

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F703426

MIKE ADAMS, EMPLOYEE	CLAIMANT
BEMIS COMPANY, INC., EMPLOYER	RESPONDENT
SEDGWICK CLAIMS MANAGEMENT, INSURANCE CARRIER	RESPONDENT

OPINION FILED MAY 28, 2010

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

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

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

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's
opinion filed November 4, 2009. The administrative law
judge found that the claimant needed continuing medical
treatment with Dr. Qureshi and Dr. Shahim. The
administrative law judge found that the claimant proved he
was entitled to additional temporary disability benefits.
After reviewing the entire record *de novo*, the Full

Commission reverses the administrative law judge's opinion. The Full Commission finds that the claimant did not prove he was entitled to a proposed discectomy. We find that the claimant did not prove he was entitled to additional temporary partial or temporary total disability benefits.

I. HISTORY

Mike Adams, age 46, testified that he began working for Bemis Company in September 1982. Mr. Adams testified that his job title in March 2006 was Maintenance and Millwright. The parties stipulated that the claimant sustained a compensable back injury on March 27, 2006. The claimant testified on direct examination:

Q. On the day that you got hurt, March the 27th, what was your job that day?
What was the job that you were doing at that time?

A. It was still maintenance. We had shut a machine down....My particular job on it was operating the hydraulic press....While we was pushing pins out I was replacing the bearings....I was sitting on like a chair in between a bar stool and an office chair....It kind of put you slumped over in a awkward position. It was too high for the job. I had done the job before, but never sat in that particular chair to do that job....

Q. At some point in time that day, the 27th, did your back begin to bother you?

A. Yes....

Q. And what were the symptoms that you began to experience?

A. A burning in my low back and in my butt....

The parties stipulated that medical expenses were paid beginning April 3, 2006. Dr. Robert Garcia saw the claimant on April 3, 2006 and diagnosed lower back pain. A Form AR-3, Physician's Report dated April 3, 2006 indicated that the claimant was placed on light duty for one week. The claimant continued follow-up visits with Dr. Garcia.

An MRI of the claimant's lumbar spine was done on May 1, 2006, with the following impression:

1. There is a small central disc protrusion of L2-L3 mild-to-moderately narrowing the central canal associated with facet degeneration.
2. There is annular disc bulging and fissuring at L4-L5 mildly narrowing the central canal with mild-to-moderate bilateral foraminal narrowing.
3. There is a small central disc extrusion of L5-S1 narrowing the central canal and neural foramen associated with facet degeneration, as noted.

Dr. Darin K. Wilbourn, a physical medicine specialist, treated the claimant beginning June 6, 2006:

Mr. Adams is a 42-year-old white male who says that he was performing his usual work duties at Bemis Bag Company on March 27, 2006 when he says he injured his lower back. He says that on that date, he was seated on a barstool that he felt was too high to perform his job running a press machine. He tells me that he had to stoop, snatch and jerk for twelve hours that day while running the press. He says that he has to perform this

particular job once a year. He says that during that particular day, he began to experience lower back pain. He says that he continued to work and completed his shift. He says that the next morning he could hardly get out of bed secondary to increased low back pain....The MRI was done on May 1, 2006. This MRI does show a small central disc protrusion at L2-3, annular disc bulge at L4-5 and small central disc herniation at L5-S1....Currently, he says that he is experiencing pain in the center of his lower back with occasional pain down the posterior aspect of his right leg to his knee. He says that the pain is worse when he coughs, sneezes and/or bends forward. He says that he is on light duty with no stooping, lifting, pushing or pulling per Dr. Garcia....

IMPRESSION:

1. 42-year-old white male with low back pain.
2. Small central disc herniation at L2-3 and L5-S1.
3. Annular disc bulge at L4-5.

Dr. Wilbourn spoke with the claimant about treatment options "including physical therapy, oral medications, epidural steroid injections and surgical intervention....I told him that since he had a good response to the oral steroids (dose packs) while he was taking them, he would more than likely benefit from an epidural steroid injection as well as physical therapy." Dr. Wilbourn stated, "3. Concerning his work status, he is able to return to work on light duty with no lifting, pushing or pulling over five

pounds. He should also be allowed to be seated while working and change positions at will."

Dr. Wilbourn performed an epidural steroid injection on June 27, 2006. Dr. Wilbourn noted on July 11, 2006, "On my last evaluation of Mr. Adams, I performed an L5-S1 epidural steroid injection under fluoroscopic guidance....He says that the injection did not help at all to relieve his pain. He continues to complain of pain in his lower back without significant change." Dr. Wilbourn's impression was "1. 42-year-old male with low back pain. 2. Small central disc herniations at L2-3 and L5-S1. 3. Annular disc bulge at L4-5." Dr. Wilbourn indicated that the claimant did not wish to proceed with a second epidural steroid injection. Dr. Wilbourn planned referral for a Functional Capacity Evaluation and stated, "3. Concerning his work status, he is to return to work as of today with the restrictions as before."

The claimant participated in a Functional Capacity Evaluation on July 25, 2006:

The results of this evaluation suggest that Mr. Adams gave an unreliable effort, with 40 of 55 consistency measures within expected limits. Mr. Adams put forth inconsistent effort throughout the evaluation process and demonstrates numerous indicators of self-limiting behavior....

