BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F501764

PAULA ARD,
EMPLOYEE CLAIMANT

ST. VINCENT HEALTH SERVICES,
EMPLOYER RESPONDENT

ALTERNATIVE INSURANCE MANAGEMENT,
INSURANCE CARRIER RESPONDENT

OPINION FILED MAY 21, 2008

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

Claimant represented by the HONORABLE STEVEN MCNEELY, Attorney at Law, Little Rock, Arkansas.

Respondent represented by the HONORABLE WALTER MURRAY, 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 September 25, 2007. The administrative law judge found, among other things, that the claimant proved she sustained a compensable injury. After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. The Full

Commission finds that the claimant did not prove she sustained a compensable injury.

I. HISTORY

Paula Jeanette Ard, age 52, testified that she was hired as a home care nurse for the respondent-employer in 2004. The parties stipulated that the employment relationship existed on January 31, 2005. The claimant testified that while lifting a patient, "I felt something pop in my back."

Dr. William Warren saw the claimant on February 2, 2005: "Patient is a 49 year old female employee of St. Vincents Health System who complains about her back which was injured on 1/31/2005 11:00:00 AM....The mechanism of injury was lifting of a patient onto a bed. The patient suffered an axial load injury of bilateral lumbar region....Lumbar: Palpation tenderness of bilateral the paraspinous muscles at the level of L5....No ecchymosis. No erythema. No external trauma. No palpable spasm. No spinous tenderness....Possitive (sic) Waddells distraction. The remainder of the back examination was unremarkable....LS-spine x-ray: Negative."

Dr. Warren assessed "lumbar strain" and "lumbar pain." Dr. Warren planned conservative treatment and physical restrictions, return to the clinic as needed. The claimant began physical therapy on February 2, 2005. The claimant informed Dr. Warren on February 4, 2005 that she had not been working because no light duty was available, and that she felt worse following physical therapy. Dr. Warren assessed lumbar strain, lumbar pain, and sciatica. A physical therapist noted on February 4, 2005, "Patient's mother brought her to PT and doctor visit and her mother ralates (sic) that 'they' had to work on her spasms all afternoon yesterday. Patient complains of severe 'spasm'....Observed one of her 'spasms'. Patient was hock lieing (sic) on a hot pack and began to moan and cry out. This went on for several minutes. Patient required assistance to come to a sitting position. Waddell's overreaction positive."

An MRI of the claimant's lumbar spine was taken on February 10, 2005:

> There is marked degenerative disk change at L4-5. On a sagittal STIR additional sequence with fat-suppression there is some signal within the marrow adjacent to the L4-5 disk which I suspect is degenerative related. There is a large disk

> herniation at L4-5 on the right in a paracentral location. There is inferiorly migrated free fragment measuring nearly 1 cm diameter which I suspect severely impinges the right L5 nerve root. Remaining lumbar disks show only a small Schmorl's nodule in the superior end-plate of L4 with some additional small Schmorl's nodules. The foramina are intact. The conus appears normal and signal marrow spaces is otherwise unremarkable. The paraspinal soft tissues are unremarkable.
>
> Conclusion:
> There is a large right paracentral disk herniation at L4-5 where there is an inferiorly migrated extruded fragment of nearly 1 cm size, severely impinging the L5 nerve root on the right. Degenerative associated marrow changes are present adjacent to the L4-5 disk.

Dr. Warren assessed "Herniated disc" on February 14, 2005 and planned a referral to Dr. Steven L. Cathey. The parties stipulated that the claim was initially accepted as compensable, and that medical expenses and temporary total disability benefits were paid. A February 22, 2005 letter from Alternative Management Services, Inc. indicated that the claimant was paid "for lost time benefits for February 14, 2005 thru February 27, 2005, two weeks."

Dr. Cathey examined the claimant and corresponded with Dr. Warren on February 24, 2005: "Point tenderness was noted in her lower back, however, no paraspinous muscle spasm or restriction of movement was observed today. The patient and I reviewed a recent MRI scan of her lumbar spine. She

appears to have an acute right paracentral (the asymptomatic side) disc herniation at L4-L5. Bill, since Mr. Ard's clinical presentation does not correlate with the MRI scan, and since she also has significant risk factors for surgery, I do not believe she is a candidate for lumbar disc surgery or other neurosurgical intervention....While awaiting a follow-up visit, I have switched her from Flexeril to valium 5 mg t.i.d. as needed for muscle spasms. The patient will remain off work pending a follow-up evaluation with you."

The claimant's attorney stated at hearing that no benefits were paid after February 27, 2005.

The claimant returned to Dr. Warren on March 2, 2005, and Dr. Warren found "No palpable spasm." Dr. Warren's assessment was herniated disc and lumbar disc degeneration. Dr. Warren assigned the following Activity Status: "Regular activity release from care today. Patient has been advised to see PCP regarding a non-work related condition." A note from Concentra Health Centers indicated that the claimant was to "Return to regular duty on 03/02/2005."

A claim coordinator for the respondent-carrier informed the claimant on March 11, 2005, "I am writing to advise you that we are now denying your claim under Workers'

Compensation as of March 2, 2005. This decision was based upon medical information from Dr. Warren. I have paid you lost time benefits through March 2, 2005. No further benefits will be payable under workers' compensation."

An administrator with the Visiting Nurse Association informed the claimant on May 19, 2005, "As you have been unable to return to work, we have terminated your employment with us effective May 19, 2005. Once you are able, we encourage you to reapply for a position with VNA. We wish you well and look forward to hearing from you soon."

Dr. Jay Holland corresponded with the respondent-employer on August 6, 2005 and stated in part, "There is no medical or historic evidence that this problem arose from any cause other than the work related incident, which precipitated this herniation. There is no evidence of other degenerative disc disease in this patient....She is still in limbo. Her insurance, Workman's Comp and Job have been stopped, all due to the erroneous statements of Dr. Warren. I recommend that she be referred to Dr. Richard Peek or Dr. Ted Saer for surgery. She may need to see Dr. Sprinkle in their group for Epidural Steroid injections to alleviate some of her symptoms, but a floating fragment herniated disc

needs surgical correction before she has significant nerve root damage. Her Workman's Comp benefits need to be re-instated, and her FEML leave extended. I also recommend that you consider stop using Dr. Warren for Workman's Comp claims until his practice parameters can be reviewed. He has released this patient to work who has a disc that can paralyze her."

Dr. Richard D. Peek examined the claimant on October 13, 2005 and diagnosed "Herniated nucleus pulposus L4-5, large....this patient does need an EMG. She has some early signs of nerve damage. Delays in treatment may be causing her harm. We need a current MRI scan to see whether the fragment has migrated. Free fragments can migrate centrally....She had a workers' compensation injury and had objective findings and reported appropriately....She may require microdiscectomy if she does not respond to conservative care."

An MRI of the claimant's lumbar spine was taken on October 13, 2005:

> Alignment of the lumbar spine is intact. Discogenic change is present at T11-12 and L4-L5. Marrow signal is otherwise within normal limits. Disk dessication is present at L3-4 and L4-5 with loss of disk height at L4-L5. There is marked

> irregularity of the end-plates at L4-5 without significant fluid signal seen within the disk space to suggest acute diskitis. The conus ends at L2. At L3-4, there is minimal broad-based disk bulge without evidence for neural compromise. At L4-5 there is a minimal broad-based posterior osteophyte in conjuction with facet hypertrophy producing mild bilateral foraminal stenosis without central canal stenosis. The remaining levels are also unremarkable.
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> IMPRESSION:
> Minimal broad-based osteophyte at L4-L5 where there is marked end-plate irregularity and loss of disk space. There is not significant fluid signal present within the disk space to suggest acute diskitis. This may represent sequela of remote diskitis. There is mild bilateral foraminal stenosis at L4-5. A minimal disk bulge is present at L3-L4.

Dr. Michael Stone performed a lumbar epidural steroid injection on October 25, 2005.

The claimant followed up with Dr. Peek on November 29, 2005: "MRI scan shows old discitis, so it looks like she developed aseptic discitis after her herniation....Her EMG does show that she has L5 radiculopathy of the left leg, which goes along with her story of severe sciatica with the herniation. The herniation has resolved some and she has developed an aseptic discitis at the L4-5 level....We will need to get a followup bone scan in addition to myelogram and CT scan....The events from the first of the year forward

are quite unusual, but she has had significant pathology to the L4-5 disc and the surrounding neurologic elements." Dr. Peek diagnosed "Status post L4-5 herniated disc with subsequent aseptic discitis."

The following impression resulted from a lumbar myelogram taken December 2, 2005: "Advanced discogenic changes are present at L4-L5. This may be related to sequela from a discitis or noninfectious inflammatory process. There is no evidence for a disc herniation or nerve impingement."

A post-myelogram CT of the claimant's lumbar spine was taken on December 2, 2005, with the impression, "Advanced degenerative change of the disc space at L4-5 likely related to remote infectious/inflammatory etiology."

A pre-hearing order was filed on December 7, 2005. The claimant contended that she injured her back in a specific incident at work on January 31, 2005. The claimant contended that she was entitled to medical expenses with Dr. Holland and Dr. Peek, temporary total disability benefits from March 2, 2005 to a date yet to be determined, and attorney's fees. The respondents contended that the

claimant did not sustain an injury arising out of the course of her employment.

The claimant underwent a "biopsy/aspiration at the L4-5 interspace level" on December 9, 2005. The claimant followed up with Dr. Peek on January 3, 2006: "Aspiration was negative. She has changes of discitis and has severe lower back pain unresponsive to conservative care. Her condition is gradually deteriorating and her ability to walk....Bone scan was hot at L4-5. She has changes fairly classic of status post avascular aseptic necrosis....I did review films from February 2005, which show a disc herniation. Sometime thereafter she developed isolated disc collapse." Dr. Peek's diagnosis was "1. Status post disc injury. 2. Possible previous aseptic discitis."

Dr. Peek and Dr. Michael M. Pollock performed surgery on or about February 9, 2006: "Anterior lumbar debridement of disc, inner body fusion and stabilization with machine femoral ring as well as bone morphogenic protein (Infuse)." The pre-operative diagnosis was "Diskitis, L4-5, with severe disc degeneration." Dr. Peek performed a "Posterior fusion" on or about February 14, 2006. The discharge diagnosis was "1. Aseptic diskitis L4-5. 2. Nutrition depleted."

Dr. Peek noted on March 16, 2006, "Her back pain is better, as well as radicular pain, than preoperatively." Dr. Peek diagnosed "Status post L4-5 anterior interbody fusion."

The matter had been set for a hearing on February 17, 2006 but was continued until April 12, 2006 at the claimant's request. The respondents' attorney did not appear at the April 12, 2006 hearing. The administrative law judge (ALJ) filed a Default Judgment on April 13, 2006. The ALJ found that the claimant sustained a compensable injury and directed the respondents to pay temporary total disability benefits and reasonably necessary medical expenses.

Dr. Peek noted on April 18, 2006 that the claimant was "doing satisfactory and continues to make progress with therapeutic management." Dr. Peek noted on June 22, 2006, "She is disabled from employment for two months, at which time she will return for followup." The claimant followed up with Dr. Peek on October 30, 2006: "Followup x-rays reveal the center portion of the graft has some incorporation, although not complete. On AP and lateral thoracic spine films there is a compression fracture at

T7....She was admitted for chest and back pain. It looks like she has developed a T7 compression fracture. The history was discussed. We need to make sure she does not have problems in that area and will get an MRI scan. I also did discuss with her about contact with workers comp and rehab nurses. She would like to wait until her appeal is over. She is temporarily disabled secondary to her back." Dr. Peek indicated on October 30, 2006 that the claimant "should not return to work until 3 months."

An MRI of the claimant's thoracic spine was done on November 21, 2006, with the following impression: "Subacute compression fractures of T11 and T12 suspected. Multilevel degenerative disk disease. Mottled appearance suggesting osteopenia. Prominent degenerative changes anteriorly at T10."

The Full Commission filed an Order on March 14, 2007 and stated in part: "[T]he April 13, 2006, Default Judgment must be and hereby is, vacated and set aside, and that this claim must be remanded to the Administrative Law Judge for a new hearing."

Dr. Peek wrote to the claimant's attorney on April 30, 2007:

> I further reviewed the depositions of Dr. David Phelan and Dr. Jonathan Fravel.
>
> After reviewing the depositions, as well as the records which have been reviewed, as well as examining and operating on Ms. Ard, it is my medical opinion that she had a herniated disc and developed discitis at the L4-5 interspace, necessitating a discectomy and interbody fusion related to traumatic herniation. An atypical course developed with discitis after herniation. However, there is clear evidence that it did.

A pre-hearing order was filed on May 17, 2007. The claimant contended that she injured her back in a specific incident at work on January 31, 2005. The claimant contended that she was entitled to payment of medical expenses with Dr. Holland and Dr. Peek, and that she was entitled to temporary total disability benefits from February 28, 2005 to a date yet to be determined. The respondents contended that the claimant did not sustain an injury arising out of the course of her employment.

The May 17, 2007 pre-hearing order indicated, "The respondents' counsel must show cause why he should not be held in contempt for failure to appear at the April 12, 2006 hearing." The parties agreed to litigate the following issues: "Compensability; medical expenses; temporary total disability benefits; contempt and attorney's fees. All other issues are reserved."

On an undated form provided to him by Medical Case Management of Arkansas, Inc., Dr. Scott Schlesinger opined that the surgery performed by Dr. Peek was not "a direct result of the alleged injury sustained on 1/31/05." Dr. Schlesinger indicated that the claimant did not develop diskitis as a direct result of the alleged injury, and that the claimant reached MMI "6-9 mos post injury."

Dr. Robert F. Sexton examined the records and informed the respondents in part, "Ms. Ard did not sustain a work-related injury that entitles her to an impairment rating."

A hearing was held on June 27, 2007. The claimant's testimony indicated that her pain was greatly reduced following surgery from Dr. Peek.

The administrative law judge filed an opinion on September 25, 2007 and found that the claimant proved she sustained a compensable injury. The ALJ ordered the respondents to pay medical expenses and temporary total disability benefits. The ALJ found that the respondents' attorney was in contempt for failure to appear at a scheduled hearing, and that the respondents' attorney was therefore liable for a $400 fine. The respondents appeal to the Full Commission.

## II. ADJUDICATION

### A. Compensability

Ark. Code Ann. §11-9-102(4)(A)(Repl. 2002) defines "compensable injury":

> (i) An accidental injury causing internal or external physical harm to the body ...arising out of and in the course of employment and which requires medical services or results in disability or death. An injury is "accidental" only if it is caused by a specific incident and is identifiable by time and place of occurrence[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4)(D). "Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16).

The claimant's burden of proof shall be a preponderance of the evidence. Ark. Code Ann. §11-9-102(4)(E). Preponderance of the evidence means the evidence having the greater weight or convincing force. *Smith v. Magnet Cove Barium Corp.*, 212 Ark. 491, 206 S.W.2d 442 (1947).

An administrative law judge found in the present matter that the claimant proved she sustained a compensable injury. The Full Commission reverses this finding. We find that the claimant did not establish a compensable injury by medical

evidence supported by objective findings. The claimant testified that she felt a "pop" in her back while working on January 31, 2005. The claimant began treating with Dr. Warren on February 2, 2005. Dr. Warren, who the Commission finds was a credible treating physician, examined the claimant and specifically noted no ecchymosis, no erythema, no external trauma, and no palpable spasm. X-ray was also negative and there were no objective medical findings establishing a compensable injury. Dr. Warren assessed lumbar strain and treated the claimant conservatively. The claimant on appeal points to the physical therapist's examination dated February 4, 2005, where the physical therapist noted that he had observed one of the claimant's "spasms." The physical therapist did not indicate that he had actually palpated or observed a muscle spasm. Instead, the physical therapist recorded his description of the claimant's complaints of pain. The physical therapist did not indicate that he had observed any objective findings not within the claimant's voluntary control. "Objective findings" are only those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16)(A)(i)(Repl. 2002).

An MRI study on February 10, 2005 showed marked degenerative change at L4-5 and “a large disk herniation at L4-5 on the right in a paracentral location.” The evidence before the Commission does not demonstrate that these diagnostic abnormalities were caused by the alleged accidental injury occurring January 31, 2005. The record does not show that the claimant sustained a herniated disc as the result of re-positioning or lifting a patient at work. Dr. Cathey, an expert neurological surgeon, noted that there apparently was an acute disc herniation, but that the herniation was on the claimant’s asymptomatic side. Dr. Cathey did not opine that the claimant had sustained a herniated disc as the result of a work-related accident.

The Full Commission recognizes that Dr. Cathey changed the claimant’s medication “from Flexeril to valium mg t.i.d. as needed for muscle spasms.” The Supreme Court of Arkansas has held that a claimant may rely on a prescription for medication for muscle spasm as part of the claimant’s evidence establishing objective medical findings. *See, Fred’s Inc. v. Jefferson*, 361 Ark. 258, 206 S.W.3d 238 (2005). In *Jefferson*, however, the claimant had also been diagnosed with the objective medical finding of a contusion.

In the present matter, Dr. Cathey examined the claimant and specifically noted "no paraspinous muscle spasm." We find in the present matter that a prescription for Valium "as needed for muscle spasms" does not constitute objective medical evidence establishing a compensable injury.

The Commission has the authority to accept or reject a medical opinion and the authority to determine its medical soundness and probative force. *Green Bay Packing v. Bartlett*, 67 Ark. 332, 999 S.W.2d 692 (1999). In the present matter, the Full Commission attaches minimal weight to Dr. Holland's opinion that the January 31, 2005 incident precipitated the claimant's disc herniation. We recognize Dr. Peek's statement in April 2007, "it is my medical opinion that she had a herniated disc and developed discitis at the L4-5 interspace, necessitating a discectomy and interbody fusion related to traumatic herniation." The evidence does not demonstrate that the instant claimant sustained a "traumatic herniation" as the result of lifting or repositioning a patient in bed on January 31, 2005. The evidence instead supports Dr. Schlesinger's opinion that the surgery performed by Dr. Peek for a herniation/discitis was not the result of the January 31, 2005 accident. The Full

Commission also attaches significant weight to Dr. Sexton's expert opinion that the claimant did not sustain a herniated disc as a result of the accident.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not establish a compensable injury by medical evidence supported by objective findings. We therefore reverse the administrative law judge's finding that the claimant proved she sustained a compensable injury. The Full Commission does not affirm the administrative law judge's finding that the respondents' attorney is in contempt, and we do not affirm the ALJ's imposition of a $400 fine. However, the Full Commission directs the respondents to pay the reporting costs and transcription costs for the April 12, 2006 hearing, pursuant to Commission Rule 099.20. This claim is otherwise denied and dismissed.

IT IS SO ORDERED.

________________________________
OLAN W. REEVES, Chairman

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KAREN H. McKINNEY, Commissioner

Commissioner Hood concurs & dissents.

**CONCURRING & DISSENTING OPINION**

I must respectfully concur & dissent from the majority's opinion. The majority, by reversing the Administrative Law Judge, finds that the claimant failed to prove that she sustained a compensable injury by medical evidence supported by objective findings. I disagree, and therefore, must respectfully dissent on this issue. Although I agree with the majority that the respondent must pay the reporting and transcription costs for the April 12, 2006 hearing, I disagree with the majority's reversal of the Administrative Law Judge's imposition of a $400 contempt fine on the respondent attorney. Based upon a de novo review of the record, I find that the claimant has met her burden of proof by a preponderance of the evidence for a compensable injury, supported by objective findings. Furthermore, due to the egregious behavior exhibited by the respondent attorney relating to the April 12, 2006 hearing, I would affirm the Administrative Law Judge's finding of contempt and imposition of a $400 fine. Therefore, I must respectfully dissent on these issues.

The claimant sustained what was initially accepted as a compensable injury on January 31, 2005. The claimant, who was employed as a home health nurse, was injured while attempting to reposition a bedridden patient. According to the claimant's testimony, she was attempting to move this patient into a different spot on her bed so as to prevent the development of bed sores, when she felt a "pop" in her back. She stated that her back quickly began causing her problems, but she completed her work at this patient's house and traveled to a second patient's house. The following day, she formally notified her employer of her back injury and they directed her to seek medical treatment. The claimant consistently related a history to her doctors of an injury as outlined in her testimony. The respondent has not disputed the facts surrounding the claimant's injury.

The claimant was initially referred for treatment to Dr. William Warren, a general practitioner with Concentra Health Services in Little Rock. In an initial treatment report of February 2, 2005, he notes the claimant's history of a job-related injury while

lifting a patient in bed. He diagnosed her as suffering from a lumbar strain and directed she continue taking medication and undergo physical therapy.

The claimant began her physical therapy regimen on February 2, 2005, under the direction of Eric Holifield. Curiously, Mr. Holifield's initial physical therapy report states that the claimant's condition was improving and that she was continuing to remain in compliance with scheduled visits. However, this was her first visit. I also note from reviewing Mr. Holifield's and Dr. Warren's report that they consist, for the most part, of boilerplate language and restatements of past medical history with little new information in them.

When the claimant's complaints of pain continued, Dr. Warren directed the claimant undergo an MRI of her lumbar spine. This was conducted on February 10, 2005, and the radiologist's report of that date indicates that the claimant had a "large right paracentral disc herniation at L4-5" and that there was a migrated fragment which was severely impinging on the L5 nerve root on the right. After receiving this report, Dr. Warren stated in his report of February 14,

2005, that the claimant was being referred to Dr. Steven Cathey, a Little Rock neurosurgeon.

In Dr. Cathey's report of February 22, 2005, he opined that the claimant would not benefit from lumbar disc surgery. This opinion was apparently based upon his finding that her symptoms were not in accordance with her MRI scan. However, that conclusion seems to be at odds with the claimant's medical records from Dr. Warren and Mr. Holifield. Specifically, Mr. Holifield noted in his report of February 8, 2005, that the claimant was complaining of radiating pain down both extremities, more so on her right. Also, in his earlier report of February 4, 2005, he stated that he observed an episode of spasms in her lower back which caused her extreme pain. Dr. Warren also specifically noted the presence of right leg pain in his reports.

Nonetheless, when Dr. Warren reviewed Dr. Cathey's report, he concluded that her injury was no longer work related and that she could return to work without restrictions. Also, in spite of the fact that both he and Dr. Cathey had previously directed the claimant to remain off work, he states in his report that she "has

not been working because she chose not to work." He also stated that the claimant's pain is located in her left leg, contradicting prior reports which consistently noted that she was complaining of right leg pain.

Upon receipt of the reports from Dr. Warren and Dr. Cathey, the respondent controverted the claimant's entitlement to any further benefits. Consequently, the claimant sought treatment on her own from her personal physician, Dr. Jay Holland, a general practitioner in Little Rock, Arkansas, who is apparently also part of the St. Vincent Medical System. In a report dated August 6, 2005, Dr. Holland outlined the claimant's treatment history. In reviewing the reports of Dr. Warren and Dr. Cathey, Dr. Holland points out several errors and inconsistencies and is sharply critical of Dr. Warren's practices. In particular, he notes Dr. Warren's reports reflect that the claimant was suffering symptoms in accordance with a right-sided disc herniation as early as February 2, 2005. He also noted that the MRI report found a free fragment which, according to Dr. Holland, is prone to migrate and can cause shifting symptoms. He also expressed concern that

the delays in the claimant getting meaningful treatment could have significantly worsened her condition. Dr. Holland also criticized Dr. Warren for releasing the claimant to return to work when her MRI showed that she had a free disc fragment, a condition which Dr. Holland believed could have caused her to suffer episodes of paralysis. Dr. Holland concluded his report by recommending that the claimant be seen by Dr. Richard Peek, a Little Rock neurosurgeon.

After seeing the claimant, Dr. Peek authored a report dated October 13, 2005, in which he reviewed the claimant’s medical history and symptoms. In discussing his examination of the claimant, he listed some bilateral symptoms but particularly noted pain, sensation decrease, and tenderness on her right leg and back. He also commented on apparent inconsistencies in Dr. Warren’s treatment notes. Dr. Peek concluded his report by expressing surprise that the claim had not been accepted and that the claimant had not been provided, at the least, conservative care. He particularly commented that the claimant’s injury was supported by objective findings and reported

appropriately. He recommended that she undergo epidural steroid injections and further diagnostic tests.

Pursuant to Dr. Peek's recommendation, the claimant underwent a second MRI on October 13, 2005. That MRI found that the claimant had a broad base posterior osteophyte at L4-L5 with a marked end-plate irregularity and loss of disc space. The radiologist also suggested that the study reflected diskitis at L4-L5 and a minimal disc bulge at L3-L4.

Dr. Peek continued to treat the claimant and eventually performed lumbar fusion surgery on February 14, 2006. During this procedure, he was assisted by Dr. Michael Pollock. In Dr. Peek's operative report, he noted that there was severe erosive changes throughout the claimant's vertebral bodies of her lumbar spine.

In an attempt to rebut the opinions of Drs. Holland and Peek, the respondent offered reports from Dr. Scott Schlesinger, a Little Rock neurosurgeon, and Dr. Robert Sexton, a neurosurgeon from Louisville, Kentucky. Neither of those doctors examined or saw the claimant. Dr. Schlesinger's report is undated and is in the form of a questionnaire sent to him by a medical

case manager. In response to a question referencing Dr. Peek's lumbar fusion performed on the claimant in February 2006, Dr. Schlesinger was asked whether the surgery was a direct result of the injury of January 31, 2005. Dr. Schlesinger checked the box marked "no." In response to another question, Dr. Schlesinger also checked "no" when asked whether the claimant developed diskitis as a direct result of the January 31, 2005 injury. He also indicated that the claimant's disc herniation caused a 7% impairment pursuant to the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993).

Dr. Sexton's report was likewise undated and consisted of responses to a series of questions. However, the questions were not set out in his report. Dr. Sexton appears to agree with Dr. Schlesinger and states that the claimant's January 31, 2005 injury was nothing more serious than a lumbar strain, and that the claimant had reached the point of maximum medical improvement by March 31, 2005 and she was under no particular restrictions.

The respondent also offered as evidence, depositions of Dr. David Phelan and Dr. Reginald Pareja, both radiologists. Dr. Phelan testified that he performed a biopsy on the claimant's spinal tissue which, according to the pathologist's report, was negative.

Dr. Pareja performed a bone scan on the claimant which he testified about in his deposition. According to Dr. Pareja, the bone scan indicated that the claimant's lumbar spine was in a state of severe deterioration, particularly at L4-L5. Dr. Pareja explained that bone scans detected damage to bones and would reflect degenerative changes. However, he stated that, in regard to the claimant's scan, the "uptake in the lumbar spine, is more intense than you usually see for a degenerative change. Dr. Pareja speculated that the change could be related to an infectious disease. However, he admitted that he did not know the exact cause, but that the bone scan reflected "end place irregularity" and the doctor felt that this irregularity was more than was normally present from degenerative disc disease. I also note that, in his written report

regarding the bone scan, he indicated that the abnormalities could be related to “post traumatic change.”

After the deposition of Drs. Phelan and Pareja were taken, claimant’s counsel wrote to Dr. Peek requesting his opinion of the findings of those two physicians. Dr. Peek responded in a letter dated April 30, 2007, and stated as follows:

> “After reviewing the depositions, as well as the records which have been reviewed, as well as examining and operating on Ms. Ard, it is my medical opinion that she had a herniated disc and developed subsequent diskitis at the L4-5 interspace, necessitating a discectomy and interbody fusion related to traumatic herniation. An atypical course developed with diskitis after herniation. However, there is clear evidence that it did.”

What creates confusion in this case is the unusual nature of how the claimant’s injury progressed after her January 31, 2005 injury. The unusual progression of the claimant’s condition may have been

due to misdiagnoses on the part of Drs. Warren and Cathey and their complete refusal to provide the claimant appropriate medical treatment. As suggested by Dr. Holland in his report, this failure may well have exacerbated the claimant’s condition and caused it to worsen.

Nonetheless, the medical records clearly establish that less than two weeks following the lifting incident on January 31, 2005, the claimant had a severely herniated disc with a free fragment. About ten months later, when she underwent another MRI scan, she was experiencing lumbar spinal deterioration to an extent that surprised even her treating physicians. For example, Dr. Pareja stated that the bone scan examination he performed on the claimant reflected damage to her L4-L5 vertebral space that is much greater than that normally observed by degenerative spinal disease by itself. By contrast, he commented that the bone scan reflected a normal amount of degenerative joint disease in the claimant’s knees as would be expected, considering her age, but that the level of degeneration at L4-L5 provided an “uptake” of much

greater magnitude which the doctor believed was the result of some process besides normal deterioration. He suggested that it was possibly the result of a spinal infection or, as noted in his report, a traumatic injury. Interestingly enough, the pathology report referred to by Dr. Phelan in his deposition indicated that the tissue at the claimant’s L4-L5 vertebral region was normal. That is, it was not the subject of any bacterial infection or cancerous disease.

The only other remaining cause of the extreme deterioration of the claimant’s lower lumbar spine would be the traumatic injury of January 31, 2005. Dr. Peek reached that conclusion as stated in his letter of April 30, 2007.

Furthermore, the medical evidence relied upon by the respondent and the majority, to refute Dr. Peek, Dr. Holland and Dr. Pareja, is unconvincing. Dr. Schlesinger’s opinions have been considered by this Commission many times, and his competence and expertise is not questioned. However, the information he provided was in the form of a response to a written question posed to him by the respondent’s case manager.

Specifically, the question gave him the option of answering either yes or no, to whether the surgery performed on the claimant was "the direct result of the alleged injury sustained on January 31, 2005?" In response, Dr. Schlesinger checked the "no" box.

In this case, Dr. Schlesinger's opinion is of little value. The premise which he answered "no" to was that the requested surgery must be a "direct result of the job related accident. However, that is not the correct standard to determine whether a respondent is liable for providing requested medical treatment. As the Appellate Courts of this State have held on numerous occasions, a compensable injury only has to be a factor in the requirement for medical treatment for a respondent to be liable for providing it. Since Dr. Schlesinger's response is based on a faulty premise, his opinion cannot be afforded any particular weight.

The same result was reached in Williams v. L. & W Janitorial, Inc., 85 Ark. App. 1, 145 S. W. 3d 383 (2004). In that case, the Court of Appeals reversed a Commission decision which denied a claimant knee replacement surgery. In denying the claim, the

Commission relied upon certain medical opinions generated by two physicians. However, the Court of Appeals reversed, noting that both of the physicians had given their opinions based upon their understanding that medical treatment was related to a compensable injury only if the compensable injury was the major cause of the need for treatment. Since that was not the correct standard, the Court held that the Commission could not rely upon those opinions in making its decision. Likewise, in the present case, the Commission cannot rely upon Dr. Schlesinger's opinion since he was answering the question of whether the medical treatment was the "direct result" of the accident, which is simply not the correct legal standard.

Dr. Sexton's opinion is likewise entitled to little, if any, weight. His report indicates that he is responding to a series of questions, but the report does not set out the questions and it is not clear as to what he was responding to or upon what medical records or information his answers were based. Since Dr. Sexton characterizes the October 2005 MRI, establishing "preexisting lumbar spondylosis, he apparently did not

have the February 10, 2005 MRI report finding a disc herniation and free fragment or results of Dr. Pareja's bone scan which indicated that the claimant's condition at L4-L5 was something much more serious than normal spinal degeneration. I also find it significant that Dr. Sexton only referenced opinions from Dr. Holland who he notes is a family physician. The report does not mention Dr. Peek, the neurosurgeon who had the same conclusions as Dr. Holland. I therefore conclude that Dr. Sexton was not provided any medical information from Dr. Peek. Since it is impossible to determine what medical information Dr. Sexton relied upon in reaching his opinions and because, like Dr. Schlesinger, he was likely provided a faulty premise upon which to base his opinions, I simply cannot place any credence in his opinion.

The Commission has the duty of weighing differing medical evidence and converting them into findings of fact. While we cannot arbitrarily disregard any evidence or testimony, we can, and must, determine how much weight should be given to evidence before us. In this case, it is clear that the opinions of Drs.

Schlesinger and Sexton simply cannot be the basis for a factual finding. Consequently, the only remaining medical evidence in this case establishes that the claimant’s lumbar deterioration at L4-L5 was a progression of the severe disc herniation she sustained on January 31, 2005. As Dr. Peek noted, this is a somewhat unusual result. However, the medical evidence demonstrates that this progression is, in fact, what happened. To find otherwise would require us to simply ignore the overwhelming body of medical evidence presented by the claimant.

Accordingly, I must address the wording of the majority’s opinion, as it can be interpreted as the majority having disregarded the February 10, 2005 MRI report because it does not prove causation. Furthering this interpretation of the majority’s opinion is the fact that the majority spent quite a bit of time discussing whether or not the muscle spasms noted in the medical record were objective findings under current case law, See, Fred’s Inc. v. Jefferson, 361 Ark. 258, 206 S.W. 3d 238 (2005), a point which is relatively moot, unless the majority has, indeed, entirely

disregarded the February 10, 2005 MRI report, which clearly represents objective findings of a herniated disk. While objective medical evidence is necessary to establish the existence and extent of an injury, it is not essential to establish the causal relationship between the injury and a work-related accident. Horticare Landscape Mgmt. v. McDonald, 80 Ark. App. 45, 89 S.W. 3d 375 (2002). Arkansas Courts have long recognized that a causal relationship may be established between an employment-related incident and a subsequent physical injury based on evidence that the injury manifested itself within a reasonable period of time following the incident so that the injury is logically attributable to the incident, where there is no other reasonable explanation for the injury. Hall v. Pittman Construction Co., 234 Ark. 104, 357 S.W.2d 263 (1962). Here, the claimant reported her injury on January 31, 2005. The respondent has not disputed the claimant's testimony as to the occurrence of the specific incident. She began treating with Dr. Warren on February 2, 2005. An MRI study on February 10, 2005 showed marked degenerative change at L4-5 and "a large disk herniation

at L4-5 on the right in a paracentral location." In light of the above evidence of record and relevant case law, the majority's statement: "We find that the claimant did not establish a compensable injury by medical evidence supported by objective findings," to the extent that it implies either that the claimant has not presented objective findings establishing the existence and extent of her injury at all, or, to the extent that it implies that the claimant has not presented objective findings establishing the causal relationship between her injury and the work incident, may be reversible error.

The remaining issue which must be considered is the Administrative Law Judge's finding that the respondent attorney's conduct resulted in him being in contempt of the Commission and her imposition of a $400.00 fine. Unfortunately, most of the focus in this appeal has shifted from the claimant's entitlement to benefits to what sanctions, if any, should be imposed on the respondent's attorney. This case originally would have been tried in April 2006. However, because of the respondent attorney's failure to appear, the end result

is that it was not actually tried until June 2007, a period of over one year. Considering the length of the delay occasioned by the respondent attorney's lapse, as well as his failure to take responsibility for that error, not to mention his unfounded allegations of bias, I find the sanctions imposed by the Administrative Law Judge to be warranted.

For the aforementioned reasons I must respectfully concur & dissent.

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PHILIP A. HOOD, Commissioner