

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E907288

ALLEN WILLIAMS, EMPLOYEE	CLAIMANT
SALINE CRUSHING & EXCAVATING, EMPLOYER	RESPONDENT NO. 1
TRANSCONTINENTAL INS. CO., CARRIER	RESPONDENT NO. 1
DEATH & PERMANENT TOTAL DISABILITY FUND	RESPONDENT NO. 2

ORDER FILED SEPTEMBER 20, 2004

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

Claimant represented by the HONORABLE SILAS H. BREWER, Attorney at Law, Little Rock, Arkansas.

Respondent No. 1 represented by the HONORABLE FRANK B. NEWELL, Attorney at Law, Little Rock, Arkansas.

Respondent No. 2 represented by the HONORABLE TERRY PENCE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondent-carrier appeals from a decision of the Administrative Law Judge filed December 12, 2003, finding that the surgeries performed by Dr. Russell in January of 2003 were reasonably necessary in connection with the claimant's compensable injury and finding that the preponderance of the evidence fails to show that the claimant's motor vehicle accident in November of 2002 was an independent intervening cause of the claimant's need for

surgery. After conducting a de novo review of the entire record, and without giving the benefit of the doubt to either party, we find that the claimant has failed to prove by a preponderance of the evidence a causal relationship between his compensable injury and the surgeries performed by Dr. Russell. Therefore, we find that the decision of the Administrative Law Judge should be reversed.

The claimant contends that the respondents should be responsible for the surgeries performed by Dr. Anthony Russell in January 2003. Conversely, the respondents contend that the claimant's condition which led to the surgeries performed by Dr. Russell, is not causally related to the claimant's compensable injury. Therefore, the respondents contend that they are not liable for the January 2003, surgeries. We agree.

The claimant sustained an admittedly compensable injury on February 8, 1999. As a result of this injury, the claimant came under the care of Dr. James Cooper. In a report dated February 12, 1999, Dr. Cooper recorded the following history:

55 year-old fellow who was shoveling on 2/8/99 and strained his back and now his right leg is going numb and his back is hurting very badly. He has an

equivocally positive straight leg raise on the right. He's got normal reflexes, however.

Dr. Cooper diagnosed the claimant with a lumbar strain.

Dr. Cooper ordered an MRI due to the claimant's complaint of leg numbness.

The MRI performed on February 18, 1999, revealed:

The vertebral bodies appear normal in height, alignment and signal. Mild anterior osteophyte formation is noted at several levels with minimal posterior osteophytes at L3-4. There is diffuse loss of signal within the intervertebral discs.

At L2-3 there is mild diffuse bulging of the disc material, greatest anteriorly. No significant deformity of the thecal sac or neural foraminal narrowing is seen. At L3-4 there is also diffuse bulging of disc material which, in combination with posterior osteophyte formation and mild facet hypertrophy causes mild neural foraminal narrowing, greater on the right.

At L4-5 there is mild right paracentral posterior disc protrusion causing slight deformity of the anterior thecal sac. There are also mild diffuse bulging of disc material and bilateral facet hypertrophy causing mild narrowing of the neural foramina bilaterally. **At L5-S1 there is also mild central posterior disc protrusion, though this has no apparent mass-effect on the nerve roots or thecal sac.** The remaining disc levels

are unremarkable. The conus medullaris appears normal in contour and position. (Emphasis added)

Dr. Cooper referred the claimant to Dr. Robert Dickens, a neurosurgeon. The claimant provided Dr. Dickens with a history of initial right leg and testicle pain, but more recent left leg pain radiating into the lateral thigh and calf. After examining the claimant and reviewing the MRI scan, Dr. Dickens noted that the claimant's diagnostic film revealed disc protrusions at the lower two levels, but that the significant level was the right paracentral disc protrusion or herniation at L4-5, as that finding corresponded with the claimant's symptoms. However, Dr. Dickens noted that the claimant's findings did not warrant surgery. Dr. Dickens prescribed medication and physical therapy for the claimant at that time. In April of 1999, Dr. Dickens prescribed epidural steroid injections from which the claimant received no benefit. Due to the claimant's "significantly symptomatic" condition, Dr. Dickens ordered a lumbar myelogram. This diagnostic test was performed on May 14, 1999, along with a post myelogram CT scan. The myelogram revealed:

There is an extradural defect on the right at L3-4 with an indentation on the nerve root sleeve.

