BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F109543

BOBBY STEWART,
EMPLOYEE — CLAIMANT

ARKANSAS GLASS CONTAINER,
SELF-INSURED EMPLOYER — RESPONDENT

RISK MANAGEMENT RESOURCES,
THIRD PARTY ADMINISTRATOR — RESPONDENT

OPINION FILED DECEMBER 15, 2004

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

Claimant represented by HONORABLE KRISTOFER E. RICHARDSON, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by HONORABLE DAVID LANDIS, Attorney at Law, Jonesboro, Arkansas.

Decision of the Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed June 28, 2004. The administrative law judge found that the claimant proved he was entitled to additional medical treatment. After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. The Full Commission finds that the claimant did not prove he was entitled to additional medical treatment.

I. HISTORY

Bobby Ray Stewart, age 38, testified that he was employed with Arkansas Glass Container. An x-ray of Mr. Stewart's lumbar spine on February 18, 1996 revealed "wedging of multiple vertebrae with no acute injury seen."

The parties stipulated that an employment relationship existed on August 8, 2001. The claimant testified, "I felt something pull in my back." The parties stipulated that the respondents provided medical treatment and temporary total disability compensation.

A CT of the lumbar spine was taken on August 17, 2001, with the following conclusion:

> 1. Broad based HNP at L5-S1 with compression of both S1 nerve roots.
> 2. Disc bulge at the other levels with slightly small canals but not the same degree of nerve compression as at L5-S1.

Dr. Jerry Engelberg, a neurological surgeon, treated the claimant conservatively. Dr. Engleberg wrote on October 10, 2001 that the claimant would not benefit from surgery. The claimant subsequently began undergoing physical therapy. The claimant also treated with Dr. Terence P. Braden, III, an osteopathic physician.

The following conclusion resulted from a lumbar myelogram taken April 12, 2002:

> Mild posterior disc bulging levels L1 through L4 without significant spinal stenosis.
>
> Old anterior wedge compression fracture of L1, with loss of anterior height less than 10%.

And a CT of the lumbar spine post-myelogram was taken on April 12, 2002, with the following conclusion:

> 1. Mild degenerative circumferential disc bulging, L2 through S1, without significant spinal canal or neuroforaminal stenosis.
> 2. Old, mild anterior wedge compression fracture of L1 with loss of anterior height, less than 10%.

The impression of an orthopaedic surgeon, Dr. R. Edward Cooper, Jr., on April 25, 2002 was "Disc bulging L5-S1 with some lateral recess stenosis worse on the left than on the right which appears to be mild enough that he should be able to get over this without surgery." Dr. Cooper wrote on October 16, 2002, "He does have some changes of his lumbar spine, but I am confident that the majority of his symptoms are emanating from the SI joint."

Dr. Earl Peeples, an orthopedist, independently evaluated the claimant on June 27, 2002 and concluded:

> I reviewed the most recent studies of the myelogram and post myelogram CT of April 12, 2002. The radiologist had interpreted these as showing no major compression. I reviewed these with one of the radiologists at Baptist Hospital, as my own review did not indicate evidence of major compression of the exiting nerve roots at L5-S1. He also agrees with this. This analysis disagrees

> with Dr. Cooper's analysis of severe foraminal stenosis.
>
> This patient does not have clear cut surgical indications and I think that the L5-S1 level by myelogram and post myelogram CT is near normal. He does have an unusual affect. It is my recommendation that psychological profile testing, such as that provided by Dr. Winston Wilson, be considered to see if there can be identified any other factors that might contribute to pain....

Dr. Winston T. Wilson, a psychologist, saw the claimant on July 28, 2002 and diagnosed "Hypochrondirasis (sic)."

A pain clinician, Dr. Moacir Schnapp, examined the claimant on October 31, 2002 and reported "a moderate degree of paravertebral spasm." Dr. Schnapp diagnosed "lumbar facet arthropathy with myofascial pain" and "depression." Dr. Schnapp stated, "He does have visible and palpable spasms, which is an objective indication of his pain." Dr. Schnapp performed a "medial branch nerve block, right L4, L5 and S1."

The claimant visited Dr. Schnapp on November 12, 2002:

> Mr. Stewart returns stating that he got no relief with the medial branch block....
>
> The only identifiable problem that I saw on the initial evaluation was what appeared to be muscle spasm but higher up where he complains of the pain. I re-evaluated him today and indeed, there is increased muscle tone that area but after he flexes the trunk, this essentially decreases and almost disappears.

> I do believe that this is possibly unconscious but voluntary muscle contraction, as opposed to muscle spasm. We offered him the option of proceeding with trigger point injections to see if this somehow could help him but the patient is phobic of needles and he refused the injections....
>
> After discussing with the patient, his wife and the case manager, I believe that we have actually reached maximum medical improvement. From an objective standpoint, I cannot place him on any specific limitations and I will therefore release him to go back to work without limitations....According to the AMA Guidelines for Permanent Physical Impairment, Mr. Stewart does not have an objective permanent physical impairment.

The record indicates that the respondents controverted additional medical treatment after November 12, 2002.

The claimant returned to Dr. Cooper on December 2, 2002:

> He went to the Mayes-Schnapp clinic where he was evaluated thoroughly and underwent two visits and received injections, but these did not help him significantly. Today he relates that he continues to have low back pain which is incapacitating causing him not to be able to do his job.
>
> Today I reveiwed (sic) his notes from before which include Dr. Peeples notes and a psychological evaluation was done in Little Rock which did test positive for hyperchondriasis (sic) and Dr. Peeples did not feel that he was a surgical candidate. Certainly I don't feel that he is a surgical candidate as well. Really there is nothing further that we can offer him from a surgical standpoint.
>
> He has also failed a try of work hardening and pain management. Therefore, I really think his

> options have played out. He has no significant objective findings. Therefore, his impairment rating is 0. I discussed these facts with he and his wife and recommended further treatment with a psychiatrist, but he does not wish to pursue this. Instead, he wishes a referral to a neurosurgeon.

Dr. Cooper's impression was "Low back pain with hypochondriasis."

A neurosurgeon, Dr. Gregory F. Ricca, saw the claimant on February 17, 2003. Dr. Ricca's impression was "1. Low back pain, bilateral hip pain with numbness and tingling into the lateral feet. 2. Degenerative disc disease with a central HNP at L5-S1 eccentric to the left." Dr. Ricca planned a lumbar discogram and reported on July 1, 2003:

> I had the pleasure to see Mr. Stewart for follow-up of discography by Dr. Hart on 6/11/03. I reviewed this study in detail as well as discography pictures and the post-discogram CT done at St. Vincent on 6/11/03. This patient has severe degenerative disc at L5-S1 with concordant pain. There is dye extending into the canal, which appears to cause compression of the left S1 root. This is his most severe level. L4-5 was a normal control. L3-4 also had severely disrupted disc with concordant pain. At L2-3 and L1-2 the discs were also markedly disrupted and produced some pain though the pain was not concordant.
>
> I used the picture of the lumbar spine and talked with the patient and his wife about posterior lumbar interbody fusion and how this is used to treat discogenic pain....I reviewed the pros and cons of proceeding with a PLIF at L5-S1 only versus a PLIF at L5-S1 and L3-4. After much consideration, I felt that if this patient had surgery his best option I believe would be to

> proceed with a PLIF only at L5-S1. I explained that this probably would improve his pain by anywhere from 30-70% but there is a possibility it would do him no good at all....

Dr. Jim J. Moore independently examined the claimant and wrote to the respondents' attorney on March 9, 2004:

> The patient has a good back range of motion and I do not palpate any spasm in the paraspinous muscle groups cervical, thoracic or lumbar. The patient has an intensely exquisite trigger in the right sacroiliac and quadratus lumborum insertion as well as at the iliolumbar angle. Stressing this area does cause him some discomfort.
>
> I have reviewed the various studies mentioned above. There is evidence of degenerative disk disease on all of these studies. He has a rather good looking disk at the L4/5 level, this even with diskography. Actually there is more disturbance in the disks at L2/3, L3/4 on the diskogram than there is L5/S1. The patient tells me that he has no recall of being wakened during the time of the diskogram so he cannot tell me whether or not it gave him pain or not nor at which level. Dr. Hart's report of 6-11-03 reflects that the patient did have pain at the L5/S1 injection and also L3/4, moderate pain L2/3, L1/2. I have also reviewed Dr. Ricca's note of 7-01-03. He is suggesting a posterior lumbar interbody fusion at L5/S1 alone. He indicates probable improvement of 30 to 70% as far as the patient's pain is concerned but he does indicate a possibility that it would do him no good at all.
>
> There is no question the patient has degenerative disk disease with some dye extravasation but he is intact neurologically. He has a very significant trigger as described above. Therefore, I believe that the possibility of false nerve pain could enter into this equation. I realize the patient has had epidural steroid injections but I do not believe that he has had any direct investigation

> as far as the trigger that is demonstrated to me today. I also feel that the patient and his lady have probably some unrealistic expectations for surgery. I certainly am sympathetic towards their desire to get better but I am not sure that any surgical exercise would necessarily provide this. I would also recommend that he have an EMG/Nerve Conduction Velocity Study. It may give some direction.
>
> The orthopedic and neurosurgical groups are not unanimous in there (sic) acceptance of this aggressive type of surgery in the diagnosis of "diskogenic pain". Having said that certainly this is a procedure that is accomplished not infrequently and for this diagnosis. However, as I indicated above I believe that a great deal of this patient's pain is pseudoneurologic, pseudoradicular based upon my findings on examination today. The patient shows absolutely no abnormality neurologically nor is there any particular range of motion restriction that would suggest primary spinal axis disease. I am inclined to believe that the majority of the patient's findings of degenerative disk disease likely preceded the episode of 2001. Certainly early investigation including that in Memphis would support this opinion. It is not felt that this patient manifests a situation that his problems are in excess of 51% relationship to the industrial injury.

Dr. Moore diagnosed "1. Lumbar DDD. 2. Spinal enthesopathy. 3. Lumbar radiculitis."

The claimant testified at hearing that his condition was "getting worse." The claimant testified that he would like to undergo surgery. The administrative law judge found, "Medical treatment rendered to the claimant subsequent to the last payment of same by respondent is

reasonably necessary relative to the August 8, 2001, compensable injury." The respondents appeal to the Full Commission.

II. ADJUDICATION

The 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). 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.2d 543 (1999). 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).

In the present matter, the Full Commission finds that the claimant did not prove he was entitled to surgery by Dr. Ricca. The record shows that the claimant had "wedging of multiple vertebrae" before the compensable injury. The claimant testified that he injured his back at work in August 2001, and the parties stipulated that the claimant received temporary total disability compensation and medical treatment. A CT of the lumbar spine in August 2001 showed a broad-based herniated nucleus pulposus at L5-S1 with

compression of both S1 nerve roots. Dr. Engleberg, a neurological surgeon, opined in October 2001 that the claimant would not benefit from surgery. Dr. Cooper, an orthopaedic surgeon, reviewed additional diagnostic testing and stated in April 2002, "he should be able to get over this without surgery." Dr. Peeples in June 2002 could not find any "clear cut surgical indications." Dr. Peeples thought there might be a non-organic basis for the claimant's pain and recommended a psychological referral.

On November 12, 2002, Dr. Schnapp pronounced maximum medical improvement and determined that the claimant had sustained no anatomical impairment. Dr. Cooper reiterated in December 2002 that the claimant was not a candidate for surgery. Like Dr. Schnapp, Dr. Cooper opined that the claimant had sustained zero anatomical impairment. Dr. Cooper determined that the claimant's options "had played out." Dr. Cooper did not recommended additional pain management or physical therapy but did recommend a psychiatric referral, which the claimant declined. The Full Commission recognizes that Dr. Ricca saw the claimant in February 2003 and subsequently discussed with the claimant the option of a "posterior lumbar interbody fusion." However, Dr. Ricca also discussed the possibility that such

surgery would "do him no good at all." Nor did Dr. Ricca causally relate the proposed surgery to the claimant's compensable injury. The Full Commission also notes Dr. Moore's expert opinion in March 2004 that the claimant showed "no abnormality neurologically." Dr. Moore opined that "the majority of the patient's findings of degenerative disk disease likely preceded the episode of 2001."

The Commission is authorized to accept or reject medical opinion and is authorized to determine its medical soundness and probative force. McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989). In the present matter, the Full Commission attaches significant probative weight to the opinions of Dr. Engelberg, Dr. Cooper, Dr. Peeples, Dr. Schnapp, and Dr. Moore. None of these physicians opined that surgery for the claimant was reasonably necessary in connection with the claimant's compensable injury. Further, even though Dr. Ricca did recommend a posterior lumbar interbody fusion at L5-S1, Dr. Ricca did not causally relate this surgery to the claimant's compensable injury.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove by a preponderance of the evidence that he was entitled to additional medical treatment. The Full Commission therefore

reverses the decision of the administrative law judge, and we deny and dismiss this claim.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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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. Notwithstanding whether claimant has proven by a preponderance of the evidence that back surgery is reasonably necessary in connection with the compensable injury, claimant has met his burden of proving entitlement to additional medical treatment.

In August 2001, claimant sustained an admittedly compensable injury to his lower back. Respondent apparently paid appropriate benefits for a period of time. Diagnostic tests performed shortly after the accident revealed a herniated nucleus pulposus at L5-S1, with compression of the S1 nerve roots. Even respondent acknowledges in its brief to the Full Commission that claimant's compensable injury is

established with medical evidence supported by objective findings.

In November 2002, Dr. Schnapp identified a trigger point and offered claimant therapeutic injections. When claimant refused to undergo this treatment at that time, Dr. Schnapp authored a report stating that claimant had reached maximum medical improvement, and had no limitations or permanent anatomical impairment. Based on this report, respondent suspended the payment of all benefits.

Claimant continued to suffer debilitating symptoms. Since respondent controverted claimant's entitlement to any additional benefits, claimant had to seek medical treatment on his own. For the first time, claimant was able to be evaluated by physicians who had not been chosen by respondent. A discogram performed in June 2003 revealed persistent compression of the S1 nerve root. When Dr. Ricca, claimant's treating neurosurgeon, began to discuss surgical options, respondent again became involved and directed claimant to Dr. Moore. While there is certainly some disagreement over whether surgery is a viable option for the treatment of this condition, Dr. Moore did recommend treatment for the inveterate trigger point, as well as electrodiagnostic studies to further delineate the

extent of claimant's abnormalities. Respondent continued to neglect its obligations to provide reasonably necessary treatment in spite of the recommendations from a physician it chose to evaluate claimant's condition.

In my opinion, claimant has met his burden of proving by a preponderance of the evidence that additional medical treatment is reasonably necessary in connection with the compensable injury. Claimant should not be denied any and all treatment for his lumbar difficulties. Respondent remains liable for compensation benefits, and the opinion of the Administrative Law Judge should be affirmed. Accordingly, I must respectfully dissent.

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SHELBY W. TURNER, Commissioner