Mr. Adams' true functional limitations remain unknown but did not demonstrate the ability to material handle over 10 lbs. bimanually or over 30 lbs. with each UE.

CONCLUSIONS

Mr. Adams underwent a functional capacity evaluation this date with unreliable results for effort. Mr. Adams put forth self-limiting behavior and inconsistent effort. Overall, Mr. Adams demonstrates the ability to work at least at the LIGHT Physical Demand Classification as determined through the Department of Labor for an 8-hour day....

Dr. Wilbourn noted on August 9, 2006, "I would like to refer Mr. Adams to a neurosurgeon for a surgical evaluation as soon as possible....Concerning his work status, he is to return to work as of today with limited lifting, pushing, or pulling over 10 pounds and allowed to be seated as before."

A neurological surgeon, Dr. Eric D. Akin, examined the claimant on August 29, 2006 and diagnosed the following: "1. Lumbar degenerative disease. 2. Lumbar sprain....I have reviewed the MRI of the lumbar spine. I do not see any immediate surgical history here. As his pain is only three months old, I think we should continue with more conservative measures for now. I would like to refer him to Dr. Qureshi for consideration of facet rhizotomy. We will discuss this with his case manager. The patient is in agreement with the current plan." Dr. Akin also indicated,

"Continue current work restrictions until seen back on September 20, 2006."

Dr. Amir M. Qureshi, a pain management and rehabilitation specialist, saw the claimant on September 21, 2006 and reported, "The patient is a 42 year old white male who has been referred to me through my partner, Dr. Eric Akin, with complaints of back pain for the last three months. The pain actually started while he was working on a press stool which was higher than when he usually worked at, and since then he has been having this pain....His MRI report does show a small central disc extrusion at L5-S1 with central canal stenosis and facet degeneration. There is also a small disc protrusion at L2-3 and an annular disc bulge at the L4-5 level." Dr. Qureshi's impression was "1. Lumbar degenerative disc disease. 2. Lumbar spondylosis with facet arthropathy....In my opinion the majority of his pain is coming from his facet area, for which I will go ahead and do the right lumbar medial branch blocks. Then we will consider doing the left lumbar medial branch blocks in the future. If the medial branch blocks are successful, we will go ahead and do the rhizotomy....I will see him back after the right lumbar medial branch blocks."

Dr. Qureshi performed a surgical procedure on October 31, 2006: "1. Right L3, L4, L5, and S1 medial branch block. 2. Fluoroscopy with interpretation." The pre- and post-operative diagnosis was "1. Lumbar spondylosis. 2. Rule out facet syndrome."

The claimant testified that he did not benefit from the medial branch block.

Dr. Qureshi noted on November 9, 2006, "The patient returns status post a medial branch block which was done on October 31, 2006. According to the patient it helped him some, but initially he had quite a bit of pain, and then in about 2-3 days the pain started to ease up....He still has the pain in the dead center of his lower spine and across his lower spine area....At this time I believe with regard to the medial branch blocks that since he did not get immediate improvement, I am not sure whether it is the right thing at this time to go for the radiofrequency nerve ablation, but rather I would like to do a discogram to just see if one of his discs is what is bothering him." Dr. Qureshi's impression was "1. Discogenic pain. 2. Lumbar degenerative disc disease. 3. Lumbar spondylosis with facet arthropathy."

Dr. Qureshi performed a procedure on December 18, 2006: "1. Discogram for L3-L4, L4-L5, and attempt at L5-S1 lumbar discogram. 2. Fluoroscopy with interpretation....This is a positive discogram for L4-L5 disc with extravasation, but L5-S1 could not be assessed, as it was too narrow to get the needle in." A CT of the claimant's lumbar spine was also done on December 18, 2006, with the impression, "Findings of complete intradiscal disruption with small epidural leak at the L4-5 level. This intradiscal disruption is posterior and central and is seen in conjunction with the disc bulge and does not cause significant mass effect on the spinal canal or neural foramina."

Dr. Akin's diagnosis on January 3, 2007 was "1. Lumbar discogenic back pain. 2. Lumbar sprain....I think we should proceed at this point with physical therapy as he has not had this yet. We may ultimately need to consider a lumbar fusion at L4-5 if he fails to improve as he has had pain for over six months which has not improved with anti-inflammatory medications and steroid injections."

The record indicates that the claimant received a course of physical therapy beginning January 22, 2007. Dr. Akin noted on February 28, 2007:

The patient returns today continuing to complain of low back pain. He has not seen any improvement at this point with nerve blocks, lumbar epidural steroid injections, anti-inflammatory medications and physical therapy. The pain is primarily confined to the lower lumbar area. He has had a positive discogram previously at the L4-5 level. L5-S1 could not be assessed in the discogram.

He has had a Functional Capacity Evaluation which showed only 40 out of 55 tests to be within expected parameters, therefore, giving him an unreliable effort. He states, however, that he was not encouraged to give his best effort during the exam. Given this, I think it is reasonable to have him repeat the Functional Capacity Evaluation to determine his true limitations. If he is limited I think that it may increase the likelihood of improvement with a fusion. The problem is determining whether or not discogenic pain is due to an on-the-job injury. My understanding (sic) of this is that there is no single attributable event for the pain. The patient apparently just reported his back pain at the end of a work day. This brings into question whether or not this is truly an on-the-job injury or more of a manifestation of degenerative disc disease. We will follow-up with him after his repeat FCE.

The claimant participated in another Functional Capacity Evaluation, with a different evaluator, on March 14, 2007:

The results of this evaluation indicate that Mr. Adams gave an unreliable effort, with 45 of 56 consistency measures within expected limits.... Mr. Adams did not demonstrate the ability to material handle more than 10 Lbs. from floor to knuckle level or more than 30 Lbs. from the knuckle to shoulder level. Mr. Adams demonstrates improved AROM as compared to a previous FCE dated

7-25-06 and a normal grip. The remainder of his functional abilities were very similar as compared to a previous FCE results (sic). Mr. Adams does demonstrate self-limiting behavior so his true functional limitations remain unknown... Overall, Mr. Adams demonstrated the ability to perform work at least at the Light Physical Demand Classification as determined through the U.S. Department of Labor over the course of a normal workday....

Dr. Akin noted on March 26, 2007:

The patient has had a second Functional Capacity Evaluation, the most recent dated March 19, 2007. He has apparently given an unreliable effort with 45 of 56 consistency measures within expected limits. During this exam he demonstrated self limiting behavior. He is deemed able to work at least at the "light" physical demand classification per definition by Functional Testing Centers, Inc. In light of these findings I think his chances of improvement with any further surgical intervention would statistically be very low. I will also (sic) him to return to work at this time. He is now at maximum medical improvement. He receives a Disability rating of 7% per the Guides to the Evaluation of Permanent Impairment, 4th Edition.

The record indicates that the respondents paid benefits for a permanent anatomical impairment rating beginning March 26, 2007.

Dr. Ronald N. Williams, a neurosurgeon, saw the claimant on April 11, 2007 and noted that the claimant was working at light duty. Dr. Williams noted, "It is possible that he might benefit from a lumbar fusion. I am going to

get Dr. Wayne Bruffett, one of the orthopedic spine surgeons, to give us an opinion about that." Dr. Williams signed a note on April 24, 2007 which indicated, "Advised to remain off work until further notice."

The parties stipulated that temporary total disability benefits were paid beginning April 24, 2007. The respondents also continued to pay benefits for a permanent anatomical impairment rating until April 29, 2007.

Dr. T. Glenn Pait saw the claimant at UAMS Neurosurgery Clinic on July 10, 2007. Dr. Pait's recommendations included a repeat MRI.

Dr. Scott M. Schlesinger corresponded with the respondent-carrier on August 13, 2007:

Thank you for asking me to see Mike Adams in neurosurgical consultation. He has previously seen a number of other neurosurgeons including my retired partner, Dr. Ron Williams. He was discharged from our care, but now comes back at your request for neurosurgical re-consultation because of onset now of leg pain....
MRI of the lumbar spine shows a small disc protrusion at L2-3 and L5-S1 on the right.
Plain x-rays show mild degenerative changes.
Impression/Plan/Discussion: I would like to go ahead and get a myelogram/CT scan of the lumbar spine to make sure there is no evidence of neural compression. I would also like some EMG and nerve conduction tests to see if there is any evidence of radiculopathy. Lastly, I will get an orthopedic evaluation of his tender right heel....

An MRI of the claimant's lumbar spine was done on August 13, 2007, with the following conclusion:

1. L2-L3 bilobed paracentral disc protrusion more pronounced rightward than leftward, mildly encroaching on right descending L3 nerve root in the right lateral recess. Right L3 is posteriorly displaced but not frankly swollen. This may contribute to right-sided radiculopathic pain syndrome.
2. L5-S1 shallow subligamentous right lateral recess disc protrusion abutting descending right S1 nerve root. No nerve root swelling or displacement. Right paracentral annular tear is present.
3. Mild SI joint hypertrophic spurs bilaterally.

The record indicates that the claimant had an accident while sitting on a trailer at home in August 2007. The claimant testified, "I shattered my left heel in a reflex, I mean, wasp. I got in a wasp nest....I had a face full of wasps. And I fell off the trailer....I shattered that left foot, or heel. The heel bone." A CT scan of the claimant's left ankle on August 24, 2007 showed "Severely comminuted fracture of the calcaneus with fracture fragments at the articulation of the talus and calcaneus, but no evidence of fragments at the calcaneal tarsal articulations...." The claimant testified that the nonwork-related injury to his left lower extremity did not affect the condition of his

back. Dr. Ruth L. Thomas diagnosed "1. Comminuted fracture of the left calcaneus" on September 5, 2007.

Dr. Brad A. Thomas, a neurosurgeon, performed a surgical procedure for the claimant's back on October 4, 2007: "Lumbar tap at L2-3 with injection of Omnipaque dye for lumbar myelogram." The pre- and post-operative diagnosis was "Lower back pain with right leg pain in the S1 distribution."

A CT of the lumbar spine was done on October 4, 2007, with the impression, "At the L2-L3 level there is evidence for a small right paracentral disc herniation. This does appear to cause impingement on the right L3 root. Mild facetar degenerative change is present at the L5-S1 level."

Dr. Brad A. Thomas reported on October 9, 2007:

Mr. Adams presents today for follow-up after a recent myelogram. He has been seen by both Dr. Williams and Dr. Schlesinger in the past. He had a work-related injury where he hurt his lower back, back in the spring of 2007. Since that time, he has continued to have lower back pain. Initially, when he saw Dr. Schlesinger in August of 2007, he also had a right leg reactive airway disease in an S1 distribution. Dr. Schlesinger set him up for a myelogram followed by recommending EMG and nerve conduction studies of his leg. He presents today for a follow-up of his myelogram which was done last week. Her (sic) reports that his leg pain has stopped over the last two months and he has not really had this.

He does report that he continues to have lower back pain....

He has his left foot in a brace/cast. He reports that he broke this while running from some stinging wasps, and fell and hurt his leg severely. He does walk on crutches.

Imaging Studies: I reviewed the CT myelogram and the plain myelogram. There does not appear to be any significant disc herniations, especially at the L5-S1 space. There is a small disc herniation at the L2-3 space that is eccentric to the right. There is no focal stenosis as well.

Dr. Thomas' assessment was "A patient with chronic back pain after a work-related injury. He does not have any evidence of stenosis that would require neurosurgical decompression. I recommended him following up with Dr. Burba to have EMG and nerve conduction studies of his right lower extremity."

Dr. Lon Burba corresponded with Dr. Schlesinger on October 24, 2007:

Thank you for referring this nice gentleman for a one extremity EMG/nerve conduction test on the right lower extremity. As you know, he is the gentleman who is having radicular pain in the right buttock and numbness and pain in the right heel. He has so much pain he cannot rest his heel on the truck. His limited EMG/nerve conduction test was basically normal with some mild denervation in the tibialis anterior on the right which does not correlate with his MRIs or his history. I suspect he is compensating using the tibialis anterior trying to avoid contact with the heel causing the changes we are seeing on the EMG. I see no denervation coming out of the lumbosacral spine.

Unfortunately, we were unable to get approval for a neurology consult or neurology management from the Worker's Compensation carrier. We were unable to get approval to expand the test to involve the other extremities. I suspect he may have the forme fruste of a neuropathy causing his pain. I doubt that anything coming out of the lower back is causing his symptoms....

Dr. Brad A. Thomas corresponded with the respondent-carrier on October 30, 2007:

Mr. Adams presents today after a recent EMG done by Dr. Burba. This EMG showed a normal EMG/nerve conduction test in the one extremity on the right lower extremity. It did show some very mild denervation of the tibialis anterior which does not correlate with the patient's symptoms or his MRI. Dr. Burba apparently had recommended testing the opposite leg; however, approval from Workman's Comp was not approved. Mr. Adams presents today and reports that his back and radicular pain is actually improved; however, he continues to have pain in his right heel, especially when he inverts and extends his foot....

I did review his MRI again and he does have a small disc bulge at L2-3 without any significant neural compression. He does not have any significant neural compression at L5-S1.

Dr. Thomas' assessment was "Patient with chronic back pain and now more of a neuropathic pain in his right heel. I have given him a prescription for Neurontin and informed him to start this slowly and increase it over a week's period. I have also informed him that I do not feel like there was any more I could offer him at this time. If he

continues to have this neuropathic pain, I would recommend him returning to his primary care physician."

The parties stipulated that medical expenses were paid until November 1, 2007. The claimant testified, however, that he was suffering from the "same symptoms" in his back: "Low back pain, and butt pain, leg pain. Any forward motion, reaching forward pain."

Dr. Brad A. Thomas corresponded with a claims examiner on November 23, 2007:

This letter is to address the following questions that you had.

Question #1 was date of maximum medical improvement. I am placing this date at November 1, 2007.

Question #2 is a two-part question. Part A is: Is the neuropathic pain in the right heel related to the herniated disc? Part B is: If not, then would it be considered part of his Worker's Compensation claim? My response to this question is: At this time, it is difficult for me to make a claim that the neuropathic pain is related to the herniated disc. The last several imaging studies have not shown any significant disc herniations at L5-S1 that would correlate with a radicular symptom down into his left heel. It is possible that he has had a herniated disc in the past and, because of that, he has had some residual numbness in his right heel. If this has happened, then the disc herniation has reduced in size without surgical procedure, which certainly cannot happen. It is my personal and professional opinion that at this time it is difficult for me to determine with any

certainty whether this neuropathic pain is related to his herniated disc. I would comment that if it is determined that the neuropathic pain is not related, then at that point it certainly would be reasonable to not consider this part of his Worker's Compensation claim.

Question #3 is: Please give specific work restrictions and advise if they are permanent in nature. At this time, I would give him work restrictions based on two factors. First of all, his left foot was in a brace, but also he has significant numbness in his right heel. Because of this, I would put him on no work at this time until his left foot is out of a brace, which I am not the treating physician for. In regards to the work restrictions for the numbness in his right heel, I believe that he should be able to return to work with this once his left foot is cleared from the treating physician for this.

Question #4 addressed the permanent partial impairment rating in accordance with the 4th Edition AMA Guidelines to Permanent Impairment. Because of the numbness, I would give this a permanent partial impairment rating of 5%.

