

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F505209

JAMES LOAR,  
EMPLOYEE

CLAIMANT

COOPER TIRE & RUBBER CO.,  
SELF-INSURED EMPLOYER

RESPONDENT

CROCKETT ADJUSTMENT,  
INSURANCE CARRIER/TPA

RESPONDENT

OPINION FILED APRIL 19, 2007

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

Claimant represented by the HONORABLE NELSON SHAW, Attorney  
at Law, Texarkana, Texas.

Respondents represented by the HONORABLE WILLIAM BULLOCK,  
Attorney at Law, Texarkana, Texas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's  
opinion filed July 17, 2006. The administrative law judge  
found that the claimant proved he was entitled to additional  
medical treatment and temporary total disability  
compensation. After reviewing the entire record *de novo*,  
the Full Commission reverses the opinion of the  
administrative law judge.

## I. HISTORY

The testimony of James Elliott Loar Jr., age 32, indicated that he began working for Cooper Tire in about 1999. The claimant complained of middle to lower back pain beginning in June 2001. A radiology exam on the lumbar spine in October 2001 gave the following impression: "1. Compression fracture of L1, probably old. 2. Mild degenerative changes."

An MR of the lumbar spine was taken in November 2001, with the following impression: "1. Mild posterior disc bulging causing moderate spinal stenosis in this patient with a congenitally narrow subarachnoid space." Dr. Richard M. Hilborn noted in November 2001, "The MRI was reviewed with no evidence of disc herniation being noted. Mild wedging of the L1 vertebra is noted but this does not appear to be secondary to an acute event....The patient's symptomatology is consistent with low back strain."

The record documents a subsequent lengthy extended series of treatment for low back pain.

An MR of the claimant's lumbar spine was taken in July 2004, with the following impression: "1. Multi-level degenerative changes of the lumbar spine with areas of canal

stenosis and foraminal narrowing as discussed above. A relative canal stenosis exists secondary to congenitally short pedicles that is made worse by the degenerative disc disease along with facet and ligamentous hypertrophy."

The parties stipulated that the claimant sustained a compensable injury to his back on April 23, 2005. The claimant testified that he slipped and fell, and that his middle to lower back was injured.

The claimant sought emergency medical treatment on April 23, 2005 and was diagnosed as having "acute low back pain." An x-ray of the claimant's pelvis was taken on April 23, 2005, with the impression, "No abnormalities are identified." An x-ray of the lumbar spine was taken on April 23, 2005, with the impression, "Slight loss of height of L1 probably due to a compression fracture of undetermined age."

The claimant presented to Dr. Craig E. Ditsch on April 25, 2005:

James Loar is a 31 year old employee of Cooper Tire who comes in with a history that on 04-23-05 which is two days ago he was on top of a machine, fell approximately 6 feet landing on his back. He is complaining of pain in the mid-back in the lower thoracic, upper lumbar area....He denies any particular pain in his buttocks or legs at this point in time....

He is tender right in the mid-back at the upper lumbar, lower thoracic area. There is no ecchymosis, no bruises noted. No particular palpable spasm. Straightening causes increase in his mid-back pain. He has no neurological deficit in his legs.

I reviewed the x-rays with him. I don't see what I would consider a compression fracture. Things seem to be aligned.

Dr. Ditsch assessed, "Fall with contusion to the back....We will get an MRI of his back....We will keep him off work until we get a definitive answer regarding this spine."

The following impression resulted from an MRI of the lower thoracic and lumbar spine on May 5, 2005:

- 1.) Component of central spinal stenosis and neural foraminal encroachment at a few levels as described above related to a combination of mild degenerative changes, bulging of the disc and a congenitally small spinal canal. Findings are greatest at the L3-4 level where there is moderate central spinal stenosis with a component of lateral recess stenosis bilaterally.
- 2.) Tiny disc protrusion on the right at the T9-10 level resulting in minimal central spinal stenosis. However no significant cord deformity is noted.
- 3.) No other significant abnormalities. No acute fracture is noted. The exam was somewhat limited by motion artifact.

