

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F302438

DETHRA R. GARDNER, EMPLOYEE	CLAIMANT
AREA AGENCY ON AGING, EMPLOYER	RESPONDENT
RISK MANAGEMENT RESOURCES, CARRIER	RESPONDENT

OPINION FILED JANUARY 4, 2006

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 MICHAEL J. DENNIS, Attorney at Law, Pine Bluff, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal this case to the Full Commission from an opinion filed by an Administrative Law Judge on May 12, 2005. The sole issue on appeal is the claimant's entitlement to additional medical benefits under the direction of Dr. Hart as awarded by the Administrative Law Judge.

Our carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove by a preponderance of the evidence that she is

entitled to additional medical benefits. Therefore we find that the decision of the Administrative Law Judge is hereby reversed and this claim for additional medical benefits is denied and dismissed.

The compensability of the claimant's injury is undisputed by the parties. On June 5, 2001, the claimant slipped and fell sustaining minor injuries to her lower back and left knee. More specifically, the medical records reveal that the claimant sustained a contusion to her left knee and a back strain as a result of her work related injury. Medical benefits, under the care and treatment of Dr. John Lytle, have been paid by the respondent. Moreover, the claimant was granted a change of physicians to Dr. Thomas Hart, who had been treating her for cervical injuries resultant from a motor vehicle accident. Dr. Hart referred the claimant to Dr. Martin for her continuing knee complaints, and to Dr. Harry Akin for her lower back. The record contains no medical documentation pertaining to Dr. Akin's treatment, but it has been acknowledged that the claimant has undergone surgery with Dr. Akin.

The claimant testified that she received medical treatment on the same day of her accident from Dr. Ralph Maxwell. The record is devoid of any documentation regarding this initial treatment, but a record from the Monticello Family Health Care Center dated November 8, 2001, indicates that the claimant was assessed on that date with multiple contusions to her left knee, and with lumbar strain. The record further reflects that Dr. Maxwell referred the claimant to Dr. Lytle, an orthopaedic surgeon for follow up treatment.

The claimant was first seen by Dr. Lytle on November 29, 2001. On that date, Dr. Lytle examined the claimant and diagnosed her with a contusion to her left knee and leg, leg weakness, and leg pain. In his report of that examination, Dr. Lytle stated:

Ms. Gardner is a 36 y/o lady I am seeing today at the request of Dr. Ralph Maxwell because of her leg. When specifically asked on three different occasions by me about why she is here today, she reminds me that she fell. When I specifically ask, she finally tells me that her leg hurts. She has no other complaints.

Dr. Lytle's physical examination showed no neurological deficits and he observed no paravertebral muscle spasm. The claimant's range of motion and her left knee strength were normal, as was her gait. Dr. Lytle reported that the claimant could toe to heel walk with "excellent strength and control". In addition, Dr. Lytle stated:

This injury is so remote that I cannot see any specific residual from it at this time. However, because of her continued subjective complaints of pain and as this sounds like weakness and deconditioning, I think it is appropriate for her to learn and do exercises.

Accordingly, Dr. Lytle referred the claimant to physical therapy for comprehensive leg strengthening and lower back conditioning. Dr. Lytle completed his report by stating:

I do not think this will be long-term.
5) She continues to work full, active duty and I think this is safe for her to continue that.

On January 14, 2002, the claimant returned to Dr. Lytle for a follow up of her back and leg pain.

Dr. Lytle stated in his note of that visit that the claimant continued to report some muscle spasms in her leg and back, but that he had not witnessed any spasms. Also, according to Dr. Lytle, the claimant was continuing to work full active duty. Dr. Lytle's physical examination of the claimant on that date was consistent with his previous examination: the claimant could toe to heel walk with excellent strength and control, and she exhibited no evidence of paravertebral muscle spasm. Dr. Lytle released the claimant on that date, stating that she had reached maximum medical improvement for her work related injuries.

The record reflects that on September 3, 2002, the claimant was seen in neurosurgical consultation by Dr. Steven L. Cathey from a referral by Dr. Sandra Sheiron. According to Dr. Cathey's report of that examination, the claimant had been involved in a automobile accident on August 12, 2002, which resulted in a musculoskeletal cervical injury superimposed over a congenital defect at C6-7. The claimant apparently failed to inform Dr. Cathey that she had undergone a cervical fusion at C6-7 ten years prior, performed by Dr. P.B. Simpson. Otherwise, as of her

September 3rd examination, the claimant's diagnostic studies of her cervical spine were normal. Upon her follow up visit with him on September 17, 2002, Dr. Cathey stated that he discussed the claimant's treatment options with her, which did not include surgery. Dr. Cathey suggested, however, that the claimant might benefit from a comprehensive pain management program.