The parties stipulated that temporary total disability benefits were paid until December 31, 2007.

Dr. Ruth L. Thomas's impression on January 9, 2008 was "Healing of the comminuted calcaneal fractures."

Dr. Brad A. Thomas stated on January 27, 2008, "Are there any permanent work restrictions for the herniated disk? At this time, I would say the answer to this questions (sic) is 'no.' There are not any permanent work restrictions. The only herniated disk that was seen in the

last several imaging studies was done at L2-3. This does not correlate with the problems he has been having in his right leg."

The claimant agreed at hearing that he was released by Dr. Ruth L. Thomas, the physician who performed surgery on his left heel, on April 16, 2008. Dr. Ruth Thomas noted, "He still has some discomfort, but he feels he can return to his previous level of work. Accordingly, I am discharging him from clinic to return on an as-needed basis, and I am also releasing him to full work duties with no restrictions."

The claimant testified that he returned to work on or about April 18, 2008, but "I worked about two hours and then work sent me home."

Dr. P.B. Simpson, Jr., a neurosurgeon, examined the claimant on May 7, 2008 and noted in part, "This gentleman hurt himself in April 2006 working at a bag mill in Crossett....He has had back pain....I reviewed an MRI done in Aug 2007. This showed he had a little central disk bulging at 2-3, certainly no evidence of anything significant. I never saw anything surgical on this study. He mainly complains of pain in his back. He has burning

pain in his R foot at times." Dr. Simpson's impression was "I think basically he has a chronic pain problem....I am not going to be able to do anything about this. I have suggested he try at TENS unit. I have given him a prescription for that. He can wear it for 1 mo, rent it and see if it helps him. I doubt very seriously if anything surgically could be done to alleviate his symptoms."

Dr. Benjamin J. Walsh, a family practitioner, corresponded with the claims examiner on May 20, 2008:

Mr. Mike Adams was seen in our office on 5/13/2008 for a return to work physical. His job duties as relayed to me include heavy lifting, walking on concrete and standing for long periods of time. I have taken a history and performed a physical exam, and I have reviewed only a portion of his extensive medical record. It appears he has seen at least eight (8) neurosurgeons and neurologists in reference to his back injury. I will have to yield to the opinion of his treating neurosurgeon, Dr. Brad A. Thomas, regarding work limitations concerning his back, as he has done a full work up over several months and I am seeing the patient for the first time. As you know, Dr. Thomas stated in his letter 1/27/2008 that the patient had no permanent work restriction regarding his back. I found no other disqualifying factors on his exam to prevent his return to work, and as stated, I am yielding to Dr. Thomas's opinion regarding his back....

The claimant testified that he returned to a "regular full-duty job" after the release from Dr. Walsh. The claimant testified that returned to full-duty work resulted

in "low back pain, leg pain, butt pain. All the way to my ankle. Couldn't hardly drive my truck, couldn't stand to sit, walk, lift. The more I stood on concrete, the more I made. The worse it hurt the next day or that night."

Judy Rogers, a Family Nurse Practitioner at Louisiana Pain Care, examined the claimant on July 8, 2008 and gave the following impression:

1. Low back pain with right lower extremity radicular type complaints.
2. MRI evidence of intervertebral disc disease and small central disc extrusion of L5-S1 narrowing the central canal and neuroforamina associated with facet degeneration, annular bulging and fissuring at L4-5, and small disc protrusion at L2-3 with mild to moderate narrowing of the central canal.
3. Status post work related injury on 03/27/2006.

Treatment recommendations included increasing the medication dosages and administering lumbar steroid injections. The claimant testified that he did not receive any additional steroid injections.

The record indicates that Dr. Mark J. Malloy, an internal medicine specialist, took the claimant off work beginning August 12, 2008. The claimant testified that he did not return to work after August 12, 2008.

Dr. Qureshi examined the claimant on September 5, 2008 and gave the following impression: "1. Lumbar discogenic

pain. 2. Lumbar degenerative disc disease. PLAN: I have spoken in length with the patient. At this time I will go ahead and order a new MRI since the last one we have is more than six months old. I will refer him to Dr. Shahim, who is one of my partners and see if he would possibly go ahead and do a fusion on him....He will remain off of work until he sees Dr. Shahim. I will give him about one month off. I want him to stay off concrete, since that helps him. Dr. Shahim will take over his care. If he would like me to see him back again, I will be more than glad to see him." Dr. Qureshi basically took the claimant off work beginning September 5, 2008.

Dr. Malloy corresponded with the respondent-employer's human resources manager on December 17, 2008: "I have seen Mr. Adams on one occasion on August 12, 2008. I reviewed all of his records from numerous physicians. I have reviewed their finding (sic) and their recommendations. When I saw him he has (sic) tenderness on the L5S1 midline ligament. He also had spasm on the L3-L5 spinous muscles. He did not give me a specific episode at work that caused this particular episode. I thought he might benefit from a pain clinic referral. As far as this visit is concerned,

this appears to be the standard back pain that is the most common symptom for primary care physicians in America. I cannot relate this to any work related injury."

Dr. Reza Shahim, a neurosurgeon, corresponded with the claimant's attorney on December 18, 2008:

I saw Mr. Adams in consultation with Dr. Qureshi. I did review his MRI from August 2007, which showed an annular tear at L4-5. There is also discography from 2006 which is positive at L4-5. The patient gives me a brief history of having chronic pain, going back to work injury. He was released back to work but was unable to work. He has back, hip and leg pain that is worsening. He has been wanting to have other treatment, but the Worker's Comp has not authorized a review. Based on his prior imaging studies and his current symptoms of radiculopathy on the right side, I would recommend a repeat MR of the lumbar spine. He may benefit from repeat epidural steroid injections. I think he has symptoms related to an annular tear at L4-5 and these may be surgeries that he may benefit from, but he would need to have new imaging studies to better assess that. I will be glad to re-evaluate him if Worker's Comp authorizes that.

An MRI of the claimant's lumbar spine was done on February 19, 2009, with the following impression:

Suspect a remote/chronic protrusion paracentral to the right at L5-S1. This may contribute to impingement of the right S1 nerve root. Correlation with the clinical assessment is essential.

ADDENDUM:

There is a report from a study performed at ProScan Imaging of Arkansas 8/13/2007. According to this prior report there is no significant

interval change. Annular tears are present at L4-L5 and L5-S1. Small tear in the annulus at L2-L3.

Dr. Qureshi reported on April 10, 2009:

This is in reference to Mike Adams who has been seen by me since August 29, 2006 for low back pain. We have recently seen him in the clinic again for his complaints of low back pain. I have done a lumbar discogram which showed concordant pain at the L4-L5 level. He recently had a new MRI which reveal (sic) chronic protrusion paracentral to the right at L5-S1 level, which may contribute to impingement of the right S1 nerve root, also present is an annular tear in the posterior margin of the disc at the L4-L5 level. These findings correspond to his right leg pain as it is the right side per the MRI. His pain radiates down to his foot. Based on his symptoms and MRI findings, I believe he is a possible surgical candidate and he needs to be followed up by Dr. Reza Shahim. We would like for Worker's Compensation to reconsider his case and have the patient seen by Dr. Reza Shahim....

Dr. Qureshi's impression on April 15, 2009 was "Lumbar degenerative disc disease. Lumbar strain." Dr. Qureshi kept the claimant off work.

Dr. Warren D. Long, Jr., a neurological surgeon, performed an Independent Medical Examination and corresponded with the claimant's attorney on May 13, 2009:

IMPRESSION: After reviewing the latest MRI, I think this gentleman has a defect at L5-S1 on the right involving the S1 nerve root. He does have limitation of motion with pain on hyperextension and flexion but he has no subluxation, he only has facet hypertrophy.

RECOMMENDATION: In answering the questions, I totally agree that Dr. Malloy took him off of work and I believe the time frame off of work is appropriate. He still remains in his healing period and I frankly recommend that he never go back to the previous job based on his situation with his back. In other words, I think after reviewing his job, I do not think that he do (sic) that job any longer. I think he still remains in a healing period and I think based on what we see, he needs to go with the recommendation of his treating physicians. I will say that the fractured calcaneus on the left heel is very debilitating and this also causes a problem with him standing for any length of time, along with his back. Based on the review of all medical records and films, I definitely think he should return [to] the neurosurgery group of Shahim and Qureshi in Little Rock. I definitely think he needs a discectomy.

A pre-hearing order was filed on May 27, 2009. The claimant contended, "he remains symptomatic and in need of continuing medical treatment. He seeks payment of medical expenses, temporary total disability benefits from August 12, 2008 to a date yet to be determined at a compensation rate of \$488.00 and temporary partial disability benefits from ___ to ___ at a compensation rate of ___ along with anatomical impairment of 7% to the body as a whole and attorney's fees."

The respondents contended, "all appropriate benefits have been paid. Furthermore, in the event of an award, the respondents seek a credit of ___ for an overpayment and an

offset pursuant to Ark. Code Ann. §11-9-411 against benefits paid by third parties. The respondents also contend that further medical treatment is unreasonable, unnecessary and unrelated to the compensable injury. The claimant suffers from a preexisting condition. The respondents further contend that the claimant is not entitled to temporary total disability benefits as the employer made work available to the claimant after his release."

The parties agreed to litigate the following issues: "Additional medical treatment; additional temporary total disability benefits; temporary partial disability benefits; anatomical impairment; attorney's fees."

A hearing was held on August 6, 2009. At that time, the claimant contended that he was entitled to temporary partial disability benefits from June 9, 2008 until August 11, 2008. The claimant reserved the issues of permanent anatomical impairment and wage-loss disability.

An administrative law judge filed an opinion on November 4, 2009. The administrative law judge found, in pertinent part:

2. The claimant has proven by a preponderance of the evidence that he remains symptomatic from the compensable injury and is in need of continuing medical treatment with Drs. Qureshi and Shahim.

This treatment is reasonable and necessary in relation to the compensable injury....

4. The respondents are directed to pay temporary partial disability benefits from June 9, 2008, to August 11, 2008, at a compensation rate of \$106.00. The respondents are directed to pay temporary total disability benefits from August 12, 2008, to a date yet to be determined as the claimant remains in his healing period unable to work. This award is subject to the respondents' credit of \$7,873.00, and the child support lien.

The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a) (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). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In the present matter, an administrative law judge found that continuing medical treatment with Dr. Qureshi and Dr. Shahim was reasonably necessary in connection with the

compensable injury. The Full Commission does not affirm this finding. The claimant sustained a compensable back injury on March 27, 2006, and the respondents paid medical expenses beginning April 3, 2006. Diagnostic testing beginning May 1, 2006 has shown abnormalities in the claimant's lumbar spine. The claimant was provided medication, an epidural steroid injection, and physical therapy. Dr. Akin treated the claimant in August 2006 and diagnosed lumbar degenerative disease and lumbar sprain. Following two functional capacity evaluations, in which the claimant's effort was unreliable, Dr. Akin pronounced maximum medical improvement on March 26, 2007, nearly one year after the claimant's compensable lumbar sprain.

On appeal, the claimant contends that the consensus of medical opinion is that he is a candidate for discectomy. Yet the record shows that three examining physicians, Dr. Akin, Dr. Brad Thomas, and Dr. Simpson, have determined that surgery was not reasonably necessary in connection with the compensable injury. Dr. Akin opined in March 2007, after the second Functional Capacity Evaluation, "I think his chances of improvement with any further surgical intervention would statistically be very low." Dr. Brad

Thomas opined in October 2007, "He does not have any evidence of stenosis that would require neurosurgical intervention." Dr. Simpson reported in May 2008, "I doubt very seriously if anything surgically could be done to alleviate his symptoms."

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). In the present matter, the Full Commission finds that the opinions of Dr. Akin, Dr. Thomas, and Dr. Simpson are entitled to more evidentiary weight than the opinions of Dr. Qureshi, Dr. Shahim, and Dr. Long. The claimant did not demonstrate that a possible discectomy would be reasonably necessary in connection with the lumbar strain he sustained on March 27, 2006. Nor does the evidence demonstrate that lumbar discectomy would benefit the claimant physically or reduce his complaints of pain. The Full Commission therefore reverses the administrative law judge's award of continued treatment with Dr. Qureshi and Dr. Shahim.

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). The healing period ends when the employee is as far restored as the permanent character of his injury will permit. *Carroll Gen. Hosp. v. Green*, 54 Ark. App. 102, 923 S.W.2d 878 (1996). The determination of when the healing period has ended is a question of fact. *Id.*

In the present matter, an administrative law judge directed the respondents to pay temporary partial disability benefits beginning June 9, 2008, and to pay temporary total disability benefits beginning August 12, 2008 and continuing until a date yet to be determined. The administrative law judge found that the claimant "remains in his healing period unable to work." The Full Commission does not affirm this finding. The parties stipulated that the claimant sustained a compensable back injury on March 27, 2006. The claimant was placed on temporary light duty beginning April 3, 2006. Dr. Wilbourn reported in June 2006 that the claimant was able to return to work at light duty. A Functional Capacity

Evaluation on July 25, 2006 showed that the claimant was able to perform at least light physical work. Dr. Wilbourn returned the claimant to restricted work on August 9, 2006.

Dr. Akin diagnosed lumbar degenerative disease and lumbar sprain on August 29, 2006. Dr. Akin continued the claimant's work restrictions. A Functional Capacity Evaluation on March 14, 2007 showed that the claimant was able to perform at least light physical work. Dr. Akin pronounced maximum medical improvement and returned the claimant to work on March 26, 2007. Dr. Akin assigned a permanent impairment rating. Nevertheless, Dr. Ronald Williams took the claimant off work on April 24, 2007 and the respondents began paying temporary total disability benefits.

Dr. Brad Thomas opined on November 23, 2007 that the claimant reached maximum medical improvement as of November 1, 2007. Dr. Thomas assigned a permanent partial impairment rating. The respondents paid temporary total disability benefits until December 31, 2007. Permanent impairment, which is usually a medical condition, is any permanent functional or anatomical loss remaining after the healing period has been reached. *Ouachita Marine v. Morrison*, 246

Ark. 882, 440 S.W.2d 216 (1969). The Full Commission attaches significant probative weight to Dr. Thomas' determination that the claimant reached maximum medical improvement as of November 1, 2007. The persistence of pain may not of itself prevent a finding that the healing period is over, provided that the underlying condition has stabilized. *Mad Butcher, Inc. v. Parker*, 4 Ark. App. 124, 628 S.W.2d 582 (1982). We find that the claimant's condition had stabilized no later than November 1, 2007 and that the claimant's healing period did not extend beyond November 1, 2007. Temporary disability benefits cannot be awarded after a claimant's healing period has ended. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987). The evidence does not show that the claimant re-entered a healing period for his compensable injury at any time after November 1, 2007. We recognize Dr. Long's statement in May 2009, to wit: "He still remains in his healing period and I frankly recommend that he never go back to the previous job based on his situation with his back." Dr. Long's opinion that the claimant remained in a healing period is not supported by the preponderance of the medical evidence and is entitled to no probative weight.

Additionally, Dr. Long's assertion that the claimant should "never go back to the previous job" is evidence relating to the reserved issue of whether the claimant is entitled to permanent partial disability benefits, rather than whether the claimant is entitled to continuing temporary total disability.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove he was entitled to a proposed discectomy by Dr. Qureshi or Dr. Shahim. The Full Commission finds that the claimant did not prove such a procedure was reasonably necessary in connection with the compensable injury. We find that the claimant did not prove he was entitled to additional temporary partial or temporary total disability benefits. The evidence demonstrates that the claimant reached the end of the healing period for his compensable injury no later than November 1, 2007. The Full Commission therefore reverses the administrative law judge's opinion, and the present claim for additional benefits is denied and dismissed.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

After my de novo review of the entire record, I must respectfully dissent from the majority opinion. I find that the claimant proved by a preponderance of the evidence that he is entitled to a discectomy and to additional temporary disability benefits.

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). 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).

The claimant developed back pain on March 27, 2006 while working for the respondent-employer. A 2006 MRI scan showed degenerative changes at L2-3 and L5-S1, and an annular bulge at L4-5 which was a new finding. The bulge was identified as the source of his symptoms through a discogram and CT scan in 2006 and an MRI in 2009. The claimant saw multiple doctors since 2006.

Dr. Akin initially planned a fusion, but he changed his mind after conferring with the nurse case

manager employed by the respondent carrier and after the claimant's functional capacity evaluation reports showed that he gave unreliable effort. However, the claimant was not given an explanation for Dr. Akin's change of plans. The claimant testified that the purpose of the FCEs was never explained to him and that the examiners did not explain their expectations of him.

The claimant continued to seek treatment for his unresolved back pain, eventually having to finance his diagnostic treatment himself. The claimant had objective findings of injury shown in the MRI and CT scans as well as more than one doctor's observation of muscle spasm throughout his treatment, even in December 2008. The claimant was released to work without restriction, despite the continuation of his difficulties, and subsequently he was restricted from working due to those unresolved injuries. His current doctors, Dr. Qureshi and Dr. Shahim, intend further treatment, including surgery to resolve the claimant's pain and allow him to return to work.

The claimant's medical records show that he consistently complained of low back pain with radiculopathy into his right leg. The respondents make much of his

complaints of left leg pain, but these complaints are in regard to the severe left heel fracture the claimant suffered. The fact that the claimant at times complained of left leg or foot pain is explained by this fracture and is not evidence that the claimant was malingering.

I find the claimant's testimony to be credible, that he continued to experience consistently reported symptoms from the date of his injury and that the treatment he received did not provide lasting relief.

The claimant credibly testified that the care he received from Dr. Akin changed drastically from one visit to the next, which was why the claimant sought a change of physician. The claimant testified repeatedly that he remained confused during his course of treatment. The reports of the FCEs show that the claimant openly limited his activities to prevent pain or further injury. I question the validity of such an exam, where the claimant has an unresolved injury and uncontrolled pain and is expected to do the very activities which either caused his injury or exacerbate his pain, especially without a clear explanation of the purpose of the exam and the expectations of the subject. I also note that Dr. Akin attempted to

decide whether the claimant's injury was compensable or not, in his February 28, 2007 note, without an adequate understanding of workers' compensation law.

The claimant's motivation and lack of malingering is demonstrated by twenty-five years of employment with the respondent-employer, his return to work after he shattered his heel, and his willingness to personally finance his medical care with savings and the sale of assets.

The claimant's role as a volunteer fire chief does not negate his testimony or the medical evidence that he was totally disabled from earning wages. The newspaper article with a picture of the claimant actually emphasizes that the claimant was not able to actively participate but that he was supervising or observing the activities. In the photograph, the claimant is supporting himself by leaning on one leg, elevated on a culvert, and holding his lumbar spine. There is no indication that the claimant was engaged in any physical activity, other than standing there for the time it took to make the photograph. The claimant testified that he continued to train as a volunteer fireman, but that he was limited to the classroom part of the training and not the physical part of the training. The respondents'

witness, Mary Temple, testified that the claimant told her once he had been in some training and was tired or sore, but she could not state that he meant that he had been physically active or that he was sore from the car ride. I do not find that the claimant's activities as a volunteer fire fighter negate his testimony or the medical records that he had low back pain and radiculopathy limiting his ability to work and requiring treatment.

Consistent low back pain and radiculopathy into the right leg and the observation of muscle spasms throughout course of treatment also support a continued need for medical treatment.

I find that the claimant is a credible witness with an unresolved compensable injury for which Dr. Qureshi and Dr. Shahim have proposed reasonable and necessary treatment. I find that the treatment that claimant has received to date has been reasonable and necessary as well.

I also find that the claimant has not left his healing period since the date of his injury. I would award temporary partial disability benefits from June 9, 2008 to August 11, 2008, for the period of time that the claimant was unable to earn wages equal to his pre-injury wage due to

his compensable injury. I would award temporary total disability benefits from August 12, 2008 to a date yet to be determined, because the claimant has proved by a preponderance of the evidence that he is totally incapacitated from earning wages due to his injury.

Lastly I would award an attorney's fee to the claimant's attorney.

After my de novo review of the entire record, I must respectfully dissent from the majority opinion. I find that the claimant proved by a preponderance of the evidence that he is entitled to a discectomy and to additional temporary partial and total disability benefits.

PHILIP A. HOOD, Commissioner