

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**CLAIM NO. F207551**

<b>RICHARD BRINKLEY, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>GATEWAY INDUSTRIAL SERVICES, INC., EMPLOYER</b>	<b>RESPONDENT</b>
<b>ZENITH INSURANCE COMPANY, CARRIER</b>	<b>RESPONDENT</b>

**OPINION FILED JUNE 27, 2005**

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

Claimant represented by HONORABLE PHILIP M. WILSON, Attorney at Law, Little Rock, Arkansas.

Respondent represented by HONORABLE MATTHEW MAULDIN, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

**OPINION AND ORDER**

The respondents appeal a decision by the Administrative Law Judge finding that the claimant proved by a preponderance of the evidence that he was entitled to additional medical treatment. Specifically, the Administrative Law Judge found that the claimant was entitled to undergo an MRI as recommended by Dr. Edward Saer. Based upon our de novo review of the record, we find that the claimant has failed to meet his burden of proof. Accordingly, we reverse the decision of the Administrative Law Judge.

The claimant sustained an admittedly compensable injury on January 18, 2002. The claimant did not consult Dr. Roger Troxel, the company physician, until approximately six months later, in June of 2002. Dr. Troxial referred the claimant to Dr. Rebecca Barrett-Tuck. Dr. Barrett-Tuck examined the claimant on June 28, 2002. The claimant was complaining of back and right leg pain. The claimant told Dr. Barrett-Tuck that his back was often so stiff and tight that he could barely walk after work. Dr. Barrett-Tuck's notes indicated that the claimant had not responded to a steroid dose pack, that he had not had any physical therapy or treatment, but that he had been using pain medication and muscle relaxants to control his pain. Dr. Barrett-Tuck noted that the claimant showed "defused lumbar tenderness, and a CT of the lumbar spine revealed a 'very, very, tiny, disc protrusion at L5-S1 on the right' which 'did not appear to cause nerve root compromise.'" Dr. Barrett-Tuck recommended conservative treatment, which included physical therapy and walking twice a day. She restricted the claimant from returning to work for 4 to 6 weeks, performing yard work, bending, lifting and stooping.

On August 2, 2002, the claimant consulted Dr. Calin Savu. The claimant complained of low back and right lower extremity pain. The claimant informed Dr. Savu that his condition had not improved despite taking Loritab and Darvocet. He also stated that he had repeated attempts at physical therapy. Dr. Savu reviewed the claimant's CT scan of the lumbar spine and noted that there was a "bulging L4 annuls on the right" as well as a "broad based small right paracentral and right postiolateral disc protrusion at L5-S1." Dr. Savu recommended diagnostic epidural steroid injections to identify the pain.

On August 21, 2002, the claimant underwent physical therapy. The physical therapist noticed that the claimant complained about pain in his low back and down into his right leg. The therapist noted that the claimant had not improved through physical therapy, but instead had regressed. He also questioned the claimant's need for psychological assessment due to the answers the claimant provided on the questionnaires.

On August 26, 2002, the claimant again sought treatment from Dr. Barrett-Tuck complaining of "a tremendous amount of pain in his back" which he reported was worse. The

claimant indicated to Dr. Barrett-Tuck that some of the physical therapy treatments were helpful. Dr. Barrett-Tuck recommended that the claimant continue the conservative treatment. She stated that surgery might be considered even though the claimant's disk rupture was very, very small.

On September 25, 2002, the claimant complained to Dr. Barrett-Tuck that the injection administered by Dr. Savu was not successful. He reported that the pain stretched across his entire low back. In her notes of that date, Dr. Barrett-Tuck expressed concern over the claimant's medication use and the number of complaints. She noted that the claimant refused to return to work even on light duty.

On October 14, 2002, the claimant again underwent physical therapy with a different therapist. This therapist noted that the claimant had not continued the exercises that had been recommended by the previous therapist. He also wrote that a questionnaire administered by the therapist showed "significant psychological components to [the claimant's] pain." When the claimant was discharged by this physical therapist there was no improvement in the claimant's lumbar range of motion or pain intensity. She

recommended that the claimant continue performing exercises at home.

On October 23, 2002, EMG's were administered to the claimant which revealed "a normal NCV of the bilateral lower extremities" with no "active radiculopathy" at that time. On November 12, 2002, Dr. Barrett-Tuck reported that the claimant continued complaining of severe back pain radiating to his left leg. She requested an MRI of the lumbar spine as well as flexion and extension films. She concluded that the EMG's and nerve conduction studies revealed "no acute radiculopathy but signs of chronic L5 irritation on his EMGs" and indicated that she intended to reduce the claimant's medication dosages. The x-rays revealed that the claimant's skeletal structures were normal and there were no spondylotic changes. The MRI revealed that the claimant's "vertebral alignment and bone marrow signal are unremarkable and disc height and hydration are maintained at all levels with the L5-S1 disk being fully developed. There was no evidence of stenosis disk bulging protrusion or herniation. The facet joints were noted as being unremarkable. Dr. Kent Roberts concluded that the MRI was a "normal study".

On January 9, 2003, the claimant returned to Dr. Barrett-Tuck complaining of low back pain, right leg pain and thoracic pain. He also reported a popping sensation in his thoracic area. Dr. Barrett-Tuck explained that the claimant's spine MRI was "a beautiful study" and appeared "entirely normal". She noted that the L5-S1 disk that appeared to questionably show a small protrusion on the right looked very good on the MRI. She saw no evidence of "implate changes or significant degenerative changes" and cautioned against a diskogram because it might irritate the disks that do not appear to be injured on the MRI. She told the claimant that she would not prescribe any more narcotics. The claimant then questioned her ability to diagnose pain. Dr. Barrett-Tuck recommended a second opinion by another neurosurgeon and also requested an MRI of the thoracic spine. She concluded that she would no longer see the claimant because she believed she had exhausted all reasonable treatment options. She would not provide off work notices for the claimant beyond February 1, 2003.

On January 14, 2003, the claimant sought treatment from his family physician, Dr. Darlene Antosh. He complained to Dr. Antosh of mid-back pain radiating into his

extremities coupled with a numb or tingling sensation. Dr. Antosh noted that he claimant's range of motion was full and concluded that she could not find the source of the claimant's chronic mid-thoracic back pain. She declined to give the claimant any medication because the claimant was still taking the medications prescribed by Dr. Barrett-Tuck. The claimant insisted and she prescribed Lorcet on January 17, 2003.

On January 14, 2003, the claimant underwent a thoracic MRI. The MRI indicated "vertebral alignment is within normal limits. The vertebral body heights are maintained...with [no significant signal abnormalities in the vertebral bodies... or [or] spinal cord." The MRI did identify a "small osteophyte arising from the facet on the right side that slightly indents the thecal sac" but no apparent "significant neural compromise." Despite the negative MRI, the claimant continued to complain of pain but with no numbness, tingling or radicular symptoms. On January 22, 2003, Dr. Antosh referred the claimant to another physician. She advised the claimant that she would no longer prescribe any additional medication.

The claimant was evaluated by Dr. W. Craig Clark on January 27, 2003. The claimant complained to Dr. Clark of mid-back pain. Dr. Clark noted that the claimant had already undergone a CT scan of the lumbar spine as well as MRIs of the lumbar and thoracic spine. Dr. Clark wrote that he could see "no palpable lumbar spasm" or "loss of segmentation" and diagnosed the claimant as having a chronic lumbar strain. Dr. Clark recommended physical therapy, work hardening and no narcotics. The claimant expressed unhappiness with Dr. Clark's conclusions and Dr. Clark suggested that the claimant should follow up with Dr. Antosh.

Dr. Barrett-Tuck assessed the claimant with a 5% permanent impairment rating on February 1, 2003. This impairment rating was accepted and paid by the respondents.

Dr. Antosh referred the claimant to Dr. K. Dwayne Eubanks who examined the claimant on March 4, 2003. The claimant complained of low back pain radiating down into his leg. After reviewing the claimant's lumbar and thoracic spine MRI's, Dr. Eubanks noted that although the MRI noted the existence of an osteophyte at T8-9, he did not see it. Dr. Eubanks opined that the claimant's thoracic MRI scan appeared "absolutely pristine". Dr. Eubanks also described

the lumbar spine as "pristine" with no evidence of root compression, canal stenosis, or lateral recess stenosis. Dr. Eubanks observed that "the only hint of an abnormality that is in the disk bulges at L5-S1, although the root itself looks like it exits without compromise." Dr. Eubanks's impression was that the claimant suffered from thoracic pain and lumbar spine pain with no clear cut neurologic etiology. He suggested that the claimant might benefit from chiropractic care. If the chiropractic care did not help, Dr. Eubanks indicated that he would like to have Dr. Terrance Braden evaluate the claimant. Otherwise he saw "no clear cut treatment for the claimant." Dr. Eubanks's certified physician's assistant wrote that the claimant refused to accept an LSO to wear for his posture. She also wrote that the claimant announced his intention to sue Dr. Eubanks for neglect, in addition to Drs. Barrett-Tuck and Antosh, upon learning that Dr. Eubanks would only prescribe claimant a Medrol dose pack.

The claimant filed a petition for a change of physician to Dr. Edward Saer, which was granted on March 19, 2004. On April 22, 2004, claimant consulted with Dr. Saer. He complained to Dr. Saer of thoracic pain radiating down

into the lumbar spine area. Dr. Saer described in his notes that the claimant's thoracolumbar exam demonstrated some tenderness, but there were no spasms. After reviewing the previous tests recommended by other physicians, Dr. Saer agreed that the claimant's lateral and extension x-rays of the lumbar spine were unremarkable and the thoracic MRI was negative. He identified a very small right side disk protrusion at the L5-S1 level on the lumbar MRI. His impression was that the claimant suffered from non-specific thoracic and lumbar pain. He agreed that the claimant's condition did not warrant surgery, but he did recommend repeating the MRI films. It is his recommendation for the repeat MRI films which are at the heart of this case. The Administrative Law Judge found that the claimant was entitled to receive those MRI's. The respondents contend that the claimant has been provided with significant medical treatment and that the additional MRI's are not reasonable and necessary medical treatment. We agree with the respondents.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. § 11-9-508(a) (Repl. 2002). However,

injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. Norma Beatty v. Ben Pearson, Inc., Full Workers' Compensation Commission Opinion filed February 17, 1989 (Claim No. D612291). 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 Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553). Also, the respondent is only responsible for medical services which are causally related to the compensable injury.

The medical evidence demonstrates that the claimant has been examined and evaluated by numerous physicians and has undergone extensive tests and treatment. The claimant has received a CT scan of the lumbar spine as well as MRI's of the lumbar and thoracic spines. The claimant had flexion and extension x-rays which were taken approximately 11 months after the claimant's injury. The x-rays revealed a normal skeletal structure with no spondilitic changes. The MRI of the lumbar spine observed no

indication of stenosis, disk protrusion, bulging or herniation. In fact, Dr. Barrett-Tuck described it as "a beautiful study."

The claimant has also been examined by Dr. Clark, whom the claimant was referred to after Dr. Barrett-Tuck indicated that there was no viable treatment options. In fact, the claimant testified during the hearing that Dr. Clark was consulted independently on the recommendation of his private physician. Dr. Clark evaluated the MRI's and x-rays and informed the claimant that there was no need to prescribe pain medication. Dr. Clark recommended physical therapy and work hardening. Although Dr. Clark noted his inability to diagnose the claimant from previous tests, he did not recommend repeat testing. Neither did Dr. Antosh or Dr. Eubanks, both of whom had the opportunity to evaluate the claimant's MRI of his lumbar spine. Dr. Eubanks, who was recommended by the claimant's own family physician, described the claimant's lumbar spine MRI as "pristine." Dr. Barrett-Tuck, Dr. Eubanks, and Dr. Clark are three neurosurgeons who have evaluated the claimant's previous MRI tests. None of these physicians, as well as Dr. Antosh, have recommended repeat MRI studies. Moreover, Dr. Saer never

disagreed with or questioned the other physicians analysis of the previous MRI tests. His notes reveal that he agreed that any abnormalities present did not warrant surgery.

The respondents have provided the claimant with significant medical treatment. The claimant has undergone CT scans, MRI's as well as x-rays. He's been evaluated by 3 neurosurgeons as well as his family physician. It is of note that the claimant has threatened to sue several of the doctors when they refused to prescribed him pain medication. In our opinion, the claimant has failed to prove by a preponderance of the evidence that the additional medical treatment in the form of an MRI is reasonable and necessary medical treatment. The claimant has independently consulted 2 neurosurgeons, Dr. Clark and Dr. Eubanks, at the recommendation of his personal physician. Before the claimant even requested a change of physician he was examined by 3 neurosurgeons, none of whom questioned the quality or accuracy of the tests or recommended repeat MRI studies. The claimant's lumbar MRI was referred to in such terms as "entirely normal", a "beautiful study", and "pristine". The claimant's thoracic MRI has also been described as "negative" and "absolutely pristine". The

claimant contended that the respondents have failed to present any evidence by any physician that would indicate that repeat MRI's are unreasonable or unnecessary. We would note, that it is the claimant's burden to prove that the medical treatment is reasonable and necessary and not the respondents' burden to prove it is unreasonable. The evidence in the record demonstrates that the repeat MRI is unnecessary. On January 9, 2003, Dr. Barrett-Tuck opined that she had exhausted all reasonable treatment options in relation to the claimant's spine. She noted that she would not recommend surgery or additional medication and that she would not provide notes to keep the claimant off work beyond February 1, 2003. She requested an MRI of the claimant's thoracic spine to be absolutely sure that nothing was wrong in that area. That MRI indicated that there was nothing wrong. She assessed the claimant with a 5% permanent impairment rating on February 1, 2003. The respondents accepted this permanent impairment assessment and paid it.

We recognize that when the claimant requests a change of physician he is entitled to be evaluated by that new physician. Dr. Saer has evaluated the claimant and has looked at all of his prior medical studies and examinations.

However, we do not agree that the claimant is entitled to the medical treatment that a doctor recommends or additional medical studies when the claimant is granted a change of physician. The claimant must establish by a preponderance of the evidence that repeat tests are necessary and reasonable in connection with the compensable injury. The evidence in this record suggests that the claimant's symptoms are psychological in nature and may be even motivated by chemical dependency. In short, the claimant has the burden of proving by a preponderance of the evidence that the additional testing is reasonable and necessary. The claimant in this case has failed to meet his burden of proof. Accordingly, we reverse the decision of the Administrative Law Judge. This claim is hereby denied and dismissed.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.