The claimant was next seen by Dr. Lytle on January 6, 2003, almost a year after he had released her from his care. At that time, the claimant reported to Dr. Lytle that her right leg and knee were giving way on her, causing her to have muscle spasms. Dr. Lytle stated that these symptoms presumably stemmed from an accident that the claimant had in December of 2001. The claimant also reported that she was experiencing anterior thigh pain down her lower left leg with tightness and spasms. Dr. Lytle noted that the claimant's physical therapy was apparently helping alleviate her symptoms, but he added that the claimant was not following up with her reconditioning exercises outside of her formal therapy. Based on his

physical examination of the claimant that day, Dr. Lytle stated:

She is significantly overweight. She walks with a waddling type gait. She appears to be neurologically intact in both lower extremities. She is able to toe and heel walk satisfactorily. She has full ROM of her hip, knee, leg, and ankle.

Dr. Lytle further stated that x-rays taken of the claimant's lumbar spine, which showed a portion of the claimant's hips, revealed no gross degenerative changes, good alignment, and well maintained disc spaces. Dr. Lytle advised the claimant to "work diligently" on her exercises, and he stated that she could continue to work full, unrestricted duty.

In a letter that Dr. Lytle wrote to Ms. Jill Johnson, a claims specialist for the respondent carrier, dated February 13, 2003, he stated:

I do feel that the problems that Ms. Gardner is experiencing can be related back to her original injury. However, I think the primary problem at this point is that she has not rehabilitated herself.

It is a very difficult problem in that Ms. Gardner obviously has a difficult time understanding the importance of this and how this will affect her long-term. My only recommendation is close supervision of a rehab program that must be very supportive and very hands on. Otherwise, Ms. Gardner will fail.

Dr. Lytle saw no benefit in further diagnostic testing or evaluation, and he did not view the claimant as a candidate for surgery.

On September 8, 2003, the claimant returned to Dr. Hart with neck and shoulder complaints. Dr. Hart explained to the claimant that she had disc protrusions at C4-5, and C5-6, above her previous fusion site at C6-7. He recommended that she undergo a series of epidural treatments, but Dr. Hart did not recommend surgery at that time.

On October 6, 2003, the claimant returned to Dr. Lytle complaining of leg numbness and lower back pain. Upon his physical examination of the claimant, Dr. Lytle could again find no objective explanation for her symptoms. At that time, Dr. Lytle observed that the claimant walked without a limp, she could toe to heel walk with excellent

strength, he observed no obvious residual abnormality of her leg, and her strength had seemingly improved in that she could squat, stand, and do a straight leg raises. Dr. Lytle noted no particular problems from palpation of the claimant's lower lumbar spine, although the claimant did report tenderness in the gluteal region of her left hip. Dr. Lytle's impression of the claimant's condition on that date was "Back and leg pain - Etiology not understood." Dr. Lytle referred the claimant for an MRI. This diagnostic study, which was taken on October 14, 2003, revealed mild or early degenerative changes at L3-L4, with no evidence of posterior disc herniation or canal narrowing.

On November 3, 2003, and November 6, 2003, the claimant presented to Dr. Sylvia Simon at the Monticello Medical Clinic, with complaints of knee pain and muscle spasms. In the clinic note from November 3rd, Dr. Simon noted, "seen here 7 days ago - wants pain med[ication] and work excuse [un]til she can see Dr. Hart on 11/17". Subsequently, an x-ray taken of the claimant's left knee on November 6, 2003, showed only an irregularity on the surface

of the patella with no obvious fracture. Otherwise, the claimant's left knee was normal.

On November 17, 2003, the claimant was seen in follow up by Dr. Hart, who stated that she was neurologically intact with no signs of complications. Based upon his review of the claimant's essentially normal recent MRI and no obvious pathological explanation for her symptoms, Dr. Hart opined that the claimant's continuing complaints of lumbar pain were attributable to discogenic pain, for which he recommended an epidural injection.

Dr. Hart further stated:

At this point Ms. Gardner informed me again that this is a worker's comp, which I have not been involved in since we were addressing her neck pain complaints from her motor vehicle accident.

