

**NOT DESIGNATED FOR PUBLICATION**

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION  
CLAIM NO. F806128

JACKIE OWENS, EMPLOYEE	CLAIMANT
SIGN ART ADVERTISING, EMPLOYER	RESPONDENT
TWIN CITY FIRE INSURANCE HARTFORD INSURANCE, CARRIER/TPA	RESPONDENT

OPINION FILED NOVEMBER 15, 2010

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

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

Respondents represented by the HONORABLE TOM HARPER, Attorney at Law, Fort Smith, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Claimant appeals from a decision of the Administrative Law Judge filed, May 12, 2010.

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

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 19, 2008, the relationship of employee-employer-carrier existed between the parties.

3. On March 19, 2008, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$386.00 for total disability and \$290.00 for permanent partial disability.
4. On March 19, 2008, the claimant sustained a compensable injury to his low back and left hip.
5. There is no dispute over accrued medical expenses or temporary disability benefits.
6. The claimant has failed to prove by the greater weight of the credible evidence that the medical services that have been recommended to him by Dr. C. G. Covington, which are currently in the form of a single level fusion at L4-5, are reasonably necessary for his compensable lumbar injury. Specifically, he has failed to prove by the greater weight of the credible evidence that these medical services have a reasonable likelihood of reducing or stabilizing the physical damage from his compensable injury or alleviating the complaints and symptoms resulting from this injury.
7. The respondents have controverted the claimant's entitlement to the additional surgical procedure recommended by Dr. Covington.

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

made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

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

IT IS SO ORDERED.

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A. WATSON BELL, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

**DISSENTING OPINION**

After my de novo review of the entire record, I must respectfully dissent from the majority opinion, because I find that the claimant has proven by a preponderance of the evidence that medical treatment recommended by Dr. Covington, including a single level fusion at L4-5, is reasonably necessary for his compensable injury. I would award the claimant medical benefits, to include the treatment recommended by Dr. Covington.

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). Treatment intended to reduce, or enable a claimant to cope with, chronic pain attributable to a compensable injury may constitute reasonably necessary medical treatment within the meaning of Ark. Code Ann. Sec. 11-9-508. Billy Chronister v. Lavaca Vault, Full Commission Opinion filed June 20, 1991 (D704562). Postsurgical improvement is a proper consideration in determining whether surgery was reasonable and necessary. Hill v. Baptist Medical Center, 74 Ark. App. 250, 48 S.W.3d 544 (2001), citing Winslow v. D & B Mechanical Contractors, 69 Ark. App. 285, 13 S.W.3d 180 (2000).

The claimant saw Dr. Wood from August 2008 to January 2009, at least. He consistently reported radicular pain, miserable pain, tingling and numbness. Dr. Wood recommended physical therapy and medications, and when physical therapy did not help his pain, Dr. Wood sent the claimant to a neurosurgeon. Dr. Covington saw the claimant at least monthly since September 2008. He physically evaluated the claimant, interviewed the claimant and performed or caused to be performed diagnostic testing of the claimant. He observed directly the results of the

conservative care the claimant received. Dr. Covington felt that there could be pathology which would respond to surgical intervention, but that the only way to know if there was a surgical approach to the claimant's problem was to explore the cause of his pain, a position supported by Dr. Standefer. Dr. Standefer was the doctor who evaluated the claimant once for a second opinion. The claimant was not evaluated physically by any of the carrier's physician advisors or peer reviewers. Apparently those personnel did not have the benefit of the claimant's entire medical record. Note that the November 2009 peer review report stated that many important facts and records were not reviewed, including the date of and mechanism of injury. While each of the medical personnel who came into contact with the claimant's medical records must have some degree of medical expertise, they did not have the benefit of the entire record, or the intimate knowledge of the claimant's history, physical condition and personal approach to his injury and health. Only Dr. Covington and Dr. Wood enjoyed that depth of knowledge of the claimant's condition.

Some of the denials of the various treatments recommended by Dr. Covington were followed up by approval,

such as the provocative discogram, the lumbar epidural steroid injections and the anesthetic injection, with no evidence to show the change in decision-making on the part of the carrier. The carrier delayed diagnostic tests and therapeutic treatments, while the claimant's symptoms only worsened. Dr. Covington noted that all but the most basic of measures were denied. Those denials interfered with his recovery.

The reports signed by nurse case manager Lyman suggest that no psychosocial evaluation of the claimant was performed to determine whether surgery would be a success. Dr. Wood's medical records reflect the claimant's desire to return to work, his willingness to walk for exercise at home, that he worked through his problems initially trying to "tough out" the pain, and that his psychiatric review of symptoms was negative. No doctor has identified any behaviors indicating symptom magnification or other psychological component to his pain. Furthermore, Dr. Covington could not get approval for lumbar, SI joint or facet injections, despite the fact that the treatment is regularly seen in low back claims. Without having approval for surgery, Dr. Covington would have no justification for

engaging in the psychosocial review recommended by the carrier's physicians, beyond that done as part of the regular evaluation by Dr. Wood and himself.

The reports prepared by nurse case manager Lyman concerning peer review of recommended treatment complain that important information is missing, from the date and mechanism of injury, to physical therapy records. It is ridiculous for the carrier's medical review team to complain that it does not have the medical records for care approved by the carrier and paid for by the carrier. That fault lies solely with the carrier, and the failure to provide such material to its own medical reviewers adds weight to the concern that the opinions of physicians employed by the carrier to review recommendations of expensive procedures could be, to put it mildly, less than objective.

Those reports also focused on Dr. Covington's desire to find a pain generator, as if Dr. Covington intended to do surgery without care for the need. The record does not support such speculation. Dr. Covington was clear that finding the pain generator is only way to find the means to effectively address problems not addressed by conservative care. In August 2009, Dr. Covington stated

clearly that the purpose of the anesthetic discogram was not to find a place on which to operate, but to determine if surgery was appropriate at all. Of course, the doctor who was charged with treating the claimant's significant back pain and radicular pain after a 16-foot fall onto his heels and bottom would want to find the cause of the pain, especially after months of failed conservative care. He would be a bad doctor if he did not do this. The problem is not that Dr. Covington was too aggressive, but that the carrier repeatedly denied all but the most basic of diagnostic and therapeutic treatment.

The peer review reports by nurse case manager Lyman also indicate the carrier's misplaced notion that the claimant had not had physical therapy, a home exercise program, or a walking program. The reports indicate that, until these were attempted, conservative care had not been exhausted, and surgery could not be warranted. The conservative measures - exercise in the form of walking, physical therapy and anti-inflammatory medications - were all used by Dr. Wood and Dr. Covington to treat the claimant, without success. The physical therapy worsened the claimant's condition and provided no lasting relief.

The claimant testified at hearing and reported to his physicians over the course of his treatment that he continued to walk at home for exercise, yet his condition has deteriorated. The record indicates that the claimant and Dr. Covington expressed concern that the regimen of medication the claimant used was no longer as effective as it had been. The peer review reports seem to be more concerned with form over substance, and are certainly limited by the carrier's failure to provide all the medical records to be reviewed.

Understanding the two kinds of discograms performed on the claimant and what they demonstrated is initially difficult. The provocative discogram tested each lumbar level for pain by injection. The discogram can be of limited value, depending on the condition of the discs. In this case, there was no control, as pointed out in the review report, because all four lumbar discs were painful. This is problematic from an empirical standpoint, because there is no baseline information about a healthy, pain-free disc. However, what was demonstrated was that, while the disks at L2-3, L3-4 and L4-5 looked normal on MRI, the discogram showed they were degenerated, symptomatic disks.

L4-5 was a fairly normal nucleus with only a single tear. L5-S1 was significantly collapsed with a disk extrusion, anterior and posterior tears, and was the most concordant and symptomatic level.

