

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F503801

BILLY G. SWEANEY, EMPLOYEE	CLAIMANT
LA DARLING CO., EMPLOYER	RESPONDENT
MANAGEMENT CLAIM SOLUTIONS, CARRIER	RESPONDENT

OPINION FILED NOVEMBER 17, 2006

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

Claimant represented by HONORABLE KENNETH A. OLSEN, Attorney at Law, Little Rock, Arkansas.

Respondent represented by HONORABLE GAIL O. MATTHEWS, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal the decision of the Administrative Law Judge finding that additional surgery to the claimant's left elbow is reasonable and necessary. Based upon our de novo review of the entire record, we find that the claimant has failed to meet his burden of proof. Therefore, we find that the decision of the Administrative Law Judge must be reversed, and this claim for benefits denied and dismissed.

The claimant sustained an admittedly compensable injury to his left elbow for which he underwent surgery to

remove a loose body and inflamed synovium. Claimant's surgeon, Dr. David M. Rhodes, noted in his follow-up reports that the claimant also had degenerative arthritis in his left elbow which is continuing to cause some discomfort for the claimant. After being released by Dr. Rhodes without an impairment rating, the claimant requested and received a change of physician to Dr. Randy R. Bindra, at UAMS. Dr. Bindra ordered several diagnostic studies of the claimant's elbow, all of which revealed negative findings. Moreover, these tests failed to support Dr. Rhodes' diagnosis of arthritis. Despite the lack of physical findings, Dr. Bindra has recommended surgery in the nature of reconstruction of the collateral ligament complex.

Ark. Code Ann. §11-9-508(a) provides that an employer shall provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Wal Mart Stores, Inc. v. Brown, 82 Ark. App. 600, 120 S.W.3d 153 (2003). However, employers are only liable for medical treatment and services which are deemed reasonably necessary for the treatment of

the employee's injuries. DeBoard v. Colson Co., 20 Ark. App. 166, 725 S.W.2d 857 (1987). The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary for the treatment of the compensable injury. Wal Mart Stores, Inc. v. Brown, supra; Specialty Chem. v. Clingan, 69 Ark. App. 369, 13 S.W.3d 218 (2000); Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999). What constitutes reasonable and necessary medical treatment is a question of fact for the Commission. Wackenhut Corp. v. Jones, 73 Ark. App. 158, 40 S.W.3d 333 (2001); White Consolidated Indus. v. Galloway, 74 Ark. App. 13, 45 S.W.3d 396 (2001); Air Compressor Equip. v. Sword, 69 Ark. App. 162, 11 S.W.3d 1 (2000); Gansky v. Hi-Tech Engineering, 325 Ark. 163, 924 S.W.2d 790 (1996).

Further, when the primary injury is shown to have arisen out of and in the course of employment, the employer is responsible for any natural consequence that flows from that injury. Wackenhut, supra. The basic test is whether there is causal connection between the two episodes. Id. 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. Gardner v. Area Agency on Aging, Full Workers' Compensation Commission Opinion filed January 4, 2006 (Claim No. F302438); Deborah Jones v. Seba, Inc., Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553).

The only support for this recommended surgery as found in Dr. Bindra's medical records is the claimant's subjective complaints of pain and feeling of subluxation. Dr. Bindra has not supplied any objective, medical basis for the recommended surgery. On the other hand, Dr. Rhodes unequivocally stated in his February 27, 2006, letter to respondents that during surgery "it was found that with passive range of motion of the elbow there was catching of inflamed tenosynovium between the radial head and capitellum. There was no instability found consistent with a radial collateral ligament tear and the anular ligament was not noted to be inflamed." Accordingly, when we analyze both the proposed procedure and the condition it is sought to

remedy, we cannot find that the proposed procedure is reasonable and necessary medical treatment in connection with the claimant's compensable injury. Neither the diagnostic studies nor the intra-operative findings suggest any evidence of collateral ligament tear. Therefore, we find that the recommended surgery is not reasonable and necessary in connection with the claimant's compensable injury. Accordingly, the decision of the Administrative Law Judge is hereby reversed and this claim for additional medical treatment is 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.

DISSENTING OPINION

I must respectfully dissent from the Majority opinion which reverses the April 26, 2006, decision to award the claimant medical benefits in the form of a second

surgery to his left elbow. In my opinion, the medical records show that from the onset of the claimant's injury, he was diagnosed with swelling and an unstable ligament as shown by the MRI indicating he had swelling and a torn ligament. Likewise, while Dr. Rhodes opined the claimant suffered from arthritis, Dr. Bindra specifically noted that he had an MRI performed to rule out osteoarthritis as the reason for the claimant's need for surgery. Finally, there is simply no explanation as to why the claimant would be totally asymptomatic until after the time of his injury, unless his need for surgery was directly related to the admittedly compensable injury. For these reasons, I would have affirmed the decision of the Administrative Law Judge.

