

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F009787

PEGGY LINDSEY, EMPLOYEE	CLAIMANT
THURL LINDSEY, EMPLOYER	RESPONDENT
HARTFORD INSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT

OPINION FILED NOVEMBER 21, 2003

Upon review before the FULL COMMISSION, Little Rock, Pulaski County, Arkansas.

Claimant represented by HONORABLE MICHAEL W. BOYD, Attorney at Law, Pine Bluff, Arkansas.

Respondent represented by HONORABLE GENE WILLIAMS, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed

OPINION AND ORDER

The respondent appeals a decision by the Administrative Law Judge finding that the claimant was entitled to additional benefits. Based upon our de novo review of the record, we find that the claimant has failed to meet her burden of proof. Accordingly, we reverse the decision of the Administrative Law Judge.

The claimant was employed by the respondent-employer, who happens to be her husband. Her husband's business was that of working property lines for different timber companies, marking boundary lines where timber is cut. On June 29, 2000, while the claimant was working with

her husband marking property lines on timber land, the claimant stumbled and fell. The claimant thought she twisted her left knee and felt immediate pain. The claimant did not seek medical treatment until about a month later, when she was seen by Dr. Joe Sarnicki. At that time, the claimant gave Dr. Sarnicki a history of falling in the last six weeks. She noted to Dr. Sarnicki that she had no immediate pain, but within 24 to 48 hours, she had pain in her lower back. The claimant was diagnosed with acute low back strain, with questionable radiculopathy. The claimant was seen by Dr. Sarnicki again on August 9, 2000. On August 23, 2000, the claimant was examined by Dr. Floss, Dr. Sarnicki's partner and who was also the claimant's regular treating physician. Dr. Floss ordered an MRI of the claimant's lumbar spine. This MRI was performed on September 8, 2000, and showed a mild posterior displacement of the L3-4 disc.

Dr. Floss referred the claimant to Dr. Vora, who examined the claimant on October 11, 2000. It is of interest that Dr. Vora noted that the claimant was injured "while walking and fell on the sidewalk on 6/22/00." Dr. Vora found a normal spinal curve, but tenderness in the claimant's lower back. The claimant's straight leg raising was positive on the left. Dr. Vora performed EMG/NCV tests on October 12, 2000. He concluded:

1. Left common peroneal, motor axonal neuropathy with denervation changes seen in the muscles supplied.
2. Right common peroneal motor amplitude low normal to minor reduced.
3. Bilateral posterior tarsal tunnel syndrome.

Clinical correlation required.

Dr. Vora did not attribute any of these findings to an injury. He last examined the claimant on October 25, 2000, and observed tenderness on the lower left lumbar area and positive straight leg raising test on the left. He noted there was no lumbar spasm. Dr. Vora scheduled the claimant for an appointment on November 22, 2000, but the claimant did not return. The claimant testified that Dr. Vora was "hateful" to her and that she asked the respondent-carrier for a different doctor to examine her.

The claimant was examined by Dr. Robert Germann, a neurosurgeon, on November 21, 2000. Dr. Germann's exam yielded completely normal results. Dr. Germann opined that the claimant had discogenic low back pain and peroneal neuropathy on the right. Dr. Germann concluded:

There is no indication for any surgery at this point and this is what I would do. There is no indication for any lumbar radiculopathy based upon the neurological findings as well as the neurological examination, the MRI, and the EMGs which show no evidence of

lumbar radiculopathy. I suggested that she follow up with her family doctor and her orthopedic surgeon for evaluation of the tarsal tunnel syndrome. I would suggest referring her to a pain clinic.

The claimant returned to Dr. Floss on December 6, 2000, who noted no objective abnormalities of the back or legs. Again, in February, 2001, there were no objective findings of abnormality documented in an exam by Dr. Floss, as well as examinations in July, 2002, and in August, 2002.

The claimant was ultimately referred to Dr. Reginald Rutherford, who examined the claimant on February 15, 2001. The claimant's examination noted inconsistent responses to testing. Dr. Rutherford noted:

She demonstrated clear cut propensity to over react to stimuli such as pin prick examination of the cranial nerves. There was also clear cut evidence of inconsistency, straight leg raising maneuver being resisted with attendant complaint of significant pain in the low back at 30 degrees elevation. On independent testing each lower extremity in supine position with seated distracted testing being unrestricted to 90 degrees extension on independent testing of each lower extremity.

With respect to the allegation of peroneal neuropathy, it was not possible to demonstrate any evidence of impaired motor function of the dorsiflexors and everters of either lower extremity. The reflexes were graded as normal and symmetrical on testing . . . knee and ankle jerks. Plantar response was flexor bilaterally. Sensory examination revealed equal appreciation of pin

prick, vibration and joint position sense all four extremities. . . .

