BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F701468

RAMIRO MONTANA, EMPLOYEE	CLAIMANT
CLAYTON'S ERECTING & WELDING, EMPLOYER	RESPONDENT
MIDWEST INSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT

OPINION FILED APRIL 27, 2010

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

Claimant represented by the HONORABLE EDDIE H. WALKER, JR., Attorney at Law, Fort Smith, Arkansas.

Respondent represented by the HONORABLE MICHAEL C. STILES, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed October 16, 2009. The administrative law judge found that the claimant proved he was entitled to additional medical treatment after June 10, 2008. The ALJ found that the claimant proved he was entitled to temporary total disability benefits from June 10, 2008 through February 10, 2009. After reviewing the entire record *de*

novo, the Full Commission affirms the administrative law judge’s opinion.

I. HISTORY

The parties stipulated that Ramiro H. Montana, age 60, sustained compensable injuries to his back and left knee on January 15, 2007. Mr. Montana testified that he slipped, fell, and injured his back and knee. Dr. Claude L. Martimbeau, an orthopaedic surgeon, examined the claimant and noted on April 10, 2007, “The x-ray of the lumbosacral spine shows quite a bit of degenerative change with disc space narrowing and a lot of spurring at different levels from L1 through L5.” Dr. Martimbeau diagnosed “1. Status post back pain with degenerative disc disease. 2. Synovitis and degenerative change, left knee.”

Dr. Martimbeau wrote to the respondent-carrier on May 1, 2007:

> Mr. Montana is a patient of mine who is treated for a back condition and left knee pain. The patient has back pain from a degenerative change with a secondary injury at work. At the same time the patient also injured his left knee, and since then has been treated for left knee pain associated with the degenerative change.
> At this point, the patient is not progressing much and is still suffering from back pain and left knee pain.

> The x-ray of the lumbosacral spine shows some degenerative change but no specific acute injury or joint lesion. The x-ray of the left knee also shows some degenerative change, mainly joint space narrowing and minimal spurring over the medial compartment and the patellofemoral joint.
>
> At this point, the patient is still in need of treatment, mainly injections of Cortisone. If, as mentioned in my previous dictation, there is not enough improvement, I will then definitely recommend he have a Synvisc injection. Also, part of the treatment will include physical therapy to try to control the back pain and eventually a program so that he can perform some exercises at home. At some point, the patient should be able to return to work as long as the following specific restrictions are followed, including no use of a scaffold or ladder, no lifting and carrying more than 20 lbs., avoid squatting, repetitive bending, no prolonged standing and avoid walking on uneven ground. The patient is really not in need of any further imaging studies, including MRI, since he had all of the radiological signs of osteoarthritis on his regular x-ray. The MRI will definitely show the same thing with more or less the degenerative change effecting the menisci which, at this point, is not really relevant. At this point, the patient is close to reaching the maximum of medical improvement since his progress is really slow. He is already four months now into his followup, and I definitely and reasonably think that two more months will probably be enough of a period of time for him to reach his maximum of improvement.

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

> There does appear to be some post surgical change at what is presumed to be L5-S1, especially in the posterior elements. There is mild diffuse disc

> bulge at L2-3 and L4-5 levels. Vertebral marrow signal is preserved. CBF signal is also normal. Posterior element changes at L5-S1 apparently from prior surgery as well. The T2 axial views demonstrate two cysts in the right kidney. There is some asymmetric left ward bulging of disc at L4-5 on axial views as well. Post enhanced views reveal bilateral facet hypertrophy also at L4-5 and L5-S1 levels.
>
> IMPRESSION
> 1. Post surgical changes L5-S1 disc level. There are disc bulges at L2-3 and L4-5 levels. Some bilateral facet hypertrophy also noted in the lower lumbar spine. No focal herniations or protrusions identified. Right renal cysts noted.

Dr. Keith J. Bolyard saw the claimant on August 28, 2007:

> Mr. Montana is a 58-year-old. We gave him an intraarticular injection of his left knee for which is doing somewhat better, still with some discomfort. His overall main problem is his low back pain and left radicular symptoms gluteal area down into the foot. His MRI that he had done on the 13th of August showed postsurgical changes with some disc bulging at 2/3 and 4/5 with facet hypertrophy in the lower lumbar spine.
>
> IMPRESSION:
> 1. Left knee osteoarthritis aggravated by worker's compensation event.
> 2. Left radicular symptoms with low back pain and possibly aggravated by his worker's compensation event.

Dr. Bolyard's plan was, "As far as his back goes what I can offer him is an evaluation for lumbar epidural steroid injection and neurosurgical evaluation, which we are going

to try to facilitate. Concerning his left knee we will see him back here in six weeks for repeat injection as necessary."

The claimant testified that injection treatment did not improve the condition of his back.

