

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E912874

RACHEL L. THOMASON,
EMPLOYEE CLAIMANT

COLEMAN CABLE SYSTEMS, INC.,
EMPLOYER RESPONDENT

FIRE & CASUALTY INSURANCE COMPANY
c/o ROYAL & SUN ALLIANCE INSURANCE CO.,
INSURANCE CARRIER RESPONDENT

OPINION FILED FEBRUARY 27, 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 AMY S. HUFFMAN,
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 September 14, 2005.

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 claimant has proven, by a preponderance of the evidence, that she is entitled to the additional diagnostic studies, specifically, an MRI of the claimant's back and an EMG of her back

and legs, as recommended by her authorized treating physician, Dr. Harold Chakales, to determine whether additional treatment is reasonably necessary.

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 September 14, 2005 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

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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 must respectfully dissent from the majority opinion finding that the claimant is entitled to additional medical testing as recommended by Dr. Harold Chakales. Based upon my de novo review of the entire record, and without giving the benefit of the doubt to either party, I find that the claimant has failed to prove by a preponderance of the evidence that additional

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diagnostic testing is reasonable and necessary in connection with the claimant's 1999 low back injury; therefore, I find that the decision of the Administrative Law Judge should be reversed.

The claimant sustained an admittedly compensable injury to her low back on September 15, 1999. Claimant was initially diagnosed with a lumbosacral strain and was placed on light duty and treated conservatively. An MRI performed on November 4, 1999, revealed the following:

...There is moderate extension of the 4-5 disc into the canal anteriorly and to the left. However, there appears to be very little compression of the subarachnoid space and nerve root sheath. The rest of the levels are clear. Decreased signal in the 4-5 disc. The rest of the discs, bones, and soft tissues are unremarkable.

Based upon these findings, the radiologists opined that the claimant had a "moderate bulge on the left at the L4-5 level." Claimant's treating physician removed the claimant from work and prescribed physical therapy. The therapist's notes dated November 10, 1999, listed the claimant's area of pain as in the low back and left hip and leg. On December 15, 1999, the claimant was evaluated by Dr. Robert Dickins, a neurosurgeon. Dr.

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Dickins recorded a history of an "abrupt onset of back pain and left leg pain. Her back pain was transient, but she has continued to have left leg pain. The pain is described as being in her thigh and down to her knee with a sense of numbness and hyperesthesias in the same distribution." The claimant reported to Dr. Dickins that the physical therapy made her condition worse, and that after the therapy was discontinued she began to improve. Dr. Dickins prescribed Celebrex and released the claimant to return to work. The claimant continued to receive follow-up treatment from Dr. Dickins during which he described her condition as fairly mild nerve root compression for which he recommended epidural steroid injections. The claimant did not note any benefit from these injections. In a report dated August 24, 2000. Dr. Dickins recommended that the claimant transfer her care to a local physician in Texarkana and he ordered a current MRI. This second MRI was performed on August 31, 2000. This test revealed the following:

...The L4-5 disc has chronic desiccation with a mild diffuse posterior protrusion and probably a small central extrusion. The extruded component extends slightly more toward the left on the sagittal images, causing at most slight left lateral recess narrowing but no significant nerve root impingement

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or foraminal stenosis. The extrusion is confined to ventral epidural space on the sagittal images and causes no significant AP canal stenosis. The L5-S1 disc has a slight diffuse posterior subligamentous protrusion on axial images. This causes no canal stenosis or neural compromise. The posterior elements are unremarkable.

In a report dated September 21, 2000, Dr. Dickins interpreted this MRI as revealing a small disc herniation at L4-5 on the left that appeared to correlate with the claimant's left hip pain. Dr. Dickins did not recommend surgery at that time although the disc herniation did appear to have increased in size since the original MRI which was performed in November of 1999.

As per Dr. Dickins' recommendation, the claimant's care was transferred back Dr. Mark Gabbie in Texarkana. On November 2, 2000, the claimant was seen by Dr. Steven Cathey, a North Little Rock Neurosurgeon, for a second opinion. Dr. Cathey noted that the claimant's neurological exam was unremarkable and that she did not have any signs of lumbar radiculopathy. After reviewing the two MRI scans, Dr. Cathey noted that both of these diagnostic tests revealed a very small left paracentral disc protrusion at L4-5 without any obvious nerve root

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impingement. Dr. Cathey did not appreciate any other findings on these tests. Dr. Cathey offered the claimant surgery given the chronicity of the claimant's pain; however, the claimant opted not to have surgery at that time. Accordingly, Dr. Cathey advised the claimant to start liberalizing her activities and he assessed her with a 7% anatomical impairment rating to the body as a whole.

In November of 2000, the claimant began physical therapy and work hardening under the direction of Dr. Mark Gabbie. A Discharge Note dated February 20, 2001, indicated that the claimant made gains in both strength and endurance and that with the exception of being able to lift 50 pounds from the floor, she was ready to return to work. Likewise, Dr. Gabbie's February 23, 2001 status report indicates that the claimant benefitted from this physical therapy. The claimant continued to seek conservative medical treatment from Dr. Gabbie throughout the spring of 2001. The Physician's Status Report dated May 15, 2001, reflects complaints of left leg weakened with drop foot symptoms. Dr. Gabbie referred the claimant to Dr. Joel Patterson who first examined the claimant on May 23, 2001. On examination, Dr. Patterson noted weakness of the foot

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extensors. After examining the claimant and reviewing the MRI scans which he interpreted as revealing spondylosis at L4-5 with a herniated disc to the left, Dr. Patterson ordered a myelogram to better define the claimant's anatomy. The lumbar myelogram revealed:

... The cross-table lateral view shows a mild ventral indentation on the sac at the 3-4 level and roughly 25% loss of disc height. The oblique views show mild lateral recess compromise on the left but the L4 dural sleeve does fill distally. The 4-5 level has a moderate ventral indentation on the sac and considerable lateral recess stenosis, flattening the L5 dural sleeve and root at the 4-5 disc level. The right L5 root is also displaced medially at the lateral recess and does not fully fill beneath the pedicle. The L5-S1 level shows slight decreased filling of the right S1 root at the L5-S1 interspace. However, the cross-table lateral film shows no significant indentation of the sac...

The post myelogram CT revealed:

...The 3-4 level has a left lateral disc protrusion which moderately narrows the left L3 foramen inferiorly. The thecal sac is only mildly flattened anteriorly. The left lateral recess is also mildly narrowed. The 4-5 level has a mild to moderate diffuse posterior disc bulge, and the ligamentum is mildly thickened. Together, this causes a moderate overall canal stenosis and bilateral lateral recess compromise,

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left slightly greater than right.
The L5-S1 disc has a minimal
posterior bulge without significant
canal or foraminal stenosis.

The claimant returned to Dr. Patterson on June 27, 2001, for an explanation of her test results. In his office note of that date, Dr. Patterson explained that the claimant had a herniated disc at L3-4 with probably compression in the lateral recess as well as a disc bulge at L4-5. Dr. Patterson recommended a two level laminectomy discectomy with exploration of the L3-L4 and L5 roots. Surgery was performed on October 12, 2001, during which it was discovered that the L3-4 nerve root was protruding and causing nerve root compression. The disc space at L4-5 was not found to be bulging, nor was there any evidence of nerve root compression at L4. In a follow-up examination dated October 22, 2001, the claimant exhibited a new complaint of anterior shin numbness. By November 5, 2001, Dr. Patterson recorded the claimant's complaints as numbness in the L4-5 distribution and left hip pain. Since the claimant's complaints did not resolve after surgery, Dr. Patterson recommended another MRI which was performed on January 24, 2002. This MRI revealed:

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... There has been prior surgery at both the L3-4 and L4-5 levels on the left. There epidural scarring on the left at both these levels. At the L3-4 level, I believe there also is a small component of the left posterolateral disc herniation. This is quite small and only causes mild inferior foraminal narrowing on the left.

As this test did not reveal the nature of the claimant's continued complaints, Dr. Patterson recommended an EMG. Dr. Linda Walby, a Texarkana Physiatrist, conducted the EMG on February 25, 2002, and concluded that it showed mild left S1 radiculopathy. After reviewing the EMG results, Dr. Patterson noted:

Mrs. Thomason returns to the office today. EMG's by Dr. Walby demonstrate a left S1 radiculopathy. This explains her toe numbness. No evidence of denervation at L3-4. I need to review her MRI and see if this demonstrates any evidence of possible impingement of the left S1 nerve root. If so, I will offer her decompression. If not, she will need a myelogram...

After re-reviewing the claimant's MRI, Dr. Patterson ordered another myelogram as the MRI results were not "very impressive." The May 20, 2002, myelogram was interpreted as normal. Likewise, the post myelogram CT only revealed the previous laminectomy at

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L3-4 and a bulging disc at L4-5. In his June 3, 2002, office note Dr. Patterson discussed the claimant's recent myelogram results. Specifically, Dr. Patterson opined:

... With the knowledge that she does have an S1 radiculopathy on EMG's one might be tempted to say that there is some compression of her left S1 nerve root on the plain film myelogram. This is not terribly impressive, however. The CT scan dose (sic) show a mild bulging disc at 5-1 with possible nerve root impingement in the lateral recess. There is a bulge at 4-5 and postop changes at 3-4 which are expected. Given the fact that her EMG's were perfectly normal except for the S1 findings, I don't think the 3-4 and 4-5 levels are causing her current complaints of left lower extremity radiculopathy...

Dr. Patterson recommended additional physical therapy and epidural steroid injections. The claimant came under the care of Dr. William Ackerman, a pain specialist, for her injection therapy. The claimant did not appreciate any benefit from the injections.

In a follow-up examination note on August 14, 2002, Dr. Patterson explained that he was hesitant to recommend surgery because he did not think the claimant "is symptomatic." Again, in his September 9, 2002, office note, Dr. Patterson stated, "The only objective

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evidence of disease is an S1 radiculopathy on the left. I do not think that she is symptomatic from this. Most of her pain is in her back and hip." Following his examination of the claimant on October 21, 2002, Dr. Patterson concluded that the claimant was having pain radiating down to the foot which he described as being symptomatic from the S1 radiculopathy. Accordingly, Dr. Patterson now determined that surgery would be warranted.

The claimant was again seen by Dr. Steven Cathey for a second opinion. Dr. Cathey reviewed the claimant's diagnostic films and specifically stated that despite the EMG results which suggested an S1 radiculopathy, he could not identify any abnormality at L5-S1 on any of the films. After examining the claimant, Dr. Cathey stated:

Although Dr. Patterson has offered Ms. Thomason additional spinal surgery, specifically a lumbar laminectomy and diskectomy at L5-S1 interspace on the left, I really do not believe the procedure has any reasonable chance of improving her leg pain. I suspect the discomfort she experiences in the left leg is related to some residual radiculopathy most likely involving the L4 nerve root on the left side.

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Dr. Cathey assessed the claimant at maximum medical improvement and rated her with an 11% permanent anatomical impairment rating to the body as a whole.

The claimant returned to Dr. Patterson on January 8, 2003, advising that she did not want to undergo surgery. Dr. Patterson noted that he was still willing to operate on the claimant due to her complaints of leg pain. Since the claimant opted not to have surgery, Dr. Patterson referred the claimant to Dr. Bruce Safman for pain management. Claimant began her treatment with Dr. Safman on January 15, 2003. The claimant was seen by Dr. Safman approximately eight times between January 15, 2003, and April 23, 2003, and consistently reported that she was improving or maintaining under his care of injections and medications. On April 23, 2003, however, the claimant complained of a flare-up of lumbar pain radiating down to her left foot after doing yard work. Dr. Safman altered the claimant's medication at that time. By May 21, 2003, the claimant reported to Dr. Safman that she was improved but still had diffuse pain in her low back and left side. Dr. Safman deemed the claimant to be at maximum medical improvement at that time. He ordered a functional capacity evaluation in order to assess the

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claimant's physical impairment and permanent restrictions. In addition, Dr. Safman advised that the claimant would continue to require medication maintenance therapy. The functional capacity evaluation placed the claimant in the light duty category with restrictions of no lifting over 20 pounds. The claimant continued to be seen by Dr. Safman on a monthly basis through November of 2003. An MRI ordered by Dr. Safman was performed at Wadley Regional Medical Center on December 19, 2003. This diagnostic test showed:

Mild disc height loss is noted at L3-4 and mild decreased T2 disc signal is noted at L3-4 and L4-5. The lumbar spine otherwise maintains normal height, contour and alignment. No fracture or subluxation is noted. Paravertebral soft tissues are unremarkable. Visualized portions of the spinal cord are grossly unremarkable and the conus medullaris appears normally positioned. The post surgical changes of the lumbar spine are not well demonstrated by this examination. There is a very small left paracentral disc bulge present but this does not appear to cause spinal stenosis or foraminal narrowing. The remainder of the lumbar disc levels are within normal range with no disc herniation, spinal stenosis, or foraminal narrowing noted...

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The radiologist interpreted these findings to reveal a "very small left paracentral disc bulge at L4-5. This causes no spinal stenosis or foraminal narrowing" and "mild degenerative disc disease at L3-4 and L4-5." No findings were noted with regard to the L5-S1 disc space or the S1 nerve root.

The medical records reflect that after her November 6, 2003, examination and treatment by Dr. Safman, the claimant did not obtain any additional medical treatment until she was seen by Dr. Chas Taylor Marrow. However, Dr. Marrow's notations from this visit do not disclose any additional complaints. The claimant requested and received a change of physician with the Commission on January 21, 2005. The claimant treated with her new physician, Dr. Harold Chakales, on February 28, 2005.

In finding that additional testing is warranted, the Administrative Law Judge found that Dr. Chakales reviewed the claimant's previous tests. However, despite the extensive medical treatment and multiple diagnostic tests performed on the claimant, there is no evidence in the record that Dr. Chakales reviewed any of these prior to examining the claimant and recommending yet another MRI and EMG. Dr. Chakales's

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February 28, 2005, report under Diagnostic Studies only addressed the fact that the claimant had "an EMG/NCV" in 2003 which showed "some chronic nerve root irritation." There is no evidence whether the EMG performed by Dr. Walby was reviewed by Dr. Chakales, or whether he received the information about this test from the claimant. Given the fact that Dr. Chakales referred to the test as both an EMG and a NCV and his characterization of the results in rather generic terms, I am unable to conclude that he, in fact, reviewed the actual test results. Nor can I find that Dr. Chakales has seen either the actual MRI and myelogram films or the radiologists' interpretations of these numerous diagnostic tests performed on the claimant since her surgery, as he makes no mention of these tests in his report.

"In determining whether a party has met the burden of proof on an issue, Administrative Law Judges and the Commission shall weigh the evidence impartially and without giving the benefit of the doubt to any party." Ark. Code Ann. § 11-9-704(c)(4) (Repl. 1996). The claimant has the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary. Norma Beatty v. Ben Pearson,

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Inc., Full Commission Opinion, Feb. 17, 1989 (D612291); B.R. Hollingshead v. Colson Caster, Full Commission Opinion, Aug. 27, 1993 (D703346). Employers are only liable for medical treatment and services which are deemed reasonably necessary for the treatment of employees' injuries. DeBoard v. Colson Co., 20 Ark. App. 166, 725 S.W.2d 857 (1987). In workers' compensation cases, the burden rests upon the claimant to establish her claim for compensation by a preponderance of the evidence. Kuhn v. Majestic Hotel, 50 Ark. App. 23, 899 S.W.2d 845 (1995); Bartlett v. Mead Container Board, 47 Ark. App. 181, 888 S.W.2d 314 (1994). 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 Commission Opinion, Dec. 13, 1989 (D512553).

The claimant has undergone numerous MRIs as well as myelograms and post myelogram Cts. None of these diagnostic tools revealed any objective medical evidence to support the claimant's continued complaints of pain. Now the claimant is under the treatment of a new doctor and he wants to initiate yet more diagnostic testing. However, there is no evidence that this doctor has even

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looked at the previous test results prior to ordering duplicate tests. Claimant's compensable injury occurred more than six years ago. She has been treated by numerous physicians and has undergone numerous diagnostic tests, yet the claimant continues to complain of pain. The claimant seeks more testing to determine the cause of her pain. The testing recommended by Dr. Chakales is not new or in any way different from the testing the claimant has already undergone. While it is understandable that the claimant is seeking answers for her complaints, she has failed to present any evidence that repeat tests will provide her with the answers she seeks. Dr. Chakales has ordered tests that have already been performed without even reviewing the existing MRIs and myelograms. Moreover, there is no evidence in the record as to what Dr. Chakales is seeking to find in yet another MRI that has not already been sought in the past. There is no evidence that the quality of the post-surgical MRIs and myelograms is poor. I cannot find that a repeat MRI would reveal or explain the claimant's symptoms at this time when the numerous diagnostic tests previously performed did not. Therefore, I find that the claimant has failed to prove by a preponderance of the evidence that the additional testing recommended by Dr.

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Chakales is reasonable and necessary in connection with her compensable injury. Therefore, I must respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner