NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NOS. F603490, F702502 & F712036

IRIS VARNADOE, EMPLOYEE — CLAIMANT

SMITH BLAIR, INC., EMPLOYER — RESPONDENT

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA C/O ESIS, INC, TPA — RESPONDENT

OPINION FILED JUNE 12, 2009

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

Claimant represented by HONORABLE GREGORY R. GILES, Attorney at Law, Texarkana, Arkansas.

Respondent represented by HONORABLE NELSON SHAW, Attorney at Law, Texarkana, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

The claimant appeals from a decision of the Administrative Law Judge filed September 11, 2008.

The Administrative Law Judge entered the following findings of fact and conclusions of law:

> 1. The Arkansas Workers’ Compensation Commission has jurisdiction of this claim.
>
> 2. The employer/employee/carrier relationship existed at all relevant times.

3. The claimant sustained a compensable back injury on February 26, 2007, and the respondents accepted and paid for medical treatment through the Gabbie Medical Clinic and Dr. Norris Knight associated with this compensable injury.

4. The respondents accepted and paid temporary total disability benefits for the compensable back injury in the amount of $377.00 per week.

5. Pursuant to a Change of Physician request concerning the compensable back injury of February 26, 2007, the claimant's primary treating physician is now Dr. Christopher Mocek pursuant to the Order entered September 18, 2007.

6. The respondents have controverted and refused to pay for any additional medical treatment being recommended by Dr. Mocek following his initial evaluation conducted October 16, 2007.

7. The claimant proved by a preponderance of the evidence that the MRI she underwent was reasonably necessary medical treatment to evaluate the possible need for fusion surgery due to her diagnosed work-related exacerbation of preexisting spondylolisthesis.

8. The claimant has failed to establish that any of the additional treatment or diagnostic testing is reasonably necessary for treatment of her compensable back injury.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the

Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings of fact made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

IT IS SO ORDERED.

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A. WATSON BELL, Chairman

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KAREN H. McKINNEY, Commissioner

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

CONCURRING AND DISSENTING OPINION

I concur with the majority opinion finding that the claimant proved by a preponderance of the evidence that the MRI she underwent was reasonably necessary to evaluate the possible need for fusion surgery due to her diagnosed work-related exacerbation of pre-existing spondylolisthesis.

However, I must respectfully dissent from the majority opinion finding that the claimant failed to establish that any of the additional treatment or diagnostic testing is reasonably necessary for treatment of her compensable back injury.

The majority affirmed and adopted the opinion of the Administrative Law Judge, which placed great significance on Dr. Knight's opinion that the claimant reached maximum medical improvement on May 8, 2007. The opinion credited Dr. Jean's interpretation of the claimant's MRI results over Dr. Mocek's interpretation. The finding was made that, since Dr. Mocek stated that the claimant should avoid surgery and since Dr. Knight placed her at maximum medical improvement without surgery, additional conservative treatment was not reasonable and necessary. Importance was placed on Dr. Mocek's failure to mention the claimant's spondylolisthesis. I dissent from this portion of the majority opinion, as I would award medical benefits to the claimant in the form of the course of treatment recommended by Dr. Mocek.

Under Arkansas workers' compensation law, employers must promptly provide medical services which are

reasonably necessary for treatment of compensable injuries. Ark Code Ann. Sec. 11-9-508(a)(Supp. 2005). Wal-Mart Stores, Inc. v. Brown, 82 Ark. App. 600, 120 S.W.3d 153 (2003). The employer takes the employee as she is found, and circumstances which aggravate preexisting conditions are compensable. Nashville Livestock Commission v. Cox, 302 Ark. 69, 787 S.W. 2d 664 (1990). Injured workers have the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary for treatment of the compensable injury. Norma Beatty v. Ben Pearson, Inc., Full Commission Opinion filed February 17, 1989 (D612291). What constitutes reasonable and necessary medical treatment is a question of fact for the Commission. Wackenhut Corp. v. Jones, 73 Ark. App. 158, 40 S.W.3d 333 (2001). Reasonable and necessary medical services may include those necessary to accurately diagnose the nature and extent of the compensable injury; to reduce or alleviate symptoms resulting from the compensable injury; to maintain the level of healing achieved; or to prevent further deterioration of the damage produced by the compensable injury. Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911 S.W.2d 593 (1995). A claimant does not have to support a continued need for

medical treatment with objective findings. Chamber Door Industries, Inc. v. Graham, 59 Ark. App. 224, 956 S.W.2d 196 (1997). Further, when the primary injury is shown to have arisen out of and in the course of employment, the employer is responsible for any natural consequence that flows from that injury. Wackenhut, supra. The basic test is whether there is causal connection between the two episodes. Id. A causal connection is established when the compensable injury is found to be "a factor" in the resulting need for medical treatment, even though the compensable injury is not the major cause of the disability or need for treatment. Williams v. L&W Janitorial, Inc., 85 Ark. App. 1, 145 S.W.3d 383 (2004).

The claimant injured her back on February 26, 2007, while performing heavy lifting during an all-day inventory project at work. She was first seen by a physician's assistant, Dr. Hebert, in Dr. Gabbie's clinic on February 28, 2007. She was diagnosed with a left sacroiliac strain. On March 15, 2007, the claimant saw Dr. Knight whose impression was spondylolisthesis L5 on S1 with secondary degenerative changes in her lumbar spine, based upon an x-ray. In this case, spondylolisthesis is the

forward displacement of the fifth lumbar vertebra on the sacrum producing pain by compression of nerve roots. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1563 (28th Ed. 1994). His treatment recommendations were conservative, including a hard surface bed, "Nsaids," moist heat, physical therapy with hot packs, ultrasound, cold laser and Williams exercises. On April 4, 2007, Dr. Knight discontinued the Naprosyn as well as physical therapy, after two more treatments, and stated that she needed to choose between living with her symptoms with continued conservative care or spinal fusion surgery.

On May 8, 2007, Dr. Knight again presented her with the same choice:

> Her options are non-operative treatment with OTC Nsaids, moist heat, hard surface bed, Williams exercises and work within the restrictions imposed on her versus spine fusion for spondylolysis and spondylolisthesis. She has not had an MRI. Case manager thinks she will be denied the spine fusion because of pre-existing disease, i.e., spondylolysis and spondylolisthesis. Therefore she will have an MRI on her personal insurance if she decides to proceed with surgery and referral to Dr. Buono. She is at MMI today. Given work release within the limits of a functional capacity evaluation. She thinks she cannot return to work in her regular capacity at this level.

He went on to note that she did have a traumatic exacerbation of her condition at work. Interestingly, Dr.

Knight placed the claimant at maximum medical improvement ("MMI") after recommending continued conservative care or surgery. These recommendations were clearly at odds with the opinion that the claimant was at MMI. The claimant explained that when Dr. Knight asked her if she wanted to schedule the fusion surgery, she replied that she wanted a second opinion first. His response was to tell the case manager that she was released under her current restrictions.

The claimant cannot be at maximum medical improvement if she remains in need of active medical treatment, in the form of conservative care or surgery. Obviously, she has not reached the maximum level of healing, if there are treatment recommendations above and beyond pain management. See Arkansas Highway & Transp. Dept. v. McWilliams, 846 S.W.2d 670, 41 Ark. App. 1 (1993), citing J.A. Riggs Tractor Co. v. Etzkorn, 30 Ark. App. 200, 785 S.W.2d 51 (1990); Mad Butcher. Inc. v. Parker, 4 Ark. App. 124, 628 S.W.2d 582 (1982).

Because Dr. Knight himself recommended a continued course of conservative care or spinal fusion surgery, I disregard his opinion that the claimant reached maximum

medical improvement. His statement regarding maximum medical improvement reflects not his medical opinion so much as his misapprehension of the law in Arkansas.

The claimant, despite having an admittedly compensable back injury, was unable to get continued care, diagnostic or therapeutic, after Dr. Knight's May 8, 2007 visit. She saw her own doctor, Dr. Pappas In June, and he ordered an MRI which was performed on June 27, 2007. The radiologist, Dr. Jean, noted:

> Findings: The vertebral bodies demonstrate normal signal and alignment. Moderate osteophyte formation is present anteriorly at the 03-04 level. Moderate dehydration of all the lumbar disks is noted.
>
> L5-S1: No significant disk bulging or protrusion. Mild to moderate facette hypertrophy.
>
> L4-L5: A small to moderate central disk protrusion is present. This only slightly compresses the thecal sac. The nerve roots do not appear to be compromised.
>
> L3-L4: Mild diffuse posterior disk bulging is present which only minimally compresses the thecal sac.
>
> L2-L3: No significant disk bulging or other abnormality.
>
> T12-L1: Mild posterior disk bulging with no spinal stenosis.
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> Impression:
> 1. Mall central protrusion of the 04-05 disk.

2. Degenerative disk disease and facet arthropathy.

A handwritten note on the report states "can refer if wants for ESI/neurosur/or PT." It appears to be signed "A" which is the first letter of Dr. Jean's first name. The author found those choices to be appropriate responses to the findings in the MRI.

On October 16, 2007, during his new patient evaluation, Dr. Mocek reviewed the MRI as well::

> MRI lumbar spine on 2-27-07 shows a small central protrusion of the L4-5 disc. On review of the films she has a disc protrusion L4-5 and L5, S1 on the lateral view and a HIZ (high intensity zone) in the L5,S1 disc. On image 14 there is a central protrusion of L4-5 disc. On image 17 there is a HIZ left paracentral L5, S1 disc consistent with annular tear.

The majority gave Dr. Jean's report more weight than Dr. Mocek's review of the MRI. There is no indication of Dr. Jean's qualifications or specialties other than the fact that he is a radiologist with Christus St. Michael Imaging Center. Dr. Mocek's practice is limited to spinal medicine and surgery. Both doctors agreed that there was a small central protrusion of the L4-L5 disc. Their opinions diverge at L5-S1, where Dr. Jean observed no "significant" disc bulging, but where Dr. Mocek observed an annular tear.

The difference is that Dr. Mocek interpreted a “high intensity zone” to be an indicator of an annular tear, where Dr. Jean did not address the presence of the high intensity zone at all. This difference is consistent with the fact that Dr. Mocek specializes in spine care. The high intensity zone is a sign on an MRI which is diagnostic for low-back pain. The presence of a high intensity zone correlates significantly with both with the presence of an annular tear and with the reproduction of the patient's pain. The high intensity zone, in one study, had a positive predictive value for a severely disrupted, symptomatic disc of 86%. Aprill, C., & Bogduk, N., High intensity zone: A diagnostic sign of painful lumbar disc on MRI, British Journal of Radiology, 65, 361-369 (1992); See also, M. J. Hancock, C. G. Maher, J. Latimer, M. F. Spindler, J. H. McAuley, M. Laslett, and N. Bogduk, Systematic review of tests to identify the disc, SIJ or facet joint as the source of low back pain., Eur Spine J. 2007 October; 16(10): 1539-1550. Published online 2007 June 14. doi: 10.1007/s00586-007-0391-1. PMCID: PMC2078309 <http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=17566796>.

In light of the significance of the high intensity zone and Dr. Mocek's practice focus on spine care, I find that his interpretation of the MRI to be a more thorough and reliable opinion than Dr. Jean's opinion.

Dr. Mocek did not mention the prior diagnosis of spondylolisthesis, a fact which the majority found to undermine the validity of his opinion. I disagree. First of all, it does not appear that Dr. Mocek had the benefit of all the claimant's medical records. There is no mention of x-ray reports in Dr. Mocek's report. Spondylolisthesis is diagnosed and graded on a lateral x-ray. Grade one, which Dr. Knight assigned to the claimant's condition, is a slippage of twenty-five percent or less and is the mildest of the grades. Medifocus Health, Classification of Slippage in Spondylolisthesis, <http://www.medifocushealth.com/RT015/Introduction-to-Spondylolisthesis_Classification-of-Slippage-in-Spondylolisthesis.php> (Last updated Dec 25, 2008). Secondly, Dr. Mocek focused on the MRI, which offered important evidence of disc disruption at two levels. The claimant's symptoms, which started on the date of her injury, did not improve, but gradually worsened to include radiational pain. This is

consistent with disc bulging and annular tears. While the claimant may have had degenerative changes such as spondylolisthesis, Dr. Mocek also uncovered diagnostic evidence of an annular tear which would explain her pain. Dr. Mocek noted that the disc protrusion at L4-L5 and the annular tear at L5-S1 are consistent with a work-related injury with load to the spine. I find that Dr. Mocek's diagnosis of the claimant's condition is of far more weight than Dr. Knight's or Dr. Jean's.

Dr. Mocek advocated continued conservative therapy and stated that "for now," it was best to avoid surgery. He outlined a treatment plan of increasing aggressiveness. With a diagnosis supported by MRI evidence, Dr. Mocek advocated, first, lumbar epidural steroid injections, and then aggressive physical therapy. He also recommended a daily walking program. If the injections and the therapy were unsuccessful in resolving her pain, Dr. Mocek recommended a lumbar discogram with CT scan to identify the exact disc causing the pain, in order to consider a percutaneous disc procedure. This progressive approach is reasonable and necessary medical treatment of her compensable injury. The surgical treatment proposed by Dr.

Knight is in fact unreasonable, because it was based on very limited x-ray studies which were proven to be insufficient to identify the extent of the claimant's condition by the MRI ordered later by Dr. Pappas. Likewise, Dr. Knight's release of the claimant at maximum medical improvement is irrelevant to the value of Dr. Mocek's opinion, because Dr. Knight recommended continued conservative care or invasive surgery and in the same visit declared her at MMI. She either needed further treatment or she was at MMI. There is no room for both. Further, Dr. Mocek did not state that the claimant is not a surgical candidate. He stated that "for now," aggressive treatment was not the preferred choice, a reasonable approach to a problem that can sometimes be addressed with conservative care.

Dr. Knight's treatment consisted of limited physical therapy and medications, lasting over less than one month. He based his treatment decisions upon one x-ray series and determined approximately three weeks after her first visit to him that she needed to decide whether to continue conservative treatment and live with her pathology or to have a spine fusion, a very aggressive treatment. His treatment of her was unsuccessful and very short-lived. On

the other hand, Dr. Mocek's proposed course of treatment was based upon an MRI, a diagnostic tool which reveals what an x-ray cannot. The import of the fact that Dr. Mocek had not seen the claimant more than once is lessened when one considers that Dr. Knight had seen the claimant only twice before making his recommendation that she could choose spinal fusion surgery. Quality is more important in this case, and Dr. Mocek's reliance on the MRI in his diagnosis and proposed treatment plan is much more reasonable than Dr. Knight's reliance on x-rays.

Dr. Mocek has recommended lumbar epidural steroid injections and physical therapy, as well as a walking program, which are reasonable conservative treatment options. While her prior course of physical therapy was unsuccessful, both Dr. Knight and the therapist were operating under a diagnosis which did not address the true extent of her condition. The combination of injections and therapy is a reasonable and necessary first step in addressing the claimant's compensable injury. Dr. Mocek also recommended, if the injections and therapy did not resolve her pain, a lumbar discogram with post-discogram CT in order to pinpoint the exact disc generating her pain, in

preparation for a possible percutaneous disc procedure. Dr. Mocek's measured plan for conservative treatment is both reasonable and necessary. The treatment is necessary, because the limited treatment the claimant has received was unsuccessful, not because she is doomed to a life of pain, but because her original treating physician, the respondent's doctor, failed to fully and reasonably investigate and treat her injury.

Even if one considered the claimant's pain to arise solely from degenerative changes in her spine, which I do not, the compensable injury she suffered on February 26, 2007 exacerbated her condition such to cause pain where she had none before the accident. She credibly testified, and the medical records support this testimony, that she did not have lower back problems or pain prior to that date. This claim is similar to the claim in <u>Estridge v. Waste Management</u>, 343 Ark. 276, 33 S.W.3d 167(2000). While the claimant does have degenerative problems, the medical records and the claimant's testimony show that the injury at work on February 26, 2007, either caused or precipitated the need for treatment. As in <u>Estridge</u>, "that is clear." <u>Estridge</u>, 343 Ark. <u>at</u> 282.

After my de novo review of the entire record, I concur with the majority that the claimant proved by a preponderance of the evidence that the MRI she underwent was reasonably necessary to evaluate the possible need for fusion surgery due to her diagnosed work-related exacerbation of pre-existing spondylolisthesis. However, I must respectfully dissent with the majority, as I find that the claimant established that additional treatment and diagnostic testing is reasonably necessary for treatment of her compensable back injury, and I would award her additional medical benefits in the form of the proposed course of treatment outlined by Dr. Mocek in his October 16, 2007 report. This claim was controverted, and the claimant's attorney is entitled to attorney's fees for his work. For the foregoing reasons, I must respectfully dissent.

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PHILIP A. HOOD, Commissioner