The claimant followed up with Dr. Ditsch on May 9, 2005:

Mr. Loar says his pain is worse; however, his MRI indicated there was no fresh fracture at T12 or L1, but he has significant spinal stenosis. He had lateral recessed stenosis on the L3-4, L4-5 areas. I really don't think any of this is due to his recent fall, but he certainly has significant evidence of nerve impingement on his x-ray. I have suggested to him that he would benefit from another opinion from a neurosurgeon and we will get him an opinion from Dr. Shahim because his low back pain back in June may be well-related to this spinal stenosis. He will remain off work until after cleared by Dr. Shahim. Of note, his examination today, despite his pain and discomfort, does not show any muscle swelling, heat, erythema or any other evidence of his recent contusion.

Dr. Shahim saw the claimant and reported on May 16, 2005:

His MRI of the lumbar spine was reviewed by me. He has a small right T9-10 disc herniation. This is very small and does not cause significant canal stenosis. The image quality at this level may be an issue because this region in the lower thoracic area is not covered well on this MRI. The lumbar spine MRI shows multilevel lumbar spondylosis and degenerative disc disease extending from L3 to S1....

Mr. Loar has had a recent work injury resulting in increasing back pain. I have recommended to him to undergo a thoracic spine MRI since his pain is in the lower thoracic region....Based on his history, his lower thoracic pain is due to the recent fall, and although the stenosis is a longstanding disease, he has certainly aggravated this condition from the trauma.

The following impression resulted from an MRI of the lumbar spine taken May 23, 2005:

1. Multi-level degenerative disease in the mid thoracic spine.
2. Small central disk protrusion at T7-8.
3. Small right paracentral disc protrusion at T9-10.
4. No spinal stenosis, foraminal stenosis, or nerve impingement is seen.

A myelogram was taken on June 3, 2005, with the following impression:

1. There is an old mild compression deformity of the L1 vertebral body. There is a background of short pedicles. Additional degenerative changes are seen to cause moderate acquired stenosis at the L2-3 level, as well as mild acquired stenosis at L3-4 and L4-5 levels.

Dr. Shahim stated on June 9, 2005, "Based on the history, his pain is work-related and should be covered by Worker's Compensation. I do not detect any disc herniation, but certainly his canal stenosis and disc degeneration were aggravated by the fall."

Dr. Shahim referred the claimant for pain management and noted on August 23, 2005:

I talked to Mr. Loar on the phone today. I explained to him that he has moderate to severe canal stenosis at L2-3. He has compression of the vertebral body of L2, which appears old. I believe he has aggravated L2-3 stenosis with recent trauma. He has failed epidural steroid injections and therapy, and for this reason I have given him the option of undergoing a lumbar laminectomy at L2-3....Because of the severity of his symptoms, he would prefer to have surgery done. I have explained to him that surgery will

reduce his pain, but will not eliminate it completely. We will plan on lumbar decompression at L2-3.

Dr. Edward H. Saer evaluated the claimant on September 16, 2005:

Mr. Loar is a 31-year-old man seen for evaluation at the request of his worker's comp carrier. He works at Cooper Tire and had an injury on April 23, 2005. He fell 5-6 feet, off a press, landing on his back. He had the onset of back pain immediately....

The flexion and extension films dated August 27, 2005, were reviewed. He has slight wedging of L1, but no evidence of acute fracture. There does not appear to be any instability.

The MRI films done May 5, 2005, were reviewed. He has a congenitally small canal, but disc spaces appear relatively normal. He has no disc herniation. There is moderate stenosis at L3-4 and mild to moderate stenosis at L2-3.

His bone scan done June 13, 2005, appears negative. This was primarily localized to the spine.

A CT myelogram done June 3, 2005, was reviewed. There is slight narrowing at L2-3 and L3-4 on the myelogram with slight bulging at the L3-4 and L4-5 levels. The CT scan shows basically the same thing with moderate stenosis at L3-4 and mild to moderate stenosis at L2-3.

Dr. Saer's impression was, "Thoracolumbar back pain....He has probably had a strain or a sprain. He does not have any radicular symptoms. In fact, he really does not have any symptoms of neurogenic claudication at all. I

really do not think that a laminectomy is likely to help him. He does have a congenitally small canal, but I do not see any acute injury that would explain his current symptoms....I encouraged him to start on some aerobic exercises, such as walking. He is basically doing nothing now, and some type of conditioning would be helpful. Getting back into a supervised (by a therapist) exercise program may also be helpful."

Dr. Shahim noted on September 22, 2005, "He was seen by Dr. Saer, who recommended continued conservative management. I agree with that, although I expect Mr. Loar to require lumbar laminectomy at some point....He may return to light duty since they have found him a position that does not require any lifting, bending, or twisting. He should remain off on the light duty for at least the next 2 months."

The claimant underwent conservative treatment with Dr. Amir M. Qureshi.

Dr. Shahim noted the following on January 5, 2006:

I saw Mr. Loar today and he is doing much better. He says that the back and hip symptoms have improved. He says his symptoms are better when he is up and walking. He would like to return back to work. He denies any leg pain, leg weakness or numbness. He still has some thoracolumbar junction pain, but it is tolerable....He would like to return to his old

job. I will release him to full duty. I will plan on following up with him in a month.

The claimant agreed on cross-examination that he returned to work at full duty.

The claimant sought emergency medical treatment on January 27, 2006, at which time he was diagnosed as having chronic lower back pain.

Dr. Shahim noted on February 2, 2006:

I saw Mr. Loar today. He returned to work on 12/5/06. He was unable to work but for a few days. He complains of severe back pain. The back pain is in the upper lumbar spine. He does have some radiation of the pain to the legs. He develops leg weakness associated with the back pain....

I reviewed his CT myelogram again. He does have moderate to severe spinal stenosis at L2-3 and L3-4. He has mild to moderate stenosis at L4-5. He has a wedge compression of L1, which appears very chronic....

Mr. Loar states that his symptoms have worsened after an accident in April of '05. Prior to that, he had chronic back symptoms, but the symptoms were not as severe. His current symptoms are very severe and different from his previous back symptoms. We have discussed all options. He has received physical therapy, lumbar epidural steroid injections times 2, and facet rhizotomies. No treatment has been very effective. Since he has lumbar spinal stenosis, I have given him the option of undergoing decompression....I don't expect the surgery to eliminate all of his symptoms. He may not be able to return back to his full duty even if his symptoms are improved.

On February 24, 2006, Dr. Shahim performed a lumbar laminectomy and bilateral foraminotomy at L2, L3, and L4. Dr. Shahim's operative report showed "no evidence of disc herniation." The preoperative and postoperative diagnoses were, "Lumbar spinal stenosis at L2-3 and L3-4."

A pre-hearing order was filed on May 1, 2006. The claimant contended that he sustained a compensable injury to his back and legs on April 23, 2005. The claimant contended that he was entitled to temporary total disability compensation, medical expenses, and attorney's fees.

The respondents contended, among other things, that the additional medical treatment sought by the claimant was not reasonably necessary in connection with the compensable injury. The respondents contended that "the disability periods claimant has sustained, if any beyond the periods of TTD paid by respondent, were not incurred as the result of a compensable injury[.]"

The administrative law judge found, in pertinent part:

3. The claimant has proven by a preponderance of the evidence that all additional medical treatment received after January 6, 2006, including the February 2006 surgery by Dr. Shahim, was reasonably necessary in connection with his compensable injury, and that additional treatment remains reasonably necessary.

4. The claimant has proven ... that he was within his healing period and totally incapacitated from earning wages from February 2, 2006, through a date yet to be determined.

5. The claimant has therefore proven ... that he is entitled to temporary total disability benefits from February 2, 2006, through a date yet to be determined.

The respondents appeal to the Full Commission.

## II. ADJUDICATION

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. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

The administrative law judge found in the present matter, "The claimant has proven by a preponderance of the evidence that all additional medical treatment after January 6, 2006, including the February 2006 surgery by Dr. Shahim, was reasonably necessary in connection with his compensable

injury, and that additional treatment remains reasonably necessary." The Full Commission reverses this finding.

