

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F402644

JERRY D. SWINK,
EMPLOYEE

CLAIMANT

RICELAND FOODS, INC.,
EMPLOYER

RESPONDENT

LIBERTY MUTUAL INSURANCE CO.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED AUGUST 8, 2006

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

Claimant represented by the HONORABLE GARY DAVIS, Attorney
at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE MIKE RYBURN,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's
opinion filed February 17, 2006. The administrative law
judge found, among other things, "that Dr. Shahim's
treatment was reasonable, necessary and related to the
compensable injury." After reviewing the entire record *de*
novo, the Full Commission reverses the administrative law
judge's opinion. The Full Commission finds that the
claimant did not prove Dr. Shahim's surgical treatment was

reasonably necessary in connection with the injury received by the claimant. We find that the claimant did not prove he was entitled to temporary total disability compensation.

I. HISTORY

Jerry Don Swink, age 54, testified that he had surgery to his neck in 2002. The claimant testified that he eventually returned to work and "my neck was doing fairly well."

The parties stipulated that the claimant sustained a compensable injury on September 16, 2003. The claimant's testimony indicated that a "spider climber" device on which he was working, "like a basket," malfunctioned and "threw me all over." The claimant testified that he "couldn't hardly even move my neck" when he woke up the next morning. The claimant testified that he had pain "from the center of my shoulders - in between my shoulder blades - all the way up my neck."

Dr. Charles E. Pearce, Jr. saw the claimant on October 9, 2003 and noted, "Mr. Swink is a 52-year old right-handed man who, about 3 weeks ago while at work, was using what he describes as a 'spider climber' which caught and fell about 2 feet. He struck the left side of his head and neck

against a rail, and has had neck and shoulder girdle pain since." Dr. Pearce's impression was "Left neck and shoulder girdle pain in a patient with a normal exam." Dr. Pearce recommended, "Since he has had recent surgery on his neck, I think that he needs to be further evaluated by his operating surgeon; and we will ask for him to be seen by Dr. Shahim."

An x-ray of the claimant's cervical spine was taken on October 20, 2003, with the impression, "Metallic artifact from prior surgery, probably from fusion device identified at C5 and C6. This obscures the C5-6 foramen at this level. Mild disk bulges at C3-4, C4-5, C6-7. Foraminal stenosis at C6-7 due to uncovertebral spurs."

Dr. Shahim saw the claimant on December 11, 2003:

He is status post cervical discectomy at C5-6 from a year ago. He continues to complain of neck and shoulder discomfort. He has had very severe posterior neck pain and left sided shoulder pain. He complains of a tingling sensation in both arms, particularly on the left side....

I reviewed an MRI obtained on Mr. Swink and this is a very poor quality MRI that shows a disc herniation at C6-7.

Dr. Shahim planned additional diagnostic studies, including a CT cervical myelogram.

A cervical spine myelogram was taken on January 8, 2004, with the impression, "1. Plate and screw fixation at C5-C6 with solid bony union at this level. 2. Ventral impression upon the anterior thecal sac at C6-C7 with no definite nerve root sleeve filling at this level on the left."

And a CT scan of the cervical spine without contrast was taken on January 8, 2004, with the following impression:

1. Posterior osteophytes at the inferoposterior end plate of C6 and superior-posterior end plate of C7. These produce moderate impression upon the anterior thecal sac.
2. Diffuse degenerative facet hypertrophic changes.
3. Anterior end plate and screw fixation at the C5-6 level with partial solid bony union at this level. There is mild relative decrease in CSF space seen circumferentially at the C6-7 level.
4. No focal herniated nucleus pulposus.

Dr. Shahim noted on January 12, 2004:

Mr. Swink is status post work injury. He says that last year a ladder fell on him at work and this has resulted in neck and shoulder pain. He complains of numbness in both hands, pain radiating from the neck into the left shoulder and at times into the right shoulder.

I obtained a CT cervical myelogram on him and I reviewed that today with him. He does have foraminal stenosis at C6-7. This is below the cervical diskectomy at C5-6. This is caused by ligamentous hypertrophy and disc herniation at this level.

Mr. Swink has mainly axial symptoms and his symptoms were brought on by an injury and for this reason I would prefer to manage him conservatively. I recommended to him to undergo trigger point injections by pain management and also cervical epidural steroid injections. I will plan on following up with him in the clinic in a few months.