Lateral view shows an anterior extradural defect at L4-5. **The thecal sac terminates just below the L5-S1 disc interspace and there are conjoined nerve roots at L5 and S1 bilaterally.** There are no significant abnormalities of the upper lumbar spine and no abnormality is seen around the conus. (Emphasis added)

The post myelogram CT scan revealed:

At L2-L3 there is no significant abnormality. The thecal sac is normal and there is no canal or foraminal stenosis.

At L3-L4 there is facet hypertrophy and mild ligamentous hypertrophy. The AP diameter of the thecal sac is slightly greater than 1.0 cm.

At L4-L5 there is a soft tissue density in the spinal canal which extends above the disc interspace as well. The thecal sac shows significant effacement on the left side and the soft tissue density extends into the lateral recess.

**At L5-S1 there is no significant abnormality.** (Emphasis added)

After reviewing the myelogram and post myelogram CT scan, Dr. Dickens concluded that the claimant had a disc herniation with an extruded disc fragment at L4-5 on the left, for which he recommended surgery.

The claimant underwent a lumbar laminotomy with diskectomy at L4-5 on the left on June 29, 1999. Following this surgery, the claimant developed a pulmonary embolus and deep vein thrombus in his right leg for which he received treatment from Dr. Timothy Cook.

Throughout the follow-up clinic notes from Dr. Dickens, it is noted that the claimant continued to complain of persistent leg pain and numbness. Likewise, Dr. Cook noted that the claimant complained of "venous congestion in his right lower extremity." In November of 1999, Dr. Dickens ordered an MRI. This diagnostic test revealed:

Changes of left laminectomy are noted at L4-5. Mild scarring is present in the left lateral recess. There is no evidence of a recurrent disc herniation. **The remainder of the lumbar discs are normal.** No canal or foraminal stenosis is evident. The conus ends normally at the T12-L1 level. No paraspinous abnormalities are identified.  
(Emphasis added)

In a report dated November 10, 1999, Dr. Dickens noted that the claimant had severe right leg pain which was not being managed well by any of the medications he had tried. Dr. Dickens explained that the November 9, 1999, MRI

scan revealed normal findings postoperatively without any evidence of a recurrent disc herniation on either the left or the right to correlate with the claimant's current right leg pain. In Dr. Dickens' clinic note of November 23, 1999, the claimant described right leg pain, a sense of numbness in the right leg, swelling in the right leg and pain radiating into the right testicle; however, the claimant's primary complaint at that time was of "a lot of pain" in the midline lumbosacral area. Dr. Dickens recommended either a referral to a pain center or a second opinion for the claimant.

On December 15, 1999, the claimant was examined by Dr. Jim J. Moore, another neurosurgeon, for a second opinion. Dr. Moore noted the following findings during his examination of the claimant:

... He is cooperative. Heel and toe gait is well preserved. There is no evidence of atrophy, atony or fasciculations in any muscle groups. The calves measure 16 1/4" right, 15 1/2" left, 2 1/2" below the fibular head. His straight leg raising although uncomfortable is not restricted. His reflexes are nicely perceived at the patella but the achilles are difficult to elicit except with reinforcement and this is especially so on the left. Sensation is dulled in the distribution of L5 in both left and right. Toe strength and

dorsiflexion is excellent. The patient has quite a bit of tenderness in the sacroiliac triggers on the rights especially, to a lesser extent of the left and stressing the sacroiliac on the right is quite painful to him. Jugular compression is negative. There is no tenderness in the sacrosclatic notch. Back range of motion is painful and restricted about 50% in all modalities.

Dr. Moore opined that the claimant's examination suggested a peripheral possibility and he recommended a TENS unit. Dr. Moore also recommended an EMG/NCV, however, he noted that the claimant's use of Coumadin would complicate the needling procedures with this testing.

In a report dated February 10, 2000, Dr. Dickens stated:

I suspect that at least a portion of the pain that he is having in his right leg is on the basis of chronic venous stasis from his thrombophlebitis. I cannot exclude nerve root compression as contributing to this. **However, as pointed out above, 3 imaging studies over the period of time since I have seen him have failed to show a significant nerve compression on the right side.** (Emphasis added)

A Venous Doppler Ultrasound performed on February 24, 2000, revealed the presence of a visible thrombus in the right superficial femoral vein. As previous

studies showed the channel to be completely blocked, this finding was described as a partial resolution of the thrombus in the superficial femoral vein of the right lower extremity. No evidence of recent thrombus was noted.

On March 9, 2000, Dr. Dickens arranged for the claimant to undergo another myelogram which was complicated by the claimant's use of Coumadin. In his report of that date, Dr. Dickens stated that he suspected the "primary cause of the right lower extremity pain [the claimant] is having is the residual of his thrombophlebitis."

The lumbar myelogram performed on March 21, 2000, revealed:

The study is compared with the examination dated 05/14/99. At the L4 interspace, the right anterolateral surface of the contrast-filled thecal sac is effaced and slightly displaced posteriorly. The ventral surface of the thecal sac is unaffected. At the L4-L5 interspace, the disc [illegible] the ventral surface of the thecal sac and asymmetric narrowing of the contract column is observed in the frontal and oblique projections. The right and left anterior quadrants of the thecal sac are effaced and posterior-medial displacement is observed, more pronounced on the left. The caudal sac is short at the superior margin of the sacrum. No abnormality is seen at the thoracolumbar junction.

The post myelogram CT scan revealed:

L2-3 Interspace: L2-L3 interspace canal volume is adequate. Neural foramina are widely patent. No disc herniation is appreciated.

L3-L4 Interspace: The right posterior quadrant of the L3-L4 intervertebral disc is diffusely prominent and effaces the right anterior surface of the thecal sac. Soft tissue density contiguous with the disc is partially obscuring epidural fat in the neural foramen. Canal volume is marginal at this level with crowding of the nerve roots.

L4-L5 Interspace: Diffusely prominent posterior surface of the annulus is observed at L4-L5. On the 05/14/99 examination, a left posterolateral soft tissue density indented the anterior surface of the thecal sac at L4-L5. Minimal effacement of the left anterior quadrant of the thecal sac remains. Some facet and ligament hypertrophy is noted bilaterally and the laminotomy defect is seen. No evidence of major nerve root entrapment is identified. The nerve roots can be seen exiting the neural foramina above the level of the prominent disc.

L5-S1 Interspace: **The thecal sac is short and attenuated just below the disc. The disc is symmetric posteriorly and no evidence of entrapment of the nerve roots in the lateral recesses is identified.** (Emphasis added)

After receiving the myelogram and post myelogram CT scan studies, Dr. Dickens noted that the claimant possessed a defect at L3-4 for which he was a candidate for surgery. However, Dr. Dickens opined that surgery would have a limited benefit for the claimant in terms of pain reduction, specifically noting; "I think the predominant pain he is having is post phlebitic pain." Dr. Dickens prescribed 300mg. tid of Neurontin at that time, which the claimant later reported provided no benefit.

On May 2, 2000, the claimant was examined by Dr. Earl Peeples, an orthopedic surgeon. Dr. Peeples stated that he reviewed the records and radiographs which accompanied the claimant. In his review of these documents, Dr. Peeples noted the presence of a conjoined nerve root at L5-S1, without any other abnormalities being noted at this level. After examining the claimant, the medical records, and diagnostic studies, Dr. Peeples concluded:

Mr. Williams' diagnosis is of sciatic type lower extremity pain, predominantly on the right at present. A secondary diagnosis is deep vein thrombosis with residual swelling and pain. Careful reading of Dr. Dickens' notes does not indicate that he has recommended surgery. In fact, he indicated that it is his impression that it would "have a limited benefit" and that he is seeking

to pursue "other nonsurgical ways to treat his pain." I have great respect for Dr. Dickens' judgment and am inclined to feel, based on the phlebitis that is present as a cause of pain, and on the less than definitive radiographic lesion, that it would be imprudent at present to proceed with surgery. I am unable to determine from the examination whether or not leg pain is total originating in the back or whether the DVT makes a substantial contribution. I did not identify a vascular compromise in any of the extremities and the right lower extremity is compromised only in that a deep vein thrombosis has occurred...

After a failed referral for epidural steroid injections, Dr. Dickens finally offered to operate on the claimant's L3-4 disc herniation, as the claimant's symptoms had recently gotten worse. Claimant underwent a lumbar laminotomy with diskectomy at L3-4 on the right on July 21, 2000. During a follow-up visit on August 28, 2000, the claimant advised Dr. Dickens that he was initially better following surgery in that the claimant was no longer having spasms or catches in his right hip and leg, but that those had now returned. Throughout the fall of 2000, the claimant continued to report to Dr. Dickens that his back pain and right leg pain were the same. In a report dated January 4,

2001, Dr. Dickens stated that the "origin of this pain has never been identified."

When the claimant was seen by Dr. Timothy Cook for deep vein thrombosis, on February 14, 2001, Dr. Cook stated in his report; "He evidently suffered from lower extremity venous valvular insult due to the thrombus. He has come to grips with the understanding that he likely always will have some degree of lower extremity swelling."

After the claimant complained of an increase in his leg pain and subjective leg numbness during his March 2, 2001, office visit, Dr. Dickens ordered a new MRI study. This study was performed on March 11, 2001. This study revealed:

Vertebral body heights and signal are well maintained. There is no evidence of acute fracture or subluxation. At L2-3, the spinal canal and neural foramina appear widely patent. At L3-4, there is mild degenerative change seen in the facet joints and apparent mild impingement upon the right neural foramen at that level in conjunction with a very mild concentric disc bulge. At L4-5 concentric disc bulge is also evident with what appears to be a small recurrent central disc herniation. Broad-based disc bulge and degenerative changes of the facet joints with hypertrophy of the ligamentum flavum is causing moderate canal stenosis at that level. Persistent scarring is seen in

the left lateral recess. There is mild encroachment upon the neural foramen bilaterally at L4-5. **At L5-S1 a mild concentric disc bulge with no significant canal stenosis evident.**  
(Emphasis added)

After reviewing the MRI scan, Dr. Dickens stated in his March 16, 2001, report that the scan did not show a discreet disc herniation at any level. Dr. Dickens recommended that the claimant be referred to an orthopedic spinal surgeon to determine whether the claimant was a candidate for a spinal fusion.

The claimant was examined by Dr. Wayne Bruffett, an orthopedic surgeon with Arkansas Spine Center, on April 30, 2001. Dr. Bruffett noted that the claimant demonstrated positive Waddell signs, with pain upon any stimulated compression or trunk rotation. With regard to the claimant's radiographic studies, Dr. Bruffett stated that the claimant had some postoperative changes, a possible small recurrent disc herniation at L4-5, and multilevel degenerative changes. Dr. Bruffett did not recommend a spinal fusion, specifically stating; "I would not recommend any further spinal surgery for him. He seems to be debilitated today, at least subjectively, and I would

imagine that further surgery would have a high likelihood of making his condition actually worse."

The claimant was then referred to Dr. Bruce Safman with Arkansas Specialty Orthopaedic Specialists. Dr. Safman examined the claimant on May 10, 2001. After examining the claimant, Dr. Safman stated:

At this point, the patient has chronic subjective pain. He has had 2 surgical procedures without success. I have no explanation as to what is causing his current pain. He may have a small recurrent disc herniation at L4-5 but it is very small. This, I do not think, would explain the profound weakness of both lower extremities and the virtual absence of subjective sensation in both lower extremities. I have no explanation for the give-way weakness throughout the left arm and almost complete loss of sensation in the left arm either.

Dr. Safman recommended an EMG/NCV and assessed the claimant with a 12% permanent anatomical impairment rating to the body as a whole. After the claimant refused the EMG/NCV testing, Dr. Safman stated that he had little else to offer the claimant.

The claimant returned to the care of his family physician in the summer of 2001. A notation in Dr. Tilley's July 9, 2001, clinic report indicates that a referral to

Dr. Mason was attempted at that time. The next report from Dr. Tilley is dated September 24, 2002. This report recorded a chief complaint of "c/o back and [right] leg pain X a while." On November 6, 2002, the claimant was again seen at the Tilly Diagnostic Clinic at which time the claimant reported that he had been involved in a motor vehicle accident the night before. The claimant complained of a headache and pain from his lower back to the top part of his body. After a few follow-up visits in November of 2002, the claimant advised Dr. Tilley on December 2, 2002, that his condition was getting a lot worse. An MRI was scheduled at that time. This diagnostic study, which was performed on December 3, 2002, revealed:

No comparison is available. The vertebral body heights, disc spaces and alignment are maintained. There is degenerative disc desiccation from L2/3 through L5/S1 level.

The conus appears normal in position without any abnormal signal or enhancement.

At L4/5, there is small minimally enhancing central disc herniation. There is marked facet and ligamentous hypertrophy causing mild canal stenosis and bilateral neural foraminal narrowing.

**At L5/S1, there is broad-based disc bulge with small central disc herniation. There is marked facet and ligamentous hypertrophy causing moderate bilateral neural foraminal narrowing.**  
(Emphasis added)

Mild posterior disc bulge and facet ligamentous hypertrophy are seen at L2/3 and L3/4 levels. No canal stenosis is seen.

In addition to these findings, the radiologist interpreting the studies noted that the "diffuse posterior disc bulge" was "asymmetric to left..." at the L5/S1 level.

The claimant underwent surgery on January 16, 2003, for a Left L5-S1 decompressive laminectomy and discectomy which was performed by Dr. Anthony Russell, a neurosurgeon. The medical records containing Dr. Russell's examination of the claimant prior to surgery were not introduced into evidence. In an operative report Dr. Russell described the MRI scan as demonstrating "...the presence of a large disc herniation at L5-S1 on the left" which appeared to be causing direct nerve root compression.

In his post-surgical follow-up examination of the claimant on January 29, 2003, Dr. Russell noted that the claimant complained of "a reonset of severe pain in his left leg." Dr. Russell further noted that the claimant initially

reported complete relief of both right and left leg pain, despite the fact that the surgery focused on the left side. A post surgical MRI revealed the presence of a recurrent disc herniation at L5/S1 which required additional surgery on January 29, 2003.

In a letter dated March 19, 2003, Dr. Russell opined that the two surgical procedures he performed on the claimant were "...directly related to the initial injury that occurred sometime ago." Dr. Russell further stated that the claimant's more recent motor vehicle accident "served only to aggravate a preexisting condition and merely brought the findings to my attention." Dr. Russell cites the claimant's right leg improvement as the basis for his opinion.

At the respondents' request, Dr. Scott Schlesinger, a neurosurgeon, reviewed the claimant's MRIs, myelograms, and CT scan from November 1999, March 2000, March 2001, March 2002, and December 2002. Dr. Schlesinger noted the presence of degenerative disc disease in all the studies, with the most significant degeneration at L4-5 and L5-S1. Dr. Schlesinger stated that he did not see any significant changes between the December 2002 MRI and the

previous studies. Moreover, Dr. Schlesinger stated that he did not observe a herniated disc on any of the films. In short, Dr. Schlesinger stated that none of the studies he reviewed, revealed the presence of a surgically significant lesion, but rather only degenerative changes.

The burden of proof rests upon the claimant to prove the compensability of his claim. Ringier America v. Comles, 41 Ark. App. 47, 849 S.W.2d 1 (1993). There is no presumption that a claim is compensable, that the claimant's injury is job-related or that a claimant is entitled to benefits. Crouch Funeral Home v. Crouch, 262 Ark. App. 417, 557 S.W.2d 392 (1977); O.K. Processing, Inc. v. Servold, 265 Ark. 352, 578 S.W.2d 224 (1979). The party having the burden of proof on the issue must establish it by a preponderance of the evidence. Ark. Code Ann. § 11-9-704(c) (2) (Repl. 1996). In determining whether a claimant has sustained his burden of proof, the Commission shall weigh the evidence impartially, without giving the benefit of the doubt to either party. Ark. Code Ann. § 11-9-704; Wade v. Mr. C Cavanaugh's, 298 Ark. 363, 768 S.W.2d 521 (1989); and Fowler v. McHenry, 22 Ark. App. 196, 737 S.W.2d 663 (1987).

An aggravation is defined as "a new injury resulting from an independent incident." Farmland Ins. Co. v. Dubois, 54 Ark. App. 141, 923 S.W.2d 883 (1996). A recurrence is defined as "a natural and probable consequence of a prior injury." Weldon v. Pierce Brothers Construction, 54 Ark. App. 344, 925 S.W.2d 179 (1996).

The Arkansas Court of Appeals has repeatedly held:

The test for determining whether a subsequent episode is a recurrence or an aggravation is whether the subsequent episode was a natural and probable result of the first injury or if it was precipitated by an independent intervening cause. Bearden Lumber Co. v. Bond, 7 Ark. App. 65, 644 S.W.2d 321 (1983). If there is a causal connection between the primary and the subsequent disability, there is no independent intervening cause unless the subsequent disability is triggered by activity on the part of the claimant which is unreasonable under the circumstances. Guidry v. J & R Eads Constr. Co., 11 Ark. App. 219, 669 S.W.2d 483 (1984).

Georgia-Pacific Corp. v. Carter, 62 Ark. App. 162, 167, 969 S.W.2d 677 (1998).

As noted by the Court of Appeals in Davis v. Old Dominion Freight Line Inc., 69 Ark. App. 74, 77, 13 S.W.3d 171 (2000):

the overriding issue in cases involving subsequent injury or disability is 'whether there is a *causal connection* between the primary injury and the subsequent disability,' and only if such a connection exists does the question of the claimant's conduct need to be addressed.

The claimant also carries the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary in connection with the compensable injury. 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). 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).

After an exhaustive review of the medical evidence, we find that the claimant has failed to prove a

causal connection by a preponderance of the evidence between the defect at L5-S1 operated on by Dr. Russell in 2003 and the claimant's 1999 compensable injury. An MRI performed in February of 1999 revealed a mild disc protrusion at L5-S1. However, there is no evidence in the record that Dr. Dickens related this finding to the claimant's complaints, or that it was even a significant finding. Moreover, the myelogram and post myelogram CT performed in May of 1999 only revealed a conjoined nerve root at L5-S1, and was specifically interpreted as revealing "no significant abnormality" at L5-S1. Even after the claimant's first and second surgeries performed by Dr. Dickens, the diagnostic studies continued to only reveal degenerative changes at L5/S1. It was not until after the claimant was involved in a motor vehicle accident in November of 2002, that a diagnostic study revealed a disc herniation at the L5-S1 level. While Dr. Schlesinger did not observe a disc herniation at the L5-S1 level in the December 2002 MRI, Dr. Russell described this MRI finding as revealing a "large herniated disc" which appeared to be causing nerve root impingement. Moreover, the operative report which states that after the discectomy was performed, the exploration of the nerve root proximally and

distally did not reveal any "further external impingement," clearly implies that the disc material removed by Dr. Russell was herniated and impinging upon the nerve root. Based upon all the diagnostic studies, we cannot find that the large herniated disc detected in December of 2002 and operated on in January of 2003 is the natural and probable result of the claimant's compensable injury. In our opinion, the diagnostic evidence reveals the findings in December of 2002, to be new findings, evidencing a new injury or aggravation for which the respondents are not liable.

In finding that the claimant has failed to establish by a preponderance of the evidence that the herniated disc at L5-S1 which necessitated surgery in 2003 is not causally related to the claimant's compensable injury, we are cognizant of Dr. Russell's March 19, 2003, letter claiming that the surgical procedures were "directly related" to the claimant's compensable injury. However, we note that Dr. Russell bases this opinion upon the claimant's resolution of right leg pain following the surgery. There is no evidence that Dr. Russell personally observed the February and March 1999 diagnostic studies. Moreover, Dr. Russell's opinion is silent with regard to whether the

L5-S1 herniated disc he operated on in January of 2003 was present in the previous studies. Dr. Russell observed a large operable herniated disc at L5-S1. No other physician described a large herniated disc at L5-S1, nor did any other physician ever describe an operable condition at L5-S1. All of the claimant's previous physicians, from Dr. Dickens to Dr. Moore to Dr. Peeples to Dr. Bruffett to Dr. Safman, all well respected specialists in their own right, concluded that the claimant's compensable injury did not result in an operable herniated disc at L5-S1. Dr. Russell did not treat the claimant until almost 4 years after the claimant's compensable injury, and not until after at least two neurosurgeons and two orthopedic surgeons concluded that the claimant did not suffer from an operable condition at L5-S1 following his compensable injury. Accordingly, we find that a preponderance of the evidence fails to reveal that the condition operated on by Dr. Russell is causally related to the claimant's compensable injury.

After reviewing the medical records, as well as the claimant's hearing testimony, we are not persuaded by Dr. Russell's causation opinion. As previously noted, there is no evidence of a large herniated disc at L5-S1 at anytime

prior to the motor vehicle accident. Furthermore, the resolution of right extremity pain, upon which Dr. Russell relied in reaching his causation opinion, appears to have been only transitory. The claimant testified that he presently suffers from "little electric shocks [that] go down the right side" even after the 2003 surgeries. In addition, the claimant testified that he still has pains shooting down into his testicles and into his right leg. Accordingly, we cannot find that the surgeries performed by Dr. Russell alleviated the claimant's lower right extremity pain. Therefore, we find that the opinion expressed by Dr. Russell that his surgeries addressed a pain that was present prior to the claimant's motor vehicle accident is not entitled to any weight. Obviously, the pain that was present prior to the claimant's motor vehicle accident and disc herniation at L5-S1 was not addressed or alleviated by the L5-S1 left sided disketomies performed by Dr. Russell, as the claimant continues to experience this shooting pain into his right lower extremity. Furthermore, even Dr. Russell noted that alleviation of this right sided pain was not the intended result of his left sided laminectomy at L5-S1.

For those reasons stated herein, we find that the claimant has failed to prove by a preponderance of the evidence that the disc herniation at L5-S1 which necessitated surgery by Dr. Russell in January of 2003, is causally related to the claimant's 1999 compensable injury. Therefore, we find that the decision of the Administrative Law Judge should be and hereby is reversed.

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 respectfully dissent from the Majority opinion. I find that the Administrative Law Judge correctly applied the law, reviewed the evidence of record and did not err when he found that the surgeries performed by Dr. Russell in January of 2003 were reasonably necessary in connection with the claimant's compensable injury. Likewise, I find that the preponderance of the evidence fails to show that the

claimant's motor vehicle accident in November of 2002 was an independent intervening cause of the claimant's need for surgery.

The evidence is clear that the claimant sustained a compensable back injury on February 8, 1999. Following that injury, claimant required four surgical procedures, two before his car accident and two following the accident. Claimant's medical records reveal that his pain level was similar to the pain he felt at the time of his original injury. On December 3, 2002, claimant was seen by Anthony Russell who performed two surgeries in January of 2003 at L5-S1.

Claimant's MRI scan dated February 18, 1999, ten days after his original injury, stated that there was a mild central posterior disc protrusion at L5-S1. His physician at that time, Dr. Dickens, wrote on April 30, 1999 that the claimant's MRI scan demonstrated a disc protrusion at L4-5 and L5-S1, although he did not then think these findings were of surgical significance. Dr. Dickens' opinion changed as to the claimant's need for surgery. Claimant testified and his medical records suggest that he continued to have significant symptoms related to his original injury even

after his original surgeries and follow-up care. Claimant testified that the symptoms he experienced when he saw Dr. Russell were similar in location and nature to his original symptoms. Therefore, I find that the preponderance of the evidence supports that claimant's need for surgery was related to his original injury.

When the primary injury is shown to be compensable, the employer is responsible for any consequence that naturally flows from it, the fundamental test being whether a causal connection exists between the primary injury and the subsequent consequence. See Bearden Lumber Co. v. Bond, 7 Ark. App. 65 (1983).

The majority found that the respondents are not liable for claimant's surgeries during January of 2003 because of the intervening motor vehicle accident which occurred during November of 2002. I disagree. Ark Code Ann. § 11-9-102(4)(F)(iii) provides that benefits are not payable for a condition which results from a nonwork-related independent intervening cause, following a compensable injury, which caused or prolonged disability or a need for treatment and that such an intervening cause does not require negligence or recklessness on the part of the

claimant. In Davis v. Old Dominion Freight Line, Inc., 341 Ark. 751 (2000), it was held that this provision leaves intact that the intervening cause be the result of unreasonable conduct on the part of the claimant. Therefore, in order for respondents to deny benefits, the incident must be related to unreasonableness on the part of the claimant. I find that claimant's activity was not unreasonable. He was not told to avoid driving a motor vehicle by his physicians and the accident was not claimant's fault.

Based on the foregoing, I find that claimant's surgeries performed by Dr. Russell in January of 2003 were reasonably necessary and causally related to claimant's compensable injury.

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SHELBY W. TURNER, Commissioner