The record indicates that the claimant began complaining of lower back pain in June 2001. Following an MR of the lumbar spine in November 2001, the claimant was first diagnosed as having spinal stenosis. Another MR in July 2004 confirmed multi-level degenerative changes in the claimant's lumbar spine. After he reported slipping and falling at work on April 23, 2005, the parties stipulated that the claimant sustained a compensable injury to his back. The initial treating physician diagnosed "acute low back pain." Dr. Ditsch examined the claimant and diagnosed "fall with contusion to the back." However, an MRI in May 2005 showed the pre-existing condition of spinal stenosis. There were no significant abnormalities and no acute fracture was noted. Dr. Ditsch opined that the claimant suffered from spinal stenosis, and that this condition was not related to the claimant's accident at work.

Dr. Shahim began treating the claimant in May 2005. Dr. Shahim noted that the claimant's stenosis was pre-existing, but he opined that this condition had been aggravated by the compensable injury. Dr. Shahim at first

treated the claimant conservatively but later planned to perform a lumbar decompression at L2-3.

Dr. Saer evaluated the claimant in September 2005. Dr. Saer confirmed each of the other medical reports in stating, "He has no disc herniation. There is moderate stenosis at L3-4 and mild to moderate stenosis at L2-3." Dr. Saer opined that the claimant had probably sustained a strain or sprain; however, Dr. Saer could see no acute injury to explain the claimant's symptoms. Dr. Saer recommended an exercise and conditioning program for the claimant. Beginning in September 2005, Dr. Shahim continued conservative treatment for the claimant. Dr. Shahim also returned the claimant to light work duty. The claimant informed Dr. Shahim on January 5, 2006 that he was doing much better. His back and leg symptoms had improved, he was up and walking, and the claimant wished to return to work. Dr. Shahim released the claimant to full work duty.

Ark. Code Ann. §11-9-102(12) defines "healing period" as "that period for healing of an injury resulting from an accident." The healing period ends when the employee is as far restored as the permanent character of the injury will permit. If the underlying condition causing the disability

has become stable and nothing further will improve that condition, the healing period has ended. *High Capacity Prods. v. Moore*, 61 Ark. App. 18, 963 S.W.2d 613 (1998).

In the present matter, the Full Commission finds that the claimant reached the end of his healing period no later than January 5, 2006. The preponderance of evidence does not indicate that the claimant suffered from the effects of the April 2005 compensable injury beyond the time he was released to return to work on January 5, 2006. We recognize that the claimant returned for treatment related to his chronic lower back pain, beginning on or about January 27, 2006. Dr. Shahim ultimately performed surgery in February 2006. Dr. Shahim's postoperative diagnosis was "Lumbar spinal stenosis at L2-3 and L3-4." The evidence does not demonstrate that this degenerative condition was caused by the compensable injury. The Full Commission reiterates Dr. Shahim's surgical finding that there was no evidence of a disc herniation. Based on the record before us, the Full Commission finds that treatment rendered to the claimant after January 5, 2006 was the result of the claimant's pre-existing degenerative condition. The evidence does not

demonstrate that treatment after this date or surgery was the result of the April 2005 compensable injury.

Based on our *de novo* review of the entire record, the Full Commission reverses the administrative law judge's award of additional medical treatment. The claimant did not prove he was entitled to additional medical treatment or continued pain management after the end of his healing period on January 5, 2006. Temporary disability cannot be awarded after the end of the claimant's healing period. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987). Since the instant claimant reached the end of his healing period no later than January 5, 2006, the Full Commission also reverses the administrative law judge's open-ended award of temporary total disability beginning February 2, 2006. This claim 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 Hood dissents.

DISSENTING OPINION

The Majority has reversed an Administrative Law Judge's decision finding that the claimant was entitled to certain medical and temporary disability benefits. For the reasons set out below, I respectfully dissent from that result. In my opinion, the claimant has met his burden of proof in establishing that the requested medical treatment and related disability were the result of his compensable injury. I would have therefore affirmed the Administrative Law Judge's decision.

The Majority has found that the disputed temporary disability and medical treatment the claimant received was the result of a pre-existing condition. I do not dispute that for several years prior to the date of this compensable injury, the claimant had received medical treatment for an ongoing back problem. However, I believe that the medical evidence clearly establishes that the claimant's condition, for which he ultimately received back surgery, was an aggravation of this pre-existing condition.

I reach that conclusion based upon my review of the medical reports of Dr. Reza Shahim, a Little Rock neurosurgeon. The claimant first saw Dr. Shahim on May 16, 2005, less than three weeks after his compensable injury. In Dr. Shahim's report of that date, he notes that the claimant has a long history of previous back pain but that on the date he saw him, the claimant reported, "his pain was different as compared to the previous pain." After reviewing the changes in the claimant's symptomology and the area in which the claimant was now reporting difficulties, Dr. Shahim stated his opinion as follows:

"Based on his history, his lower thoracic pain is due to the recent fall, and although the stenosis is a longstanding disease, he has certainly aggravated this condition from the trauma."

The claimant also underwent an MRI scan of his thoracic and lumbar spine following his injury. Those scans establish conclusively that the claimant did suffer an injury in the fall to that part of his back. Both the MRIs of May 23, 2005 and May 5, 2005, showed a disc protrusion or herniation at T9-T10, an abnormality

not present on the claimant's pre-injury MRIs. While Dr. Shahim later described this disc herniation as being "not significant," it is apparent that the thoracolumbar region of the claimant's back sustained a verifiable injury.

In Dr. Shahim's report of June 23, 2005, he once again reiterates the claimant's back history and states his belief that the symptoms the claimant suffered from were related to a work injury. The report is also significant because Dr. Shahim recommends that the claimant undergo facet nerve blocks for treatment of his back condition. Prior to the claimant's injury, this type of treatment had been considered and rejected because the claimant's condition was not severe enough to justify such treatment. However, Dr. Shahim's reports make it clear that the claimant's condition has worsened to the point that this type of invasive procedure was now necessary.

Later, Dr. Shahim reiterated his beliefs that the ailments for which he was treating the claimant were occasioned by his job related accident. In his report of August 23, 2005, he states as follows:

I talked to Mr. Loar on the phone today. I explained to him that he has moderate to severe canal stenosis at L2-3. He has compression of the vertebral body of L2, which appears old. I believe he has aggravated L2-3 stenosis with recent trauma. He has failed epidural steroid injections and therapy, and for this reason I have given him the option of undergoing a lumbar laminectomy at L2-3.

Eventually, Dr. Shahim did perform the laminectomy referred to in the above-quoted report. However, this surgery was not performed until the claimant had undergone extensive conservative treatment, including medications, facet injections, nerve blocks, and physical therapy. However, none of those treatment modalities was successful in providing the claimant long term relief. In contrast, the laminectomy performed by Dr. Shahim was an unqualified success. Prior to the surgery, the claimant had made several attempts to return to work. However, he was not able to consistently perform his former job, even under significant restrictions. However, after the surgery,

he was able to return and, by the time of the hearing, he testified that he was able to perform his former job, with little or no restrictions, for at least six hours per day. He stated that he was confident that he would be able to return to a full eight (8) hour day in the near future.

I find that the evidence in this case strongly preponderates in favor of the claimant. While it is true that he had a pre-existing back condition, he was able to continue working with this problem and his pre-injury condition responded well to medical treatment, allowing him to remain fully employed. However, after the injury, he was no longer able to perform his job duties because of severe pain, stiffness, and other debilitating symptoms. Post-injury MRI scans establish that the claimant's fall was traumatic enough to cause a disc herniation at T9-T10, and the other medical evidence documents that his symptoms had changed following his injury. It is also significant that after the accident, the focus of treatment moved from the claimant's lower lumbar spine to his thoracolumbar region. In fact, it was this area, L2-L3, upon which

Dr. Shahim's treatment primarily focused. Dr. Shahim's medical reports also strongly set out his opinion that the claimant had sustained an aggravation because of his fall at work and that this aggravation is what necessitated his surgical treatment.

I find Dr. Shahim's opinion that the claimant's job related fall aggravated his pre-existing condition to be very persuasive. His opinion is supported by the unrefuted evidence that the claimant's condition significantly declined following his fall, but improved markedly after the surgery. While this Commission has the discretion to weigh disputed medical records and testimony, it cannot simply ignore the facts presented in the record. The Majority simply has chosen to disregard the applicable medical evidence in reaching its decision. For that reason, I must respectfully dissent from the Majority's Opinion.

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PHILIP A. HOOD, Commissioner