Dr. James B. Blankenship, a neurosurgeon, saw the claimant on September 19, 2007:

> Mr. Montana is a very pleasant 58-year-old gentleman who was injured in January. He slipped and fell and twisted and had lower back pain, left posterolateral paresthesias as well as left knee pain. His knee was actually his primary concern for some time, and he was being treated for that by an orthopedist in Fort Smith. He also had some back therapy during his long course of therapy for his knee. His knee has actually gotten significantly better but his back if anything has gotten worse. The patient's prior history is significant for surgery in 1985 for another work-related injury on his lower back. He had the surgery in Texas and did extremely well. He did physical therapy afterwards with good relief. The patient had an injection in his knee but has had no other systemic steroids or steroids in his back. The patient is scheduled for an epidural steroid injection in two weeks down in Fort Smith. The patient has a five plus history of smoking but has been abstinent from tobacco use for the past 15 years.
>
> PHYSICAL EXAMINATION: The patient has decreased sensation in both the L5 and S1 dermatome. He also has positive mechanical signs with a straight leg raise on the left.
>
> His mechanical examination reveals an exacerbation of his left-sided lower back pain, more so with

> extension but also present in flexion with significant reduction of motion secondary to guarding.
>
> I have reviewed the gentleman's MRI in its entirety. He has had previous surgical decompression at the L5-S1 level. No residual disk herniations are noted at the L5-S1 level. It appears that he had a complete laminectomy at this level and bilateral decompression. He does have some mild lateral recess stenosis at L4-5 secondary to broad-based disk bulging and also has a lateral disk protrusion at L4-5. Sagittal images demonstrates marked disc space settling at L5-S1 where he has had previous surgery. He also had significant arthritic changes with lateral traction spur formation.

Dr. Blankenship's impression was "I think it is likely that he has a combination of zygapophyscal (sic) joint pain on the left hand side with myofascial back pain. I do not see any evidence of residual or retained disk fragments. I think that the paresthesias that the gentleman is having are likely to be a stretch injury to the nerve encased in scar tissue from his original injury." Dr. Blankenship recommended an epidural steroid injection at L4-5 and L5-S1, medication, and additional physical therapy.

Dr. Blankenship also provided a Radiographic Interpretation on September 19, 2007:

> The AP and lateral radiograph demonstrates that the patient has five moveable lumbar segments. He has multi-level degenerative changes with lateral traction spurs at all levels. He also has marked

> disk space settling at L5-S1 with a near complete auto effusion at this level. He has marked neuroforaminal narrowing of the exiting L5 nerve root at this level also. No pathologic motion is noted.

Dr. Bolyard's impression on October 9, 2007 was "1. Left knee osteoarthritis, approaching baseline. 2. Low back pain with left radicular symptoms being treated by Dr. Blankenship and Dr. Cannon."

A CT scan of the claimant's lumbar spine was done on January 2, 2008, with the following impression:

> 1. Status post discogram at L4-5 without evidence of annular tear.
> 2. Status post decompressive laminectomies at L5 with posterior fusion of L5 and S1.
> 3. Spondylosis as noted which would be more accurately assessed with MRI.

A lumbar MRI was taken on January 3, 2008, and Dr. Blankenship gave the following impression:

> 1. Marked disc space settling at L5-S1 status post decompression with a complete laminectomy with no residual, recurrent or new disk herniations or stenosis. There is also no compression of the L5 ganglion laterally on either side at the exiting nerve roots.
> 2. Mild to moderate lateral recess stenosis secondary to an eccentric disk protrusion to the left hand side with a lateral component to this.
> 3. Mild lateral recess stenosis at the L3-4 level without significant neural impingement.

Dr. Blankenship noted on January 3, 2008:

> His new MRI does show a lateral disk protrusion at L4-5 but this is not confirmed with discography. This is more of an annular bulge with no soft disk material noted on his post discogram. Without a gross annular tear and without provocation at this level, I am hard pressed to blame his current pain complaints on that level. Also with the fact that I feel like it is likely he is solidly fused at L5-S1 I am also hard pressed to blame his current clinical complaints on that either....
>
> I have recommended to the gentleman today that we get a functional capacity evaluation. This is not done with the intent of returning him to work, but to look more at the capabilities and the strength of his back. It also is done for a concern of possible non-physiologic components to his current pain complaints. We discussed this with his case manager and once I have gotten the functional capacity evaluation report I will review this and we will make formal determinations of where we are going to go from here at that time.

Dr. Blankenship gave an x-ray interpretation on January 7, 2008: "The L4-5 disk injection demonstrates a fairly well localized central nuclear injection without any significant annular disruption. The injections were done in AP, lateral and right and left oblique."

The claimant participated in a Functional Capacity Evaluation on January 29, 2008:

> Overall test findings, in combination with clinical observations, suggest the presence of near full, though not entirely full, effort on Mr. Montana's behalf. In describing sub-maximal effort, this evaluator is by no means implying

> intent. Rather, it is simply stated that Mr. Montana can do more physically at times than was demonstrated during this testing day. Any final vocational or rehabilitation decisions for Mr. Montana should be made with this in mind....
>
> Based upon the results of this evaluation, Mr. Montana is able to perform work to the light physical demand level. He would be unable to return to work as a welder without restrictions. He was able to complete about 5 hours of testing but had to change positions frequently. He had high reports of pain from the start of testing, throughout testing, and the next day. Mr. Montana was able to lift to the light strength demand level from 12 inches to overhead. He was able to carry 13 pounds and push/pull an empty sled 30 feet, with increased reports of pain in the left knee. Overall tests were limited by client and by high blood pressure. Mr. Montana is to follow up with Dr. Blankenship and all further rehabilitation needs and limitations will be at his discretion. The results of this evaluation were reviewed with Mr. Montana at the conclusion of the evaluation.

The claimant followed up with Dr. Bolyard on January 31, 2008: "I think he has reached maximum medical benefit concerning his left knee from his fall. I do not know why his arthritis became so problematic specifically after the fall, but I do not think a knee arthroscopy will help him with that at all. I think his fall did aggravate his condition. We will see him back here as necessary."

Dr. Blankenship noted in part on February 7, 2008:

I have reviewed Mr. Montana’s functional capacity evaluation in its entirety. This was performed on 1/29/08. This was performed by Jennifer Fowler at Performance Physical Therapy. I have reviewed the FCE in its entirety and find it to be valid.

I saw Mr. Montana last on January the 3rd. He did have a lateral disk protrusion at L4-5 by MRI, but it was not confirmed with his discography. His discography actually was somewhat equivocal in its findings. He did appear to have a solid fusion at L5-S1. At that time, we recommended a functional capacity evaluation for better delineation of a further treatment plan....

In summary, I do feel like the gentleman can work although it would be at a light physical demand level with a 20 pound weight lifting restriction. Based on the significant concerns that were raised in his FCE, I do not feel like that any further treatment either from a standpoint of conservative treatment and most certainly a consideration of surgical intervention would be warranted. Mr. Montana has been well taught on his limitations and abilities. The gentleman has good knowledge of his physical therapy program and his home exercise program. We have passed along to him that we do feel like that he is at MMI as of this date.

Concerning an impairment rating, the gentleman does not have a radiographic evidence of an objective finding that I can attribute to his injury on the job. He has had surgery before but is solidly fused at the L5-S1 level and he had no provocation of adjacent segments. Based on those findings and the Fourth Edition AMA Guidelines that we are tied to in Arkansas, this does not allow any significant laterality and therefore the gentleman would not qualify for an impairment rating at present.

In summary, I do feel like the gentleman is at MMI and would not qualify for a partial permanent

> impairment based on the Fourth Edition AMA Guidelines. He is able to work at light physical demand levels as outlined in his FCE. No scheduled followup will be arranged. Rhonda will notify him of my unfortunate opinion that I do not think there is anything that we can do to be of assistance to him....

The record contains a Change of Physician Order dated May 13, 2008: "A change of physician is hereby approved by the Arkansas Workers' Compensation Commission for Ramiro Montana to change from Dr. James Blankenship to Dr. Arthur Johnson[.]"

The parties stipulated there was "no dispute over temporary total disability benefits accruing through June 9, 2008."

Dr. Arthur Johnson, a neurosurgeon, saw the claimant on June 10, 2008:

> He fell on 01/15/07 and 01/19/07 at work. He was working with a ladle at the time and slipped on ice. He has had left sciatica and butt pain and lateral leg pain to the toes with numbness to his feet. He has difficulty sitting. He also had physical therapy in the past without traction. He had lumbar steroid injections by Dr. Kennedy in Fayetteville, Arkansas. He has continued to have significant problems with pain. He has also been seen by Dr. Blankenship as well.
>
> He had a one level discogram that was negative at L4-5 and he has had previous fusions of the lumbar spine at L5-S1 22 years ago in Texas....

> The patient is a welder. He has not worked since his injury....
>
> MRI scan shows that he is status post lumbar spine surgery at L5-S1 with fusion L5 to S1 and has a mild amount of recess stenosis at L3-4 with no marked neural foraminal narrowing or compression and the nerve roots or a broad based disc protrusion off to the left side with narrowing of the L4 nerve root laterally. No gross annular destruction, however is noted.

Dr. Johnson's impression was "Degenerative disc disease of the lumbar spine with broad based disc bulge eccentric to the left at L4-5 with bilateral recess stenosis. PLAN: We will send the patient for lumbar myelogram post myelogram CT to see how significant his compression is on his nerve roots and we will start him on Naprolyn and Osteobioflex and alpha lipotic acid and Omega 3 fatty acid. We will see him back in the clinic after these studies have been performed."

Dr. Johnson signed an x-ray report on June 10, 2008:

> Lumbar spine x-ray, AP and lateral shows that the patient has osteophytic changes, at this point lateral, L1-2, 2-3 and 3-4 levels with some bridging at the L3-4 level particularly on the right side. There is posterior fusion at the L5-S1 region.
>
> IMPRESSION: Degenerative disc disease changes with osteophytes L1 through L4 with some bridging osteophyte fusion at the L5-S1 level.

The parties stipulated there was "no dispute over medical services through the initial visit with Dr. Arthur

Johnson on June 10, 2008." The record indicates that Dr. Johnson took the claimant off work beginning June 10, 2008.

A lumbar myelogram was performed on June 27, 2008 with the following findings:

> There is normal stature and alignment of lumbar vertebrae without compression fractures. There are mild ventral extradural defects involving the L4/5 and L2/3 levels which could represent disc bulges and/or protrusions.
> IMPRESSION:
> 1. Mild ventral dural defects involving the L4/5 and L2/3 levels which may represent disc bulges and/or protrusions.

A CT of the claimant's lumbar spine was performed on June 27, 2008, with the impression, "1. Mild degenerative changes involving the lumbar spine without disc herniation."

The claimant followed up with Dr. Johnson on July 1, 2008:

> He was sent for a lumbar myelogram and post myelogram CT for complaints of pain after he had fallen. The myelogram shows that he has a small synovial cyst on the right L4-5 facet joint that appears to project down onto the L5-S1 nerve root region in the lateral recess....
>
> IMPRESSION: Small synovial cyst in the left L4-5 area with impression on the left L5-S1 nerve root.
>
> PLAN: At this point, I think the patient's pain was precipitated by the accident, however, he does have degenerative facet joint disease and the synovial cyst on the left at L4-5 that may be source of his pain.

> As far as treatment options for him, he would best be served with performing decompressive laminectomy at L4 with removal of the synovial cyst at L4-5 and a left L4-5 transforaminal lumbar interbody fusion procedure.
>
> He is restricted to lifting no more than 15 pounds and he is given a permanent disability rating of 7% for the lumbar spine as a whole.

Dr. T. Glenn Pait examined the claimant on September 11, 2008:

> Mr. Montana is a very pleasant 59-year-old gentleman who was seen today in consultation with Dr. Alyssa Payne for back and left knee pain. The patient reports that he had back surgery in 1985 in San Antonio for a ruptured disk and he had fusion at L5-S1. The patient did well after surgery until he had an accident at work at which time he began to suffer low back pain primarily on the left side radiating down to the left leg. The patient also noted a knee injury at that time.
>
> He comes in today for multiple radiographic workup including MRI, CT and CT myelograms....He reports significant back and left pain for which he uses a cane to assist with ambulation....The patient is currently unemployed....
>
> The patient has MRI, CT and CT myelogram with which he presents to the clinic today. The patient has evidence of previous surgery at L5 which consists of a partial laminectomy and fusion at L5-S1. The patient is also noted to have disk protrusion at L4-5, left side, with significant lateral recess stenosis on the left side at L5....
>
> He is a 59-year-old gentleman with chronic back pain. However, he has had significant worsening since his injury at work. We have explained to him that he does appear to have neurologic compromise secondary to lateral recess stenosis

> and degenerative changes in his spine. We have offered him L4-5 T-lift and extending of fusion from L4 to S1 as well as decompression of the neural elements. We explained to him that there is no doubt that he does have some element of knee pain but it is primarily from his torn meniscus and that his back will not be completely pain-free postoperatively....We will plan on taking him to the operating room on Monday for L4 to S1 fusion with transforaminal lumbar body fusion at L4, L5.

Dr. Hazem Ahmed performed neurosurgery on September 15, 2008: "1. L4-5 decompression laminectomy. 2. L4-5 bilateral foraminotomy. 3. Transforaminal interbody allograft mixed with autograft, fusion and arthrodesis, L4-5. 4. Pedicle screw fixation, L4-5, using a Medtronic Legacy System screws. 5. Posterolateral fusion using mixed autograft with cancellous bone allograft, L4-5, over the transverse process. 6. Neurophysiological monitoring using EMG." The pre- and post-operative diagnosis was "L4-5 degenerative stenosis, instability, disc herniation."

Dr. Ahmed signed a note dated October 2, 2008 indicating, "Patient needs to stay out of work for at least 12 weeks after surgery. Surgery date was 9/15/2008."

A pre-hearing order was filed on October 22, 2008. The claimant contended that "his authorized treating physician, Dr. Johnson, recommended surgery; however, the respondents would not authorize that surgery; therefore, additional

medical treatment was controverted and the claimant was free to seek medical treatment on his own. The claimant contends that any medical treatment that he has received for his back after the respondents denied liability for the surgery should be the responsibility of the respondent/carrier."

