

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 AUGUST 6, 2009

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 Arkansas Court of Appeals has reversed the Full Commission and has remanded for a full examination of the relevant evidence presented. *Diggs v. Cattlemen's Livestock Market, Inc.*, CA 08-717 (April 8, 2009). After reviewing the entire record *de novo*, the Full Commission finds that the claimant did not prove he was entitled to surgery as recommended by Dr. Shahim. We find that the claimant did

not prove he was entitled to additional temporary total disability benefits.

I. HISTORY

The testimony of Darrell Wayne Diggs, now age 47, indicated that he began working for the respondent-employer in November 2004. The claimant was a foreman and mechanic in the respondents' maintenance shop. 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 (sic) a hot knife in there....In my lower back, right at my belt."

James Huffman, PA-C, saw the claimant beginning January 21, 2005. James Huffman's handwritten diagnosis appeared to be lumbar back pain with radiculitis down the left leg. Mr. Huffman planned conservative treatment, follow-up visits, and "activities as tolerated."

An MRI of the claimant's lumbar spine was done 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 began treating with Dr. John R. Pace on March 8, 2005. The claimant testified that he did not work after March 8, 2005.

Dr. Scott W. F. Carle performed an Independent Medical Evaluation on April 21, 2005 and reported in part:

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 states that his back aches constantly. The pain goes into his left leg, into his thigh and calf, with jerking-type sensation. He has a needles-like sensation in his thigh....

The client's current work status is that he has been off work for about the last six weeks, since March 8, 2005....

The client's childhood illnesses have included a bilateral congenital clubfoot deformity with surgical intervention on the left foot around the age of six months. There has been no surgery on the right foot....

The deep tendon reflexes are brisk and symmetric at the knees and ankles. The extensor hallucis longus strength is symmetrical. There is a negative straight-leg raise testing, seated and recumbent....

The standing examination revealed some mild left leg shortening, probably around 1.5 to 2 centimeters....

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....

February 16, 2005

Magnetic Resonance Imaging Study

Disk desiccation is shown at two levels, L4-5 and L5-S1, with some degenerative narrowing at L5-S1. Edema on the inferior end-plate of L5 with slight central compression, probably old. There is small central subligamentous disk herniation at L5-S1 with a moderate-sized broad-based subligamentous herniation at L4-5.

There is mild central bulging of T12 and L1. Degenerative disk narrowing noted there as well. The soft tissue structures are unremarkable....

His physical examination is consistent with iliolumbar or sacroiliac joint dysfunction and a radiculitis on the left. He has congenital left

leg shortening. He has a normal neurological examination on the date of the exam of April 21, 2005....

DIAGNOSTIC IMPRESSIONS

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....

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. If found to have electrodiagnostic evidence of radiculopathy, this period may warrant extension if surgical intervention takes place....

There has been no objective evidence of neurological injury to produce a radiculopathy, fracture or motion segment integrity loss....The presence of his MRI symptoms are considered non-specific and are present in a large population of asymptomatic individuals and there current (sic) exists no way to objectively determine the acuteness of the finding....

Once further testing has been done to ascertain the origin of Mr. Diggs' complaints, LESI, Transforminal (sic) Selective Nerve Root Block or SI joint injections may be indicated or completion of conservative management....

With respect to Mr. Diggs, his work ability, based on the information and findings

to date, appear (sic) 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....

Dr. Darin K. Wilbourn performed electrodiagnostic testing and gave the following interpretation on April 26, 2005: "1. Abnormal study. 2. Electrodiagnostic evidence of left L5 radiculopathy."

The claimant began treating with Dr. William E. Ackerman on April 28, 2005:

He relates that he was injured in the course of his employment on January 20th. He was taking a front end loader of a tractor. He was attempting to lift a heavy object. As he did so he felt like a "knife was stuck in the back"....He had electrodiagnostic evidence of a left L5 radiculopathy. Mr. Diggs has 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....

The patient symptoms over the last 7-9 days have become progressively worse with respect to the radiation of pain to the bottom of his foot. The question at this time is whether or not he needs an epidural steroid injection of the lumbar spine which will provide a global spread of steroid as apposed (sic) to a selective nerve root injection

at L5 on the left side. However, today he is also giving some symptoms of a S1 lesion. For this reason it is my medical opinion that an epidural injection with needle placement directed to the left side would probably provide him with the best pain relief....He will be scheduled for an epidural steroid injection with fluoroscopic needle control early next week....Dr. Scott Carle has recommended physical therapy. He will be given a prescription for therapy and will contact his nurse case worker, Ms. Natasha Karki, R.N. He was advised that his prognosis is good. Following epidural steroid injection therapy his sacroiliac joint sprain/strain pain may resolve or it may not resolve....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 administered a lumbar epidural steroid injection on May 5, 2005. The claimant testified regarding the steroid injection, "when I walked out of his office, where that needle went in, I was burning like you stuck a kitchen match, as big as it felt, a big burning. And that was on Thursday morning, and it burnt like that till Sunday afternoon. And then it just seemed like it was just constantly being clamped down on. And it's been that way ever since."

A handwritten note from Arkansas Specialty Orthopaedic dated May 11, 2005 appeared to indicate that the claimant could return to work on June 11, 2005.

Dr. Steven L. Cathey examined the claimant on May 12, 2005:

Mr. Diggs is a 42-year-old white male who works as a maintenance welder for Cattlemen's Trail Shop in Glennwood, Arkansas. He is referred today for a second neurosurgical opinion by Dr. William Ackerman, an excellent pain management specialist here in North Little Rock. Mr. Diggs presents with an almost four month history of lower back pain associated, at times, with radiation down the posterolateral aspect of his left leg. The patient relates the onset of his symptoms to an occupational injury sustained on January 20, 2005. According to Mr. Diggs, he was working on a front end loader when he noted the onset of pain in his lower back....

On physical examination, the patient appears to have bilateral club feet. There is no sign of lumbar radiculopathy. Straight leg raising on the right is negative. Straight leg raising on the left, however, reproduces pain in his left buttock and hamstring at 90 degrees. The patient demonstrates full range of motion of the lumbar spine without paraspinous muscle spasm.

I reviewed a report of an MRI scan demonstrating midline disc protrusions at L4-L5 and L5-S1. There is however no mention of any resulting nerve root compression. Electrodiagnostic testing, however, suggests an L5 radiculopathy on the left.

Unfortunately, Mr. Diggs did not bring his MRI scan with him so I have not had an opportunity to review the films with him firsthand.

ASSESSMENT/PLAN: Since the patient remains symptomatic despite almost four months of conservative treatment, I would certainly like to identify a problem amenable to neurosurgical intervention. I have asked Mr. Diggs to capture his MRI scan so that he and I may review it together here in the office. The patient will be

reevaluated once the films have been located. In the interim, he will remain off work and continue his current drug regimen....

Dr. Cathey corresponded with Dr. Ackerman on May 24, 2005:

I am writing to bring you up-to-date on Mr. Diggs. As you may recall, he was initially evaluated here on May 12, 2005, to render a second opinion regarding the chronic lower back pain he has been experiencing for the past four months. Mr. Diggs relates the onset of his lower back pain to an occupational injury sustained on January 20, 2005. The pain will occasionally radiate down the posterolateral aspect of his left leg. His pain has thus far been refractory to medication, epidural steroid injections, etc. 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 for 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.

Dr. Ackerman noted on May 26, 2005, "He relates that therapy is not helping him and is making his pain worse. The patient has not followed with Dr. Pace. He has had two epidural steroid injections which did not provide him with any pain relief....He currently is not working as Dr. Pace took him off work. He feels he is unable to work at this time....He will follow-up in two weeks. At that time, final disposition will be done." Dr. Ackerman assessed "Status post injury to lumbar spine with persistent pain in left lower extremity."

The claimant underwent a Functional Capacity Evaluation on June 6, 2005:

The results of this evaluation suggest that Mr. Diggs gave an unreliable effort, with 28 of 48 consistency measures within expected limits. Mr. Diggs put forth inconsistent effort throughout the evaluation process.

It is noted that Mr. Diggs refused to perform ANY lifting, stooping, carrying, pushing/pulling or and crawling testing. He reported that Dr. Pace has restricted him to no lifting or bending and he was not going to go against these restrictions. When explained that the purpose of this test was to determine his ACTUAL lifting and carrying abilities/restrictions and Dr. Ackerman had ordered this test and that this was needed for his own benefit from a work restriction standpoint, Mr. Diggs again refused testing. The testing performed outside of these specific tests indicated inconsistent effort and self limiting behavior, so it is highly unlikely that valid lifting results would have been obtained even if these tests had been performed....

CONCLUSIONS

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 noted in part on June 9, 2005, "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....He is noncompliant with respect to his treatment. I would recommend an attempt at gradual return to work. 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 record indicates that the respondents paid temporary total disability benefits through June 29, 2005. Dr. Carle corresponded with a representative of CompChoice on June 30, 2005:

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 a 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 claims specialist informed the claimant on August 1, 2005, "We have received Dr. Carle's report of 06-30-2005. Dr. Carle opines that you have reached maximum medical improvement and has given you an impairment rating of 5% to the body as a whole. Under the Arkansas Worker's Compensation Commission Rules and Regulations, this entitles you to 22.5 weeks of permanent partial disability benefits at the \$325 per week for a total of \$7,312.50 in permanent partial disability benefits. You will be receiving your bi-weekly benefit checks under separate cover."

Dr. Carle informed the respondents' attorney in part on March 14, 2006, "Mr. Diggs appears to have sacro-iliac joint syndrome with radiating leg pain and paresthesias. This is temporally related to a lifting incident at work and is felt to be combined with a variety of idiopathic degenerative processes....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 an MRI of the claimant's lumbar spine 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 testified that the claimant's symptoms were consistent with a disc herniation. Dr. Pace testified regarding his second visit with the claimant on March 31, 2005, "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." Dr. Pace's last visit with the claimant occurred on December 13, 2005. The claimant's attorney questioned Dr. Pace:

Q. Doctor, what was your determination as to what your care of Mr. Diggs should be?

A. Well, at that point he had 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 at 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. On December of 2005, was there anything conservatively that you felt would benefit Mr. Diggs at that time?

A. I think he could have had some further physical therapy to help in the wasting in his left leg, to prevent muscle wasting.

Q. Would it have relieved his pain?

A. I think - yes, it can be helpful for back pain. And if they can recondition some of the muscles that support the spine it could help us with nerve root compression, as well....

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 entered an ORDER on September 12, 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 examination."

The claimant began treating with Dr. Reza Shahim on November 7, 2006. Dr. Shahim recommended repeating the claimant's lumbar spine MR. An MRI of the claimant's lumbar spine was taken on November 7, 2006, with the following impression:

1. L5-S1 Broad-based disc bulge with a small right paracentral and subarticular protrusion which also has a fairly broad-base but extends slightly superiorly from the disc level causing mild right foraminal narrowing and mild mass effect on the exiting right L5 nerve root. This is appreciate (sic) best on the sagittal acquisition image no. 10 and the axial acquisition image no. 29 and 30.
2. Evidence of small right paracentral annular tear at the T12-L1 level.
3. Mild degenerative disc changes at the L4-5 level.

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 angular 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. I will plan on following up with him after that study."

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.

On January 25, 2007, Dr. Shahim kept the claimant off work "pending WCC approval for LESI." The claimant testified that an injection ordered by Dr. Shahim "didn't help either. It was like the second one, a match in there burning, just like a ball of fire setting there where that needle went in and plumb in there to where the medication was put in."

Dr. Shahim saw the claimant on February 27, 2007:

He underwent a lumbar epidural steroid injection with no improvement in his symptoms.

STUDIES REVIEWED: I reviewed his myelography. He does have what appears to be a foraminal disc herniation at left L4-5 on the MRI and also on the myelogram. He also has an annular tear at L5-S1.

He had EMG evidence of a left L5 radiculopathy.

DECISION MAKING: I had a long discussion with him and his wife. A recommendation had been made to him previously for a fusion. I suspect that most

of his symptoms are due to an L4-5 disc herniation. We discussed all options. I think that a surgical decompression with discectomies is probably the best initial option. He may ultimately require a fusion as was recommended previously. We discussed the technical aspects of a laminectomy and discectomy. The risks of surgery include infection, bleeding resulting in a hematoma requiring evacuation of the hematoma, paralysis which could be permanent, resulting in weakness or numbness, and spinal fluid leakage requiring further surgery. Further surgery including an operation at the same level for recurrent disc disease or adjacent level due to progression of disc disease, and failure to improve due to chronic nerve irritation or severe disc disease. I have explained to him and his wife that I do not expect to completely eliminate all of his radicular pain since he has had very chronic nerve pain and he has EMG changes.

Dr. Shahim also wrote in hand on February 27, 2007, "Recommended pt to get left lumbar laminectomy at L4-5-S1."

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 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, Cathey, and Carle.”

A hearing was held on May 29, 2007. At that time, the claimant's attorney stated that the claimant had received three additional temporary total disability payments since June 29, 2005. Those additional TTD payments were in February and March 2007.

An administrative law judge filed an opinion on September 5, 2007. The ALJ 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 appealed to the Full Commission. The Full Commission found that the claimant did not prove he was entitled to surgery or additional temporary total disability benefits. The Arkansas Court of Appeals has reversed and remanded for further findings.

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) (Repl. 2002). The employee 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). See also *Fayetteville School District v. Kunzelman*, 93 Ark. App. 160, 217 S.W.3d 878 (2002). 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, the Full Commission finds that the claimant did not prove he was entitled to surgery as recommended by Dr. Shahim. The parties stipulated that the claimant sustained a compensable injury to his back on January 20, 2005. The claimant testified that he felt a sharp burning pain in his back, at the belt line. An MRI in February 2005 showed broad-based herniations and degenerative changes at L4-5 and L5-S1, along with mild central bulging at T12-L1. The claimant treated with Dr.

Pace beginning in March 2005. Dr. Carle's diagnostic impression in April 2005 included left sacroiliac joint pain with left leg pain and paresthesias. Dr. Carle did not find evidence of a neurological injury. Electrodiagnostic testing administered by Dr. Wilbourn in April 2005 was abnormal with electrodiagnostic evidence of left L5 radiculopathy.

The claimant began treating with Dr. Ackerman in April 2005, and Dr. Ackerman noted the abnormal electrodiagnostic testing. Dr. Ackerman began pain management treatment. Dr. Cathey examined the claimant on May 12, 2005 and noted, "I reviewed a report of an MRI scan demonstrating midline disc protrusions at L4-L5 and L5-S1. There is however no mention of any resulting nerve root compression. Electrodiagnostic testing, however, suggests an L5 radiculopathy on the left." Dr. Cathey stated after a May 24, 2005 follow-up visit, "I don't believe Mr. Diggs would benefit from lumbar disc surgery or other neurosurgical intervention." Dr. Cathey suggested a follow-up appointment with Dr. Pace and noted that Dr. Pace had possibly recommended surgery. Nevertheless, Dr. Cathey reiterated his opinion, "I am not,

however, optimistic that lumbar disc surgery will be beneficial in this case based on what I have seen."

Dr. Ackerman opined on June 9, 2005, "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 claimant subsequently began treating with Dr. Shahim, and Dr. Shahim eventually recommended "a left lumbar laminectomy at L4-5-S1."

The Full Commission finds that the claimant did not prove surgery as recommended by Dr. Shahim was reasonably necessary in connection with the January 20, 2005 compensable injury. The Full Commission has reviewed all of the medical examinations, treatments of record, and medical opinions concerning the claimant's condition. The Full Commission has also reviewed each and every diagnostic test, including the February 16, 2005 MRI; the April 26, 2005 electrodiagnostic testing; the November 7, 2006 MRI; and the December 2006 lumbar myelogram. We find that the expert opinions of Dr. Ackerman and Dr. Cathey are entitled to significant weight. Dr. Pace did not expressly opine in his

June 2006 deposition testimony that surgery would benefit the claimant. Dr. Pace actually recommended additional diagnostic testing and pain management treatment.

We recognize that Dr. Shahim recommended at least one, possibly two surgeries in the form of decompression and fusion. 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). The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). In the present matter, the Court of Appeals has not directed the Commission to award surgical treatment to the claimant. Nor is the Full Commission "ignoring" the Court's mandate or disregarding any aspect of the Court's instructions to fully examine all of the relevant medical evidence before us. Based on our *de novo* review of the entire record, including all of the medical opinions and examinations of record, and including each and every diagnostic test of record, the Full Commission finds that the opinions of Dr. Carle, Dr. Ackerman, and Dr. Cathey are entitled to significant

evidentiary weight. We find that these doctors' opinions are entitled to more probative weight than the opinions of Dr. Pace and Dr. Shahim. The Full Commission finds that the claimant did not prove that surgery as recommended by Dr. Shahim was reasonably necessary in connection with the claimant's January 20, 2005 compensable injury.

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). A claimant's healing period ends when the underlying condition causing the disability has become stable and if nothing further in the way of treatment will improve the condition. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987). The healing period has not ended so long as treatment is administered for healing and alleviation of the condition and continues until the employee is as far restored as the permanent character of the injury will permit. *Arkansas Highway & Transp. Dept' v. McWilliams*, 41 Ark. App. 1, 846 S.W.2d 670 (1993). The determination of when the healing period ends is a question of fact for the

Commission. *Thurman v. Clarke Indus., Inc.*, 45 Ark. App. 87, 872 S.W.2d 418 (1994).

In the present matter, the parties stipulated that the claimant sustained a compensable injury to his back on January 20, 2005. The claimant testified that he did not work after March 8, 2005. Dr. Ackerman noted on April 28, 2005 that the claimant was "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." Dr. Ackerman opined on May 11, 2005 that the claimant could return to work on June 11, 2005. It was concluded following 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 reviewed the functional evaluation and opined on June 9, 2005 that the claimant had reached maximum medical improvement. The respondents paid temporary total disability benefits through June 29, 2005. Dr. Carle opined on June 30, 2005 that the claimant was "at MMI with respect to his workplace strain on January 20th, 2005." Pursuant to

the evidence before us and the opinions of Dr. Ackerman and Dr. Carle, the Full Commission finds that the claimant reached the end of the healing period no later than June 30, 2005. The claimant did not prove that he was entitled to temporary total disability benefits after June 30, 2005.

Based on our *de novo* review of the entire record and in accordance with the remand from the Court of Appeals, the Full Commission finds that the claimant did not prove he was entitled to surgery as recommended by Dr. Shahim.. We find that the claimant did not prove he was entitled to additional temporary total disability benefits. The Full Commission reverses the administrative law judge's award of additional benefits. This claim is denied and dismissed.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion. The Court of Appeals instructed the Full Commission

to consider the factors considered by Dr. Pace and Dr. Shahim, including the claimant's symptoms of radiculopathy, positive straight leg tests, MRI, nerve conduction study, another MRI, myelogram and post-myelogram CT. The majority has failed to do so, instead presenting its determination as the result of a "dueling doctors" analysis. However, the majority cannot avoid the substantial evidence standard of review merely by presenting its determination as a matter of "dueling doctors." The majority cannot simply pick one doctor versus another doctor without explanation. And the opinions of the doctors relied upon by the majority must still withstand scrutiny. Here, the opinions of Drs. Carle, Cathey and Ackerman, relied upon by the majority versus the opinions of Drs. Pace and Shahim, are inconsistent, contradictory, and based on very little actual contact with the claimant. They simply do not withstand scrutiny.

Furthermore, the majority must do more than state that it has considered all of the evidence of record; the majority must actually consider all of the evidence of record. Here, although the majority states that it has considered all of the evidence of record, the majority fails to explain why it has ignored the specific instructions of

the Court of Appeals to consider the claimant's symptoms of radiculopathy, positive straight leg tests, MRI, nerve conduction study, another MRI, myelogram and post-myelogram CT. When this evidence is considered, in conjunction with the findings of Drs. Pace and Shahim, it is clear that the claimant is entitled to the additional reasonably necessary medical treatment recommended by Dr. Shahim. The majority opinion is not based on substantial evidence and should be reversed.

For the aforementioned reasons, I must respectfully dissent.

PHILIP A. HOOD, Commissioner