The claimant was injured at work on May 20, 2004, while operating a machine. The claimant testified that he was pulling on a part and then immediately suffered a sharp pain and stinging in his arm. The claimant reported the injury, but continued to work despite his injury. The claimant testified that some five to six weeks later his symptoms had not resolved and that after his supervisor saw

the swelling in his arm, he was taken to the emergency room.

A medical report dated July 9, 2004, from the Arkansas Methodist Medical Center indicates the claimant submitted to an MRI. The claimant was assessed with,

1. Moderate joint effusion with partial tear and abnormal signal, edema of the radial collateral ligament
2. Inflammatory change involving the annular ligament.

On July 13, 2004, Dr. Ron Schechter noted the claimant had mild swelling around his elbow. He further noted the claimant's MRI showed, "some edema around the radial and an annular ligament." He further opined,

I advised the patient that his history, exam and radiographic studies are suggestive of an unstable radiocapitellar joint with disruption of the lateral collateral ligament complex and recurrent dislocations other regional head. I believe he is unstable enough that he may require surgical intervention.

He referred the claimant to an orthopedic specialist.

On May 20, 2004, Dr. David M. Rhodes treated the claimant for his elbow. He noted the claimant's MRI showed,

"moderate joint effusion with partial tear and abnormal signal edema of the radial collateral ligament, inflammatory changes involving the annular ligament." Dr. Rhodes diagnosed the claimant with, "Possible radial collateral ligament, annular ligament tear." He also recommended a second reading of the claimant's MRI. On August 19, 2004, Dr. Rhodes indicated that the new reading showed a small osteophytic spur and possible tear of the extensor tendon. He diagnosed the claimant with a loose body and recommended the claimant undergo surgery.

On September 8, 2004, Dr. Rhodes indicated that the claimant underwent surgery to have removal of loose body. He also noted that he had removed synovium that was causing catching in the claimant's joint. The claimant briefly reported that his elbow had stopped popping and catching. The claimant was seen three times in which Dr. Rhodes failed to indicate the claimant had arthritis. Then on November 11, 2004, Dr. Rhodes indicated that the claimant was being assessed for "Status post left elbow synovectomy and degenerative arthritis." He released the

claimant to return to full duty without any impairment rating. He also told the claimant he would continue to have some "discomfort" in his elbow but that it would be related to his arthritis and would not be work-related.

\_\_\_\_\_ On November 10, 2004, the claimant was treated by Dr. Paul Cooper. Dr. Cooper noted the claimant reported popping and snapping in his elbow. He further indicated the claimant had noticed such popping and snapping before his surgery and indicated the claimant had "minimal residual edema" in his elbow.

On January 17, 2005, Dr. Rhodes treated the claimant for pain and crepitation, noting that he had previously treated the claimant. He opined, "He had an MRI that showed acute changes and also chronic changes consistent with osteoarthritis." He noted the claimant had osteophytic spurs in his elbow. He diagnosed the claimant with a "Flare-up" of his arthritis and indicated the claimant's ongoing pain was not related to his past work injury.

The claimant became dissatisfied with Dr. Rhodes' treatment and requested and was given a change of physician. On September 19, 2005, Dr. Randy R. Bindra assessed the claimant. Dr. Bindra noted that during the first surgery, Dr. Rhodes failed to document the severity of the claimant's arthritis, the amount of lost articular cartilage, or the size of the removed loose body. Dr. Bindra repeated x-rays, which he noted showed no signs of osteoarthritis. Dr. Bindra opined as follows,

In my opinion, it is possible this gentleman may have some osteoarthritis in his elbow. However, most of his symptoms appear to be stemming from instability of the elbow, which appears to have resulted when he first had his injury.

Dr. Bindra also indicated that the claimant might eventually need a surgery in the form of a reconstruction of the collateral ligament complex and arranged for the claimant to undergo another MRI and an MR arthrogram in order to, "evaluate the lateral collateral ligament complex fully and to see if he has any additional loose bodies or any other signs of arthritis in his elbow."

