

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F011975

SHIRLEY W. WALKER,
EMPLOYEE

CLAIMANT

UNITED CEREBRAL PALSY
OF CENTRAL ARKANSAS,
EMPLOYER

RESPONDENT

GREAT RIVER INS. CO.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED JANUARY 8, 2007

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

Claimant represented by the HONORABLE LEWIS E. RITCHEY,
Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE BETTY J. DEMORY,
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 March 9, 2006. 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 the parties
and subject matter of this claim.

2. Pursuant to the stipulations of the parties and the record, the employment relationship existed at all pertinent times; the claimant sustained a compensable injury to her low back[.]
3. The preponderance of the evidence shows that, as a result of her compensable injury, the claimant has sustained anatomical impairment in an amount equal to 11% to the body as a whole.
4. The preponderance of the evidence shows that the claimant is entitled to additional reasonably necessary medical and related services, specifically including her continued membership at the North Little Rock Athletic Club and massage therapy, as recommended by her treating physician.
5. The respondents have controverted the payment of benefits hereinafter awarded and the claimant's attorney is entitled to the maximum statutory attorney's fee thereon, payable one-half by the claimant and one-half by the respondents.

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 March 9, 2006 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 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 sustained an anatomical impairment in an amount equal to 11% and that the a continued membership at the North Little Rock Athletic Club and massage therapy are reasonable and necessary medical treatment in connection with her July 15, 2000, compensable injury. Based upon my de novo review of the entire record, I find that the claimant has failed to prove by a preponderance of the evidence that she sustained an anatomical impairment greater than 6% to the body as a whole or that a continued membership at the North Little Rock Athletic Club and massage therapy are reasonable and necessary medical treatment in connection with her compensable injury.

The facts of this claim are not in dispute. The claimant sustained a minor compensable injury to her low back on July 15, 2000, when she was helping a patient in a wheel chair. The claimant received treatment from Dr. William Joseph and was initially diagnosed with a lumbar strain. The claimant was referred to Dr. John Wilson, an orthopedic surgeon, who examined the claimant on August 15,

2000. Dr. Wilson concurred in the claimant's diagnosis of lumbar strain and opined that the claimant did not have objective evidence of permanent impairment. By January of 2001 the claimant came under the care of Dr. Kenneth Rosenweig and Dr. Kevin Collins. Throughout her treatment with these physicians, the claimant's diagnosis of lumbar strain did not change. Dr. Collins treated the claimant through July of 2001 with medication and physical therapy. An MRI performed on July 9, 2001, was read by the radiologist as depicting impingement of the right sided L3 nerve root related to disc extrusion and mild hypertrophy of the articular facets, a broad-based disc bulge at L4/5, and pseudoarthrosis to the left of midline at the lumbosacral junctions related to hypertrophy of the transverse process. (This report was not introduced into evidence at the most recent hearing but was introduced at a previous hearing and was addressed in the May 10, 2002, Administrative Law Judge opinion which was affirmed and adopted by the Full Commission on November 20, 2002. The May 10, 2002, Administrative Law Judge opinion and the November 20, 2002, Full Commission opinion were made exhibits to the records. Although the respondents requested that the previous transcript be made a part of the record in their Prehearing Questionnaire filing, nothing was said at the hearing about

this matter.) In his July 16, 2001, clinic note, Dr. Collins assessed the claimant's MRI as evidencing a herniated disc to the right at L-3, with no comment regarding the other levels in the claimant's lumbar spine. Dr. Collins further noted that he was running out of options for the claimant and deferred to Dr. Mocek, a pain specialist with whom he practices, with regard to any other treatment. The record reflects that the claimant was seen by Dr. Carl Covey, who administered bilateral lumbar facet blocks at L3/4, L4/5, and L5/S1 on August 25, 2001.