Ms. Lindsey's examination fails to demonstrate any objective abnormalities which would reasonably account for her pain-related complaints. Her diagnostic testing to date comprises an MRI study of the lumbar spine which fails to disclose any significant abnormality and an EMG/Nerve Conduction Study with reported abnormalities which are without clinical counterpart and difficult to reconcile with her subjective complaints for history of injury. The overall picture at this point suggests that Ms. Lindsey's complaints are predominantly, if not exclusively, behavioral in nature representative of chronic pain syndrome.

Dr. Rutherford conducted another EMG/NCV test on March 7, 2001. The tests yielded normal results.

Dr. Rutherford noted that there was no evidence of lumbar radiculopathy, lumbosacralplexopathy, peripheral neuropathy/compression neuropathy that would contribute to the claimant's complaints. A bone scan was also normal.

Dr. Rutherford met with the claimant to discuss the results of her tests on that date and he advised the claimant to stop taking Vicodin and Soma, which had been prescribed by Dr. Floss. He was concerned about the potential of addiction with the Vicodin. Dr. Rutherford noted that neither Soma nor Vicodin were agents that had any value in the treatment of chronic pain and were subject to misuse and abuse. He

advised the claimant to discontinue both and substitute amitriptyline and a TENS unit.

On April 13, 2001, the claimant called Dr. Rutherford's office with a self-diagnosis, stating that the amitriptyline had caused numbness in her left side. She told Dr. Rutherford's office that she had received medicine from Dr. Floss. This medicine included carisoprodol and hydrocodone, which were the two agents that Dr. Rutherford had advised the claimant to stop taking. At that time, Dr. Rutherford discharged the claimant from his care for being noncompliant.

The claimant has the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary. Norma Beatty v. Ben Pearson, Inc., Full Commission Opinion, Feb. 17, 1989 (D612291); B.R. Hollingshead v. Colson Caster, Full Commission Opinion, Aug. 27, 1993 (D703346). Employers are only liable for medical treatment and services which are deemed reasonably necessary for the treatment of employees' injuries. DeBoard v. Colson Co., 20 Ark. App. 166, 725 S.W.2d 857 (1987). In workers' compensation cases, the burden rests upon the claimant to establish his/her claim for compensation by a preponderance of the evidence. Kuhn v. Majestic Hotel, 50 Ark. App. 23, 899 S.W.2d 845 (1995); Bartlett v. Mead Container Board, 47 Ark. App. 181, 888

S.W.2d 314 (1994). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Commission Opinion, Dec. 13, 1989 (D512553).

A review of the evidence indicates that additional medical treatment is not warranted. A month after the claimant allegedly hurt her back, she first sought medical treatment, complaining of "several occasions of falling in the last six weeks" with "no immediate pain." This history is completely opposite of the claimant's dramatic testimony of an immediate pain that "felt like a million and one hundred rockets." Dr. Sarnicki, when he first evaluated the claimant, found tenderness over the claimant's SI joint, but did not record any palpated spasm. Dr. Floss, referring to Dr. Sarnicki's notes, indicated that he could not tell what was actually occurring with respect to a muscle spasm at the time. There was straightening on the claimant's x-ray, which would suggest spasm, but Dr. Floss conceded that straightening could have had other causes.

When Dr. Floss first examined the claimant on August 23, 2000, he suggested several labels, including sacroiliitis, sciatica, possible herniated disc, and degenerative disc disease. However, none of these diagnoses were borne out in any of the objective tests that were

conducted on the claimant. The claimant's bone scan was normal. The EMG/NCV tests in October 2000 did not confirm sciatica or radiculopathy. Further, the claimant had a normal EMG/NCV test in March of 2001. The MRI performed on September 8, 2000, showed only mild posterior displacement at the L3-4 disc. Simply put, there are absolutely no objective testings that indicate that the claimant had any sort of objective findings. However, there are some inconsistencies with respect to the claimant's psychological basis for her symptoms. Dr. Rutherford testified that he thought there was evidence of psychological involvement in terms of the claimant's varied subjective complaints. When the claimant described to Dr. Rutherford that it felt like "a million and one hundred rockets going off" and that her "back and legs exploded", Dr. Rutherford agreed that these descriptions possibly indicated conscious or unconscious exaggeration of symptoms. This dramatic description of symptoms was never recited to any of the physicians who had examined the claimant within the months following the incident.