The respondents contended that the claimant had been paid all benefits to which he was entitled and that the claimant was not entitled to any additional benefits. The respondents contended that the claimant "received temporary disability benefits during the period of time he was in his healing period" and that the claimant was not entitled to any additional temporary total disability benefits. The respondents contended that according to Dr. Blankenship, the claimant had reached maximum medical improvement and had not sustained any anatomical impairment rating as a result of his back injury. The respondents contended that the claimant had received a Change of Physician Order to Dr. Arthur Johnson, and that they had "paid for the treatment of Dr. Johnson." The respondents contended that back surgery was not reasonably necessary. The respondents contended, "11. The back surgery suggested by Dr. Johnson is not related to the injury in question but to the claimant's pre-

existing condition. 12. The rating assessed by Dr. Johnson is not related to the injury in question but to the claimant's pre-existing degenerative condition."

The parties agreed to litigate the following issues:

> 1. The claimant's entitlement to additional medical services after June 10, 2008.
> 2. The claimant's entitlement to additional temporary total disability benefits from June 10, 2008 through a date yet to be determined.
> 3. Appropriate attorney's fees.

Dr. Johnson wrote to the respondent-carrier on December 4, 2008:

> This is in response to the 17 July '08 letter I received from Ms. Liz Mullen with CorVel.
> 1. Please confirm that the recommended surgery is for the degeneration and not the 15 January '07 work injury. Yes.
> 2. Please specify the 7% impairment rating included in your 1 July '08 dictation.
> Is this impairment rating directly related to the 15 January '07 work injury or the pre-existing degeneration. Pre-existing disease.

Dr. Ahmed was provided the text of a Medical Opinion which contained the following questions:

> 1. Is it likely that the need for the September 15, 2008 surgery that I performed was caused by Mr. Montana's on the job fall that I understand occurred on January 15, 2007?
> 2. Was there a disc herniation at L4-5 of Mr. Montana's back?
> 3. Is Mr. Montana temporarily totally disabled because of his back injury?

Dr. Ahmed signed the opinion on February 10, 2009 and wrote in answer to Question 1, "undetermined the etiology but the patient needed the surgery based on his medical condition and radiological findings." Dr. Ahmed agreed that there was a disc herniation at L4-5. Dr. Ahmed crossed out the word "totally" in Question 3 and wrote "partially disabled."

Dr. Johnson signed the following Medical Opinion on April 21, 2009:

> I have now reviewed a September 15, 2008 Operative Report from Dr. Hazem Ahmed regarding surgery that was performed on Ramiro Montana at the University Hospital of Arkansas and I have further considered my July 1, 2008 Progress Note.
>
> It is my opinion, within a reasonable degree of medical certainty, that the herniated disc noted in the September 15, 2008 Operative Report was likely caused by Mr. Montana's fall that he gave me a history of occurring at Mac Steel. Further, it is my opinion, within a reasonable degree of medical certainty, that the disc herniation at L4-5 caused the need for the September 15, 2008 surgery.

Dr. Blankenship reported on June 22, 2009:

> At Mr. Montana's workers' compensation carrier's request, I have reviewed his chart again and also reviewed new information that was provided to me, namely a report from Dr. Arthur Johnson, as well as clinic notes from Dr. Johnson and also an operative note from the University Hospital.

I last saw Mr. Montana in the office on January 3, 2008. At that time, we reviewed his discography, which did not confirm the MRI finding of an L4 lateral disc herniation. He had an annular bulge with no soft disc material. There was no provocation at that level either. Based on that finding, I did feel like the gentleman was a candidate for surgical intervention. I also felt like he had a solid arthrodesis at L5-S1. We performed a functional capacity on the gentleman, which I reviewed. There were some significant questions concerning reliabilities and accuracy of this FCE. The gentleman provided submaximal effort, and did not have correlation with heart rate with elevations with complaints of pain and had significant findings of inappropriate illness behavior. Based on those findings, final recommendations were made concerning final treatment. Since a review of this was not what I was asked to do, I will not reiterate it at this time.

The gentleman subsequently after me seeing him was referred to the University of Arkansas for Medical Sciences. The gentleman underwent surgical intervention at UAMS. I have reviewed this operative note in its entirety. The surgical intervention was performed on September 15, 2008. The gentleman underwent an L4-5 decompression, laminectomy, and foraminotomy and underwent an interbody allograft, as well as pedicle fixation. It is noted on the operative note from UAMS that the gentleman had markedly hypertrophic ligamentum flavum. There is no mention of any intraoperative finding of disc herniation, however.

The gentleman's workers' compensation carrier has declined coverage for this based on the fact that a previous evaluation by Dr. Arthur Johnson that indicated, in Dr. Johnson's opinion, his treatment at L4-5 was related to degenerative findings. There is a note dated December 4, 2008, where Dr. Johnson indicated that the recommended surgery was for degeneration and not the 15th of January

work injury. The gentleman also had been noted previous by myelography to have a small synovial cyst on the right L4-5 zygapophyseal joint that appeared to project down into the L5-S1 nerve root region in the lateral recess.