The claimant was seen by Dr. Mocek in the fall of 2001. As noted in the May 10, 2002, Administrative Law Judge opinion, Dr. Mocek performed diagnostic lumbar facet blocks on August 29, 2001. The claimant's reduction in pain from these blocks was not great enough to indicate that the claimant would benefit from radiofrequency lesioning of the lumbar facet nerves. Dr. Mocek ordered a diagnostic discogram to determine whether the claimant might have an annular tear. Respondents controverted the discogram. A hearing as to whether the discogram constituted reasonable and necessary treatment was conducted on February 19, 2002. In an opinion filed May 10, 2002, the Administrative Law Judge found that such diagnostic treatment was reasonable and necessary and awarded a discogram for the claimant. The

Full Commission affirmed and adopted the Administrative Law Judge's opinion. The discogram was performed on January 31, 2003. This procedure revealed evidence of an annular tear at L3/4 and L4/5. Likewise, an MRI was performed on January 31, 2003, which revealed degenerative disc disease and degenerative annular tears at L3/4 and L4/5.

After conducting these diagnostic tests, Dr. Mocek wrote in his February 13, 2003, office report:

There is no question that Ms. Shirley Walker has pain in her back coming from this L3-4 and L4-5 disc. Both of these discs were painful on injection. Both appeared grossly abnormal. These annular tears can be very painful and the disc chemicals that leak out of the discs are very acidic and inflame the nerves and can cause chronic pain in the back. The best procedure we have to offer her for relief of this pain is arthroscopic assisted discectomy and decompression of the L3-4 and L4-5 discs. We have a small scope about the size of a number 2 pencil, same technology as the arthroscope for the knee, where we can actually remove the herniated disc tissue and diseased tissue and seal off the tears with a laser. The patient has about a 75% chance of relief of the back and bilateral hip pain with the procedure. The procedure should relieve at least 50% of the pain, although she could be having some pain from the arthritis in her back as well. I discussed the risks and benefits of the procedure with the patient....

At the respondent's request, the claimant obtained a second opinion from Dr. Scott Schlesinger on May 30, 2003. In his report of that date, Dr. Schlesinger opined:

I have reviewed the MR discogram on Ms. Shirley Walker than (sic) was done on 1/3/03. I feel that the findings of degenerative changes at L3-4 and L4-5 and diffuse annular tear on this MRI are consistent with my previous IME report. I do not feel that this patient would benefit from any sort of surgical intervention aimed at these degenerative changes. I do not feel in any way that this MRI discogram study is indicative that she would benefit from any surgical intervention. As before, I think she has reached maximum medical improvement and I do not feel that further aggressive care is warranted. I state this with a reasonable degree of medical certainty.

Since Dr. Schlesinger specifically referred to his previous IME, a review of this IME report is crucial to a full understanding of the facts. In their Prehearing Questionnaire filing, the respondents specifically listed the transcript from the February 19, 2002, hearing as an exhibit to the most recent hearing. Although it was not specifically mentioned as an exhibit at the December 9, 2005, hearing, I find that the transcript from the first hearing should be made a part of the record. Accordingly, I have blue-backed the transcript from the February 19, 2002, hearing and made it a part of the record from the

December 9, 2005, hearing. In his IME report dated November 8, 2001, Dr. Schlesinger stated:

I have read the MRI scan of the lumbar spine. She has degenerative changes and minimal bulges at the L3-4 and L4-5 levels. These appear to be longstanding changes and almost certainly not the result of any acute trauma. I disagree with the radiologist's interpretation. Dr. Frail is not a neuroradiologist and I do not believe there is a disc herniation. She has a generalized bulge at the L3-4 and L4-5 level, but there is no nerve root compression despite his report. Clinically she has no nerve root compression as she has no sciatica. There is nothing to do from a neurosurgical standpoint. I believe she has reached maximum medical healing from her "injury". I do not believe in lumbar fusion for the pain, so I do not believe from a neurosurgical standpoint that lumbar disography is indicated. There are surgeons who perform lumbar discography and lumbar fusion for back pain, but the results in this patient population are terrible and I certainly could not recommend this. I would recommend that she undergo a functional capacity evaluation, which we can schedule if you desire, at the Arkansas Specialty Physical Therapy Center. I will release her to return to work with the limitations as outlined in a functional capacity evaluation. I don't think any further medical or surgical consideration is indicated.

The claimant was also evaluated by Dr. Steven Cathey on July 29, 2003. After reviewing her medical records, obtaining a thorough history from the claimant, and

conducting a physical examination of the claimant,
Dr. Cathey opined:

... it is my opinion that Ms. Walker's continued complaints of low back pain stem from degenerative lumbar disc disease with associated facet osteoarthritis. Although Ms. Walker denies any previous history of low back pain or injury prior to the 07/15/2000 event, these degenerative changes, including the "annular tears" are oftentimes common in otherwise asymptomatic individuals of her age. It is therefore impossible to say to any degree of medical certainty, that the structural changes noted on her subsequent MRI scans were directly related to the occupational injury of July 15, 2000, although the possibility exists that they are. I do not believe Ms. Walker is a candidate for traditional surgical intervention such as lumbar discectomy, spinal fusion, etc. As far as the indications for "arthroscopic-assisted decompression," I have absolutely no experience with this type of procedure. Sometimes the only way to know if such intervention is beneficial is to take a "try it and see" approach. It is however, my opinion, that Ms. Walker is going to be extremely disappointed with the results of this proposed surgical procedure. I certainly have been disappointed with the outcome when simple discectomy is performed for chronic low back pain in the context of degenerative lumbar disc disease. This appears to be consistent with Dr. Scott Schlesinger's opinion rendered on November 8, 2001. Furthermore, I share Dr. Schlesinger's disdain for lumbar diskography. I also do not believe from a neurosurgical standpoint diskography is indicated. As I have stated before, all of the information supposedly

obtained from Ms. Walker's diskography was already apparent on her initial MRI scan. Unfortunately, I am not aware of any additional conservative treatment that might be beneficial. One possible option however, would be the use of the "MedX" program of spinal rehab and stabilization. This would certainly seem a preferable option to the proposed arthroscopic procedure envisioned by Dr. Mocek.

In addition to performing an Independent Medical Evaluation regarding the claimant's proposed treatment, Dr. Cathey also assigned the claimant a 6% permanent anatomical impairment rating and stated that the claimant was at maximum medical improvement at the time of his evaluation. Finally, Dr. Cathey stated, "...I anticipate Ms. Walker will always have a perception of chronic lower back pain."

The record contains a letter from Dr. Mocek dated August 11, 2003, wherein he further explained the proposed arthroscopic assisted diskectomy procedure he had recommended for the claimant. Most interestingly, Dr. Mocek cited his experience of about 90% of his patients undergoing this procedure experience relief from leg pain. The operative report was not introduced into evidence, however a February 10, 2004, followup patient visit note reveals that the claimant underwent the two level arthroscopic diskectomy

and that she experienced pain relief in her low back and hips. In addition, this report indicates that the claimant completed four MedX treatments and had returned to work. By the March 23, 2004, followup report, Dr. Mocek noted that the claimant had complete resolution of right leg pain, but continued to have some residual back pain and that the claimant was not taking any narcotic pain medications. Moreover, Dr. Mocek noted that he was very pleased with the claimant's response from the surgical procedure. It was at this time that Dr. Mocek first made mention of pool therapy. In his June 15, 2004, followup patient report, Dr. Mocek noted the claimant's residual back pain and stated:

I'm extremely pleased with the patient's response to the arthroscopic diskectomy procedure. We will continue the water therapy since the patient states it really helps her. I suspect the residual back pain is coming from arthritis. She cannot take anti-inflammatories due to peptic ulcer disease.

Dr. Mocek continued to prescribe "pool therapy" and continuing at the North Little Rock Athletic Club in his followup examinations of the claimant through December 2, 2004. In the Followup Office Visit report dated February 17, 2005, Dr. Mocek recited the claimant's history including having undergone "water therapy". After examining the claimant, Dr. Mocek noted:

Patient has a history of discogenic related back pain at L3-4 and L4-5 disc levels from discography on 1-31-03. She could still be having some pain from the discogenic related pain. She also has severe disc disease at L5, S1. We can try to get a new MRI of the lumbar spine. If she does not have any central herniations the residual pain may be coming mostly from lumbar spondylosis. We do have some treatment for this; diagnostic facet injections. If she gets relief she would be a candidate for RF denervation of the facet joint nerves for prolonged pain relief.

Dr. Mocek ordered an MRI of the lumbar spine, and prescribed non-steroidal anti-inflammatory and muscle relaxers. No mention was made following this examination of continuation of "water therapy." After reviewing the new MRI results, Dr. Mocek specifically stated in his April 4, 2005, Followup report:

it appears from the patient's new MRI of the lumbar spine that there are no new disc herniations. All of the pain is likely coming from the lumbar facet arthritis in combination with the residual discogenic back pain. We can try lumbar facet denervation bilaterally from L3, L4, and L5. This would be the last procedure I have to offer her to get rid of some more residual back pain.

Dr. Mocek recommended scheduling the claimant for the radio frequency denervation procedure and prescribed pain, anti-inflammatory, and muscle relaxer medications.

Again, Dr. Mocek did not recommend "water therapy" at that time; however, a prescription which including among other things to "continue to otherwise @ NLR Athletic Club" was completed and dated April 21, 2005. On April 29, 2005, the claimant underwent the previously recommended Radio frequency lesioning procedure at L4, L5, and S1.

The claimant was seen in followup from this procedure on May 19, 2005. It is noted that in less than four weeks following this procedure, the claimant reported to Dr. Mocek that she had been working double shifts and had not noticed a decrease in her pain. Dr. Mocek specifically restricted the claimant from working double shifts at that time. Nevertheless, at her June 28, 2005, followup visit, the claimant again advised Dr. Mocek that she was working 16 hour shifts and could not detect any relief from the RF denervation procedure.

The claimant returned to Dr. Kevin Collins on July 19, 2005, to attain an impairment rating. The record does not reflect whether Dr. Collins reviewed all of the claimant's medical records from the claimant's other treating physicians since he last saw her in July of 2001. With regard to her intervening treatment, Dr. Collins merely noted; "She has had a total of three surgeries, two level. She had an L3-4, L4-5 disc herniation with arthroscopy

discectomy on 10-27-04." With regard to the claimant's continuing symptoms, Dr. Collins recorded complaints which were completely contrary to those noted by Dr. Mocek. Specifically, Dr. Collins noted that the claimant continued to complain of "chronic S1 pain, pain in right lower extremity." Dr. Collins assessed the claimant with an 11% permanent impairment rating based upon the DRE Category III of the Guides to the Evaluation of Permanent Impairment, 5th edition.

A prescription note from Dr. Mocek dated August 17, 2005, reflects a prescription for Physical therapy for "Eval & TX + massage therapy." The final report from Dr. Mocek which was introduced into evidence reveals that the claimant continues on medication therapy, obtained temporary relief from traction therapy, and was continuing to have difficulty sleeping due to back pain. Dr. Mocek placed the claimant on a six month return visit at that time.

I find that the claimant failed to prove by a preponderance of the evidence that she is entitled permanent partial disability benefits for an 11% anatomical impairment rating as assigned by Dr. Collins. Injured workers bear the burden of proving by a preponderance of the evidence that they are entitled to an award for a permanent physical

impairment. Therefore, when considering claims for permanent physical impairments, the Commission must impartially weigh all of the evidence in the record to determine whether the preponderance of the evidence establishes that the worker sustained a permanent physical impairment as a result of a compensable injury. Crow v. Weyerhaeuser Co., 46 Ark. App. 295, 880 S.W.2d 320 (1994). Physical impairments occur when an anatomical physiological, or psychological abnormality permanently limits the ability of the worker to effectively use part of the body or the body as a whole. Consequently, an injured worker must prove that the work-related injury resulted in a physical or psychological abnormality which limits the ability of the worker to effectively use part of the body or the body as a whole. Therefore, an injured worker must prove that the work-related injury resulted in a physical or psychological abnormality which limits the ability of the worker to effectively use part of the body or the body as a whole. Moreover, in considering such claims, the Commission must first determine whether the evidence shows the presence of an abnormality which could reasonably be expected to produce the permanent physical impairment alleged by the injury worker. Crow, supra.

With regard to this determination, Ark. Code Ann. § 11-9-704(c) (1) (Repl. 1996) provides that "[a]ny

determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings." Act 796 of 1993 amended the Arkansas Workers' Compensation Law to define objective findings as "those findings which cannot come under the voluntary control of the patient." Ark. Code Ann. § 11-9-102(16) (Supp. 1997). In addition, as amended by Act 796, medical providers, Administrative Law Judges, and this Commission cannot consider complaints of pain when determining physical or anatomical impairment. Id.

Furthermore, the amended law provides that, "for the purpose of making physical or anatomical impairment ratings to the spine, straight-leg raising tests or range-of-motion tests shall not be considered objective findings."

Furthermore, Ark. Code Ann. § 11-9-522(g) provides that the Commission shall adopt an impairment rating guide to be used in the assessment of anatomical impairment and specifically provides the guide shall not include pain as a basis for the impairment. In compliance with this statutory mandate, the Commission adopted The AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition with the enactment of Commission Rule 34. Rule 34 specifically states:

That The Guides are adopted "exclusive at any section which refer to pain and exclusive of straight leg raising tests or range of motion tests when making physical or anatomical impairment ratings to the spine."

The Commission has adopted the Guides and to the extent that the Guides allow the use of subjective criteria for the establishment of an impairment rating, the Guides must give way to the statutory definition of objective findings as defined by the General Assembly. The portions of the Guides which are based upon subjective criteria cannot supersede the statutory definition established by the General Assembly. Therefore, to the extent that there is a conflict, the statutory definition as established by the General Assembly takes precedence over any subjective criteria set forth in the Guides.

Although the claimant underwent an arthroscopic assisted diskectomy in August of 2003, the objective medical evidence overwhelming confirms that the claimant did not suffer from a herniated disc in her lumbar spine. As noted by both Dr. Schlesinger and Dr. Cathey, the claimant suffered from degenerative changes and minimal bulges at L3-4 and L4-5, but she clearly did not exhibit any evidence of disc herniations. Moreover, the arthroscopic diskectomy procedure performed by Dr. Mocek in October of 2003, was

only intended to address the annular tears found by Dr. Mocek in the discogram performed in January of 2003. In recommending this procedure, Dr. Mocek opined, "[t]he patient has about a 75% chance of relief of the back and bilateral hip pain with the procedure. The procedure should relieve at least 50% of the pain, although she could be having some pain from the arthritis in her back as well."

While Dr. Mocek noted in his follow-up reports that the claimant received relief from her leg pain, the claimant's physicians never noted radiculopathy during their examinations of the claimant. Dr. Schlesinger specifically noted that the claimant did not have "nerve root compression as she has no sciatica."

Accordingly, I find that Dr. Collins's assessment of an 11% anatomical impairment rating based upon DRE Lumbar Category III in the Guides to the Evaluation of Permanent Impairment, 5th Edition is misplaced. First, Dr. Collins utilized the wrong edition of the Guides. Second, Dr. Collins specifically stated in assigning the impairment, "...since the claimant had surgery, note midway down herniated disc level on the side that would be expected with objective clinical findings associated with radiculopathy, version of surgery for radiculopathy, now he is asymptomatic..." As noted above, the claimant possessed

neither a herniated disc nor any objective clinical findings associated with radiculopathy. Therefore, I find even if reliance of the 5th edition of the Guides were permissible, it is improper to rely upon this portion of the Guides in assessing the claimant's impairment. Likewise, under DRE Category III for a Lumbosacral injury in the 4th edition of the Guides, the claimant fails to satisfy the criteria for impairment.

Although Dr. Cathey assessed the claimant with a 6% anatomical impairment rating prior to the arthroscopic assisted diskectomy procedure, this procedure was not intended to address a herniated disc or radiculopathy, but rather annular tears and pain. The Guides do not provide impairments for these conditions alone and of themselves. I find that Dr. Cathey more adequately assessed the claimant's impairment. The Guides to the Evaluation of Permanent Impairment, 4th edition, establishes a 5% anatomical impairment rating under the DRE Lumbosacral Category II: Minor Impairment section for the following conditions:

The clinical history and examination findings are compatible with a specific injury or illness. The findings may include significant intermittent or continuous muscle guarding that has been observed and documented by a physician, nonuniform loss of range of motion (dysmetria, differentiator 1 Table 71, p. 109), or nonverifiable radicular

complaints. There is no objective sign of radiculopathy and no loss of structural integrity.

As the claimant never possessed any objective sign of radiculopathy, and as the claimant never suffered from a herniated disc (only degenerative changes and minimal bulging), I find that DRE Category II more accurately reflects the claimant's physical condition. While Dr. Cathey assessed a 6% anatomical rating and DRE Category II only assesses a 5% anatomical impairment rating, the respondents have accepted the rating as assigned by Dr. Cathey.

The claimant also has the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary. Norma Beatty v. Ben Pearson, 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).

In the present claim, the respondents have controverted the proposed procedure of "pool therapy," "massage therapy," and "to continue otherwise @ NLR Athletic Club." Dr. Mocek has prescribed this so-called treatment because the claimant "states that it really helps her." However, as stated in Deborah Jones v. Seba, Inc. we must analyze the condition this so-called treatment is sought to remedy. All Dr. Mocek has stated with regard to this treatment is that it "helps" the claimant. While it is generally recognized that physical activity "helps" with pain and discomfort, there is no evidence that the "pool therapy," "massage therapy," and "to continue otherwise @ NLR Athletic Club" constitute actual medical treatment for which the respondents are liable. Arkansas Code Annotated §11-9-508 specifically provides:

The employer shall promptly provide for an injured employee such medical, surgical, hospital, chiropractic, optometric, podiatric, and nursing services and medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing

aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee.

Unlike Physical Therapy or Chiropractic treatments, a medical care provider does not oversee, monitor, or apply the "treatment" received by the claimant at the health club. Records are not maintained with regard to the claimant's attendance or compliance with the so called "treatment" and there is no medical personnel supervising the claimant's "treatment" or progress. Accordingly, I cannot find that the claimant has proven by a preponderance of the evidence that the prescription for "pool therapy," "massage therapy," and "continuance at the NLR Athletic Club" amounts to medical treatment. Merely because exercise "helps" the claimant does not elevate it to the level of medical treatment within the meaning of the workers' compensation act.

Moreover, even if one were to find that a general prescription for exercise, massage, and unsupervised pool therapy amounts to medical treatment, a finding which I specifically do not make, I cannot find that the condition such treatment is sought to remedy is causally related to the claimant's compensable injury. It is undisputed that the claimant suffers from pre-existing degenerative disc

disease. Over her physician's objections and orders, the claimant continues to work overtime and double shifts which would be straining on even a normal spine.

Even when Dr. Mocek first recommended the arthroscopic assisted diskectomy, he acknowledged that the claimant's back pain may very well be related to "the arthritis in her back as well." After stating how pleased he was with the claimant's response to the arthroscopic diskectomy, and that water therapy was helping the claimant, Dr. Mocek noted in his June 15, 2004, Followup Patient Visit report: "I suspect the residual back pain is coming from arthritis." Again in his February 17, 2005, report, Dr. Mocek opined that the claimant's residual pain "may be coming mostly from lumbar spondylosis." Finally, in his April 6, 2005, report, Dr. Mocek again stated, "All the pain is likely coming from the lumbar facet arthritis in combination with residual discogenic back pain." Thus, while he could not state conclusively the cause for the claimant's continued back pain, Dr. Mocek consistently attributed such pain to the claimant's degenerative disc disease and underlying arthritis, neither of which are a result of the claimant's compensable injury. It is this underlying, pre-existing condition that is more than likely causing the claimant's pain for which she seeks relief in

"pool therapy," "massage therapy," and exercise at the North Little Rock Athletic Club. As such, I cannot find that treatment the claimant now seeks is reasonably necessary in connection with her compensable lumbar injury. The claimant was diagnosed with a lumbar strain by all of her treating physicians. Dr. Mocek, attempted to address the claimant's pain through discography, arthroscopic diskectomy, and radio frequency lessioning. In the end, Dr. Mocek's treatments have not sufficiently relieved the claimant of her pain. As a result, Dr. Mocek has, himself, even acknowledged that the claimant's pre-existing arthritis is to blame. Respondents are not liable for treatment of the claimant's pre-existing arthritis as it is not causally related to the claimant's minor compensable lumbar strain for which she has exhausted all treatment. Therefore, I find that the decision of the Administrative Law Judge awarding such treatment must be reversed.

Accordingly, for all the reasons set forth herein, I must respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner