

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F801987

ASHLEY MONTGOMERY, EMPLOYEE	CLAIMANT
R & R FOODSERVICES, INC., EMPLOYER	RESPONDENT
STATE FARM INSURANCE, INSURANCE CARRIER	RESPONDENT

OPINION FILED OCTOBER 12, 2010

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

Claimant represented by the HONORABLE PHILIP M. WILSON, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE JARROD PARRISH, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Respondents appeal an opinion and order of the Administrative Law Judge filed June 8, 2010. In said order, the Administrative Law Judge made the following findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The stipulations agreed to by the parties and recited herein are reasonable and are hereby accepted as fact.

3. The claimant has failed to prove by a preponderance of the evidence that she remained in her healing period and was unable to earn wages from February 25, 2009, through June 1, 2009. Therefore, the claimant has failed to prove by a preponderance of the evidence that she would be entitled to temporary total disability benefits for the period of February 25, 2009, through June 1, 2009.
4. The claimant has however proven by a preponderance of the evidence that she remained in her healing period and was unable to earn wages from June 2, 2009, to a date yet to be determined. Therefore, the claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits from June 2, 2009, to a date yet to be determined.
5. The claimant has proven by a preponderance of the evidence that the additional medical treatment performed by Dr. Thomas and the prior medical treatment performed by Dr. Thomas was reasonable, necessary, and related to the claimant's compensable injury of January 2008. Therefore, respondents are responsible for all medical treatment contained in the record herein b Dr. Thomas pursuant to Rule 30. Further, respondents are responsible for the additional treatment now recommended by Dr. Thomas for pain management, as I find that such additional treatment is reasonable, necessary, and related to the claimant's compensable injury.
6. Nothing in the record indicates that the respondents should be found in contempt for violation of the Change of Physician Order pursuant to A.C.A. §11-9-706.
7. The claimant's attorney is entitled to the maximum statutory attorney's fees on all indemnity benefits awarded herein, one-half of which is to be paid by the

claimant and one-half to be paid by respondents in accordance with A.C.A. §11-9-715.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the June 8, 2010, decision of the Administrative Law Judge, including all findings of fact and conclusions of law therein, and adopt the opinion as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2002).

Since the claimant's injury occurred after July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as

amended by Act 1281 of 2001. Compare Ark. Code Ann. § 11-9-715 (Repl. 1996) with Ark. Code Ann. § 11-9-715 (Repl. 2002). For prevailing on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$500.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority's findings that the claimant proved by a preponderance of the evidence that she was entitled to the surgery performed by Dr. Brad Thomas. Based upon my de novo review of the record, I find that the claimant has failed to meet her burden of proof.

First and foremost, the evidence reveals that the surgery performed by Dr. Brad Thomas on June 2, 2009 was never properly submitted for pre-certification pursuant to the requirements of Rule 30. Rule 099.30(I)(s) provides for the pre-authorization. This section requires:

Preauthorization is required for all non-emergency hospitalizations, transfers between facilities, and outpatient services expected to exceed \$1000.00 in billed charges for a single date of service by provider. A denial decision for payment for any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury, shall only be made by an Arkansas certified private review agent. The Arkansas Department of Health Utilization Review certification number is required upon request. See Arkansas Workers' Compensation Hospital Inpatient Fee Schedule Part III for procedures for requesting preauthorization. Upon emergency admission, notice must be given to the carrier within 24 hours or the next business day.

In the case of Dodson v. Little Rock National Airport, a Full Commission Opinion filed March 30, 2009, Claim No. F511909, the Full Commission found that Rule 30 required that an MRI, if it exceeded \$1000 to be preauthorized. Preauthorizations does not presume that the service was reasonable and necessary and it does not

guarantee that the service is reasonable and necessary for treatment of a claimant. Simply put, "preauthorization and a determination of whether treatment is reasonable and necessary are mutually exclusive."

The medical evidence demonstrates that Dr. Timothy Burson released the claimant and placed her at maximum medical improvement on February 4, 2009. Afterwards, adjuster Suzanne Schmall approved treatment with Dr. Brad Thomas subsequent to the change of physician order entered by the Medical Cost Containment Division. After Dr. Thomas's initial evaluation, his nurse called the adjuster to request a new MRI of the lumbar spine. The nurse followed the telephone conversation with a bare-bones written request for a new MRI. Dr. Thomas then had his nurse set up a phone conference with the adjuster wherein he inquired about whether the MRI request was being denied. Ms. Schmall explained that the MRI would not be approved based on the medical documentation that had been submitted in the claim thus far. Ms. Schmall asked the doctor if there was any additional information to be reviewed or considered.

Dr. Thomas never submitted any additional information for consideration other than a one-page

request for an MRI. At no time did Dr. Thomas or his staff ever submit any surgical request for pre-certification or approval. Ms. Schmall testified that if the surgery had been submitted for pre-certification, she would have considered the surgery for approval, denial, pre-cert review or possibly a second opinion evaluation. Instead, Ms. Schmall found out about the surgery roughly two months after it had taken place. By proceeding with the surgery without even submitting it for approval or pre-certification, Dr. Thomas and/or the claimant violated the requirements of Rule 30(I)(S). Therefore, regardless of whether or not the procedure is deemed reasonable and necessary, Dr. Thomas's failure to comply with the rules of the Commission's absolves the respondents of any liability for his bill. It is apparent that Dr. Thomas's office failed to comply with the pre-certification procedures of Rule 30. Therefore, the respondents would not be responsible for the payment of the procedure.

However, if I were to find that the claimant's treating physician complied with Rule 30, a finding I do not make, I also find that the claimant failed to prove that the treatment was reasonable and necessary medical treatment. The evidence demonstrates that the claimant was released by Dr. Tim Burson on February 4, 2009. Dr.

Burson released the claimant after she had an MRI, a CT lumbar myelogram and a plain film myelogram. On October 16, 2008, Dr. Burson stated:

We discussed myelogram, which does not show anything surgical at this writing. I do not see anything else surgically.

The claimant continued with pain management and she eventually filed a change of physician to Dr. Brad Thomas.

The claimant first saw Dr. Thomas on May 6, 2009. Dr. Thomas noted that the claimant had full range of motion in the lumbar spine, full range of motion in the joints of the lower extremities, no tenderness to palpation of the lumbar sacral spine and paraspinal regions, no kyphotic deformities, negative straight leg raise testing, negative crossed straight leg testing, full strength throughout the bilateral upper and lower extremities, an absence of fasciculations, no sensory dysfunction, normal tendon reflexes, normal pathologic reflexes, normal gait, normal peripheral vascular findings, normal neurological findings, normal cranial nerve function, and a completely normal physical examination. Dr. Thomas ordered an MRI, which was noted to show on May 20, 2009:

Post-op changes left side laminotomy L5 level. Appearance is stable. Some

thickening of the ligamentum flavum is noted that does not appear to be compressing the adjacent left side S1 nerve root. No other significant finding and no evidence of recurring or retained disc herniation.

Despite the MRI showing no abnormalities and the claimant having a completely normal examination, Dr. Thomas proceeded to schedule the claimant for an exploratory and inspection surgery. The claimant continued to have the same problems of left-sided radiculopathy even after this "exploration and inspection".

Dr. Michael Calhoun reviewed the claimant's medical records and diagnostic studies, and he opined that surgery was not reasonable and necessary. Specifically, Dr. Calhoun stated:

It appears that she did not have a recurrent disc herniation either on a postoperative MRI with and without contrast or on a CT myelogram. Both of these were obtained by Dr. Burson and then a second MRI was later obtained by Dr. Thomas in May of 2009. He did re-explore the area and reports taking away some bony stenosis and slight bulging of the disc. With the above findings described in Dr. Thomas's operative report and no evidence of a true recurrent disc herniation, I do not think the second surgery in June of 2009 is related to the original work injury in 2008. Even though she continued to have radicular pain after Dr. Burson's surgery, this did

not really change after Dr. Thomas's surgery.

The claimant has argued that the surgery was appropriate because it reduced some pain in her left buttocks. However, the claimant's hip and buttocks pain pre-existed her work-related injury. The evidence demonstrates that the claimant had experienced pain in her lower back for years. The medical records even document a surgical recommendation made by Dr. Richard Jordan to address problems at the L5-S1 level. On February 23 2007, the claimant's family physician, Jeffery Carfagno noted,

In the past she had a MRI of her L-spine and saw Dr. Jordan for this. He told her he would operate on her when she could not stand it anymore. The pain radiates all the way into her left ankle.

Less than three months prior to her injury, the claimant had been in her family doctor's office with persistent low back pain. The medical records show that the claimant suffered from chronic hip, SI joint and lower back (L5-S1) pain since at least May of 2005. On April 30, 2007, the claimant presented at Dr. Carl Covey's office complaining of constant, "nagging pain" in her left hip that sometimes ran down into her foot. Dr. Covey went on to note "exquisite (sic) left SI joint tenderness" markedly increased pain with extension in

the region of her left SI joint. The claimant was scheduled for SI joint injections which she a never underwent.

In my opinion, it is crystal clear that Dr. Thomas treated this claimant at the same level she had previously received a surgical recommendation from Dr. Richard Jordan. The claimant had pre-existing symptoms that were in no way related to her compensable injury. The surgery performed by Dr. Thomas was not reasonable, nor was it related to the claimant's work-related injury. Simply put, I cannot find that the claimant has proved by a preponderance of the evidence that she is entitled to additional treatment. Even if she could prove that the surgery performed by Dr. Thomas was reasonable and necessary, a finding I do not make, I find that Dr. Thomas failed to properly pre-certify the procedure according to the procedures of Rule 30.

Accordingly, for all the reasons set forth herein, I must dissent from the majority's award of benefits.

KAREN H. MCKINNEY, Commissioner