Dr. Johnson, subsequently on an undated note to change his mind considering that he thought it was a reasonable degree of medical certainty the disc herniation at L4-5 was the need for his surgery. Once again, I have reviewed this operative note in its entirety. Within the entire first portion of the operative note where the decompression is noted, starting with the sentence, the bony fusion mass at L5 was then osteotomized; there is no indication in the following sentence of any disc herniation noted. I now will quote from the operative note. The laminectomy was performed using a Leksell and Kerrison rongeur and Midas Rex drill to remove the lamina at L4 and a partial L5 with the markedly hypertrophy ligamentum flavum. The durum was then found markedly decompressed and then the foraminotomy was performed on both sides, mostly on the left, using the Kerrison rongeur and the drill exposing the nerve root.

Discectomy for preparation for arthrodesis is noted later in the dictation, but no documentation of finding of an intraoperative disc herniation is noted.

Based on the intraoperative findings that are documented on the operative note, my review of the gentleman’s discography, coupled with his pre-discography MRI, along with my complete review of his chart leads to the following conclusion. It is my opinion, based on a reasonable degree of medical certainty that the data provided to me do not support the contention that the gentleman had a disc herniation. His discography did not demonstrate a lateral disc protrusion. His intraoperative findings and CT myelography confirmed a probable synovial cyst and ligamentous

> hypertrophy, which is consistent with degenerative changes. I have no doubt that the gentleman had an exacerbation of back pain with his fall, but there is no documented findings consistent with an acute neurologic event with that fall, nor is there any documentation either on documentation on discography or even intraoperative findings that indicate the gentleman had any findings consistent with a disc herniation.
>
> Once again, in summary, based on all the information that I have reviewed and the rationale for this conclusion listed above, it is my opinion based on a reasonable degree of medical certainty that the gentleman did not have an acute disc herniation with his on-the-job injury, and therefore, his subsequent surgical intervention, which may very well have been appropriate to do to treat the gentleman, but still not related to his work injury....

A hearing was held on July 28, 2009. The claimant testified that he still had problems with his back following surgery, but "the numbness down my leg and the tingling in my toes, it's gone away....I'm still improving." The claimant testified on cross-examination that he had been released from treatment for his back as of February 2009.

An administrative law judge filed an opinion on October 16, 2009. The administrative law judge found, among other things, that medical services provided to the claimant after June 10, 2008 were reasonably necessary in connection with the compensable injury. The administrative law judge found that the claimant was "temporarily totally disabled ... from

June 10, 2008 through at least, February 10, 2009." 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 has the burden of proving by a preponderance of the evidence that additional medical treatment is reasonably necessary. *Fayetteville School Dist. v. Kunzelman*, 93 Ark. App. 160, 217 S.W.3d 149 (2005). 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 essentially found that medical treatment provided to the claimant after June 10, 2008, including surgery, was reasonably necessary. The Full Commission affirms this finding. The parties stipulated that the claimant sustained compensable injuries to his back and left knee on January 15, 2007. A lumbar MRI in August 2007 showed post-surgical

changes at L5-S1, along with disc bulges at L2-3 and L4-5. The claimant treated conservatively with Dr. Bolyard for his knee and Dr. Blankenship for his back. Dr. Blankenship found the claimant to be at maximum medical improvement on February 7, 2008. The claimant thereafter received a change of physician to Dr. Johnson. Dr. Johnson's impression on June 10, 2008 was degenerative disc disease of the lumbar spine with bulging at L4-5. Additional diagnostic testing was carried out and Dr. Johnson opined on July 1, 2008, "I think the patient's pain was precipitated by the accident, however, he does have degenerative facet joint disease and the synovial cyst on the left at L4-5 that may be the source of his pain. As far as treatment options for him, he would best be served with performing decompressive laminectomy at L4 with removal of the synovial cyst at L4-5 and a left L4-5 transforaminal lumbar interbody fusion procedure."

Dr. Pait saw the claimant on September 11, 2008. Dr. Pait noted that the claimant had undergone a prior back surgery in 1985, along with chronic back pain, but that the compensable injury had caused significant worsening of the claimant's chronic pain. Dr. Pait arranged surgery for the claimant. Dr. Ahmed performed a laminectomy and

foraminotomy at L4-5 on September 15, 2008. The post-operative diagnosis was "L4-5 degenerative stenosis, instability, disc herniation." Dr. Johnson advised the respondents in December 2008 that surgery had been causally related to pre-existing degenerative disc disease rather than the compensable injury. Nevertheless, Dr. Johnson opined in April 2009, "the herniated disc noted in the September 15, 2008 Operative Report was likely caused by Mr. Montana's fall that he gave me a history of occurring at Mac Steel. Further, it is my opinion, within a reasonable degree of medical certainty, that the disc herniation at L4-5 caused the need for the September 15, 2008 surgery."

