

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F512919

KIMBERLY GRIFFITH, EMPLOYEE	CLAIMANT
ARKANSAS HEART HOSPITAL, EMPLOYER	RESPONDENT
LIBERTY MUTUAL INSURANCE CO., CARRIER	RESPONDENT

OPINION FILED APRIL 16, 2009

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

Claimant represented by HONORABLE THOMAS W. MICKEL, Attorney at Law, Conway, Arkansas.

Respondent represented by HONORABLE GUY A. WADE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

Respondents appeal from the Administrative Law Judge opinion finding that the claimant was temporarily totally disabled from December 22, 2007, through February 6, 2008, and finding that the claimant's medical treatment subsequent to April 10, 2006, was reasonable and necessary medical treatment and thus the respondents' responsibility. Based upon our de novo review of the entire record, without giving the benefit of the doubt to either party, we find that the claimant has failed to prove by a preponderance of the evidence a causal connection between her admitted

compensable injury and her need for medical treatment nor has she proven entitlement to the temporary total disability benefits. Therefore, we find that the decision of the Administrative Law Judge must be reversed.

The claimant sustained an admittedly compensable injury to her low back in the form of a back strain on October 26, 2005, when she was repositioning a patient in the bed. The claimant reported this injury and proper medical treatment was initiated. Claimant was initially treated by Dr. John Adametz at Concentra Medical Centers where she provided a history of present illness as follows:

The mechanism of injury was lifting a patient at work. The pain began immediately. The pain is located on bilateral upper back, lumbar region, and thoracic region. Pain intensity level: 5/10. The pain is described as dull, sharp and throbbing. The symptoms are exacerbated by bending or movement. The pain did not radiate.

The claimant was diagnosed with a cervical, thoracic, and lumbar strain, and back pain. Physical and medication therapy were prescribed. Upon her return visit to Dr. Adametz two days later, the claimant advised that the

pain was now primarily localized on the right side. By November 1, 2005, the claimant reported to Dr. Adametz that she had noted improvement and felt better. Again, on November 8, 2005, the claimant reported to Dr. Adametz that she felt better and that her symptoms were improving. On her November 18, 2005, office visit, the claimant advised that she had pain in her posterior right thigh. Dr. Adametz administered trigger point injections in the right lumbar area at that time. A second trigger point injection was administered on November 23, 2005, into a tender area on the left lumbar region. On November 30, 2005, the claimant again advised that she felt that her pattern of symptoms was improving. Claimant's pain intensity at that time was 3/10, but she complained of pain radiating into her right leg and foot. Dr. Adametz ordered an MRI scan at that time. Prior to undergoing the MRI, the claimant returned for a follow-up appointment with Dr. Adametz on December 5, 2005. Claimant reported at that time that her condition was stable since her last appointment. Dr. Adametz noted that the claimant's pain was located on the right lumbar and thoracic region with associated numbness into the right leg and foot.

The MRI performed on December 6, 2005 revealed the following findings:

FINDINGS: The vertebral bodies are normally aligned without subluxation. There is normal vertebral body and disc height. There is normal homogeneous marrow signal.. The conus is visualized at T12/L1. The visualized cord demonstrates no signal abnormalities.

L5-S1: There is an asymmetric diffuse disc bulge, greater on the left. There is slight posterior displacement of the left S1 nerve root. There is no neural foraminal or cord stenosis at this level. There is disc desiccation.

L4-5: An asymmetric diffuse disc bulge is again seen, greater on the left. There is no canal or neural foraminal stenosis. Disc desiccation and degenerative facet disease is seen.

There is disc desiccation at L1-2, L4-5, and L5-S1. There are early and mild degenerative changes seen in the facets at all levels.

During her physical therapy on December 7, 2005, the claimant advised that she was mildly improved but that she continued to experience pain radiating into her right foot. Again on December 8 and 12, when examined by Dr. Adametz, the claimant advised that her symptoms had

stabilized but that she was continuing to have shooting and radiating pain into her right leg associated with numbness. The claimant also complained of pain in both sides of her neck for the first time.

Dr. Adametz authored a report dated December 30, 2005, discussing the claimant's physical findings and recommended treatment. Dr. Adametz described the claimant's pain as severe muscle spasms with pain from the neck to the buttock. The pain was described mostly in the low back, with pain into the right buttocks and intermittent numbness in the right leg with tingling into the foot. Dr. Adametz discussed the claimant's objective MRI studies and concluded that the findings were not really very bad, and that the findings did not correlate with the claimant's complaints.

As for recommended treatment, Dr. Adametz stated:

...I think she has a combination of muscle spasms, a right SI joint sprain, and some symptoms, though of radiculopathy, where she is obviously irritating the nerves in some fashion. I went over treatment options with her. She is already on multiple medications and has taken Skelaxin, Celebrex, Tylenol, Ultram and Flexeril, and so I do not think I have much to add to that. Otherwise, I do not think that she is

really bad enough to warrant surgery, and so otherwise, what I have to offer her would be a steroid injection. If I was going to do this, I would do a combination of an epidural to try to get some of the nerve root pain, and an SI joint injection, both under flouroscopy....

The claimant returned to Dr. Adametz on January 10, 2006, after turning wrong and causing a flare-up of pain in her SI joint. Dr. Adametz noted an increase in tenderness on the right side at that time.

The next medical report in the record is dated February 9, 2006, from claimant's initial visit with Dr. Brent Sprinkle of Arkansas Specialty Care Centers. The claimant completed an Initial History Survey at that time in which she described her pain as "back pain, numbness & tingling ® foot." Claimant checked the boxes for pain in the neck, shoulder, buttocks, and leg as well as checking the boxes for pain in the right side only. Dr. Sprinkle examined the claimant and ordered an EMG of the right lower extremity due to the numbness and tingling in the claimant's right leg and foot. After undergoing the EMG claimant returned to Dr. Sprinkle on February 10th where he advised the claimant

that her EMG was normal. Dr. Sprinkle ordered physical therapy and put the claimant on Neurontin. In a follow-up visit on March 3, 2006, Dr. Sprinkle ordered a continuation of therapy and a TENS unit. On the April 10, 2006, visit with Dr. Sprinkle, the claimant advised that the TENS unit had been helpful but that she could not tolerate the Neurontin. For her pain, the claimant was only taking over the counter Tylenol and Ibuprofen. Dr. Sprinkle performed trigger point injections at that time. Dr. Sprinkle recommended that the claimant continue to use the TENS unit permanently and he decreased the claimant's lifting restrictions to only 25 pounds per week, eventually working up to regular duty by increasing her lifting by 10 pounds per week. Finally, Dr. Sprinkle deemed the claimant to have attained maximum medical improvement and released her with a 0% permanent impairment rating.

The claimant hired an attorney and petitioned the Commission for a Change of Physician to Dr. Zachary Mason on November 14, 2006. Claimant's attorney apparently propounded discovery upon respondents on November 24, 2006. When respondents had not responded to the discovery requests by

January 16, 2007, claimant's attorney wrote Pat Hannah with the Medical Cost Containment Division enclosing a Motion to Compel Discovery. As a result, the file was transferred from the Medical Cost Containment Division to the Adjudication Division for action of claimant's motion. Nevertheless, the Medical Cost Containment Division continued to work on the Change of Physician request. As claimant requested a change to a specific physician, arrangements with this physician, Dr. Mason, were being worked out. Correspondence from claimant's attorney accuses respondents of failing to authorize an appointment with Dr. Mason, however, there is no record that the Medical Cost Containment Division ever issued a Change of Physician Order changing the claimant's physician from Dr. Sprinkle to Dr. Mason. Moreover, as noted in the November 12, 2007, letter from claimant's attorney, it appears that Dr. Mason required a referral from Dr. Sprinkle in order to initiate treatment. Again, claimant alleges that respondents failed to obtain this requested referral. There is no record whatsoever of any Change of Physician Order issued by this Commission requiring any action on behalf of respondents to authorize medical

treatment for the claimant, nor is there any evidence that the claimant ever attempted to seek medical treatment for her back and was thwarted in her attempt by respondents. Although the claimant testified that she sought medical treatment from her family physician, she did not present any supporting documentation corroborating this allegation. In fact, there is no credible evidence that during this entire period of time, the claimant ever sought any additional medical treatment for her compensable injury.

The next medical treatment the claimant received was from the emergency room on December 22, 2007, for a sore throat and fever in addition to low back pain radiating down her left leg. The claimant underwent an MRI on January 7, 2008. This diagnostic test revealed:

L4-L5 - There is minimal diffuse degenerative bulge without evidence for neural impingement. Minimal left neural foraminal narrowing is present. There is mild facet hypertrophy.

L5-S1 - There is left paracentral protrusion which contracts and displaces the descending left S1 nerve root. No significant central canal stenosis. Minimal left neural foraminal narrowing is present without evidence for impingement upon exiting left L5 nerve.

There is no marrow edema.

Dr. Aaron M. Spann, read the films and released the radiology report. The following day, Dr. Aaron L. Janos read the previous MRI films dated December 6, 2005 and was able to compare the 2005 films with the new 2008 films. Dr. Janos stated, "The left paracentral disc protrusion at L5-S1 was not present on the prior exam." Dr. Aaron Spann, who read and released the radiology report on January 6, 2008, was also the Releasing Radiologist for the addendum added by Dr. Janos after comparing the two studies.

The claimant was next seen by Dr. Wayne Bruffett with Arkansas Speciality Spine Center, a partner of Dr. Brent Sprinkle. Upon initiating treatment with Dr. Bruffett, the claimant again had to complete an Initial History Survey. This survey completed in 2008, lists only pain in the claimant's back and leg radiating down the left leg. The claimant reported that she had only had these symptoms for two months. The claimant did not associate this new pain with her 2005 compensable injury, but advised that she experience "sudden sharp pains in [left] back and [left]

leg" after bending over. Dr. Bruffett recorded the following history:

Kimberly is referred to me by Linda New, her mom, and by her primary care physician, Dr. Tim Hodges. She complains of pain in her low pack with radiation down her left leg. She had an original work injury back in October of 2005, but during that occurrence she had more right-sided symptoms. She bent over in December to dry her legs off, I believe after getting out of the shower, and she had severe pain in her left leg. The pain is now severe, sharp, burning and rather constant. It seems to be worse with exercise, lying in bed, sitting, coughing and sneezing, and relieved to some degree by ice. She also takes Anaprox and Ultram. She's had Vicodin in the past, but she says it really didn't help much.

Dr. Bruffett examined the claimant and reviewed her MRI studies. Dr. Bruffett diagnosed the claimant with a herniated disc at L5-S1 which he described as "not the biggest disk herniation I've ever seen" and initiated conservative treatment. Dr. Bruffett ordered a selective nerve root block and restricted the claimant to working alternate 12 hour shifts rather than three nights in a row.

It should also be noted that the claimant was released to work and has continued to work full-duty since April of 2006.

With regard to the claimant's pain, the claimant unequivocally testified that after her episode of bending over to dry off, her pain changed. The claimant described her pain at that time as "lightning bolts going down your back and your left leg now." After this episode, the claimant was unable to get comfortable in any way. She even sought chiropractic and acupuncture treatment for her new pain. As the pain was so intense, the claimant ultimately went to the emergency room on December 7, 2007. According to the claimant's medical records and her testimony, the claimant's pain after this bending episode was primarily on her left low back and left leg.

When an employee is determined to have a compensable injury, the employee is entitled to medical and temporary total disability benefits. Ark. Code Ann. § 11-9-102(4)(F)(i)(Supp. 2005). Benefits are not payable for a condition which results from a non-work-related independent intervening cause following a compensable injury which

causes or prolongs disability or need for treatment Ark. Code Ann. § 11-9-102(4)(F)(iii)(Supp. 2005). Whether there is a causal connection between an injury and a disability and whether there is an independent intervening cause are questions of fact for the Commission to determine. Oak Grove Lumber Co. V. Highfill, 62 Ark. App. 42, 968 S.W.2d 637 (1998). Further, there is no independent intervening cause unless the subsequent disability is caused by activity on the part of the claimant that is unreasonable under the circumstances. Davis v. Old Dominion Freight Line, Inc., 341 Ark. 751, 20 S.W.3d 326 (2000). Only when there is a causal connection between the primary injury and the subsequent disability does the question of the claimant's conduct need to be addressed.

In the present claim, the Administrative Law Judge failed to address the issue of causal connection. Based upon our de novo review of the entire record, we find that the claimant failed to prove that her present condition is causally connected to her compensable injury. Therefore, we find that the decision of the Administrative Law Judge must

be reversed and this claim for medical and indemnity benefits denied and dismissed.

In Maverick Transp. V. Buzzard, 69 Ark. App. 128, 10 S.W.3d 467 (2000), the Arkansas Court of Appeals discussed the difference between an aggravation and a recurrence as it relates to workers' compensation law. The Court stated:

An aggravation is a new injury resulting from an independent incident. Farmland Ins. Co. v. DuBois, 54 Ark. App. 141, 923 S.W.2d 883 (1996). A recurrence is not a new injury but merely another period of incapacitation resulting from a previous injury. Atkins Nursing Home v. Gray, 54 Ark. App. 125, 923 S.W.2d 897 (1996). A recurrence exists when the second complication is a natural and probable consequence of a prior injury. Weldon v. Pierce Bros. Constr., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Only where it is found that a second episode has resulted from an independent intervening cause is liability imposed upon the second carrier.

Id. at 130, 10 S.W.3d at 468. An aggravation is a new injury with an independent cause and, therefore, must meet the requirements for a compensable injury. Crudup v. Regal Ware,

Inc., 341 Ark. 804, 20 S.W.3d 900 (2000); Ford v. Chemipulp Process, Inc., 63 Ark. App. 260, 977 S.W.2d 5 (1998).

The test to determine whether a subsequent episode is a recurrence or an aggravation is whether the subsequent episode was a natural and probable result of the first injury or if it was precipitated by an independent intervening cause. Bearden Lumber Co. v. Bond, 7 Ark. App. 65, 644 S.W.2d 321 (1983). If there is a causal connection between the primary and the subsequent disability, there is no independent intervening cause unless the subsequent disability is triggered by activity on the part of the claimant which is unreasonable under the circumstances. Davis v. Old Dominion Freight Line, Inc. 341 Ark. 751, 20 S.W.3d 326 (2000), Georgia-Pacific Corp. v. Carter, 62 Ark. App. 162, 969 S.W.2d 677 (1998), Guidry v. J & R Eads Const. Co., 11 Ark. App. 219, 669 S.W.2d 483 (1984).

A recurrence exists when the second complication is a natural and probable consequence of a prior injury. Aetna Ins. Co. v. Dunlap, 16 Ark. App. 51, 696 S.W.2d 771 (1985). Only where it is found that a second episode has resulted from an independent intervening cause is liability

imposed upon the second carrier. Id. A recurrence is not a new injury but simply another period of incapacitation resulting from a previous injury. Atkins Nursing Home v. Gray, 54 Ark. App. 125, 923 S.W.2d 897 (1996).

In the present claim, the claimant sustained a full back strain primarily affecting her right side. An MRI performed on December 6, 2005, revealed a disc bulge on the left. Dr. Adametz opined that the findings were not compatible with the claimant's clinical findings of right leg pain. Moreover, the EMG ordered by Dr. Spinkle revealed normal findings. After undergoing conservative treatment, the claimant was released to full duty without restrictions and without an impairment rating. The claimant was capable of not only working full time, but of continuing her taekwondo instructions. It was not until after the claimant bent over while drying off, that she experienced a new, sharp, shooting pain, this time going down her back and into her left leg. It is undisputed that this pain was not in the same location as the pain from her compensable injury and that the claimant clearly advised Dr. Bruffett that this new pain was different from the pain from her compensable

injury. When the claimant sought treatment from Dr. Sprinkle in February of 2006, she completed the Initial History Survey describing her pain as on her right side. When she completed a similar Initial History Survey upon seeking treatment from Dr. Bruffett in February of 2008, she described her pain as in her back radiating down her left leg. When the claimant provided a history to Dr. Bruffett she clearly described her compensable injury pain as right sided symptoms but after her bending over episode her pain was now severe, sharp and constant in her left leg. Moreover, a comparison on the 2006 and 2008 MRI's distinctly reveals objective medical evidence of a new injury. The claimant's compensable injury only resulted in a full back strain, with pain into her right leg. The claimant did not have a herniated disc as a result of her compensable injury. It was not until the claimant bent over while at home getting out of the shower that she first developed severe, sharp, shooting pain in her back and into her left leg. A subsequent MRI revealed significant new objective medical evidence of a herniated disc that was not present following her compensable injury. Following this new injury,

Dr. Bruffett diagnosed the claimant with a herniated disc at L5-S1 for the first time. The record fails to support a finding that the claimant sustained this herniated disc as a result of her compensable injury or that this herniated disc is the natural and probable result of her compensable injury.

Based upon the evidence present before the Commission, we find that the claimant has failed to prove by a preponderance of the evidence that her need for medical treatment after December of 2007 was causally related to her 2005 compensable injury.

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. After a de novo review of the record, I find that the preponderance of the evidence shows that the claimant sustained a bilateral lumbar injury in 2005 and that the 2008 incident was a recurrence of the claimant's compensable 2005 injury. Therefore, I must respectfully dissent.

The decision in this case hinges on the medical evidence, and how the claimant's initial injury is characterized. The majority has characterized the claimant's initial injury as "a full back strain primarily affecting her right side." However, I find that as almost every medical report in the medical record shows that the claimant consistently complained of bilateral lumbar back pain, the majority's characterization of the claimant's injury as "primarily affecting her right side" is clearly incorrect. On October 26, 2005, a report from Dr. Adametz indicates: "The pain is located on bilateral upper back, lumbar region and thoracic region." On October 28, 2005, a report from Dr. Adametz again indicates: "The pain is located on right cervical, bilateral thoracic region and lumbar region. On November 18, 2005 another report from Dr. Adametz states:

The pain is located on bilateral thoracic region, lumbar region and both shoulders. The pain is described as aching, burning and throbbing. Pain Intensity Level: 4/10. The pain radiated to both legs.

Interpretation of Dr. Adametz' reports as indicating bilateral lumbar pain, and not just merely bilateral upper back or merely bilateral thoracic pain is correct, as the picture diagrams accompanying the medical reports clearly show marked left side lumbar pain. On November 23, 2005, again complaining of bilateral lumbar pain, the claimant had a trigger point injection in the left lumbar area as it was deemed to be the "area of greatest tenderness." On November 30, 2005, Dr. Adametz report states: "The pain is located on the bilateral lumbosacral region." On December 8, 2005, Dr. Adametz report again indicates that the pain is located on the bilateral lumbar region.

The majority states that the claimant did not report left side lumbar pain to Dr. Sprinkle. Again, a review of the medical record indicates that the majority is incorrect. The diagram accompanying Dr. Sprinkle's initial intake survey clearly shows that the claimant marked the

left lumbar side as an area where she was experiencing pain.

Dr. Sprinkle's report states:

This has been going on since October 26th. She was re-positioning a patient in bed and felt this pain in her back. It is primarily aching and burning. It can be sharp at times. It is moderate to severe. It is worse with standing, walking, lifting, twisting, lying in bed, stairs, sitting, and sneezing. It is improved with heat. She has tried Tylenol, ibuprofen, Celebrex, Skelaxin, Flexeril, and Ultram with minimal response. She had a trigger point injection that helped fairly significantly temporarily. She had some therapy at Concentra. She had some limited core exercise program on the therapy ball. She had x-rays which I have reviewed and an MRI in December of 2005 of the lumbar spine.

Dr. Sprinkle's report, including the diagram, clearly indicates that the claimant reported left side lumbar pain to Dr. Sprinkle. I would also note that the trigger point injection Dr. Sprinkle refers to as helping "fairly significantly" is the left side lumbar trigger point injection given by Dr. Adametz on November 23, 2005. Despite all of the evidence to the contrary, the majority concludes that the claimant only sustained "a full back strain

primarily affecting her right side" and did not complain of left lumbar pain until after the recurrence incident in 2008. The Commission may not arbitrarily disregard medical evidence or the testimony of any witness. Coleman v. Pro. Transportation Inc., ___ Ark. App ___, ___ S.W.3d. ___ (2007). As outlined above, the majority's conclusion that the claimant's 2005 injury primarily affected her right side is simply incorrect.

The majority seems to base its erroneous conclusion on a comparison of two MRI reports. The first MRI report, dated December 6, 2005 states:

FINDINGS: The vertebral bodies are normally aligned without subluxation. There is normal vertebral body and disc height. There is normal homogeneous marrow signal. The conus is visualized at T12/L1. The visualized cord demonstrates no signal abnormalities. L5-S1: There is an asymmetric diffuse disc bulge, greater on the left. There is slight posterior displacement of the left S1 nerve root. There is no neural foraminal or canal stenosis at this level. There is disc dessication. L4-5: An asymmetric diffuse disc bulge is again seen, greater on the left. There is no canal or neural foraminal stenosis. Disc desiccation and degenerative facet disease is seen.

There is disc desiccation at L1-2, L4-5, and L5-S1. There are early and mild degenerative changes seen in the facets at all levels.

Dr. Adametz, in a report dated December 30, 2005, commented on the MRI results:

She had an MRI scan of the lumbar spine and it shows some degenerative disc disease at L4-5 and L5-S1, and some minimal bulges. The worst one is at L5-S1 on the left side. This does not fit well with her symptoms and it is not really very bad.

The second MRI report, dated January 7, 2008 states:

FINDINGS: Lumbar spine shows normal alignment. Conus medullaris appears normal. Degenerative disc desiccation is seen at the L4-L5 and L5-S1 level. L1-L2 through L3-L4 levels are normal. L4-L5- There is minimal diffuse degenerative bulge without evidence for neural impingement. Minimal left neural foraminal narrowing is present. There is mild facet hypertrophy.

L5-S1- There is left paracentral protrusion which contacts and displaces the descending left S1 nerve root. No significant central canal stenosis. Minimal left neural foraminal narrowing is present without evidence for impingement upon exiting left L5 nerve. There is no marrow edema.

IMPRESSION-

Left paracentral protrusion contacting and displacing the descending left S1

nerve root. This likely causes a left S1 radiculopathy. This is best seen on series 6 image 15. Exam is otherwise unremarkable without evidence for neural impingement.

Rather confusingly, as the two MRI reports seem to contain essentially the same findings regarding L5-S1, on January 8, 2008, a notation was added to the second MRI report stating: "Previous MRI of the Lumbar Spine dated 12/6/2005 is now available for comparison. The left paracentral disc protrusion at L5-S1 was not present on the prior exam." While the majority makes much of this notation, characterizing the 2005 MRI report as containing merely a disc bulge and the 2008 report as containing a herniation, I would note that when referring to a disk injury, the terms bulge, herniation, and protrusion can be used interchangeably, usually indicating only a difference of degree, varying by the interpreting doctor, and are actually synonymous terms. The 2005 MRI report showed a disc bulge at L5-S1, objective findings of a left lumbar side injury, as noted by the interpreting radiologist and by Dr. Adametz.

Regarding the claimant's symptoms after the 2008 recurrence incident the majority states:

It was not until after the claimant bent over while drying off, that she experienced a new, sharp, shooting pain, this time going down her back and into her left leg. It is undisputed that this pain was not in the same location as the pain from her compensable injury and that the claimant clearly advised Dr. Bruffett that this new pain was different from the pain from her compensable injury.

However, in addition to the fact discussed above, which is that the claimant did experience pain in the left lumbar area, a review of Dr. Bruffett's report also does not show that the claimant "clearly advised" Dr. Bruffett that this "new" pain was "different." Dr. Bruffett's report actually states:

...She complains of pain in her low back with radiation down her left leg. She had an original work injury back in October of 2005, but during that occurrence she had more right sided symptoms. She bent over in December to dry her legs off, I believe after getting out of the shower, and she had severe pain in her left leg. The pain is now severe, sharp, burning and rather constant. It seems to be worse with exercise, lying in bed, sitting coughing

and sneezing and relieved to some degree by ice. She also takes Anaprox and Ultram. She's had Vicodin in the past, but she says it really didn't help much.

...

Her MRI scan is from Saint Vincent North. It is somewhat haphazardly put together. She appears to have a left-sided paracentral disk herniation at L5-S1, with probable nerve root impingement.

IMPRESSION:

Herniated disk at L5-S1 on the left.

PLAN:

I reviewed things with Kim and her mom. I think she's having pain now from her disk herniation at L5-S1 on the left. This is not the biggest disk herniation I've ever seen. Hopefully, we can get this to calm down nonoperatively. I'm going to have her obtain a selective nerve root block at S1 on the left...

Dr. Bruffett's report of the claimant's symptoms is almost identical to that of Dr. Sprinkle's, which, as noted above, clearly encompassed pain in the left lumbar area. Furthermore, Dr. Bruffett's description of the L5-S1 disk area as "not the biggest disk herniation I've ever seen" is comparable to that of Dr. Adametz, who described it as "not really very bad." It is evident from the reports of Dr. Adametz and Dr. Bruffett that the claimant's injury in 2008 is the same L5-S1 disk area affected in 2005.

In conclusion, the preponderance of the evidence of record shows that the claimant sustained a bilateral lumbar injury in 2005 and that the 2008 incident was a recurrence of the claimant's compensable 2005 injury. The claimant is entitled to reasonably necessary medical treatment and temporary total disability benefits associated with her compensable injury.

For the aforementioned reasons I must respectfully dissent.

PHILIP A. HOOD, Commissioner