NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E012523

RALPH GOULD,
EMPLOYEE — CLAIMANT

JOHN & LAVONNE COPELAND,
EMPLOYER — RESPONDENT

HARTFORD,
INSURANCE CARRIER — RESPONDENT

OPINION FILED OCTOBER 6, 2004

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

Claimant represented by HONORABLE JAY TOLLEY, Attorney at Law, Fayetteville, Arkansas.

Respondents represented by HONORABLE CURTIS NEBBEN, Attorney at Law, Fayetteville, Arkansas.

Decision of the Administrative Law Judge: Affirmed and adopted.

OPINION AND ORDER

The respondents appeal and claimant cross-appeals from a decision of the Administrative Law Judge filed March 17, 2004. The Administrative Law Judge entered the following findings of fact and conclusions of law:

1. All prior opinions are res judicata and the law of this case.

2. The claimant is permanently and totally disabled as a result of his compensable injury.

3. The claimant has shown by a preponderance of the evidence that he is entitled to

additional medical treatment at the expense of the respondents for the treatment of his compensable injuries.

4. The respondents controverted this claimant's claim for additional medical treatment in December 2002.

5. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

We have carefully conducted a de novo review of the entire record herein, and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings of fact made by the Administrative Law Judge are correct, and they are, therefore, adopted by the Full Commission.

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2002).

Since the claimant's injury occurred prior to July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as it existed prior to the amendments of Act 1281 of 2001. Compare Ark. Code Ann. § 11-9-715(Repl. 1996) with Ark. Code Ann. § 11-9-715 (Repl. 2002). For prevailing on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of $250.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 1996).

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

Commissioner Turner concurs.

CONCURRING OPINION

I concur with the principal opinion's findings that claimant is entitled to additional medical treatment subsequent to December 2002 and that claimant's attorney is entitled to a fee based on respondents' controversion of this treatment. I concur only to point out that claimant's attorney cross-appealed the Administrative Law Judge's failure to make findings on additional issues concerning attorneys' fees. Claimant's attorney brought this omission to the attention of the Administrative Law Judge. However,

the Administrative Law Judge informed claimant's attorney that he must request another hearing to address these specific issues. Thereafter, a majority of this Commission denied claimant's motion for a stay of the appeal and a remand to the Administrative Law Judge for additional proceedings on these issues. I believe claimant's attorney has done all he can to preserve these issues for a determination at a later date.

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority Opinion affirming and adopting the decision of the Administrative Law Judge for the following reasons.

By way of history, on May 21, 1990, the claimant suffered a heart attack after climbing down from a work ladder. Following this episode, the claimant, who was 38 years old at that time, presented at the emergency room with a history of obesity, substance abuse, frequent indigestion, chest fullness, arm pain, and heavy smoking. The claimant was treated for myocardial infarction (MI), and later

assessed with hyperlipidemia and diabetes mellitus type II. On June 7, 1990, Dr. J.B. Weiss performed triple coronary artery bypass surgery, implantation of an AICD and intra-aortic balloon pump, and Swan Ganz catheter. The claimant was discharged on June 14, 2003, and seen thereafter in follow-up by Dr. Joel Carver.

Upon Dr. Carver's retirement in 1996, Dr. Michael Green assumed treatment of the claimant's heart condition. The claimant is treated by Dr. Bell for his diabetes. Despite the claimant's history of myocardial infarction, congestive heart failure, and progressive coronary artery disease, Dr. Green reported that the claimant was in stable condition at the time he came into is care. Dr. Green assessed the claimant as a Class I or II in terms of risk, which meant that the claimant should have been able to live an active life as long as he took his medication and watched his diet.

On November 12, 1996, the claimant underwent a routine change out of his AICD. At that time the claimant was noted to have three vessel coronary artery disease, as was evidenced by a 100% proximal native right coronary artery occlusion. The claimant's left descending artery was 50% blocked and the circumflex was 75% stenosis in mild

segment. The right coronary artery saphenous vein graft was occluded, the left mammary artery was patent, and the saphenous vein graft to the third obtuse marginal was noted to have 95% proximal stenosis. It was documented that the claimant has had severe problems in regards to ongoing coronary artery diseases as well as abnormal electrical rhythm disturbance. The claimant underwent another abdominal AICD ex-plant on July 3, 2001, at which time a new AICD/dual chamber pacing system was implanted.

The claimant was hospitalized again on May 2, 2001, for, among other things, ischemic cardiomyopathy and arrhythmia, pneumonia, and congestive heart failure. The claimant was diagnosed at that time with unstable angina with occluded saphenous vein grafts X2, ventricular tachycardia, and arteriosclerotic heart disease. By the end of May, 2001, the claimant began having episodes of dizziness and falling, and by July, the claimant exhibited peripheral edema. On July 28, 2002, the claimant presented to the ER in Eureka Springs with severe dyspnea, and when his blood gases showed him to be hypoxemic, hypercapnic, and acidotic, he was referred Northwest Medical Center where he was admitted with the diagnosis of pulmonary edema and acute respiratory failure. The claimant was discharged from NMC on

August 2, 2002, with a final diagnosis which included chronic pulmonary edema with respirator/arrest and chronic obstructive pulmonary disease (COPD). The claimant required intubation during this hospital stay.

On November 3, 2002, cardiologist, Dr. Russell Enke, performed a peer review from which he noted that the sudden onset of the claimant’s cardiac event on May 21, 1990 was definitely related to circumstances involved with his work related activities. Dr. Enke further opined, however, that the claimant’s symptoms were highly suggestive of coronary artery disease prior to his cardiac event of May 1990. In a letter dated September 15, 2003, Dr. Enke wrote:

> It is my opinion that the medications, which he is taking related to his coronary artery disease and his diabetes, are crucial to his well being, but I do not feel that his ongoing medications are related to the incident of May 21, 1990. He had a long-standing history of coronary artery disease long before the incident, and this was corroborated by cardiac catheterization, which revealed three vessel coronary artery disease. ... I do not believe that his cardiac arrest was due to the development of de novo coronary artery disease.
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> He obviously had the inexorable progression of coronary artery disease before and subsequent to his cardiac event. He was a high-risk candidate for a coronary event at any time prior to

> the accident, but I do not believe that his current cardiovascular status is related to the incident in question.

Likewise, in his clinical assessment of the claimant's medical history dated March 10, 2003, Dr. Casey G. Cochran opined that, although the claimant's sudden onset MI of May 1990 was obviously work related, the claimant had severe three vessel coronary disease which antedated the cardiac event. Moreover, Dr. Cochran stated:

> [E]ven if the claimant had not had an event on 05/21/90, in all probability, he would be in the same position that he is in today. The effects of his significant disease would have progressed irrespective of whether or not the event of 05/21/90 occurred. Thus, his ongoing need for treatment would not be secondary the 05/21/90 event, but rather to the progression of the coronary artery disease, which is in no way related. The current heart condition would not therefore, be related to the event of 05/21/90. Therefore, while he does require treatment for his condition, which includes coronary artery disease, diabetes, and hyperlipidemia, these treatments are for conditions that are not specifically related to the 05/21/90 activity.

Dr. Cochran further opined that the claimant's athersclerotic heart disease, his diabetes, and his hyperlipidemia are "diseases of life" that would have been

present regardless of his cardiac event of 1990. Furthermore, Dr. Cochran stated that the claimant's original injury was an acute MI, which had required no further treatment for quite some time after that which he received immediately following this event.

In contradiction to the opinions of Dr. Enke and Dr. Cochran, in his deposition of September 3, 2003, Dr. Green stated conclusively that the claimant's current heart condition, which he described as systolic dysfunction, is resultant from his MI of May 1990. Had the claimant's most recent heart failure been caused by coronary artery disease, according to Dr. Green his current dysfunction would be diastolic as opposed to systolic. Likewise, Dr. Green opined that the claimant's ventricular arrhythmia and ischemic cardiomyopathy (which causes congestive heart failure), are directly resultant from his heart attack of 1990. However, Dr. Green agreed that the claimant's coronary artery disease predated his heart attack of 1990, and he further admitted that diabetes with uncontrolled high blood pressure can cause systolic dysfunction. Dr. Green stated that he was unaware whether or not the claimant was diabetic prior to his 1990 MI.

The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value Poulan Weed Eater v. Marshall, 79 Ark. App. 129, 74 S.W.3d 878 (2002). The Commission may accept only those portions of testimony that it determines are worthy of belief. Tucker v. Roberts-McNutt, 342 Ark. 511, 29 S.W.3d 706 (2000). Furthermore, it is well established that it is within the Commission's province to weigh all the medical evidence and to determine what is most credible. Smith Blair, Inc. v. Jones, 77 Ark. App. 273, 280, 72 S.W.3d 560 (2002). Finally, the Commission is entitled to review the basis for a doctor's opinion in deciding the weight and credibility of the opinion and medical evidence. Id.

I find that all three doctors - Green, Cochran, and Enke - are competent and that they each present credible opinions in this claim. However, the totality of the medical evidence weighs in favor of the opinions of Dr. Cochran and Dr. Enke over that of Dr. Green. All three of these doctors agree that the claimant's coronary disease predates his cardiac event of 1990. Two of these doctors, Cochran and Enke, agree that the claimant's cardiac event was secondary to his coronary disease, and that his current condition is due to the progression of his coronary artery disease rather

than his compensable heart attack. Basically, the claimant recovered from his acute MI in the sense that he received appropriate medical treatment for that injury, including surgery to correct the blockage which had essentially caused his sudden onset heart attack. Since that time, the claimant has developed more blockages due to his progressive coronary disease, which again, predated his heart attack of 1990. Even Dr. Green admitted that the claimant now functions on one artery, and that because of his “silent ischemia,” which is directly due to his diabetes, he continues to develop worsening failure. Although the claimant may suffer from systolic dysfunction rather than diastolic, the fact the claimant’s diabetes is a possible cause of systolic dysfunction, even if indirectly, and that it complicates his current condition cannot be ignored.

An employer must promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W.2d 750 (1984). Furthermore, the claimant must prove by a preponderance of the evidence that

he is entitled to additional medical treatment. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.3d 543 (1999). In order to do that, the claimant must also prove a causal connection between the work related accident and the later disabling injury. Bates v. Frost Logging Co., 38 Ark. App. 36, 827 S.W. 2d 664 (1992). Doctors in this claim unanimously agree that this claimant must have continued medical treatment, including numerous medications, in order to survive his condition. However, the preponderance of the medical evidence in this claim fails to establish a causal connection between the claimant's compensable heart attack and his disabling coronary disease and its continuing physical results.

In conclusion, the weight of the medical evidence shows that the claimant's compensable heart attack, for which he received all necessary and appropriate medical treatment and services, was due to his pre-existing coronary disease, regardless of any physical activity which eventually caused the claimant's sudden onset cardiac event. Moreover, it is well documented that the claimant has developed new blockage since the time of his compensable heart attack. This new blockage is an obvious result of the claimant's progressive coronary artery disease. In addition,

it is evident that the claimant's diabetes is a significant contributing factor to his current physical condition, and that it is a possible cause of the claimant's systolic dysfunction. The claimant's current physical problems are clearly caused by "diseases of life" which would have been present regardless of his 1990 cardiac event. Based upon the above and foregoing, the claimant has failed to prove by a preponderance of the evidence that he is entitled to additional medical treatment.

Therefore, for all the reasons set forth herein, I respectfully dissent from the majority opinion.

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KAREN H. McKINNEY, Commissioner