When Dr. Rutherford discharged the claimant, she had called his office complaining of numbness in her left side, which she attributed to the use of amitriptyline. In her deposition, the claimant gave a detailed description of the symptoms she thought were due to the drug. She

testified that within an hour her symptoms included numbness, constriction of the throat, increased heart rate, and breathing difficulties. When Dr. Rutherford was given this description at his May 21, 2002, deposition, he testified that the symptoms sounded like an anxiety attack. He also testified that the symptoms were quite unlikely to be attributable to amitriptyline. However, he was unable to examine the claimant, as she did not show up for her visit on that date. Dr. Rutherford opined that it was most likely caused by the carisoprodol which the claimant was taking against his advice.

Physicians Desk Reference, (7th Ed. 2003) at page 3255 states:

On very rare occasions, the first dose of carisoprodol has been followed by idiosyncratic reaction with symptoms appearing within minutes or hours. These may include extreme weakness, transit quadriplegia, dizziness, ataxia, temporary loss of vision, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion, and disorientation. ... Severe reactions have been manifested by asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock.

The unequivocal evidence is that the claimant had self-reported subjective symptoms to her family doctor. She has been referred to three different specialists and stopped treatment with each of these or has refused to follow their

recommendations. Therefore, when we consider all the evidence, we cannot find that the claimant has proven by a preponderance of the evidence that she is entitled to any additional medical treatment. We recognize that objective findings are not necessary for an award of additional medical treatment. However, we would note that the claimant in this case has failed to follow doctors' orders and has purely subjective symptoms at this time. Accordingly, we hereby reverse the decision of the Administrative Law Judge.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.

DISSENTING OPINION

_____I must respectfully dissent from the opinion of the majority finding that claimant is not entitled to any additional medical treatment.

The allegation that claimant failed to follow doctor's orders is not supported by the greater weight of the evidence. This criticism of claimant is based primarily

on the opinions and conduct of Dr. Reginald Rutherford. This reliance is misplaced.

Dr. Rutherford's abuse of injured workers is practically legendary. He is insensitive, hostile, and downright vindictive. Further, a frequent grievance of injured workers is that Dr. Rutherford is condescending toward them, he ignores their complaints, and he often humiliates them. Moreover, he has no shame when engaging in rank speculation to assist respondents in efforts to deny or delay appropriate treatment and indemnity benefits to legitimately injured workers. In my view, Dr. Rutherford's opinions lack credibility and are entitled to no weight whatsoever.

After claimant was forced by respondent to come under the care of Dr. Rutherford, Dr. Rutherford predictably began laying down a paper trail of an injured worker who has no objective findings, who exaggerates her symptoms, and who exhibits a significant psychological and/or emotional component to her condition. To his atypical credit, however, Dr. Rutherford did initiate conservative treatment in the form of a TENS unit and the prescribed drug Amitriptyline.

Claimant took her first dose of Amitriptyline on a Friday night. Almost immediately after taking this medication, claimant began to experience significant and serious adverse physical symptoms. She tried to reach

Dr. Rutherford, but these efforts were unsuccessful. Claimant did the next best thing by contacting Dr. Floss, her family physician, who had also provided treatment for the work-related injury. Dr. Floss's office advised claimant to discontinue the Amitriptyline. When claimant informed Dr. Rutherford's office of this situation, Dr. Rutherford overreacted by discharging claimant from his care for perceived "noncompliance." He then authored his usual report stating that there was nothing wrong with claimant, that she is not entitled to any additional treatment for her work-related injury, and that she could return to any work without restrictions.

Amazingly, Dr. Rutherford insisted that claimant could not have had an adverse reaction to the Amitriptyline. How could he possibly have known? He never examined her, much less spoke to her personally. Incidentally, Dr. Floss credibly pointed out that he has considerable difficulty prescribing medication for claimant because she is so sensitive to many drugs.

Additionally, Dr. Rutherford never sought to ascertain whether claimant benefitted from the TENS unit. (In fact, claimant testified that the TENS unit appeared to give her some relief.) It seems incredible to me that Dr. Rutherford can believe on one day that claimant needs conservative treatment in the form of a TENS unit and

prescription medication, as well as additional diagnostic studies, and then the next day conclude that claimant's symptoms are all in her head and she can return to work without any restrictions.

Finally, I note that claimant has been chastised for her alleged "self-diagnosis" concerning the reaction to Amitriptyline. She certainly received no help in this regard from Dr. Rutherford, who prescribed the drug. Be that as it may, I would say it was a pretty good "self-diagnosis" when claimant experienced debilitating symptoms immediately after, or contemporaneously with, the taking of a new prescription medication and the symptoms subsided when she stopped taking the drug on the advice of her family physician.

In my opinion, claimant has met her burden of proving by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable injury. Any reliance on Dr. Rutherford is totally misplaced. Accordingly, the opinion of the Administrative Law Judge should be affirmed.

SHELBY W. TURNER, Commissioner