One test revealed the claimant might have a loose body or a spur in his elbow. The MRI revealed the claimant suffered from lateral epicondylitis, but that his ligaments were intact. Based on these findings, Dr. Bindra diagnosed the claimant with a possible lateral collateral ligament injury and recommended surgery. In making this recommendation, Dr. Bindra indicated that the MR was, "essentially negative for any loose bodies or other reasons for his pain," and indicated that the claimant appeared to have a lateral ulnar collateral ligament injury.

\_\_\_\_\_ Upon the claimant's request to undergo the surgery recommended by Dr. Bindra, the respondents requested additional information regarding the need for surgery. Ultimately, they denied the surgery, but at the hearing maintained that they were not necessarily denying the surgery, but rather that Dr. Bindra had not given adequate physical findings to show why the claimant needed surgery.

The Majority finds that because the claimant allegedly failed to show physical findings indicating a need for surgery, he should be denied benefits. They further

contend that the claimant's diagnostic tests returned as normal and rely on Dr. Rhodes opinion that the claimant did not suffer from instability. However, after reviewing the records, I find that the evidence simply does not comport with the Majority's findings.

The record reflects a long history indicating the claimant suffered from instability in his elbow. Both MRI readings from before the claimant's first surgery indicated the claimant suffered from at least a partial tear of the radial collateral ligament. Likewise, both Dr. Schecter and Dr. Rhodes made notation that the claimant's ligament was torn. In fact, Dr. Schecter, after viewing the MRI diagnosed the claimant with an unstable radiocapitellar joint and indicated that the claimant might need surgical intervention to correct the instability. Likewise, Dr. Rhodes diagnosed the claimant with, "Possible radial collateral ligament, annular ligament tear," and indicated the claimant might need to undergo surgery.

The claimant underwent surgery, but his instability and pain did not resolve. The undisputed

testimony of the claimant indicates he suffered from snapping and popping, and swelling of his elbow. Likewise, multiple reports after the first surgery suggest the claimant suffered from at least some degree of edema in his elbow. Specifically, I note that on November 5, 2004, Dr. Cooper noted the claimant's complaints of popping and snapping and indicated the claimant had, "no significant edema." On November 10, 2004, Dr. Cooper noted the claimant had, "minimal residual edema," which further supports a finding the claimant had at least some degree of edema even after his initial surgery.

I note the Majority's assertion that the claimant's surgery was based on subjective reports of pain and subluxation. However, the facts do not support this finding. Dr. Bindra's recommendations are contained in a November 4, 2005, report which followed three physical examinations and diagnostic testing. That diagnostic testing included an MRI indicating the claimant had at least a partial tear to his tendon and an MRI revealing epicondylitis and which was interpreted to exclude the

possibility that arthritis or a loose body were the cause for the claimant's need for surgery. Furthermore, the claimant was noted to have popping and snapping and swelling, which was reported immediately after the admittedly compensable injury and continued to present even after his first surgery.

Furthermore, I note that under Arkansas Workers' Compensation Law, while the claimant has to show objective findings to show a compensable injury, he is not required to show objective findings in order to receive medical treatment. See, Chamber Door Industries, Inc., v. Graham, 59 Ark. App. 224, 956 S.W.2d 196 (1997); See also, Green Bay Packing v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999).

I also note the respondents' reliance on Dr. Bindra, in asserting that the claimant's symptoms were due to pre-existing arthritis rather than being due to instability. I find this argument to be unpersuasive for numerous reasons. First, Dr. Rhodes initially diagnosed the claimant with an unstable joint and specifically noted the

diagnostic studies which supported that diagnosis. Additionally, even after the claimant had surgery, Dr. Rhodes indicated that the diagnostic studies initially performed showed, "acute changes and also chronic changes consistent with osteoarthritis." When considered in conjunction with the fact that the x-ray performed by Dr. Bindra failed to reveal osteoarthritis, I find it is improbable that arthritis was the reason for the claimant's need for surgery.

More importantly, I note that the claimant testified he had never suffered from popping or snapping in his elbow and had never had problems with his elbow prior to his admittedly compensable injury. This testimony is unrefuted and corroborates the findings in the medical records throughout the course of the claimant's treatment. Additionally, when considering that the claimant's symptoms were the same immediately after the injury and first surgery, and the diagnostic studies showing epicondylitis and a torn ligament, I find it is only logical to conclude that the claimant's reason for ongoing symptoms was due to

instability rather than arthritis. Therefore, I find that the claimant's request for surgery was reasonably necessary to treat his admittedly compensable injury.

For the aforementioned reasons, I must respectfully dissent.

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SHELBY W. TURNER, Commissioner