The claimant began treating with a pain manager, Dr. M. Carl Covey, in February 2004. The claimant testified that an injection from Dr. Covey "didn't seem to help that much."

Dr. Shahim noted in April 2004:

Ms. Swink (sic) is status post cervical injury after a work injury. He has had chronic neck, shoulder and arm pain. He has undergone physical therapy with no improvement. He complains of posterior neck pain, interscapular pain and pain radiating to both shoulders. I reviewed her (sic) cervical myelogram again and he does have nerve root compression at the C6-7 level bilaterally and there is anterior thecal sac compression on these imaging studies. This is adjacent to the C5-6 level fusion.

Mr. Swink continues to work despite significant cervical radicular symptoms. I have given him the option of undergoing a cervical diskectomy and fusion at C6-7. Because of the severity of his symptoms he would prefer to have surgery done....We will plan on anterior cervical decompression and fusion at C6-7.

Dr. Wayne L. Bruffett evaluated the claimant in June 2004:

He has a history of surgery in the past on his neck and also his right elbow by Dr. Shahim. This

involved an anterior cervical discectomy and fusion with plating at C5-6 and an ulnar nerve transposition. Both of these operations helped Mr. Swink with regards to his arm symptoms. He says he (sic) arm is really not bothering him now. His main complaint is neck pain radiating down into his upper thoracic region. He sustained a work-related injury after these surgeries in September 2003. He was thrown into a side rail, striking his head and neck and left shoulder....

I reviewed the myelogram that he had prior to his original surgery, which is dated 03/08/02, and also the myelogram after his work injury. On the study dated 03/08/02 there is degenerative changes and spurring at C5-6. At C6-7 there is decreased filling it appears of the nerve root sleeve out in the foramen on the left side. The right side seems to fill better. I think this is probably due to degenerative changes and foraminal narrowing.

On the more recent study, dated 01/08/04, there is evidence of his surgery at C5-6, which looks great. I do not see any evidence of a focal disc herniation. There are some generalized degenerative changes at the other levels. At C6-7 there appears to be some blunting of the filling of the nerve root sleeves bilaterally, but I do not see any specific nerve root cutoff on his myelogram per se.

Dr. Bruffett gave the following impression: "1.

Previous anterior cervical discectomy and fusion, which looks great. 2. Previous ulnar nerve transposition on the right side. 3. Degenerative disc disease, cervical spine. 4. Cervical strain. 5. Axial neck pain and upper thoracic back pain."

Dr. Bruffett planned the following:

He has continued to be treated by Dr. Shahim appropriate (sic), in my opinion, and he has been managed nonsurgically up to this point for his more recent injury. On 04/14/04, because of an inability to improve symptomatically, consideration was given to an anterior cervical discectomy and fusion. At that time Mr. Swink stated he wanted to proceed with this.

Today, I have talked to him more about it, and he says that his main complaint is neck and thoracic pain. He really does not have any radicular arm pain. I have told him that certainly the surgery may be helpful, but I think Dr. Shahim would agree that this is an operation primarily for arm pain. Certainly, neck pain can improve after this type of surgery if there are isolated degenerative changes and that sort of thing, but there is also a chance that Mr. Swink could go through a pretty extensive operation and may have symptoms just as bad as he is having now, and there is also a risk of further complications, such as esophageal injury, tracheal injury, bleeding, etc. I spoke with Mr. Swink about this a little bit longer today, and he really does not want to proceed with the surgery particularly. However, I have certainly left the final decision up to him. I have just tried to educate him about things to the best of my knowledge.

I would recommend that he try some physical therapy again to see if there are any modalities, ultrasound, TENS unit or whatever, that can be done to help with his symptoms....I would like for him to see Dr. Brent Sprinkle for continued nonsurgical management. He seems to be in agreement with this. He is going to come back and see me as needed.

The claimant subsequently began treating with Dr. Brent Sprinkle, D.O., a physical medicine & rehabilitation specialist. Dr. Sprinkle's impression in June 2004 was "1. Exacerbation of cervical degenerative disc disease. 2. Cervical myofascial pain."

Dr. Sprinkle arranged an EMG study and reported on June 30, 2004, "I do not see any evidence of cervical radiculopathy on the EMG. There is evidence of median and ulnar nerve entrapment bilaterally, and those could explain the sensory hand complaints. However, that would not have been caused by his work-related injury. I have advised him to pursue his regular medical insurance to address those findings."

The claimant continued to treat with Dr. Sprinkle. Dr. Sprinkle stated in August 2004, "I again reiterated, since his pain is non-radicular primarily axial neck pain and he has also seen Dr. Bruffett, I do not see any evidence here to suggest that surgery would have any significant improvement in his symptoms and has significant potential to make his neck pain even worse."

After treating the claimant on September 14, 2004, Dr. Sprinkle stated in part:

4. At this point I think he is at maximum medical improvement from a nonsurgical standpoint. I just do not know what else to offer him to try to reduce his symptoms. Dr. Bruffett's previous note has indicated that without any clear radicular pain he did not feel confident that a surgery at C6-7 would reduce his symptoms. I would concur with that, but he did leave the decision ultimately to the patient.

5. Mr. Swink expresses a desire to go back to talk to Dr. Shahim, as he recalls Dr. Shahim telling him that he thought he could fix his problem with surgery. I will leave that to the patient's discretion.

6. As far as any return to work restrictions, I would need to obtain a functional capacity evaluation and base any permanent return to work restrictions on that.

The parties stipulated that the respondents paid medical expenses until controverting the claim on September 15, 2004.

The claimant testified that he was taking six to eight doses of Ultracet on a daily basis at about this time.

The following conclusion resulted from a Functional Capacity Evaluation carried out in October 2004: "Mr. Swink underwent functional capacity evaluation with reliable results for a valid FCE. Mr. Swink demonstrated the ability to perform work at the HEAVY Physical Demand Classification with limitations of overhead work as determined through the Department of Labor for an 8-hour day."

Dr. Shahim stated on December 6, 2004:

I have given him the option of undergoing an anterior fusion at C6-7 because of the question of the disc disease at that level. Since he has not had a recent MRI of the cervical spine, I will obtain a new MRI of the cervical spine. He has undergone physical therapy with no improvement. Flexion/extension x-rays of the cervical spine shows (sic) cervical spondylosis above the fusion at C4-5 and also below the fusion at C6-7. There is a solid fusion at the C56 level. I still think Mr. Swink has symptoms due to progression of the adjacent level disease and may benefit from an anterior fusion at the C6-7 level. I will plan on following up with him after his MRI.

Dr. Bruffett informed the claimant's attorney on December 9, 2004, "I received your correspondence dated 12/06/04 regarding the above patient. I saw him on one occasion, on 06/02/04. He has subsequently had treatments by Dr. Brent Sprinkle in our group. I am not aware of his current condition, and, therefore, I do not feel I can appropriately comment on his ability to work, his permanent impairment or his healing period. This could probably be better done by Dr. Sprinkle."

An MRI of the cervical spine without contrast was taken on December 14, 2004, with the following impression:

1. Anterior cervical disc fusion has been performed at the C5-6 level since the previous study.

2. There is a minimal right paracentral protrusion at C4-5, which has developed since the prior examination. It partially effaces the ventral subarachnoid space, but there is no central canal stenosis or clear evidence of neural impingement.
3. There is mild stable left sided foraminal narrowing at C3-4 secondary to asymmetric posterior marginal osteophyte and uncinata spurring.
4. No focal disc extrusion or central canal stenosis is suggested in the cervical spine.
5. Stable 1.5 cm cystic mass in the posterior aspect of the left thyroid lobe is again identified. A colloid cyst is a likely explanation for this finding. However, this could be further evaluated with thyroid ultrasonography, if clinically indicated.
6. A 2.3 x 1.5 x 2.5 cm cystic mass posterior to the left sternocleidomastoid muscle has developed since the previous examination. It is centered at the level of the C5-6 disc. Potential explanations include a third branchial cleft cyst or a cystic necrotic lymph node.

Dr. Shahim noted on December 14, 2004:

We obtained a new MRI of the cervical spine. I reviewed the MRI with him. He has a disc herniation at C6-7. This is more to the left side, causing thecal sac compression. There is spondylosis also at C6-7, resulting in end plate changes and foraminal stenosis. Mr. Swink has had very chronic neck and shoulder symptoms. He complains of pain radiating proximally into the left arm....

Mr. Swink has left sided radiculopathy due to C6-7 disc herniation and spondylosis. He has failed conservative management including trigger point injections. I have given him the option of receiving cervical epidural steroid injections....Because of the severity of his

symptoms, he wants to undergo surgery....Since his symptoms have been very chronic in nature, I don't expect surgery to completely eliminate is (sic) symptoms, but it should certainly reduce his radicular pain. We will plan on anterior decompression and fusion at C6-7.

Dr. Shahim noted in June 2005, "A review of his MRI does show degenerative disc disease at C6-7 below the prior fusion at C5-6. There is foraminal stenosis." Dr. Shahim scheduled yet another CT cervical myelogram. A CT cervical myelogram was therefore taken on June 21, 2005, with the following impression:

Status post cervical fusion anteriorly at C5-6 with changes of cervical spondylosis at C4-5 and C6-7. Severe right and moderate left foraminal stenosis at C5-6 secondary to bony encroachment. Severe right and moderate left foraminal stenosis at C6-7 secondary to uncovertebral osteophytes. Mild left foraminal stenosis due to ipsilateral facet hypertrophy.

Dr. Shahim noted on June 30, 2005:

He underwent a CT cervical myelogram, which shows bilateral foraminal stenosis at C6-7 due to a large osteophyte, more to the right side. There is evidence of prior fusion at C5-6 with foraminal narrowing at that level. MRI of the cervical spine shows progression of disc disease at C6-71....

Mr. Swink is symptomatic from transitional level syndrome at C6-7. His symptoms have been ongoing for many months....We will plan on removal of the plating at C5-6 and fusion at C6-7.

Dr. Shahim performed surgery on July 26, 2005: "1. Exploration of fusion at C5-6 with removal of anterior plating. 2. Anterior decompression and discectomy at C6-7. 3. Partial colpectomy of C6 and C7. 4. Anterior fusion using structural allograft and anterior Syntax plating at C6-7. 5. Interpretation of intraoperative fluoroscopy." Dr. Shahim's pre-operative and post-operative diagnoses were, "Cervical stenosis at C6-7."

Dr. Shahim noted in August 2005 that the claimant "continues to have significant axial neck pain."

A pre-hearing order was filed on September 22, 2005. According to the pre-hearing order, the claimant contended that he "remains symptomatic an (sic) wishes to undergo surgery (cervical fusion) as recommended by his treating physician, Dr. Reza Shahim. The claimant seeks payment of medical expenses, temporary total disability benefits from July 28, 2005 to a date yet to be determined and attorney's fees." The respondents contended that the claimant's injury "was accepted as a temporary aggravation of a previous condition (2002 cervical fusion). He was treated and released for the 2003 injury with no impairment. Any

additional treatment is unrelated, unreasonable and unnecessary."

The parties agreed to litigate the following issues: "Additional medical treatment and payment of expenses; controversion and attorney's fees. All other issues are reserved."

An MRI of the claimant's cervical spine was taken on September 26, 2005, with the impression, "Postoperative changes are present at C5-6 and C6-7. There is no evidence for disk herniation or central canal stenosis. The right side neural foramina are widely patent. Mild-moderate foraminal narrowing for the exiting C6 and C7 nerve roots."

Dr. Sprinkle wrote to the respondents' attorney on September 27, 2005:

In answer to your recent questions, there is not any evidence in the claim that Mr. Swink sustained a new injury. As of the 2003 accident, as I stated in my note of September 14, 2004, he did have a pre- and post-injury CT myelogram. There is a C6-7 disc herniation with compression and mass effect on the left neural foramen evident on the CT myelogram in March 2002. Post-myelogram CT done again on January 8, 2004, also describes similar findings at C6-7, but no focal disc herniations were described on that CT myelogram. Therefore, I would not conclude that the changes at C6-7 would likely be related to his injury in 2003. To me, there is

insufficient objective evidence to support a significant interval change. This is further supported by the negative EMG for radiculopathy. In reviewing this MRI report from December 2004, at C6-7 marginal osteophytes are present and diffuse disc bulge, but no focal disc extrusions are described. There is no clear evidence of central canal stenosis.

However, there could have been an exacerbation of this pre-existing degenerative disc disease and upon that aggravation had reached a point of maximum medical improvement on September 14, 2004. Any future treatment requirements for his neck, I think, would be more related to his pre-existing degenerative disc disease than to any specific injury from this work injury in September 2003. Another surgery, extension of his fusion down to C6-7 as proposed by Dr. Shahim, may be of benefit for his pre-existing degenerative disc disease, but I would not be able to relate the need for that surgery to his injury in 2003.

I am not certain of the exact surgery Dr. Shahim was proposing. I am assuming it was at C6-7, but, without specific radicular complaints, cervical fusion for neck pain only has a poor success rate. The degree of pain relief could be anywhere from a 0% to 50% range and there is a chance of worse pain; however, I would not think that would be the pain reduction related to his injury in 2003.

I do not feel that there is a new disc herniation at C6-7, as described previously in this report. As I have indicated on my exam in September 2004, I do not think a permanent impairment rating would apply, as I think there is sufficient objective evidence to indicate that there is no significant interval change and no significant objective evidence to support any new disc herniations.

Dr. Shahim saw the claimant on October 17, 2005 and indicated, "Return to work 10-17-05. Light duty work status. No lifting over 10 pounds, no repetitive (sic) twisting or bending, follow restrictions until seen back on 12-19-05. If light is not available, remain off work until seen back on 12-19-05."

A hearing was held on November 22, 2005. The claimant testified with regard to the second surgery performed by Dr. Shahim:

Q. Okay, are you better from having had that surgery?

A. Well, I'm not trying to work, but I'm only - I'll take, at the most right now, I'm taking four pills a day.

Q. Okay, so you've been able to lessen your medication a little bit?

A. From the way things have been, yes.

Q. Okay. Have you worked since you had the surgery, Jerry?

A. No.

Q. Have you been able to work since you've had the surgery?

A. Not really, cause I can't keep my mind on stuff.

The claimant agreed that a return appointment with Dr. Shahim was scheduled for December 19, 2005.

The administrative law judge found, in pertinent part:

2. The claimant has proven by a preponderance of the credible evidence of record that he sustained a compensable aggravation of a preexisting condition.

3. The claimant has proven by a preponderance of the credible evidence of record that Dr. Shahim's treatment was reasonable, necessary and related to the compensable injury.

5. The claimant is entitled to temporary total disability benefits from July 28, 2005 to a date yet to be determined as he remained in a healing period, unable to work.

The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a

question of fact for the Commission. *DeBoard v. Colson Co.*, 20 Ark. App. 166, 725 S.W.2d 857 (1987).

In the present matter, the preponderance of evidence does not demonstrate that the surgery performed by Dr. Shahim in July 2005 was reasonably necessary in connection with the injury sustained by the claimant in September 2003. The parties stipulated that the claimant sustained a compensable injury in September 2003. The claimant testified that he was "thrown around" while operating a lifting device at work. The record does not demonstrate, however, that the claimant sustained a herniated disc as a result of this specific incident. We recognize Dr. Shahim's December 2003 report, "MRI shows a disc herniation at C6-7." The Commission has the authority to accept or reject medical opinion and the authority to determine its medical soundness and probative force. *Green Bay Packing v. Bartlett*, 67 Ark. App. 332, 999 S.W.2d 692 (1999). We attach significant weight to the September 2005 expert opinion of Dr. Sprinkle. Dr. Sprinkle stated that the C6-7 herniation had existed prior to the compensable injury. Dr. Sprinkle opined, "I would not conclude that the changes at C6-7 would likely be related to his injury in 2003."

The Full Commission recognizes Dr. Shahim's January 2004 note, "his symptoms were brought on by an injury." Again however, the record does not demonstrate that the claimant sustained a herniated disc at C6-7 as a result of the compensable injury. Dr. Bruffett, a spine specialist, opined in June 2004 that the claimant had degenerative disc disease of the cervical spine. There is no indication of record that the compensable injury caused the claimant's cervical spine disease. Dr. Bruffett also opined that the claimant had sustained a "cervical strain." Dr. Bruffett did not conclude, however, that the claimant had sustained an acute herniated cervical disc. Dr. Bruffett also stated, "there is also a chance that Mr. Swink could go through a pretty extensive operation and may have symptoms just as bad as he is having now." Dr. Sprinkle subsequently opined that the claimant had exacerbated a cervical degenerative condition. Like Dr. Bruffett, Dr. Sprinkle did not opine that the claimant had sustained a herniated disc as a result of the compensable injury. Dr. Sprinkle also stated that neck surgery "has significant potential to make his neck pain even worse."

Dr. Sprinkle concluded on September 14, 2004, "At this point I think he is at maximum medical improvement from a nonsurgical standpoint." The respondents controverted additional medical treatment beginning September 15, 2004. The claimant essentially contends on appeal that he sustained a compensable aggravation of a pre-existing condition. The Full Commission recognizes that an aggravation of a pre-existing noncompensable condition by a compensable injury is, itself, compensable. *Oliver v. Guardsmark*, 68 Ark. App. 24, 3 S.W.3d (1999), citing *Hublely v. Best Western-Governor's Inn*, 52 Ark. App. 226, 916 S.W.2d 143 (1996). In the present matter, if the claimant's compensable injury were deemed to be an aggravation of a pre-existing condition, such aggravation would be in the form of a cervical strain. The preponderance of evidence demonstrates that the claimant's cervical strain resolved no later than September 14, 2004, at which time Dr. Sprinkle pronounced maximum medical improvement. The record does not demonstrate that the claimant sustained a herniated disc as a result of the September 16, 2003 compensable injury.

Moreover, Dr. Shahim's reports beginning in December 2004 and following did not describe a herniated disc as a

result of the 2003 compensable injury. Beginning on December 6, 2004, Dr. Shahim discussed "disc disease" at C6-7. We have already determined *supra* that the claimant's cervical disc disease was not a result of the 2003 compensable event. Dr. Shahim noted in June 2005, "MRI of the cervical spine shows progression of disc disease at C6-7.Mr. Swink is symptomatic from transitional level syndrome at C6-7." The record does not show that these noted conditions in 2005 were the result of the 2003 compensable injury. Dr. Shahim's post-surgical diagnosis in July 2005 was "cervical stenosis at C6-7." There is no indication of record that this cervical stenosis was the result of the compensable injury.

Finally, the Full Commission notes Dr. Shahim's August 2005 report that the claimant "continues to have significant axial neck pain." The claimant essentially testified that the only "post-surgical improvement" he had enjoyed was a decrease in the medication he was taking. The claimant still did not think he was able to work, because "I can't keep my mind on stuff." Post-surgical improvement is a relevant consideration in determining whether surgery was reasonably necessary. *Winslow v. D&B Mech. Contractors*, 69

Ark. App. 285, 13 S.W.3d 180 (2000). We are unable to find in the present matter that the claimant experienced substantive post-surgical improvement.

Pursuant to Ark. Code Ann. §11-9-508(a), the Full Commission finds that surgery performed by Dr. Shahim in the present matter was not reasonably necessary in connection with the compensable injury received by the claimant. We therefore reverse the decision of the administrative law judge.

B. Temporary Disability

Temporary total disability is that period within the healing period in which the employee suffers a total incapacity to earn wages. *Ark. State Hwy. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). "Healing period" means "that period for healing of an injury resulting from an accident." Ark. Code Ann. §11-9-102(12). The determination of when the healing period ends is a question of fact for the Commission. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002).

In the present matter, the parties stipulated that the claimant sustained a compensable injury on September 16, 2003. The Full Commission has determined *supra* that the

compensable injury was in the form of a cervical strain; the record does not indicate that the claimant sustained an acute herniated disc or otherwise needed surgery as a result of the compensable injury. The preponderance of the evidence demonstrates that the claimant's cervical strain resolved no later than September 14, 2004, on which date Dr. Sprinkle pronounced maximum medical improvement. The claimant therefore reached the end of his healing period no later than September 14, 2004. The claimant underwent surgery on July 26, 2005, and the claimant contended that he was entitled to temporary total disability compensation from July 28, 2005 to a date yet to be determined. However, we have determined that the July 2005 surgery was not reasonably necessary in connection with the injury received by the claimant. We do not find that the surgery performed by Dr. Shahim extended the claimant's healing period or otherwise entitled the claimant to temporary total disability compensation.

The Full Commission therefore reverses the administrative law judge's finding that the claimant proved he was entitled to temporary total disability compensation from July 28, 2005 to a date yet to be determined. We find

that the claimant did not prove he was entitled to temporary total disability for his cervical strain.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove that Dr. Shahim's surgical treatment was reasonably necessary in connection with the injury received by the claimant. The Full Commission finds that the claimant sustained a cervical strain which resolved no later than September 14, 2004, and that surgery was not reasonably necessary in connection with the cervical strain. We find that the claimant did not prove he was entitled to temporary total disability compensation. The decision of the administrative law judge is reversed, and this claim is denied and dismissed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Turner dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority opinion finding that the claimant's need for back surgery

was not reasonably necessary or causally related to his admittedly compensable injury. After a de novo review of the record, I find that the claimant's back injury was not a temporary strain as asserted by the Majority. Rather, I find that the claimant aggravated his pre-existing back conditions and that his need for surgery was directly caused by his work-related injury. I further find that surgery was reasonably necessary to treat that injury and that the claimant is entitled to temporary total disability benefits as previously awarded by the Administrative Law Judge.

_____In finding that the claimant's injury amounted to a temporary strain, the Majority argues that the claimant's disc herniation at level C6-C7 pre-existed his admittedly compensable injury. They further argue that the claimant's need for surgery was due to stenosis at C6-C7 rather than due to a disc herniation caused by his work-related injury. Finally, the Majority finds that the claimant is not entitled to the recommended surgery because it was not successful in alleviating his symptoms.

_____In my opinion, there is insufficient evidence to support a finding that the claimant's exacerbation was temporary in nature. Rather, I find that while the claimant suffered from degenerative disc disease it is unclear

whether he suffered from a bulging disc prior to the incident in question. However, regardless of whether the claimant had a small disc bulge at level C6-C7 prior to the work-related injury, his conditions were aggravated and caused the need for surgery. The medical records and testimony of the claimant indicate that he was not symptomatic prior to the admittedly compensable injury. Additionally, since there is no evidence his symptoms resolved subsequent to the work-related injury, I find that his need for surgery was directly related to his injury. I also find that while the claimant was never guaranteed the surgery would totally alleviate his symptoms, he is not required to show such proof. Instead, he is only required to show that the treatment was reasonably necessary. As multiple doctors considered surgery and the claimant indicated he has had at least some relief due to the surgery, I find that the surgery was reasonably necessary to treat his condition.

I will first address the Majority's assertion that the claimant's need for surgery was not related to his work-related injury. As previously noted by the Court of Appeals in Heritage Baptist Temple v. Robison, 82 Ark. App. 460, 120 S.W.3d 150 (2003),

In workers' compensation law, an employer takes the employee as he finds him, and employment circumstances which aggravate pre-existing conditions are compensable. An aggravation of a preexisting noncompensable condition by a compensable injury is, itself, compensable. An aggravation is a new injury resulting from an independent incident. An aggravation, being a new injury with an independent cause, must meet the definition of a compensable injury in order to establish compensability for the aggravation. (Internal citations omitted).

_____In the present case, there is no dispute that the claimant was largely asymptomatic prior to the time of the admittedly compensable injury. Furthermore, the evidence indicates that the claimant's symptoms after the injury were on the left side of his body, whereas after the 2002 non-work related incident they were only on the right side of his body. Additionally, I find that the other relevant medical records show that the claimant suffered an aggravation to his pre-existing back problems and that his need for treatment was directly related to that injury.

_____I note the Majority's reliance on Dr. Sprinkle's opinion that the claimant's herniated disc did not occur as a result of the work injury and that he sustained no new injury as a result of his accident. However, after reviewing the other remaining medical evidence, I find Dr.

Sprinkle's analysis to be flawed. First, I note that the radiographic studies from the time period before the incident in question were not in the record. Additionally, in the September 27, 2005, letter from Dr. Sprinkle, he only indicates that there was no "significant" change in the radiographic studies from before and after the time of the injury. Pursuant to Arkansas Workers' Compensation law, the claimant is not required to show that there was a significant change. Rather the claimant is only required to show an aggravation or an exacerbation of a pre-existing condition. I also note that Dr. Sprinkle diagnosed the claimant with such an exacerbation on June 22, 2004, and that he later indicated that while the claimant's need for surgery was due to degenerative disc disease, there could have been an exacerbation of that condition. In my opinion, each of these things show that the claimant suffered an aggravation and a need for surgery for which the respondent's should be liable.

As to the Majority's assertion that the claimant's need for surgery is due to central canal stenosis rather than due to a disc herniation, I note that as early as January 2004, Dr. Shahim indicated there was evidence of stenosis. This was confirmed by the operative report.

While the Majority argues that there is no evidence that the claimant's stenosis was caused by his work-related injury, I note that prior to his injury, the claimant was largely asymptomatic. However, after the work-related injury, he had an onset of symptoms that were consistent with having a herniated disc and stenosis that is commonly associated with having a herniated disc or having degenerative disc disease. In fact, Dr. Shahim explicitly indicated that the claimant's symptoms were due to an injury. As the claimant's only known injury was his work-related injury, I can only conclude that the claimant exacerbated any pre-existing stenosis.

Furthermore, it is important to note that the respondents have already agreed that the claimant sustained an aggravation to his pre-existing conditions. While the respondents contend that this aggravation was simply a strain, there is simply no evidence to indicate that the claimant's symptoms ever resolved after the time of his work related injury. Accordingly, the respondents should be liable for the treatment associated with that exacerbation, even if the major cause for treatment was due to his pre-existing conditions. See, Williams v. L & W Janitorial, Inc., 85 Ark. App. 1, 145 S.W.3d 383, (2004), (finding that

a claimant that sustained an aggravation is only required to show that their injury was a factor in the need for treatment when only medical benefits and temporary total disability benefits are the only benefits in question).

In finding that the claimant's condition was temporary in nature the Majority relies on Dr. Sprinkle's placing the claimant at MMI as of September 14, 2004. When reviewing the medical records it becomes apparent that there was no explanation of why the claimant was placed at MMI at that time. Instead it appears that Dr. Sprinkle seemed to run out of conservative treatment options and then placed the claimant at MMI. In my opinion, this indicates that all doctors were aware that even if the claimant's injury amounted to a strain, might be in need of surgery to treat his work-related injuries. I note in particular that the claimant's symptoms remained the same from the time of his injury until well after September 14, 2004. I also find it important to note that Dr. Shahim, Dr. Bruffett, and Dr. Sprinkle all discussed surgery as a treatment option for treating the claimant's compensable injury prior to him being placed at MMI.

As early as June 2, 2004, Dr. Bruffett indicated that the claimant could receive at least some benefit from

the surgery recommended by Dr. Shahim. Likewise, on August 25, 2004, Dr. Sprinkle indicated that the claimant, "may ultimately have to go back to Dr. Bruffett to discuss surgery since he has not responded to any other measures." Despite this conclusion, and despite there being no change in the claimant's condition or diagnosis, less than one month later Dr. Sprinkle released the claimant.

The Majority also concludes the claimant is not entitled to additional medical because he allegedly did not get relief from the surgery. This is in direct contradiction to the claimant's testimony that he has had relief from the surgery and that he has been able to reduce the amount of pain medication he takes after having the surgery. Additionally, I know of no requirement that requires a claimant be able to return to work in order to be entitled to additional medical treatment.

Ultimately, I find that the claimant sustained an aggravation to his pre-existing back conditions. There is no dispute that he did not suffer from symptoms associated with these conditions until after the time of the accident. There is no evidence that the claimant's condition changed or resolved at any point after the time of his work-related injury. As such, it is clear that the claimant's need for

ongoing treatment was directly due to his work related injury. Likewise, it is clear that the claimant underwent surgery only after exhausting all other measures and after three physicians had discussed surgery with him. While each physician expressed reservations and concerns about the surgery, they admitted that the surgery could result in some relief for the claimant. Finally, the claimant testified that he had, indeed, received at least some relief from the surgery and that he had been able to reduce his pain medication after the surgery. Accordingly, I would have found that the claimant was entitled to additional medical treatment and temporary total disability benefits as awarded by the Administrative Law Judge.

For the aforementioned reasons I must respectfully dissent.

SHELBY W. TURNER, Commissioner