

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E906998

ALLEN HARTE,
EMPLOYEE

CLAIMANT

CITY OF ROGERS,
EMPLOYER

RESPONDENT

MUNICIPAL LEAGUE WCT,
INSURANCE CARRIER

RESPONDENT

OPINION FILED JULY 14, 2008

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

Claimant represented by the HONORABLE EVELYN BROOKS,
Attorney at Law, Fayetteville, Arkansas.

Respondent represented by the HONORABLE J. CHRIS BRADLEY,
Attorney at Law, North Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed June 27, 2007. The administrative law judge found that the claimant proved he was entitled to additional medical treatment for his ongoing liver problems. 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 that

treatment for his liver problems was reasonably necessary in connection with the claimant's compensable injury.

I. HISTORY

Allen Harte, age 46, testified that he began working for Rogers Police Department in 1984. Mr. Harte testified that he began developing low back problems in 1999. Dr. Gary A. Neaville saw the claimant in March 1999 and diagnosed back pain with spasm. Dr. Neaville's treatment included prescriptions at various times of Flexeril, Prednisone, Lodine, Vioxx, and Amitriptyline. Dr. Neaville noted in September 1999 that the claimant was "taking Vioxx 12.5 mg one daily." The claimant testified that he also took Celebrex.

In an opinion filed May 21, 2001, an administrative law judge (ALJ) found that the claimant proved he sustained a compensable injury. The ALJ found that the respondents should pay for the cost of the claimant's medical treatment for his compensable injury. The parties have stipulated that the ALJ's opinion is "*res judicata* and the law of the case."

The claimant followed up with Dr. Neaville on February 1, 2002 for "abnormal liver enzymes thought possibly to be

due to non steroidal used to treat his back pain which is secondary to worker's compensation." Dr. Neaville assessed "Abnormal liver enzymes. Left knee injury. Both worker's compensation."

Dr. Neaville assessed "Abnormal tranasaminase/LDH" on April 2, 2002.

Dr. Neaville reported on July 15, 2002:

The patient comes in for follow up of abnormal liver functions. He states he has been feeling okay. He has had some flare up of his back pain intermittently. It should be noted on review of his records in 1985 he was found to have moderately severe colitis, acute and chronic and this was also noted on Dr. McKnight's colonoscope. It is certainly possible his liver functions are due to this abnormality....

Dr. Neaville assessed "Abnormal liver enzymes."

Dr. William D. McKnight noted on August 1, 2002:

Allen Harte is an interesting Rogers policeman that has had over quite a length of time documented elevations of alkaline phosphatase and gamma GT. His hepatitis screen has been negative. A recent antimitochondrial antibody study was negative and a MRCP was normal with no evidence of biliary tract disease. At the time the MCRP documented the presence of gallstones, but the patient is clinically asymptomatic regarding any biliary tract symptoms. I have advised him to consider a low fat diet, and have discussed the case with Neaville, and we feel like presently the approach should be to repeat liver functions at about 6 month intervals, but no further diagnostic studies. We feel like the MRCP

has adequately addressed the possibility of any biliary tract disease and negative hepatitis screen with negative antimitochondrial antibody would be a reasonable end point regarding causes of alkaline phosphatase elevations. Whether or not the cholelithiasis will become a problem worthy of surgical therapy remains to be determined.

Dr. Neaville corresponded on January 17, 2003:

This patient was found to have abnormal liver functions after he was treated with nonsteroidal medications for his back injury and degenerative disc disease which was worker's compensation related. Due to his having abnormal liver function studies, we were looking for other causes including abnormal bile ducts and this is why MR-CP was done. It was not done to check on gallstones but was done to rule out other causes which certainly would not be worker's compensation. However, no other cause was found. MR-CP was essentially normal with the exception of gallstones and this was not felt to be causing the abnormal liver functions. Consultation with Dr. William McKnight, a gastroenterologist, was done....

The claimant consulted with a gastroenterologist, Dr.

Gary A. Thomas, on September 2, 2003:

Mr. Harte is a very nice 42 year old gentleman who was first told of abnormal liver enzymes in November of 2001. These have been persistently elevated since. This elevation has been typically more of an obstructive type pattern with an elevated alkaline phosphatase and GGT....He does have degenerative joint disease. It sounds as though this may be job related to his previous workups by other physicians. No family history of liver disease....

ASSESSMENT:

1) Persistently elevated liver enzymes. These have been present now for almost two years. Elevated alkaline phosphatase does suggest an infiltrative process such as fatty liver. Early sclerosing cholangitis would also be a consideration in a young man. However, he does not have symptoms to suggest ulcerative colitis and did have apparently a negative colonoscopy in 1985. He has had an elevated ALT on occasion and an unusual presentation of hemochromatosis would have to be considered as well. Statistically this most likely represents fatty infiltration of the liver.

2. Cholelithiasis apparently asymptomatic. We discussed the symptoms of symptomatic cholelithiasis today. If he developed these symptoms certainly cholecystectomy with cholangiography and liver biopsy would be justified.

Dr. Thomas planned additional diagnostic studies.

Dr. Neaville saw the claimant on September 23, 2003 and assessed "Abnormal liver enzymes or transaminases....Refer back to physician to consider liver biopsy if he deems necessary."

Dr. Thomas corresponded with the claimant on November 6, 2003:

I received the results of your liver biopsy today. I had suspected that your abnormal liver enzymes were due to fatty liver. The liver biopsy, however, did not show evidence of significant fat. Some mild inflammatory changes were noted, however, the pathologist, did not feel that there was enough inflammation to call "active hepatitis." Minimal fibrosis or scarring was noted. They did not see evidence of bile duct disease known as sclerosing cholangitis, which I

had considered based on the pattern of your liver enzymes. Although I am pleased the pathologist did not see (sic) anything concerning, I do not have a definite call for your liver function abnormalities. It is possible that you have low-grade autoimmune hepatitis in which the bodies (sic) immune system attacks the liver tissue, or, I suppose that it is possibly due to medications.

I feel one of the better liver pathologists in the United States is Dr. Patrick Dean in Memphis, Tennessee. I would like to send your biopsy slides to him and get his opinion. He has been extremely helpful in the past with confusing biopsy pictures such as yours. The main goal in having this reviewed, is to be sure that we are not overlooking a treatable condition. If he feels these changes could be due to mild autoimmune hepatitis, we may need to begin treatment with low-dose steroids and see how your liver enzymes respond.

I am pleased that your biopsy did not show any significant damage to your liver....

On November 6, 2003, Dr. Thomas referred the claimant to Dr. Patrick Dean for his opinion regarding a recent liver biopsy specimen of the claimant. Dr. Thomas wrote to the claimant on November 21, 2003:

I have received the review of your liver biopsy from Dr. Patrick Dean in Memphis. He noted very mild changes of the inflammation in your liver. In fact, the changes were so mild that he really could not ascribe it to a certain cause. He felt that these changes could be due to your past use of medications but did not see evidence of autoimmune hepatitis or fatty liver. This is an excellent report. This current condition does not

suggest that there is any significant risk of liver damage.

At this point I would recommend simply checking liver enzymes every six months. If they rise excessively then reevaluation may be needed. If you start any new medications then liver enzymes should also be monitored for any abnormality. Unless there is a significant rise in your liver enzymes, I would not recommend additional evaluation at this point. This is an excellent report....

Dr. Neaville stated on August 19, 2005, "Allen Harte did have a period of 20 years that he was wearing a 20-pound duty belt regularly. This has been a significant factor in his degenerative disk disease....He was able to take medication at first, but due to abnormal liver enzymes while taking them the medications were discontinued and the pain became even more difficult. Because of this, he was forced to quit work at the police station because of no reassignment to any lighter duty positions in the office."

Dr. Neaville's assessment on April 4, 2006 was "1. Back pain. 2. Abnormal transaminases."

Dr. Neaville stated on April 4, 2006, "I am still seeing Allen R. Harte in followup for chronic back pain along with abnormal liver enzymes which was felt to be due to medication use (sic) to treat back pain when he was wearing a police holster. He still has limitations of his

back including range of motion and pain specifically on the right side due to this."

Dr. Neaville assessed "Abnormal transaminase" and depression on September 19, 2006.

Dr. Neaville wrote on September 19, 2006:

The patient has been followed for abnormal liver enzymes for a period of years. This was first noticed after he was taking a nonsteroidal for back pain due to an injury he had on the job. At the present time he does seem to have an exacerbation of the liver function test. Because of this, he will be referred to a gastroenterologist. Prior biopsy did not show anything serious, but the worsening of the liver functions is a concern. Please give this your attention.

A Magnetic Resonance Cholangiopancreatography was done on December 6, 2006 with the following impression:

1. Mildly prominent common bile duct at 7 mm caliber, but no filling defect is identified to suggest stone, and no discrete stricture identified. This is minimally more prominent than on exam of 7/25/2002.
2. Cholelithiasis.

A liver biopsy was performed on December 11, 2006. The final diagnosis included bile duct centered liver damage with chronic inflammation in portal tracts, mild piecemeal necrosis, and fibrous expansion of the portal tracts with concentric periductal fibrosis. The following comment was entered:

The changes are suggestive of primary sclerosing cholangitis (PSC). Differential diagnosis also includes atypical primary biliary cirrhosis (AMA negative PBC), and autoimmune cholangitis. Due to the difficult nature of the case and upon the request of Dr. Stagg, the case was sent to Dr. Patrick Dean at GI Pathology Partners in Memphis, Tennessee, for expert consultation. Dr. Malkapugay reviewed the case instead. Dr. Makapugay's diagnosis reads as above and letter reads as follows:

"Dr. Gui, this is a very interesting case. I have reviewed the patient's 2003 liver biopsy slides, and I agree with Dr. Dean that the biopsy shows only minor nonspecific reactive changes that cannot be ascribes (sic) to a specific category of liver injury. Unfortunately, the recent biopsy presents quite a different picture, with definitive evidence of bile duct centered injury. This injury is characterized by bile duct destruction, areas of concentric periductal "onion skinning" fibrosis, portal tract expansion by lymphocytes and plasma cells, and reactive bile duct proliferation. In addition to the portal tract fibrosis, there is periportal and focal bridging fibrosis. Piecemeal necrosis is also evident. The features are strongly suggestive of primary sclerosing cholangitis. I noted the history of a negative MRCP but wonder if this could be a case of small-duct PSC, which may not produce a classic picture on cholangiogram. Primary biliary cirrhosis is also in the differential, this may be an AMA negative primary biliary cirrhosis. Since the negative AMA is from 2003, retesting for AMA is recommended. ..."

A pre-hearing order was filed on March 5, 2007. The claimant contended that he "was injured as a result of the continual work activity that he was doing as a police officer. He injured his back and had to take medication for

his injury. The medication caused permanent liver damage." The parties agreed to litigate the following issue: "1. Additional medical for the claimant's liver problems."

An administrative law judge found that the claimant proved he was entitled to additional medical treatment "for his ongoing liver problems....The respondents should pay for all reasonable and necessary medical treatment for this claimant's liver problems since they are found to be a compensable consequence of his compensable injury."

The respondents appeal to the Full Commission.

II. ADJUDICATION

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

The administrative law judge found in the present matter, "The respondents should pay for all reasonable and necessary medical treatment for this claimant's liver problems since they are found to be a compensable consequence of his compensable injury." The Full Commission reverses this finding. There is no probative evidence of record connecting the claimant's elevated liver enzymes or other liver conditions to any medication the claimant was taking for back pain. Dr. Neaville was never able to state with specificity which "nonsteroidals" purportedly caused the claimant's liver problems. Dr. Knight in August 2002 did not enter an opinion on causation. Dr. Thomas in September 2003 discussed "fatty infiltration of the liver" but he did not make a causal connection to the claimant's medication. Dr. Thomas stated that the claimant's liver problems were "possibly due to medications" and "could be due" to use of medication for back pain. Medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. Ark. Code Ann. §11-9-102(16) (B). Where a medical opinion is sufficiently clear to remove any reason for the trier of fact to have to guess at the cause of the injury, that opinion is stated within a

reasonable degree of medical certainty. *Howell v. Scroll Tech.*, 343 Ark. 297, 35 S.W.3d 800 (2001). However, expert opinions based on "could," "may," or "possibly" lack the definiteness required to prove the causal connection. *Frances v. Gaylord Container Corp.*, 341 Ark. 527, 20 S.W.3d 280 (2000).

Dr. Thomas' use of the terms "possibly" and "could be" in the present matter lack the definiteness required to prove the causal connection. We recognize Dr. Neaville's opinion in April 2006 that the claimant's abnormal liver enzymes were "felt to be due to medication" for back pain. It is within the Commission's province to weigh all of the medical evidence and to determine what is most credible. *Minnesota Mining & Mfg. v. Baker*, 337 Ark. 94, 989 S.W.2d 151 (1999). Based on the evidence of record before us in the present matter, the Full Commission assigns minimal weight to Dr. Neaville's causation opinion.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove that treatment for his liver problems was reasonably necessary in connection with the claimant's compensable injury. 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 dissents.

DISSENTING OPINION

The majority is reversing an Administrative Law Judge's finding that the claimant's liver condition was the result of medication prescribed for a compensable injury. The majority has concluded that the Administrative Law Judge erred in finding that the claimant had met his burden of proof on this issue. After a de novo review of the record, I find that the claimant has met his burden of establishing that his liver condition was the result of medication prescribed for his compensable injury, therefore, I must respectfully dissent from the majority's Opinion.

The claimant was a 20 year veteran with the Rogers Police Department. In 1999, he sustained a compensable injury to his lower back. As a result of that injury, the claimant was prescribed numerous nonsteroidal medications for treatment of his back condition, including Flexeril, Celebrex, and Vioxx. For the next few years, the claimant continued taking those medications, and others that his doctor prescribed for him.

By February 2002, the claimant was diagnosed as having elevated liver enzymes. The claimant's treating physician, Dr. Gary Neaville, a Rogers general practitioner, noted this abnormality in his report of February 1, 2002, and commented: "The patient comes in with two problems. One is for follow-up of abnormal liver enzymes what possibly could be due to nonsteroidal used to treat back pain which is secondary to workers' compensation."

The claimant underwent other tests regarding his liver condition and Dr. Neaville continued to treat him. In a report dated January 17, 2003, Dr. Neaville once again reviewed the claimant's liver testing and its

likely causes. In his report of that date, Dr. Neaville, stated as follows:

This patient was found to have abnormal liver functions after he was treated with nonsteroidal medications for his lower back injury and degenerative disc disease which was workers' compensation related. Due to his having abnormal liver function studies, we were looking for other causes including abnormal bile duct and this is why MR-CP was done. It was not done to check on gallstones but was done to rule out other causes which certainly would not be workers' compensation. However, no other cause was found. MR-CP was essentially normal with the exception of gallstones and this was not felt to be causing the abnormal liver functions. Consultation with Dr. William McKnight, a gastroenterologist, was done.

The claimant was also treated by Dr. Gary Thomas, a Fayetteville gastroenterologist. While Dr. Thomas did not positively connect the claimant's liver abnormality with medications given to him for his back

condition, Dr. Thomas repeatedly mentioned this connection. In fact, in his report of September 2, 2003, he specifically stated that in regard to his liver condition, "It sounds as though this may be job related. . . ."

I find that the claimant has offered sufficient medical evidence to causally connect his liver abnormality with the taking of medications prescribed to him for treatment of his compensable back injury. In the medical community, the likelihood of liver damage from taking the types of medications that the claimant was given are clearly documented. In fact, this connection is why the claimant's treating physician began having him undergo regular liver testing after he had been prescribed these drugs.

The majority's apparent rationale for denying this claim is that there is insufficient medical opinion establishing a causal connection between the claimant's liver condition and his use of nonsteroidal pain relievers and anti-inflammatories. However, I find that the majority is confusing the statutory prohibition on relying upon medical opinion which is not stated within

a reasonable degree of medical certainty, and our obligation to consider all medical evidence. I agree that we cannot base our decision on a doctor's opinion which is vague or uncertain. However, it is not necessary to have a medical opinion in order to evaluate a claim. In fact, in reviewing this matter, I note that there is ample medical evidence establishing that the claimant had no history of liver abnormalities or any other problems with his liver until his diagnosis of abnormal liver enzymes in early 2002. As the test results conducted by and at the direction of Drs. Neaville and Thomas continued, every other possible cause of the claimant's liver condition was ruled out except for the connection between his medications and liver function. The majority discounts Dr. Neaville's opinion that the medication caused his liver condition because he is a general practitioner. The majority does attach great significance to the lack of such a clear opinion from Dr. Thomas. However, Dr. Thomas did not ever opine that the claimant's job related medications were not the problem. Rather, he simply failed to unequivocally state that he believed they were.

Significantly, he did repeatedly make a possible connection between the claimant's use of his prescribed medication and his declining liver function.

I find that the claimant has more than met his burden of proof. The majority, on the other hand, seems to be saying that the claimant must establish a causal connection with near certainty. The Workers' Compensation Act does not place such a high burden on the claimant to establish his entitlement to benefits. The claimant must merely demonstrate that the evidence preponderates in his favor. That is, the claimant must show that the weight of the evidence shows that the development of his condition is more likely than not the result of his job related use of certain medications. I have no doubt that the claimant has done so.

For the aforementioned reasons I must respectfully dissent.

PHILIP A. HOOD, Commissioner