A slip from the Monticello Medical Clinic dated December 30, 2003, reflects that claimant was excused from work for two days per Dr. Simon due to her left knee. On January 29, 2004, the claimant was examined by Dr. Hart, who at that point was pushing for a discography due to her continuing complaints of pain. It is noted that in his

report of that visit, as with his other reports, Dr. Hart was openly critical of the medical care and treatment that the claimant had received from other health care professionals, particularly Dr. Lytle. Ultimately, Dr. Hart referred the claimant for an evaluation by Dr. Martin, and for an MRI of her left knee.

On February 24, 2004, the claimant underwent a discography at the direction of Dr. Hart. At the claimant's next appointment of March 9, 2003, Dr. Hart reported to her that this diagnostic study revealed "intervertebral disc disruption with discogenic pain," which he planned to treat with percutaneous discectomy.

On March 8, 2004, the claimant underwent a functional capacity evaluation. In his report of that evaluation, the evaluator made the following comments:

The results of the evaluation suggest that Ms. Gardner gave an unreliable effort, with 14 of 46 consistency measures within expected limits. Ms. Gardner reported a pain rating of 10+ on the 0-10 analog pain scale during intake and reported this pain throughout the evaluation. Ms. Gardner was advised that a pain rating of 10 meant she needed medical attention and would not be able to participate in the evaluation

if she was in that much pain. The explanation did not alter Ms. Gardner's rating of pain. ...

The evaluator further commented that the claimant demonstrated inconsistent abilities during all portions of the evaluation. He followed this comment with detailed examples of these inconsistencies. The evaluator also stated that the claimant was positive on Waddell's signs for non-organic exhibited inappropriate illness responses concerning her bilateral lumbosacral area, along with reports of increased back pain with passive hip rotation and light axial compression. For example, although the claimant had been observed walking approximately 50-plus feet from one testing area to another without complaint of increased pain, she could only walk 12 feet before stopping with complaints of increased pain and leg tightness during formal testing. Finally, the claimant demonstrated body mechanics and lifting techniques not expected in someone with complaints of the most severe level of pain in her lower back and lower extremities. The claimant did not complete the evaluation due to her subjective complaints of unbearable pain. Because

of her unreliable effort during this evaluation, the claimant was assessed with the ability to work at a sedentary type job only. However, in his letter to Ms. Johnson dated April 1, 2004, Dr. Lytle stated:

It is my clinical opinion that this significantly understates Ms. Gardner's actual function. In my opinion, she can do her job as a nursing assistant working for the Area Agency without limitation.

On August 13, 2004, in what appears to be a three-page letter to the claimant's attorney, Dr. Hart stated that the claimant's neck pain was directly related to her automobile accident. In an earlier paragraph, Dr. Hart stated that the claimant's "intractable back complaints" were directly related to her work related injury, as opposed to her automobile accident. He did not, however, explain the objective basis for his opinion regarding the cause of the claimant's back complaints. Dr. Hart went further to lambast the insurance industry, which he accused of having "poorly trained personnel who appear to have honorary medical degrees and make medical decisions."

Although Dr. Hart's frustration that the respondent does not accept *carte blanche* responsibility for providing the claimant with any medical treatment which he opines will "help her" is somewhat understandable, Arkansas Worker's Compensation law does not require the respondent to do so. According to Ark. Code Ann. §11-9-508(a), employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Injured employees, however, 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). Furthermore, 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). Lastly, the respondent is only responsible for medical services which are causally related to the compensable injury.

The preponderance of the evidence demonstrates that the claimant sustained a back strain and contusions to her left knee as a result of her fall in June of 2001. The respondent provided comprehensive medical treatment for those minor injuries well beyond the date at which Dr. Lytle assessed the claimant to be at maximum medical improvement, which was January 14, 2002. Even after the claimant was released by Dr. Lytle, she continued to receive medical treatment from him for her continuing complaints, and the respondent continued to pay for that treatment. However, numerous physical examinations and diagnostic studies conducted throughout the course of the claimant's treatment failed to produce objective findings to corroborate the claimant's continuing subjective complaints of unbearable pain. For example, the claimant's neurological examinations were consistently normal, and there were no observable muscle spasms upon examination. X-rays taken of the claimant's back and knee showed normal findings. Furthermore, an MRI taken in October of 2004 showed findings consistent with an MRI taken in 1996 following a rear end collision in which the claimant was injured. More

particularly, a report dated May 28, 1996, by the claimant's general practitioner, Dr. Simpson, states:

Patient initially seen in 1993 for neck, right shoulder, and right arm pain with surgery following on 4/06/93 for a HNP at C6-7 on the right. Ms. Gardner was involved in a motor vehicle accident on 3/25/96. ... She was complaining of pain in her neck and lower back. She has also complained of pain in both hips and both shoulders. ... She now complains of mainly pain in the lower lumbar area.

