of the fusion procedure.

The claimant was seen on one occasion and evaluated by Dr. William F. Blankenship, an orthopedic surgeon, at the request of respondent #1. In his evaluation, Dr. Blankenship had access to the claimant's prior pertinent medical records, to include operative reports and diagnostic studies. While the claimant may have had degenerative disk disease in place prior to the September 14, 2000, injury, there is no evidence in the record that the same adversely impacted her ability to function or remain gainfully employed. The claimant did sustain a injury within the course and scope of her employment with respondent #1 on September 14, 2000.

Ark. Code Ann. §11-9-508 (a) (Repl. 2002) mandates that an employer provide such medical services as may be reasonably necessary in connection with an employee's injury. *Cox v. Klipsch & Associates*, 71 Ark App. 433, 30 S.W.3d 764 (2000). What constitutes reasonable and necessary medical treatment is a question of fact for the Commission. *Wackenhut Corp. v. Jones*, 73 Ark. App. 158, 40 S.W.3d 333 (2001).

The evidence preponderates that Drs Barrett-Tuck and Greaser are in a better position to assess the claimant's current medical treatment needs given the extent and nature of their contact with same. Both physicians have had numerous visits with the claimant, during which time physical examinations were conducted and diagnostic studies were reviewed. In addition to physical examinations and diagnostic studies Dr. Barrett-Tuck has performed surgery. The afore places her in the unique position of reconciling the clinical findings with diagnostic studies in arriving at the appropriate course of treatment at this juncture. The claimant has sustained her burden of proof by a preponderance of the evidence that additional medical treatment as recommended by Dr. Barrett-Tuck is reasonably necessary in connection with the September 14, 2000, compensable low back injury, as well as causally related to same. Respondent #1 has controverted the claimant's entitlement to the afore additional medical treatment.

AWARD

Respondent #1 is hereby ordered and directed to pay all reasonable medical, hospital, nursing, and other apparatus expenses in connection with the compensable injury of September 14, 2000, to include the medical treatment as recommended by and at the directions of Dr. Rebecca Barrett-Tuck.

Maximum attorney fees are herein awarded to the claimant's attorney, the Honorable

Frederick S. Spencer on the controverted portions of this award, pursuant to Ark. Code Ann. §11-9-715, and in accordance with *Holiday Inn-West v. Coleman*, 31 Ark. App. 224, 792 S.W.2d 345 (1990).

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

Matters not addressed herein, to include permanency/ wage loss, is specifically reserved.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE