BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F502733

DARRELL W. DIGGS, EMPLOYEE	CLAIMANT
CATTLEMEN'S LIVESTOCK MARKET, INC., EMPLOYER	RESPONDENT
COMMERCE & INDUSTRY INSURANCE COMPANY, 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 SHANNON MUSE CARROLL, Attorney at Law, Hot Springs, Arkansas.

Respondent represented by the HONORABLE JARROD S. PARRISH, 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 5, 2007. The administrative law judge found that the claimant proved he was entitled to low back surgery and additional temporary total disability compensation. 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 he was entitled to low back surgery or additional temporary total disability.

I. HISTORY

Darrell Wayne Diggs, age 45, testified that he began working for Cattlemen's Livestock Market in November 2004, where he was foreman of a maintenance shop and a mechanic. The parties stipulated that the claimant sustained "a compensable injury to his back" on January 20, 2005. The claimant testified, "I was taking the front-end loader off of a tractor. I had to rebuild the engine in the tractor. And the bolts on the front-end loader, I had two wrenches connected as a leverage break point. And when I come up on them, I just felt it. It was like you runned a hot knife in there....In my lower back, right at my belt."

The record indicates that James Huffman, PA-C saw the claimant on January 21, 2005 and diagnosed lumbar back pain with pain radiating to the left.

An MRI of the claimant's lumbar spine was taken on February 16, 2005:

> Multiple imaging shows desiccation of L4-5 and L5-S1 with some degenerative narrowing of L5-S1. There is some edema of the inferior endplate of L5 with slight central compression, but this is probably old. There is a small central

> subligamentous herniation of L5-S1 with moderate size broad based central subligamentous herniation of L4-5. Mild central bulging of T12-L1 is seen with some degenerative disk narrowing. The surrounding soft tissue structures are unremarkable and no other findings are seen.
>
> Impression
> OPINION:
> Moderate size broad-based central subligamentous herniation of L4-5 with small central subligamentous herniation of L5-S1 and some degenerative disk changes at both levels. Mild central bulging of T12-L1 is incidentally seen.

The claimant testified that James Huffman referred him to Dr. Pace. Dr. John R. Pace, a neurosurgeon, took the claimant off work on March 8, 2005 "until re-evaluated on March 29, 2005." The claimant testified that he did not work after March 8, 2005. Respondents' Exhibit Two indicates that the claimant was paid temporary total disability for the period beginning March 8, 2005.

Dr. Scott W.F. Carle provided an Independent Medical Evaluation on April 21, 2005: "This is a forty-two-year-old Caucasian male who states that one (sic) January 20, 2005 he was pulling on the front end of a front-end loader, in order to work on it, or gain access to the engine compartment and began to feel an acute burning sensation in the left side of his back and into his left thigh. For several days, his symptoms progressively worsened with respect to low back and

leg pain....The client has had pulled muscles in his back in 1984. He has had three or four spells of muscle pulls since then. The last of these was four or five years prior to his injury date....It should be noted that there is bilateral calf atrophy, secondary to peripheral musculoskeletal disorder in the form of talipes equinovarus. The client has a history of an Achilles Z-plasty on the left and subsequently has worsened atrophy on the left. The lower calf extremity circumference measurements are considered to be invalid. There is evidence of bilateral clubfoot deformity with calf atrophy, which is worse on the left....His physical examination is consistent with iliolumbar or sacroiliac joint dysfunction and a radiculitis on the left. He has a congenital left leg shortening. He has a normal neurological examination on the date of the exam of April 21, 2005."

Dr. Carle's diagnostic impressions were as follows: "1. Left sacroiliac joint pain and Left leg pain and paresthesias. Status post strain injury with radiating left leg, groin and distal dysesthesias. Normal neurological examination with neural tension testing signs not revealing a compression radiculopathy. 2. Congenital and bilateral

talipes equinovarus with associated atrophy of both calf muscles. No evidence of chronic denervation. 3. Left leg shortening, idiopathic and not acquired. 4. Moderate disability risk." Dr. Carle opined that the claimant should reach maximum medical improvement "not to exceed twelve weeks from the date of this report. If found to have electrodiagnostic evidence of radiculopathy, this period may warrant extension if surgical intervention takes place....With respect to Mr. Diggs, his work ability, based on the information and findings to date, appear to be impacted by his otherwise unstabilized medical condition. His current symptom complex and would not be expected to function outside of a sedentary job class defined by the Department of Labor in the Dictionary of Occupational Titles. This would include lifting objects weighing up to ten pounds occasionally and with minimal torso bending less than six times per hour and being seated at least 6 out of an 8 hour work day. As the symptom complex improves however, encouraging activity as tolerated would be in order."

Electro-diagnostic testing was administered to the claimant on April 26, 2005, with the following

interpretation: “1. Abnormal study. 2. Electrodiagnostic evidence of left L5 radiculopathy.”

A pain manager, Dr. William E. Ackerman, evaluated the claimant on April 28, 2005. Dr. Ackerman stated in part, “He had electrodiagnostic evidence of a left L5 radiculopathy. Mr. Diggs also had an MRI done. It was noted that he had a disc herniation at 2 levels in his lower lumbar spine. He does have a lesion at L4-5. This disc herniation is probably contributing to his radiculopathy.” Dr. Ackerman planned injection therapy and noted, “He is concerned about returning back to work and re-injuring himself. He was advised that he will be shown ways to lift that he can return back to normal employment. He will return for followup in 2 weeks.”

Dr. Ackerman performed an injection procedure on May 5, 2005. A note from Dr. Ackerman, apparently dated May 11, 2005, indicated that the claimant should not return to work until June 11, 2005.

A neurosurgeon, Dr. Steven L. Cathey, first examined the claimant on May 12, 2005 and wrote to Dr. Ackerman on May 24, 2005:

Mr. Diggs neurological examination was negative at the time of his initial evaluation, but since he did not have his MRI scan with him, I asked him to return today for follow-up.

His neurological examination remains entirely negative. He specifically has no sign of lumbar radiculopathy. Straight leg raising on the right is negative. Straight leg raising on the left produces pain in his lower back. The patient demonstrates full range of motion of the lumbar spine without paraspinous muscle spasm.

The patient, his wife and I reviewed an MRI scan of his lower back obtained in February of this year. There is evidence of a broad-based, midline disc protrusion at L4-L5. I was not, however, impressed with any resulting canal stenosis or nerve root impingement. At the lumbosacral level there are degenerative changes within the disc space. Again, no obvious disc herniation or nerve root entrapment was noted. The changes noted on the MRI scan appear longstanding.

Bill, I believe Mr. Diggs is the victim of a musculoskeletal injury superimposed on these preexisting degenerative changes in his lower back. He may have suffered some type of stretch to the left L5 nerve root. I base this on the fact that while he has a normal neurological examination, electrodiagnostic testing suggested an L5 radiculopathy on the left. There certainly doesn’t appear to be any clinical or radiographic evidence of nerve root entrapment at any level. Unfortunately, I don’t believe Mr. Diggs would benefit from lumbar disc surgery or other neurosurgical intervention. He has an appointment to see you later in the week to discuss additional conservative management. I have suggested that he follow-up with Dr. John Pace, the neurological surgeon in Hot Springs who initially evaluated him for this problem, since he says that Dr. Pace had at one time entertained some type of operative intervention. I am not, however, optimistic

> that lumbar disc surgery will be beneficial in this case based on what I have seen.

The claimant underwent a Functional Capacity Evaluation on June 6, 2005: "Mr. Diggs underwent functional capacity evaluation with unreliable results for effort. His true abilities remain unknown at this time. He did perform at a level that would allow him to perform Sedentary work."

Dr. Ackerman entered the following Chart Note on June 9, 2005:

> Darrell Diggs did not show up to his appointment today. He did not notify my office that he would not be coming. I did obtain a copy of his functional capacity test. His effort was unreliable....Dr. Cathey feels he is definitely not a candidate for surgery. When I last saw Mr. Diggs in the office, I proposed to him a gradual return to work with working 3 to 4 hours for one to two weeks followed by 6 hours for one to two weeks and then a return to full duty. He seemed at that time amenable to doing this. However he did not show today. I have nothing further to offer him....
> I do feel he is at maximum medical improvement. He does have an objective finding of a radiculopathy on his EMG. However when Dr. Cathey saw him, his extensor hallucis longus strength had returned back to normal. The question is whether or not he is a candidate for an impairment rating. I will discuss this fact with Dr. Carle, as we are both fellows of the American Academy of Disability Evaluating Physicians. Our goal is to be fair to the patient, but if he does not warrant an impairment rating, it will not be assigned.

Dr. Ackerman noted on June 23, 2005, "This individual did not notify my office that he would not be coming. He did not notify the surgery center that he was skipping his injection. He has been noncompliant with respect to his treatment and is returned back to work with full duty. Today's injection was to help ascertain an impairment rating. I do not feel that he qualifies for an impairment to the body as a whole."

The respondents generally stopped paying temporary total disability after June 29, 2005.

Dr. Carle reported on June 30, 2005:

> Mr. Diggs appeared to have a strain type injury associated with his Jan 2005 work incident. While he does complain of left leg pain, his neurological exam was normal as documented by several medical examiners including Dr. Cathey, a neurosurgeon. He did have a non verifiable abnormality with respect to his EMG testing done in the past by Dr. Welbourne. This was no correlative lesion found on his MRI to unequivocally explain this abnormality. He did not participate in a recent request for an FCE and was a "no show" for a recommended sacro-iliac injection.
>
> It is reasonably certainty (sic), that his recovery curve is flattened and he would therefore be considered stabilized. There are no additional medical interventions which are likely to benefit him. He has no objective indication for surgery and no clinical compressive neurologic findings are detected. He is therefore at MMI

> with respect to his workplace strain on Jan 20th, 2005. According to the DRE model of the AMA Guides, he would receive 5% according to non-verifiable radiculitis in his left leg. See table 71, page 109. His current disability, or altered capacity to work, is not fully explained by his impairment and is likely impacted by either comorbid group health factors or non-physiologic factors. His current work ability appears to be determined by his psycho-social tolerance of symptoms and not by risk of complications or lack of capacity due to a specific occupationally acquired medical disorder.

A representative of the respondent-carrier notified the claimant on August 1, 2005 that he would be receiving permanent partial disability benefits.

Dr. Carle informed the respondents' attorney on March 14, 2006, "With regards to further testing, as it relates to the 'origin of the nerve problem to the leg', I would recommend repeating the EMG and NCV of both lower extremities. Dr. Brent Sprinkle in Little Rock would be appropriate for this. If this is negative, I believe he is at the end of the treatment chain for 'continuing the hunt' for an acquired structural inclusion that resulted in a 'radiculopathy'."

The parties deposed Dr. Pace on June 22, 2006. Dr. Pace testified that he first saw the claimant on March 8, 2005 and that an MRI had shown "a disc herniation at L4-5,

which was moderate in size and he had a small disc herniation at L5-S1." Dr. Pace opined that the claimant's symptoms were consistent with a disc herniation and stated, "I thought he had a lumbar radiculopathy at L5 and S1 on the left. And with a disc herniation." Dr. Pace described "lumbar radiculopathy" as "a nerve root irritation or nerve root damage." The claimant's attorney questioned Dr. Pace:

> Q. Have you made a conclusion within a reasonable degree of medical certainty as to the cause of that diagnosis?
>
> A. Yes, I believe he hurt himself on the job....I saw him the last time on December 13 of '05....
>
> Q. What did you determine was his diagnosis on that date?
>
> A. I thought he had a left L5 radiculopathy....Had degenerative disc disease at L4-5 and L5-S1....It's rare for a disc to herniate unless it is degenerative in the first place.
>
> Q. Does it change your opinion with regard to the causation of his injury?
>
> A. No.
>
> Q. Okay. Doctor, what was your determination as to what your care of Mr. Diggs should be?
>
> A. Well, at that point he had a very long course of conservative treatment with really no improvement. So, I wanted to order a myelogram and a post myelogram CT and a discogram to be performed by the Pain Clinic to assess what the competency of his disc space was at L4-5 and L5-

> S1. Then comes dispute with this discogenic back pain and leg pain. We'll have a positive discogram that would be preventive from sort of spine fusion procedure.
>
> Q. Okay. What if he doesn't have a positive one?
>
> A. Then I don't think certainly it would be helpful.
>
> Q. So, what is his option then?
>
> A. Pain management.
>
> Q. Is it important to you to have the results of those tests before taking Mr. Diggs into surgery?
>
> A. Yes....
>
> Q. Doctor, in your opinion, based upon the last time you saw Mr. Diggs, had he reached MMI or maximum medical improvement?
>
> A. No.

An administrative law judge signed an Order on September 12, 2006: "This matter comes before the Commission on the respondents' motion for an independent medical evaluation, dated September 11, 2006....I find that an independent medical evaluation pursuant to Ark. Code Ann. §11-9-511 is reasonable and necessary to evaluate the claimant's condition and need for treatment, and I hereby appoint Dr. Reza Shahim in Little Rock, Arkansas to perform the evaluation....The cost of the claimant's evaluation, together with any diagnostic studies which Dr. Shahim should

deem necessary, is to be borne by the respondent-carrier, Commerce and Industry Insurance Company."

Dr. Reza Shahim, a neurological surgeon, first consulted with the claimant on November 7, 2006 and arranged another MRI of the lumbar spine. Dr. Shahim noted on November 9, 2006, "I saw Mr. Diggs' lumbar spine MRI and reviewed that with him. He does have a broad disc protrusion at L4-5 and an annular tear at L5-S1. I do not see any clear nerve root compression. Mr. Diggs had an EMG study a year ago which showed left L5 radiculopathy and for this reason I will recommend a CT lumbar myelogram."

Dr. Shahim reported on December 28, 2006:

> I reviewed Mr. Diggs' CT lumbar myelogram. He does have foraminal stenosis at L4-5 and L5-S1. The radiologist has not noticed severe foraminal stenosis, particularly at left L4-5. The patient does not have canal stenosis, but he has marked foraminal stenosis, particularly on the left side at L4-5. On the MRI he has annular bulging at L4-5 and an annular tear at L4-5 and L5-S1. This most likely contributes to the patient's symptoms.
>
> DECISION MAKING: He has two surgical options. I would recommend a foraminal decompression for treatment of his radiculopathy. He has EMG evidence of L5 radiculopathy. He could also undergo a posterior lumbar interbody fusion if his symptoms were to continue. Since he primarily has radiculopathy I would recommend placing him in a brace. We will plan on a decompression at left L5, possibly at L5-S1.

Dr. Shahim took the claimant off work on January 25, 2007 "pending WCC approval for LESI." Respondents' Exhibit Two indicates that temporary total disability was paid for the period of February 1, 2007 through March 14, 2007. The parties stipulated that the respondents "have controverted decompression surgery and claimant's entitlement to additional TTD not already paid."

A pre-hearing order was filed on April 23, 2007. The claimant contended that he was entitled to additional medical and temporary disability benefits, "including but not limited to decompression surgery proposed by Dr. Shahim, controverted temporary disability benefits, and a controverted attorney's fee. The claimant reserves the issue of permanent disability."

The respondents contended that "all appropriate benefits have been paid with regard to this claim; that the claimant has been released as having reached maximum medical improvement; that the claimant has medically plateaued; and that medical treatment associated with anything recommended by Dr. Shahim is not reasonable and necessary in light of the opinions of Drs. Ackerman, Cathay (sic), and Carle."

A hearing was scheduled to be held on Tuesday, May 29, 2007. The pre-hearing order included the following language: "Exhibits and the identity of witnesses must be exchanged at least seven (7) days prior to the hearing. All depositions must be completed prior to the hearing. Medical reports must be exchanged at least seven (7) days prior to the hearing pursuant to Ark. Code Ann. §11-9-705(c). Evidence not disclosed in compliance with this Order shall not be considered as evidence unless prior permission of the Commission is obtained and for good cause shown."

A hearing was held on May 29, 2007. The parties agreed that the respondents did not pay temporary total disability benefits after June 29, 2005, except for three additional payments in 2007. The parties agreed that the claimant's attorney sent Claimant's Proffered Exhibit No. 3 to the respondents' attorney on Friday, May 25, 2007. Proffered Exhibit No. 3 consists of typed correspondence from Dr. Shahim and a handwritten note from Dr. Shahim, both dated February 27, 2007. The claimant's attorney requested a continuance because the proffered records were inadvertently omitted from the claimant's exhibit packet. The claimant's attorney asked to have the records admitted into evidence or

have a continuance of the hearing in order not to be penalized by the seven-day rule. In the event either motion was denied, counsel asked to nonsuit without prejudice "so that we can bring this matter back up and present these records in a timely fashion to the court for their review." The respondents' attorney stated that he had spoken with Ms. Carroll about the Exhibit on May 25, 2007, and that the respondents objected to admitting the document into evidence. The respondents' attorney also objected to continuing the hearing.

The administrative law judge noted that he took all of the motions under advisement and stated, "I'm going to request that we go ahead and present what appears to be all of the oral testimony that would be presented at this hearing or any future hearing, even if a continuance is granted at some point in the future."

The claimant testified that he wanted to undergo the recommended surgery "if it will help."

Nearly three months after the hearing had already been held, the administrative law judge "continued" the case on August 21, 2007. One week later, the administrative law judge "closed" the record and determined, "The claimant

having how satisfied the seven day requirement for exchange of medical records, I am hereby admitting into evidence Dr. Shahim's February 27, 2007, reports, proffered as Claimant's Exhibit No. 3 at the May 29, 2007, hearing." The administrative law judge then filed an opinion on September 5, 2007 and found, in pertinent part:

> 7. The claimant proved by a preponderance of the evidence that additional medical treatment, including but not limited to an L5 decompression surgery proposed by Dr. Shahim, is reasonably necessary to treat the claimant's compensable back injury.
> 8. The claimant has established by a preponderance of the evidence that he is entitled to additional temporary total disability compensation beginning on June 29, 2005, through the date of the May 29, 2007, hearing and continuing to a date yet to be determined.

The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

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

constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In the present matter, an administrative law judge found that the claimant proved "additional medical treatment, including but not limited to an L5 decompression surgery proposed by Dr. Shahim, is reasonably necessary to treat the claimant's compensable back injury." The Full Commission reverses this finding. The Commission has the duty of weighing medical evidence and, if the evidence is conflicting, its resolution is a question of fact for the Commission. *Green Bay Packaging v. Bartlett*, 67 Ark. App. 332, 999 S.W.2d 695 (1999). Three competent treating physicians, Dr. Ackerman, Dr. Cathey, and Dr. Carle, have determined that surgery is not necessary and would not improve the claimant's post-injury physical condition. We note that the claimant did not follow through with the non-operative treatment modalities offered by Dr. Ackerman. The Full Commission finds in the present matter that the opinions of Dr. Ackerman, Dr. Cathey, and Dr. Carle are entitled to more weight than the opinions of Dr. Pace and Dr. Shahim.

It is clear that Dr. Pace's recommendation of surgery, and Dr. Shahim's agreement, is based upon Dr. Pace's inaccurate assumption that the claimant's calf muscle were equal prior to claimant's injury in January of 2005. That is simply NOT the case. The claimant's left leg has been small than his right leg most of his life. I give more weight to the opinions of Dr. Cathey and Dr. Carle that the claimant was not a surgical candidate. The Commission has a duty to translate the evidence on all the issues before it into findings of fact. Weldon v. Pierce Bros. Const. Co., 54 Ark. App. 115, 924 S.W.2d 179 (1996). Moreover, the Commission has the authority to resolve conflicting evidence and this extends to medical testimony. Foxx v. American Transp., 54 Ark. App. 115, 924 S.W.2d 814 (1996). The Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. Emerson Electric v. Gaston, 75 Ark. App. 232, 58 S.W.3d 848 (2001); CDI Contractors v. McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993); McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989).

The Full Commission also finds that the claimant's Proffered Exhibit No. 3 should be admitted into the record on appeal. We recognize that any party proposing to introduce medical reports at the hearing shall, as a condition precedent to the right to do so, furnish to the opposing party and to the Commission copies of the written reports of the physicians of their findings and opinions at least seven (7) days prior to the date of the hearing. Ark. Code Ann. §11-9-705(c)(2)(A)(Repl. 2002). The claimant's Proffered Exhibit No. 3 was not submitted at least seven days prior to the hearing. However, the Commission is not bound by technical or statutory rules of evidence but may make such investigation or inquiry in a manner as will best ascertain the rights of the parties. Ark. Code Ann. §11-9-705(a)(1)(Repl. 2002). The Commission should also be more liberal with the admission of evidence rather than more stringent. *Bryant v. Staffmark, Inc.*, 76 Ark. App. 64, 61 S.W.3d 856 (2001).

Claimant's Proffered Exhibit No. 3 consists of a letter from Dr. Shahim dated February 27, 2007 and a handwritten note from Dr. Shahim dated February 27, 2007. These documents essentially reiterate Dr. Shahim's opinion that

the claimant should undergo surgery. Dr. Shahim’s opinion in this regard was already established in other evidentiary documents timely submitted by the claimant. The proffered documents do not break any new evidentiary ground or otherwise help the claimant prove his case. We also note Dr. Shahim’s admonition to the claimant, as expressed in the February 27, 2007 letter, that surgery would not completely eliminate all of the claimant’s radicular pain. The Full Commission admits into the record claimant’s Proffered Exhibit No. 3.

B. Temporary Disability

Temporary total disability is that period within the healing period in which the employee suffers a total incapacity to earn wages. *Ark. State Hwy. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). “Healing period” means “that period for healing of an injury resulting from an accident.” Ark. Code Ann. §11-9-102(12). Whether or not a claimant’s healing period has ended is a question of fact for the Commission. *K II Constr. Co. v. Crabtree*, 78 Ark. App. 222, 79 S.W.3d 414 (2002).

An administrative law judge found in the present matter that the claimant proved he was entitled to temporary total

disability compensation beginning June 29, 2007 until a date yet to be determined. The Full Commission reverses this finding. The instant claimant sustained a compensable injury to his back on January 20, 2005. The claimant was off work beginning March 8, 2005 and the respondents paid temporary total disability compensation. Dr. Carle evaluated the claimant on April 21, 2005 and his impression included "status-post strain injury." Dr. Carle opined that the claimant should reach maximum medical improvement within 12 weeks. The claimant began undergoing pain management with Dr. Ackerman. Dr. Cathey began treating the claimant in May 2005 and believed that the claimant had suffered a musculokeletal injury superimposed on pre-existing degenerative changes. Dr. Cathey opined that the claimant would not benefit from lumbar disc surgery.

The claimant underwent a Functional Capacity Evaluation (FCE) on June 6, 2005 but gave unreliable results for effort. The results of the FCE indicated that the claimant could perform sedentary work. Dr. Ackerman opined on June 9, 2005 that the claimant had reached maximum medical improvement. The respondents stopped paying temporary total disability on June 29, 2005. Dr. Carle opined on June 30,

2005 that the claimant had reached maximum medical improvement. Based on the credible expert opinions of Dr. Ackerman and Dr. Carle, the Full Commission finds that the claimant reached the end of his healing period no later than June 30, 2005. Temporary total disability benefits cannot be awarded after the healing period has ended. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987).

The Full Commission therefore finds that the claimant did not prove he was entitled to additional temporary total disability after June 30, 2005.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove he was entitled to low back surgery or additional temporary total disability benefits. We therefore reverse the opinion of the administrative law judge, and this claim is denied and dismissed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. McKINNEY, Commissioner

Commissioner Hood concurs, in part, and dissents, in part.

CONCURRING AND DISSENTING OPINION

I concur with the majority's decision to admit Claimant's proffered Exhibit 3 into the record. However, for the reasons set out below, I must respectfully dissent from the balance of the majority's opinion.

There were two substantive issues before the Commission on this appeal. The first issue was whether the claimant is entitled to additional medical treatment from Dr. Reza Shahim, a Little Rock neurosurgeon. Second, the Commission was asked to determine whether the claimant is entitled to additional total disability benefits and, if so, when his healing period ended. I find that the Administrative Law Judge was entirely correct in finding that the lumbar surgery performed by Dr. Shahim was reasonable and necessary medical treatment and was the liability of the respondent, and that the clamant's healing period had not ended at the time of the hearing and he was entitled to additional temporary total disability benefits to a date yet to be determined. For reasons that I cannot fathom, the majority has reversed a well-reasoned decision and

decided to ignore the specific findings of two respected neurosurgeons and, instead, rely upon the opinions of three doctors who, between them, provided little, if any, actual treatment to the claimant.

After his injury of January 20, 2005, the claimant was referred for treatment at the Mercy Medical Clinic in Glenwood, Arkansas, under the treatment of Dr. Robert Daniel. When the claimant was seen at the clinic on January 21, 2005, he was examined by Mr. James Huffman, a physician's assistant. Mr. Huffman's treatment notes indicate that the claimant was suffering from low back pain and left-sided radicular symptoms. Because of those complaints, Dr. Daniel directed the claimant to undergo an MRI scan which was performed on February 16, 2005. The radiologist's report from that scan reflects that the claimant was suffering from, "moderate size broad-based central subligamentous herniation of L4-5 with small central subligamentous herniation of L5-S1 and degenerative disk changes at both levels. Mild central bulging of T12-L1 is incidentally seen."

Because of the results of the MRI, the claimant was referred to Dr. John Pace, a Hot Springs neurosurgeon. The claimant first saw Dr. Pace on March 8, 2005, again on March 31, 2005, and a third time, on April 14, 2005. As indicated in Dr. Pace's treatment notes on those dates, and more fully explained in his later deposition, the doctor immediately diagnosed the claimant as suffering from an L5 nerve root radiculopathy. According to Dr. Pace, the claimant related the classic symptoms of such an injury. That is, radiating pain across his buttocks into his leg, tingling and numbness, and some urinary incontinence. The claimant was also positive on straight leg raising tests, and his Waddel signs were negative (the latter is a test to detect malingering or symptom magnification). However, as Dr. Pace later explained, the claimant's MRI was unclear as to the extent of this possible radiculopathy, so, in order to pinpoint it further, he directed the claimant to undergo a nerve conduction study.

This study was performed by Dr. Darren Wilbourn, a Little Rock. The exam was performed on

April 26, 2005, and Dr. Wilbourn authored a report setting out his findings. Dr. Wilbourn interpreted the claimant's nerve conduction results as establishing a left L5 radiculopathy, as suspected by Dr. Pace.

For reasons that were not entirely clear, considering the claimant was already under the treatment of a neurosurgeon, the respondent directed that the claimant undergo a consultative exam by Dr. Scott Carle, from Concentra Medical Center in Little Rock. Dr. Carle is apparently a general practitioner who states that he is a Board Certified independent medical examiner. Significantly, Dr. Carle's examination of the claimant was on April 21, 2005, several days prior to the claimant's nerve conduction study. Dr. Carle's lengthy report is based on one brief examination of the claimant and a review of the claimant's medical records. I also note that much of his report consists of boilerplate explanations of medical practices and very little of it actually relates to the claimant's particular condition.

Dr. Carle's report is cited by both the respondent and the majority as finding that the claimant did not suffer a neurological injury in his job-related

accident and that the surgery is not appropriate. However, I note that, in reviewing Dr. Carle's report, the portions that do specifically refer to the claimant find that the claimant was suffering from a radiculopathy. Dr. Carle described this as being a "non-compressive radiculopathy" which he stated would be due to the claimant's incident. Even more interesting, Dr. Carle made the following statement about the extent of the claimant's healing period:

> "With respect to Mr. Diggs, his technical MMI date should be reached at a point in time when reasonable medical care has been administered for the above diagnosis, not to exceed twelve weeks from the date of this report. <u>If found to have electrodiagnostic evidence radiculopathy, this period may warrant extension if surgical intervention takes place</u>." (Emphasis added).

In other words, Dr. Carle is stating that his opinion about the extent of the claimant's healing period would be different if there would be a positive test for a radiculopathy. As explained above, just such

a test, in the form of nerve conduction study, was performed on the claimant which was positive for a lumbar radiculopathy. Undeniably, the result of the nerve conduction study substantially undercuts the reliability of Dr. Carle’s opinion, not only in regard to the extent of the claimant’s healing period, but to his opinions regarding the necessity of surgical treatment.

In an attempt to refute the opinion of Dr. Pace and the objective findings of the nerve conduction study, as well as to shore up any questions that might remain after Dr. Carle’s report, the respondent directed the claimant to be seen by Dr. William Ackerman, a pain specialist, and Dr. Steven Cathey, a neurosurgeon practicing in North Little Rock, Arkansas.

While Dr. Cathey presumably does see patients for treatment, his opinions are most often seen before this Commission as a result of a consultative exam performed at the request of the respondents. His consultative exams are usually sought after a treating physician has either recommended surgery or a course of conservative treatment for a spinal injury. Dr. Cathey

almost invariably concludes that the claimant did not have any symptoms of a neurological condition, is not in need of surgery or any other significant amount of treatment, and does not, in fact, have any serious injury. In this case, Dr. Cathey ran true to form.

The claimant first saw Dr. Cathey on May 12, 2005. However, Dr. Cathey did not have copies of the claimant's MRI's and, consequently, directed the claimant to return for a follow-up visit at a later date. Even though Dr. Cathey, in his initial examination report, states that there is no sign of lumbar radiculopathy, he notes that the claimant's straight leg raising reproduces pain in the claimant's left buttocks and hamstrings. He also mentions that the nerve conduction study suggests an L5 radiculopathy on the left.

In his follow-up report of May 24, 2005, Dr. Cathey outlines the findings of his second visit with the claimant. Once again, he states that there is no indication that the claimant has a lumbar radiculopathy, and now he states that the claimant's straight leg testing only produces pain in his lower back. He also

notes in reviewing the claimant’s MRI that there was no disk herniation or nerve root entrapment. Dr. Cathey eventually concludes that the claimant is “the victim of a musculoskeletal injury superimposed on these preexisting degenerative changes in his lower back.” He also suggests that the claimant suffered a “stretch of the L5 nerve root.” He concludes the report by stating that he was not optimistic that lumbar surgery would be beneficial to the claimant.

The findings set out in Dr. Cathey’s report are questionable for a number of reasons. First, the reports themselves are not internally consistent. The doctor states that there is no evidence of a lumbar radiculopathy when he recites in his report that his exam produced a positive left leg raising test and that the nerve conduction study revealed a radiculopathy at the L5 nerve root. Dr. Cathey’s conclusions are even more surprising when it is considered that every other doctor that saw the claimant, including Drs. Carle and Ackerman, the other two relied upon by the Majority, noted the presence of lumbar radiculopathy. Dr. Cathey also states that the claimant’s MRI of February 2005,

did not reveal a herniated disk. However, every other doctor who saw the claimant and reviewed this MRI scan was of the opinion that it did, including the radiologist who performed the study. (The presence of a herniation was confirmed when the claimant underwent a second MRI on November 7, 2006). In reaching his opinion, Dr. Cathey apparently ignored a substantial body of medical evidence that was discerned by every other doctor who saw the claimant. For that reason, I simply cannot give his opinion any weight whatsoever.

Another doctor which the majority has relied upon in denying this claim was that of Dr. William Ackerman. This doctor specializes in pain management techniques and saw the claimant at the direction of the respondent. Like Drs. Carle and Cathey, his actual contact with the claimant was extremely limited. It is not clear from the medical records how often he saw the claimant, but it does not appear that he saw him more than one or two times. Dr. Ackerman apparently saw the claimant on at least one occasion in late May 2005, and provided him an epidural steroid injection in his lower

back or hip. He also directed the claimant to undergo a functional capacity exam.

According to the claimant's testimony, the injection caused him a great deal of pain and discomfort, but did not result in any benefit to him. It is also significant that Dr. Pace had tried a similar therapy approximately one month before, which did not have a successful result. As explained by Dr. Pace in his deposition, if the first such injection is not successful, subsequent ones are not likely to be, either. However, Dr. Pace gave the claimant two injections, neither of which afforded the claimant any relief. When Dr. Ackerman began giving the claimant another series of injections, the result was the same.

The claimant attended the functional capacity exam arranged by Dr. Ackerman, but did not fully participate in the activities. According to the report and the claimant's testimony, he advised the FCE examiner that Dr. Pace had directed him not to participate in lifting and stooping activities and that he, therefore, would not do so during the course of the exam. Apparently, this restriction limited the

claimant’s participation in many of the parts of the FCE and, consequently, the report regarding the exam indicated that it was not a valid profile of the claimant’s functional ability.

The claimant had apparently become disillusioned with Dr. Ackerman’s treatment and did not believe that the epidural steroid injections were of any particular value. Consequently, the claimant did not return to Dr. Ackerman to complete the series of injections. While this was probably not a wise choice on the part of the claimant, nonetheless, it is understandable since this mode of treatment was not successful before and had little, if any, chance of success now. Also, the injections were causing the claimant a substantial amount of pain and discomfort.

Dr. Ackerman apparently became rather upset over the claimant’s failure to appear and in two reports written in June 2005, noted that the claimant was “non compliant” with medical treatment and that he was therefore being released to return to work with no particular restrictions. Dr. Ackerman also opined that the claimant was at the end of his healing period.

The claimant eventually sought treatment from Dr. Reza Shahim, a Little Rock neurosurgeon. In his treatment note of February 27, 2007, Dr. Shahim noted that the claimant's myelogram and recent MRI demonstrated a foraminal disk herniation at L4-L5 and an annular tear at L5-S1. In this, and in his follow-up letter also of February 27, 2007, Dr. Shahim recommended that the claimant undergo a lumbar laminectomy at L4-L5 and L5-S1.

In denying the claimant the surgery recommended by Dr. Shahim and Dr. Pace, the majority first notes our obligation to weigh medical evidence and to resolve any conflicts therein. After making an entirely correct statement, the majority then makes the following comment:

> Three competent treating physicians, Dr. Ackerman, Dr. Cathey, and Dr. Carle, have determined that surgery is not necessary and will not improve the claimant's post-injury physical condition.

The majority then concludes that the opinions of those doctors are entitled to more weight than the opinions of Drs. Pace and Shahim.

The majority states:

> It is clear that Dr. Pace's recommendation of surgery and Dr. Shahim's agreement, is based upon Dr. Pace's inaccurate assumption that the claimant's calf muscle were equal prior to claimant's injury in January of 2005. That is simply not the case. The claimant's left leg has been small (sic) than his right leg most of his life.

The majority's conclusion regarding Dr. Pace's "inaccurate assumption" is, as adequately discussed by the Administrative Law Judge, based on sheer speculation contained in the respondent's brief. As the Administrative Law Judge stated:

> The respondent's brief notes that Dr. Carle's observation of leg muscle atrophy is inconsistent with Dr. Pace's deposition testimony. The respondents assert that Dr. Pace's surgical recommendation was based on a misunderstanding of the cause and nature of the claimant's decreased left leg muscle mass observed in December of 2005.
>
> I note that there is no quantitative data in the record from which to determine, objectively how much, if at all, the claimant's left leg muscle mass may have decreased specifically during the period frm January to December of 2005. However, the claimant testified that his left leg was smaller than his right leg before January of 2005 but not to the extent that it is smaller now. The claimant's testimony is

> consistent with Dr. Pace's testimony of muscle wasting in December of 2005. In addition, I note that the issue before the Commission is Dr. Shahim's surgical recommendation, and Dr. Shahim's surgical recommendation appears to be based on the claimant's myelogram, electrodiagnostic testing, persistent symptoms, and failure to respond to conservative treatment.

The majority has erred by placing more weight on the opinions of Dr. Ackerman, Dr. Cathey and Dr. Carle than on the opinions of Dr. Pace and Dr. Shahim. In the first place, neither Dr. Ackerman, Dr. Cathey, nor Dr. Carle were the claimant's treating physicians. The only one of those doctors who provided the claimant any treatment was Dr. Ackerman, and he only saw the claimant on the one or two occasions. Drs. Cathey and Carle saw the claimant only on a consultative basis. Also, while I do not question Dr. Carle's or Dr. Ackerman's competency in their respective fields, I note that neither is a surgeon, and that neither one is competent to determine whether the claimant should or should not undergo neurosurgery. I also note that Dr. Carle was of the opinion that if further diagnostic testing established the presence of radiculopathy, the

claimant might need surgery. While Drs. Carle and Ackerman are capable within their fields, they are not surgeons, and I do not feel that their opinions are helpful when we must decide whether an individual must undergo neurological surgery. Such an opinion is best left to Board Certified neurosurgeons such as Drs. Pace and Shahim.

While Dr. Cathey is a neurosurgeon, and I do not question his competence, I do question his objectivity. Dr. Cathey almost invariably sees claimant's in workers' compensation cases and opines that they are not going to benefit from any additional treatment. In almost all of those cases, Dr. Cathey, as he does here, ignores all evidence which does not conform to his opinion. In the present case, Dr. Cathey's blatant refusal to acknowledge medical evidence previously found by every other doctor who saw the claimant is particularly egregious.

I find that the medical evidence is simply overwhelming that the claimant is entitled to the requested surgery. Two respected and competent neurosurgeons were of the opinion that the claimant

needed surgery to correct a problem which was obviously causing him significant difficulty. Further, as explained by Dr. Pace, continued delay is likely to cause his condition to worsen and will make whatever resulting permanent impairment he has even worse. I find this case particularly disturbing because had Dr. Pace's recommendation been followed in 2005, the claimant might have made a much better recovery than he is likely to make now, and might well have returned to work. Unfortunately, because of the lengthy delay in this case, and because of the respondent's continual referrals to doctors who did not treat the claimant's condition, he has worsened and spent three years without meaningful treatment. I, therefore, find that the claimant's medical condition is such that the treatment recommended by Dr. Shahim is both reasonable and necessary and critical to the claimant's future health, and the majority's determination otherwise is clearly erroneous.

I also find that the claimant is entitled to receive temporary total disability benefits to a date yet to be determined. The respondent stopped paying the

claimant temporary disability based upon the report by Dr. Ackerman stating the claimant reached the end of his healing period. However, as indicated above, the claimant needed the lumbar surgery that originally was recommended by Dr. Pace. The reason he did not undergo such surgery is because the respondent continually refused to authorize it, and continued to direct him to a carousal of consulting doctors who did not provide him any treatment. Further, Dr. Ackerman’s report in which he releases the claimant to return to work, was obviously written while the doctor was angry over the claimant’s failure to appear for his appointment. I do not think that a doctor’s pique is a sufficient reason to terminate a disabled worker’s benefits. The claimant was clearly in need of further medical treatment which the respondent was not providing him. I note that even Dr. Carle in his report stated that if diagnostic testing determined that the claimant did have a radiculopathy, his healing period would be extended by his need for surgery. Since such additional testing did establish the presence of radiculopathy for which surgery was necessary, I find that the claimant remained

in his healing period and that he is entitled to receive certain temporary total disability benefits through a date yet to be determined.

In conclusion, I find that the majority has chosen to ignore opinions from competent and qualified neurosurgeons, and, instead, rely on that of two physicians who have no expertise in the area of lumbar surgeries and another who has a pronounced bias for concluding that such surgeries are not necessary for injured workers. Based upon a preponderance of the credible evidence of record, the majority's decision to reverse the Administrative Law Judge is clearly in error.

For the aforementioned reasons, I must respectfully concur in part and dissent in part.

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PHILIP A. HOOD, Commissioner