...

Her MRI of her lumbar and cervical areas done on May 3, 1996 at Drew Memorial show that there is no evidence of any significant abnormality in the cervical area other than some fusion changes at C6-7. The only thing that I see in the lower lumbar area is on the T2 weighted images she has some degenerative changes with loss of water content and loss of bright signal in the 3-4 disk. She has some mild minimal bulging at the 4-5 disk, but no evidence of any herniation.

Accordingly, Dr. Simpson diagnosed the claimant with lumbar strain, mild resolving cervical strain, and post-operative cervical disc. Dr. Simpson released the claimant to regular work duties in two weeks after that examination.

Likewise, the claimant's MRI taken on October 14, 2003, showed precisely the following:

There is a loss of T2 signal of the L3-L4 intervertebral discs without evidence of posterior disc herniation. The rest of the intervertebral discs are normal.

When questioned about this 1996 motor vehicle accident during her hearing, the claimant could not recall it. This was in spite of her having received emergency medical care and having been hospitalized overnight for observation. Nor could the claimant recall having been treated by Dr. Simpson in follow-up from this accident. However, the claimant readily remembered her head on collision which occurred in August of 2002, and in which she testified that she injured only her neck. In addition, the claimant's FCE, which was conducted in March of 2004, plainly demonstrated that the claimant was engaging in symptom magnification, as her symptoms did not correlate with her objective physical findings. Certainly, questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. White v. Gregg Agricultural Ent., 72 Ark.

App 309, 37 S.W.3d 649 (2001). Clearly, the claimant has proven herself to be unreliable and inconsistent in her responses both outside and inside the courtroom. Therefore, her testimony concerning the alleged severity of her symptoms should be given little weight.

The February 2004 discography, which according to Dr. Hart, "clearly demonstrates that she has an abnormal disc", was conducted over three years after the claimant's fall in June of 2001. When Dr. Lytle first saw the claimant, some three months after her fall, he commented that her injury was "so remote" that he could see no residual signs of her having sustained an injury. Furthermore, from the time of the claimant's first visit with Dr. Lytle through the time when the claimant underwent her FCE, the claimant's neurological findings remained consistently within normal limits with no observable or measurable signs of a lumbar injury, such as muscle spasms. Whereas Dr. Lytle, who was the claimant's primary treating physician regarding her compensable injury, has opined that the claimant's current condition is not related to that injury, Dr. Hart, who had been the claimant's treating physician primarily for her

neck complaints, has opined that the claimant's back complaints are linked to her fall of June 2001. It is well established that the Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. CDI Contractors v. McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993). Dr. Lytle's opinion is based upon his examinations of the claimant from shortly after her fall in June 2001, throughout his continuing treatment of the claimant over the next 2½ years. The claimant was granted a change of physician in reference to her lumbar spine and knee to Dr. Hart, who was treating her for her cervical symptoms. However, the claimant's testimony reflects that Dr. Hart's treatment was not beneficial. Therefore, Dr. Hart eventually referred the claimant to Dr. Akins. However, the record is devoid of any medical documents from the claimant's treatment with Dr. Akins, however. In our opinion, Dr. Lytle's opinion is entitled to more weight than is Dr. Hart's.

Finally, the Administrative Law Judge reasoned that the claimant's motivation to continue to work full duty

and pay for her own testing with Dr. Hart evidences that her complaints of pain were not exaggerated. However, the fact that the claimant continued to work after her fall, indicates quite the opposite. Surely, had the claimant been experiencing the degree of pain of which she continuously complained to doctors, she could not have maintained a full time job in a fairly physically demanding position. Moreover, the claimant only missed two months of work during the entire time that she was under treatment for her alleged lumbar back and knee injuries, and that was after her latest automobile accident. In addition, we do not find the fact that Dr. Lytle did not order an MRI of the claimant's lumbar spine for almost 2½ years after her compensable fall, determinative of whether or not the claimant's current lumbar disc abnormalities are causally connected to her compensable injury. The claimant's most recent MRI shows that the claimant's lumbar condition has not changed since her MRI of 1996. Therefore, the claimant's disc abnormalities were clearly not the result of her compensable injury of 2001. Rather, as the respondent has asserted, the disc abnormalities seen in the claimant's 2004 MRI were

preexisting, and are, therefore, not causally connected to the claimant's fall of 2001.

Based upon the above and foregoing, we find that the claimant has failed to prove that she is entitled to additional medical treatment. The decision of the Administrative Law Judge is hereby reversed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.