We recognize Dr. Blankenship's letter in June 2009 stating that the claimant "did not have an acute disc herniation with his on the job injury." However, the instant claimant did not have to prove that he sustained a herniated disc as a result of the admitted compensable injury, because objective medical findings are not required to prove that an employee who has sustained a compensable injury is in need of additional medical treatment. *Castleberry v. Elite Lamp Co.*, 69 Ark. App. 359, 13 S.W.3d 211 (2000), citing *Chamber Door Industries, Inc. v. Graham*,

59 Ark. App. 224, 956 S.W.2d 196 (1997). Moreover, the claimant was a credible witness who reported improvement in his physical condition following surgery. Post-surgical improvement is a relevant consideration in determining whether surgery was reasonably necessary. *Hill v. Baptist Medical Center*, 74 Ark. App. 250, 48 S.W.3d 544 (2001).

The Full Commission finds that the claimant proved he was entitled to surgery from Dr. Ahmed. The claimant proved said surgery was reasonably necessary in connection with the compensable injury. The administrative law judge's finding is affirmed.

B. Temporary Disability

Temporary total disability is that period within the healing period in which the employee suffers a total incapacity to earn wages. *Ark. State Hwy. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). A claimant's healing period ends when the underlying condition causing the disability has become stable and if nothing further in the way of treatment will improve the condition. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987).

In the present matter, an administrative law judge essentially found that the claimant proved he was entitled to temporary total disability benefits from June 10, 2008 through February 10, 2009. The Full Commission affirms this finding. The parties stipulated that the claimant sustained compensable injuries on January 15, 2007. The parties stipulated that temporary total disability benefits were paid through June 9, 2008. Dr. Johnson noted on June 10, 2008 that the claimant had not returned to work since the compensable injury. Dr. Johnson kept the claimant off work beginning June 10, 2008. The claimant underwent low back surgery on September 15, 2008, which treatment the Commission has determined to be reasonably necessary in connection with the compensable injury. The treating surgeon, Dr. Ahmed, kept the claimant off work beginning October 2, 2008. The claimant testified at hearing that he had been released from further treatment for his back as of February 2009. The evidence demonstrates that the claimant remained in a healing period and was totally incapacitated from earning wages beginning June 10, 2008 and continuing through February 10, 2009. The Full Commission therefore affirms the administrative law judge’s award of temporary

total disability benefits beginning June 10, 2008 until February 10, 2009.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant proved he was entitled to additional medical treatment after June 10, 2008. The claimant proved that said treatment, including surgery provided on September 15, 2008, was reasonably necessary in connection with the compensable injury. The claimant proved he was entitled to temporary total disability benefits beginning June 10, 2008 until February 10, 2009. The Full Commission therefore affirms the administrative law judge's opinion. The claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715(a)(Repl. 2002). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to an additional fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b)(Repl. 2002).

IT IS SO ORDERED.

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A. WATSON BELL, Chairman

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PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority's opinion finding that the claimant proved by a preponderance of the evidence that he was entitled to additional medical treatment after June 18, 2008 and awarding additional temporary total disability benefits from June 10, 2008 to February 10, 2009. Based upon my de novo review of the record, I find that the claimant has failed to meet his burden of proof.

In my opinion, a review of the evidence demonstrates that the claimant's need for additional medical treatment after June 8, 2008, does not stem from the claimant's January 15, 2007 admittedly compensable injury. My review of the evidence demonstrates that the claimant's pre-existing degenerative condition in his lumbar spine is the sole cause of the claimant's need for medical treatment. Dr. Blankenship, in his February 7, 2008 report, stated that the claimant sustained a temporary aggravation of his pre-existing degenerative condition when he was injured on January 15, 2007. Dr. Blankenship could not "find any objective evidence of other recent physical damage to the claimant's lumbar spine." Prior to the claimant's September 15, 2008 surgery, none of the claimant's treating physicians

could state within a reasonable degree of medical certainty that the claimant sustained a herniation in his lumbar spine as a result of the January 15, 2007 incident.

Further, in a report dated December 4, 2008, Dr. Johnson, the physician hand-picked by the claimant pursuant to the Claimant's Change of Physician request, indicated "it was his expert medical opinion that the [C]laimant's need for additional medical services, specifically the September 15, 2008 surgical procedure, [were the] degenerative changes in [the Claimant's] lumbar spine, rather than the employment-related injury of January 15, 2007." In this same report, Dr. Johnson then explained that the 7% permanent anatomical impairment rating, which he had assigned to the claimant on July 1, 2008, was attributable to the [C]laimant's pre-existing degenerative disease and not to the claimant's employment-related injury of January 15, 2007. Similarly, in a June 22, 2009 report, Dr. Blankenship reiterated his opinion that the claimant's "discography did not show the presence of any lateral disc herniation of the L4-5 disc but showed only a degenerative annular bulge." Dr. Blankenship also explained:

> Based on the intraoperative findings that are documented on the operative note, my review of the gentleman's discography, coupled with his pre-discography MRI, along with my complete

> review of his chart leads to the following conclusion. It is my opinion, based on a reasonable degree of medical certainty that the data provided to me do not support the contention that the gentleman had a disc herniation. His discography did not demonstrate a lateral disc protrusion. His intraoperative findings and CT myleography confirmed a probable synovial cyst and ligamentous hypertrophy, which is consistent with degenerative changes. I have no doubt that the gentleman had an exacerbation of back pain with his fall, but there is (sic) no documented findings consistent with an acute neurologic event with that fall, nor is there any documentation either on documentation on discography or even intraoperative findings that indicate the gentleman had any findings consistent with a disc herniation.
>
> Once again, in summary, based on all the information that I have reviewed and the rationale for this conclusion listed above, it is my opinion, based on a reasonable degree of medical certainty, that the gentleman did not have an acute disc herniation with his on-the-job injury, and therefore, his subsequent surgical intervention, which may very well have been appropriate to do to treat the gentleman, but still not related to his work injury.

Without a doubt, the evidence proves that the claimant's back problems were attributable to the claimant's pre-existing degenerative condition and to the work related incident on January 15, 2007. Further, none of the physicians selected by the claimant or any other physician have specifically attributed the claimant's need for medical

treatment after June 10, 2008, to the claimant’s work-related injury on January 15, 2007.

In response to an inquiry, Dr. Ahmed stated on February 10, 2009:

> Is it likely that the need for the September 15, 2008 surgery that I performed was caused by Mr. Montana’s on-the-job fall that I understand occurred on January 15, 2007: Undetermined the etiology, but the patient needed the surgery based on his medical condition and radiological findings.

Dr. Johnson, in an April 21, 2009 report, reversed his own opinion regarding the claimant’s herniated disc. However, Dr. Johnson released the claimant from his care on July 1, 2008. Dr. Johnson had not seen the claimant in more than nine months, but he suddenly and inexplicably changed his own opinion regarding the claimant’s medical condition and need for treatment. It was in December 2008 when he stated that the claimant’s need for medical stemmed from the degenerative changes in the claimant’s lumbar spine rather than the January 15, 2007 incident. Dr. Johnson’s opinion should not be given any weight.

I give more weight to the opinion of Dr. Blankenship, who has treated the claimant for a longer period of time than any other physician after the claimant’s January 15, 2007 incident. The Commission has a duty to

translate the evidence on all the issues before it into findings of fact. Weldon v. Pierce Bros. Const. Co., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Moreover, the Commission has the authority to resolve conflicting evidence and this extends to medical testimony. Foxx v. American Transp., 54 Ark. App. 115, 924 S.W.2d 814 (1996). The Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. Emerson Electric v. Gaston, 75 Ark. App. 232, 58 S.W.3d 848 (2001); CDI Contractors McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993); McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989).

Although the Commission is not bound by medical testimony, it may not arbitrarily disregard any witness's testimony. Reeder v. Rheem Mfg. Co., 38 Ark. App. 248, 832 S.W.2d 505 (1992). However, it is well established that the determination of the credibility and weight to be given a witness's testimony is within the sole province of the Workers' Compensation Commission. Wal-Mart Stores, Inc. v. Sands, 80 Ark. App. 51, 91 S.W.3d 93 (2002). The Commission is not required to believe the testimony of the claimant or any other witness, but may accept and translate into

findings of fact only those portions of the testimony it deems worthy of belief. McClain, supra.

The Commission is never limited to medical evidence in arriving at its decision. Moreover, it is well within the Commission's province to weigh all the medical evidence and determine what is most credible. Smith-Blair, Inc. v. Jones, 77 Ark. App. 273, 72 S.W.3d 560 (2002). The Commission is entitled to review the basis for a doctor's opinion in deciding the weight and credibility of the opinion and medical evidence. Id. In addition, the Commission has the authority to accept or reject a medical opinion and determine its medical soundness and probative force. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). The Commission's resolution of the medical evidence has the force and effect of a jury verdict. McClain, supra.

Therefore, when I consider the opinion of Dr. Johnson, Dr. Ahmed, and Dr. Blankenship, I give the opinion of Dr. Blankenship more weight and find that the claimant's need for treatment after June 10, 2008 was due to the claimant's pre-existing, degenerative problems rather than his January 15, 2007 incident. Similarly, I also find that the claimant is not entitled to any temporary total

disability benefits. Accordingly, I must dissent from the majority's award of benefits.

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KAREN H. MCKINNEY, COMMISSIONER