

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F213823

MARIE HERRON,
EMPLOYEE

CLAIMANT

MEDICALODGE PROGRESSIVE CARE,
EMPLOYER

RESPONDENT

TRAVELERS PROPERTY & CASUALTY CO.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED JULY 7, 2005

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

Claimant represented by the HONORABLE GREG GILES,
Attorney at Law, Texarkana, Arkansas.

Respondents represented by the HONORABLE ROBERT
MONTGOMERY, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and
Adopted.

OPINION AND ORDER

Respondents appeal an opinion and order of the
Administrative Law Judge filed October 26, 2004. In
said order, the Administrative Law Judge made the
following findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation
Commission has jurisdiction of this
claim.
2. The stipulations agreed to by the parties
are reasonable and are hereby accepted as
fact.

3. The claimant has proven by a preponderance of the evidence that the medical treatment she received from February 17, 2004, through June 11, 2004, by and at the referral of Drs. Prychodko, Hart and Akin, was reasonably necessary in connection with the compensable injury.
4. The claimant has proven by a preponderance of the evidence that she remained in her healing period until May 12, 2004.
5. The claimant has proven by a preponderance of the evidence that she was totally incapacitated from earning wages from December 16, 2003, until May 12, 2004.
6. The claimant has therefore proven by a preponderance of the evidence that she was entitled to temporary total disability benefits from December 16, 2003, until May 12, 2004.
7. The claimant has proven by a preponderance of the evidence that she has sustained permanent impairment in the amount of 20% to the body as a whole.
8. The claimant has proven by a preponderance of the evidence that the existence of her permanent impairment is supported by objective and measurable physical findings.
9. The claimant has proven by a preponderance of the evidence that her compensable injury is the major cause of her permanent impairment or disability.
10. The claimant has therefore proven by a preponderance of the evidence that she is entitled to permanent partial disability benefits in the amount of 20% to the body as a whole.

11. The claimant has failed to prove by a preponderance of the evidence that she is permanently totally disabled.
12. The claimant has proven by a preponderance of the evidence that she has sustained wage loss of 50% over and above her permanent anatomical impairment of 20%.
13. The respondents have controverted all benefits sought 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 made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the October 26, 2004 decision of the Administrative Law Judge, including all findings of fact and conclusions of law therein, and adopt the opinion 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.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I respectfully dissent from the majority opinion finding, in relevant part, that the claimant was totally incapacitated from earning wages from December 16, 2003 through May 12, 2004, and that she is, therefore, entitled to temporary total disability benefits for that period; that the medical treatment she

received from February 17, 2004 through June 11, 2004 by and at the referral of Dr. Prychodko, Dr. Hart, and Dr. Akin, was reasonably necessary in connection with the claimant's compensable injury; and that she sustained a permanent anatomical impairment of 20% to her body as a whole, over which she has sustained a 50% wage loss disability.

A carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove her entitlement to additional medical benefits, temporary total disability benefits, wage loss benefits, and permanent physical impairment benefits as described above.

The claimant worked as a CNA for the respondent employer at the time of her compensable back injury of February 8, 2000. The claimant reportedly sustained her injured while bathing a patient who began to seize and had to be physically restrained. Although the claimant contends that she first sought treatment for her injury in the emergency room, the record is devoid of any evidence to support that contention. The medical record commences with the claimant's examination by family practitioner, Dr. Leon Purifoy, on February 17, 2000. Dr. Purifoy's initial examination of the claimant included x-rays which showed "mild degenerative changes

of the lumbar spine" with arthritic changes seen in the claimant's SI joints. Dr. Purifoy diagnosed the claimant with acute L/S strain for which he prescribed medications and placed her on light work duty. When the claimant's condition appeared resistant to conservative treatment, Dr. Purifoy ordered an MRI of the claimant's lumbar spine. The results of this MRI, which was taken on March 23, 2000, was normal. Therefore, Dr. Purifoy referred the claimant to orthopedic specialist, Dr. Michael Pappas. Dr. Pappas confirmed the claimant's earlier diagnosis for which he continued the claimant on a course of conservative treatment, including physical therapy and light work duty.

In order to rule out subline bony abnormalities, the claimant underwent a bone scan on September 14, 2000. This scan revealed only "mild arthritic changes" in the claimant's lumbar spine, with no evidence of spinal pathology or significant asymmetry. In a report dated September 18, 2000, Dr. Pappas noted that the claimant had taken a new job that was less physically demanding. In addition, Dr. Pappas noted that the claimant's condition was "actually slowly improving." In contrast, on October 30, 2000, Dr. Pappas commented that the claimant had become "quite upset"

that her condition had not improved. Specifically, Dr. Pappas stated:

We have tried physical therapy, point injections, as well as anti-inflammatory and she has not gotten any better. She now comes into my office quite upset from the fact that she is not getting any better. We got MRI's as well as a bone scan of her lower back. The bone scan showed mild arthritic changes in the extremities bilaterally with no spine pathology or significant asymmetry. The MRI ordered by Dr. Purifoy on 3-23-00 was a normal MRI of the lumbar spine and more recently she's had some GI bleeding from her anti-inflammatory, thus, she is unable to take these any longer. At this point we are at a loss with regards to her continued pain. It appears to be more muscular in nature. It does not appear to have any bony abnormalities and/or foraminal stenosis or lumbar stenosis causing her pain and/or any type of acute injury.

In addition to the above, Dr. Pappas wrote that he was referring the claimant for a neurosurgical evaluation to "see if there is anything else we're missing here." Dr. Pappas added that he had advised the claimant that hers was a "long ongoing course and that she might not ever get 100% better." He stated that the claimant left his office in tears.

On November 21, 2000, Dr. Brett Dietze examined the claimant and opined that her injury was

indeed musculoskeletal in nature. Dr. Dietze stated, "There is no neurosurgical lesion identified and she is neurologically intact." Dr. Dietze further stated that the claimant would best benefit from a conservative course of treatment, including muscle relaxers and anti-inflammatories. The claimant returned for treatment with Dr. Pappas, who ordered a repeat MRI of the claimant's lumbar spine. This test, which was conducted on February 21, 2001, showed no significant changes from the previous MRI. Likewise, an MRI taken of the claimant's pelvis showed normal hip location with no evidence of fracture or dislocation. However, the claimant's pelvic MRI revealed mild sclerosis along the SI joint "suggestive of previous pregnancies," with mild degenerative changes. In addition, this test revealed a dermoid tumor on the claimant's right ovary and a fibroid tumor in her uterus. By April of 2001, the claimant reported that "pain gel" prescribed by Dr. Pappas had given her "significant relief," and according to Dr. Pappas, the claimant was doing "significantly better." In August of 2001, Dr. Pappas reported that the use of a TENS unit had provided the claimant additional relief. By November 15, 2001, Dr. Pappas stated that the claimant had undergone pelvic surgery during which her

right ovary was removed. This procedure reportedly did not relieve the claimant's back symptoms.

In the fall of 2001, Dr. Pappas referred the claimant to a chiropractor, namely Paul Baker. "Slow and gradual improvement" in the claimant's condition was noted during this time. On January 21, 2002, Dr. Pappas stated:

I believe she is plateauing with regards to her getting better. We have made all the referrals with regards to the neurosurgeons, as well as therapy. We have tried all different modalities and now, as a last effort, we are trying a chiropractor, who seems to be helping somewhat.

On April 19, 2002, Dr. Pappas opined that the claimant "might be" at maximum medical improvement with regards to her lower back. Because of her unresolved pain issues, however, Dr. Pappas stated that the "only other option" was to refer the claimant to a back institute for a second opinion. On May 30, 2002, Dr. Nayan Patel of the Texas Back Institute, diagnosed the claimant with lumbar strain and sacroiliac dysfunction. Suspecting some type of internal disc disruption in the claimant's lower spine, Dr. Patel performed SI and facet injections, which reportedly failed to alleviate the claimant's symptoms. In addition, Dr. Patel recommended

another MRI, which was not approved by the respondent carrier. In the alternative, Dr. Patel recommended that a discogram study of the claimant's lumbar spine be conducted.

On November 18, 2002, Dr. Barry Green evaluated the claimant for an impairment rating. Based upon his review of the records, Dr. Green stated that the claimant had reached maximum medical improvement for her injury of February 2000, and he assigned her a 5% permanent impairment rating to the body as a whole. The respondent accepted and paid this rating. Dr. Patel disagreed with Dr. Green's assessment based upon the fact that her facet joint injections had produced no anesthetic or therapeutic response.

On March 6, 2003, the claimant sought and was granted a change of physician to Dr. Andrew Prychodko. The claimant's initial visit with Dr. Prychodko was on March 17, 2003, at which time he continued the claimant on a course of conservative treatment. A third MRI conducted on October 25, 2003, revealed multi-level mild bulging and degenerative facet changes, without herniation. On November 6, 2003, the claimant's employment was terminated, and on December 16, 2003, Dr. Prychodko gave the claimant an off-work slip. The claimant was seen again on January 5, 2004 by Dr.

Prychodko, who noted that the claimant's underlying problem appeared to be a malposition of the sacroiliac joint. Dr. Prychodko referred the claimant to Nathan Tumlinson for physical therapy. Dr. Prychodko eventually referred the claimant to Dr. Thomas Hart for a discogram to address her discogenic pain. On February 17, 2004, the respondent controverted further medical treatment. Nonetheless, the claimant returned to Dr. Prychodko for treatment, and by February 20, 2004, improvement in the claimant's sacroiliac condition was noted.

On March 25, 2004, Dr. Hart performed a discogram with post-discogram CT. These studies revealed annular tears at L4-L5 and L5-L6. The claimant was referred to Dr. Eric Akin for a neurosurgical evaluation. Dr. Akin determined that no surgical treatment for the claimant's condition was indicated. On June 11, 2004, Dr. Prychodko pronounced that the claimant had reached maximum medical improvement and he assigned her with a 20% permanent impairment rating for the body as a whole.

On August 12, 2004, the claimant underwent a functional capacity evaluation. This test placed the claimant in the "unable to work" category due to her limited lifting capability and a "balance deficit."

In my opinion, the claimant has failed to prove that the additional medical treatment which she received from February 17, 2004 through June 11, 2004, was reasonably necessary to the treatment of her compensable injury for the following reasons. First, the claimant was provided with a comprehensive range of medical treatment for her back strain over an extended period of time. The medical record confirms that the claimant sustained a lumbar strain in February of 2000, for which she received medical treatment from several different physicians in several areas of specialty. Based upon their respective examinations and the results of numerous diagnostic studies, each of these doctors recommended a conservative course of treatment for the claimant's injury. The claimant's conservative treatment was comprehensive and spanned a period of more than four years. That treatment included, among other things, numerous and various medications, physical therapy, chiropractic treatment, special devices (i.e., TENS unit), injections, and multiple diagnostic studies. Much to the bewilderment of the claimant's authorized treating physicians, however, none of these treatment modalities reportedly provided the claimant with sustained relief. In a letter dated May 12, 2004, Dr. Akin confirmed the claimant's original diagnosis, and he

mentioned that the claimant appeared to have a "poor attitude toward the possibility of becoming well." By that time, Dr. Akin, like the claimant's previous treating physicians, was "at a loss" to make further treatment recommendations.

Second, objective medical testing failed to support a finding that additional medical treatment was appropriate and necessary for the treatment of the claimant's compensable injury. For example, an MRI taken of the claimant's spine on February 21, 2001, showed no significant changes from the MRI taken less than two months after the claimant's injury. Likewise, a third MRI taken in October of 2003, revealed only degenerative changes in the affected area of the claimant's spine. In addition, a bone scan conducted in September of 2000 showed no evidence of spinal pathology or significant asymmetry. Although the nature of the claimant's back strain was perhaps "acute," test after objective medical test failed to reveal that her injury was anything other than muscular in nature. Indeed, throughout the course of the claimant's treatment, her diagnosis remained the same. Furthermore, the record reveals that Dr. Pappas was correct in his assumption that the claimant's condition had begun to "plateau" towards the end of January, 2002. And, although on April 19, 2002,

Dr. Pappas's opinion that the claimant had reached MMI was guarded, the record of the claimant's chronic symptoms and medical treatment thereafter strongly suggests that she had reached MMI by that date. Therefore, the respondent was justified in denying additional diagnostic testing and/or medical services that would "not likely result in any change in the [claimant's] treatment plan." The fact that additional medical treatment received by the claimant, including the discogram performed by Dr. Hart in March of 2004, did not change the course of the claimant's medical treatment supports the conclusion that the medical treatment the claimant received between February 17, 2004 through June 11, 2004 by and at the referral of Dr. Prychodko, Dr. Hart, and Dr. Akin, was not reasonably necessary in connection with the claimant's compensable injury.

Lastly, the claimant has failed to prove that the annular tears discovered four years after her compensable back strain were causally related to that compensable injury. In view of the extensive and continuous medical treatment received by the claimant, had these tears been caused by her injury of 2000, it is highly likely that this condition would have been found earlier on.

In addition to failing to prove that she is entitled to additional medical treatment as described above, the claimant has failed to prove that she is entitled to temporary total disability benefits.

In my opinion, the claimant has failed to prove that the underlying condition causing her disability, namely her back strain, had not stabilized by at least April of 2002. The record reveals that nothing further in the way of treatment helped improve the claimant's condition after that time. Therefore, the claimant has failed to prove that she remained in her healing period for her compensable injury after April 19, 2002. Furthermore, even if the claimant had proved that she remained in her healing period after April of 2002, she has failed to prove that she was totally incapacitated from working as a result of her compensable injury. After her injury of February 2000, the claimant continued to work with restrictions up until November of 2003, at which time she was terminated for reasons not associated with her medical condition. In a report dated October 31, 2003, Dr. Prychodko noted that the claimant was able to return to work with limitations through February 29, 2003. This continued to be the case up until December 16, 2003, at which time Dr. Prychodko took the claimant off of work until March

5, 2004. In his report of the claimant's office visit of December 16, 2003, under "Work Status," Dr. Prychodko states that "employee is unable to return to work," but he gives no medical reason why. In another section of that report, Dr. Prychodko states that "She [the claimant] is not working, and is in the process of regaining her CNA license, which was wrongly revoked based on factual misrepresentations made by others." By February 20, 2004, Dr. Prychodko had extended the claimant's return to work date through April 2, 2004, but still with no medical justification or explanation as to why he felt this time should be extended.

Likewise, on April 15, 2004, Dr. Prychodko extended the claimant's off-work status through May 27, 2005. On June 11, 2004, Dr. Prychodko placed the claimant at MMI, stating, "After several specialist consultations we are resigned that the extent and location of the most severely involved discs leaves us no interventional treatment approaches for the discogenic pain, therefore placing her at MMI."

The claimant testified that she was terminated from her job on November 6, 2003, for "neglect of a patient." The claimant further testified that she lost her CNA license due to this incident, but that she is in the process of getting that license back. Although the

claimant testified that her current activities are severely limited due to her chronic back pain, she further testified that she would return to work as a CNA should she regain her license. The claimant admitted that she has not attempted to seek employment since her termination of November 6th. Based upon the foregoing, I find that the claimant has failed to prove that she was totally incapacitated from working during that time for which the Administrative Law Judge awarded temporary total disability benefits.

Finally, I find that the claimant has failed to prove, however, that she has sustained a permanent anatomical impairment of 20% to her body as a whole, or that she has sustained a 50% wage loss over and above this anatomical rating.

The respondent carrier accepted and paid the 5% permanent physical impairment assigned to the claimant in November of 2002 by Dr. Green. Subsequently, in June of 2004, Dr. Prychodko assigned the claimant with a 20% permanent impairment rating to the body as a whole. In a letter concerning the claimant's impairment rating, Dr. Prychodko stated:

Ms. Herron's impairment is most closely reflected in DRE Lumbosacral Category IV (Ch 3, P 102) given the multilevel spine segment structural compromise established on

discography. The sacro-iliac dysfunction is not a ratable condition under the Guides. This results in 20% **whole person impairment**.

The "multilevel spine segment structural compromise" to which Dr. Prychodko refers are apparently the annular tears at L4-L5 and L5-L6, and the diffuse disc degeneration at L6-S1, as were identified from the discography and CT scan of the claimant's spine conducted on March 25, 2004. Since I find that these tears and/or degeneration are not causally related to the claimant's injury of February 2000, I find that the rating assigned by Dr. Prychodko is not related to the claimant's compensable injury. Even if it were so established, a finding that I specifically do not make, the claimant's impairment would most closely match DRE Lumbosacral Category II, which allows for a 5% permanent impairment rating, and is described below.

The clinical history and examination findings are compatible with a specific injury or illness. The findings may include significant intermittent or continuous muscle guarding that has been observed and documented by a physician, nonuniform loss of range of motion, ..., or nonverifiable radicular complaints. There is no objective sign of radiculopathy and no loss of structural integrity.

In a clinic note dated July 17, 200, Dr. Pappas wrote, "Again, this is most likely muscular in nature since MRI was normal, no radiculopathy" On August 28, 2000, Dr. Pappas noted, "On examination she is neurovascularly intact," A radiology report dated September 17, 2000, states "The spine is unremarkable. There is no evidence of fracture or neoplasm." Upon his examination of the claimant on November 21, 2000, Dr. Dietze found no neurological or sensory deficits. Furthermore, the claimant's reflexes were normal. X-rays taken of the claimant's lumbar spine taken on February 21, 2001 showed normal alignment. In fact, all of the diagnostic testing and physical examinations related to the claimant's lumbar spine were normal up until her discogram, which was performed over four years after her injury, showed annular tears. In addition, the record clearly indicates that the degeneration causing dysfunction in the claimant's sacroiliac joint is more likely than not a result of child bearing. Therefore, the weight of the medical evidence indicates that Dr. Green's permanent physical impairment rating of 5% to the body as a whole provided a more accurate reflection of the claimant's true anatomical impairment than the 20% impairment rating assigned by Dr. Prychodko.

Lastly, the claimant has failed to prove that she is entitled to 50% wage loss as a result of her compensable back strain of 2000.

After her compensable injury of February 2000, the claimant continued to work for the respondent employer until such time as she was fired for negligence. And although the claimant testified that her physical activities are extremely limited due to her injury, she further testified that she would gladly return to work as a CNA upon the first opportunity to do so. Indeed, the claimant is currently seeking to have her CNA license reinstated towards that end. In the meantime, the claimant has not sought employment of any kind. Although the claimant was placed in the "unable to work" category based upon the results of her functional capacity evaluation test, the test giver, Mr. Stephen Joseph, stated that the claimant was unable to complete the test because of her elevated vital signs. Because the results of this test are unreliable, they should be given little to no weight in determining the claimant's present ability to work. Furthermore, because the claimant returned to gainful employment and worked for over three-and-half years after her injury, she is not entitled to permanent partial disability benefits in excess of the percentage of permanent physical

impairment established by a preponderance of the medical testimony and evidence, which is 5%. Finally, at the time of the claimant' hearing, she was 49 years old. Although she does not hold a high school diploma, the claimant has shown by obtaining her CNA credentials that she is capable of training. Moreover, the claimant testified that while in high school, she, at least, considered herself to be intelligent. Based upon the above and foregoing, I find that the claimant has failed to prove that she is entitled to permanent partial disability benefits in excess of her 5% anatomical impairment, which was accepted and paid by the respondents.

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

KAREN H. MCKINNEY, Commissioner