Dr. Standefer suggested that the anesthetic discogram would be useful to identify the pain generator, and Dr. Covington agreed. This was finally approved by the carrier, and when performed, it showed that upon injection of a fast acting anesthetic to one disc at a time and upon the performance of pain-producing exercise, all of the positive discs from the previous discogram remained painful, except one. Even though a disc was injected with an anesthetic, the claimant's pain did not change, at L2-3, L3-4 and L5-S1. However, when L4-5 was injected, his pain levels did change. This level was actually tested twice. The first time, less than half of the planned amount of anesthetic was injected (due to the shearing of the needle), but there was some improvement of his pain on forward flexion and walking. After an appropriate recovery period, during which the effects of the first injection at L4-5 had ended, the test was repeated at full strength, resulting in even more pain reduction. The test showed that L4-5 is a

major pain generator for the claimant. The injection reduced his pain, allowing him to move much more easily and with significantly decreased pain mannerisms, although his discomfort was not completely alleviated.

The anesthetic discogram identified the disc which was causing some, if not all, of the pain, but, more importantly, showed the disc which could be treated to alleviate some, if not all, of the pain. The suggestion that a single-level fusion at L4-5 would not address his pain, because he has four levels of problems, belies the fact that the claimant had relief of his pain only with anesthetic to the single L4-5 disc. That meant that the pain he was experiencing was generated by the single disc, from which logically flows the conclusion that the repair of that disc will address that pain.

The provocative discogram showed that the claimant experienced pain upon non-anesthetic injection of four discs in his lumbar spine. It did not show that the claimant's every day pain was caused by each of the four discs. The anesthetic discogram did show that by deadening the pain in one disc, all of his pain was addressed (although not

eradicated). This seems to be a straightforward endorsement of the treatment of that single disc.

As to whether the recommended fusion surgery at level L4-5 will reduce or alleviate symptoms resulting from the compensable injury, I agree with Dr. Covington that surgical treatment of the claimant's symptomatic L4-5, demonstrated to be the major pain generator, is warranted, where conservative treatment, including physical therapy, anti-inflammatory medication, walking and lumbar epidural steroid injections have failed. Dr. Covington was confident that the claimant could return to work and a productive life, and that the option of maintaining the claimant at his current status was unacceptable where there were other treatment options.

Compared to the opinions of the carrier's reviewers, Dr. Covington had the time and all of the information about the claimant's medical history, as opposed to the reviewers who did not see him and did not have all the information. For example, the undated denial focuses on the absence of radicular pain, which is again factually inaccurate. The claimant had radicular symptoms consistently over the course of his treatment for his work-

related injury. I also note that the reviewers are in the employ of the carrier, and that the resultant appearance of bias is bolstered by the carrier's interference with Dr. Covington's treatment, denying a procedure for a time, only to approve it later as a hearing date approached, and by the carrier's failure to provide all the medical information to the reviewers.

Dr. Standefer's opinion that the anesthetic discogram did not show that "the bulk of his pain" was from a single level is nonsensical in the face of the report that showed only positive pain-relief at one level and none at any other. The discogram showed that treating the other four lumbar discs was non-productive, but that the claimant did have significant improvement with treatment at L4-5. He did not have significant improvement of only his L4-5 pain; he had significant improvement of his pain. Further, Dr. Standefer only examined the claimant once and was hired by the carrier.

Surgery is indeed a risky endeavor and should only be approached cautiously. Dr. Covington and the claimant have addressed the risks of harm and the potential for improvement and, based upon the extensive diagnostic

testing, the results of the course of conservative care, the claimant's level of pain, limitations, and use of medications with lessening benefit, and the many physical evaluations and office visits. I find that the claimant has proven by a preponderance of the evidence that the recommended fusion surgery at L4-5 is reasonable necessary medical treatment of his compensable injury.

After my de novo review of the entire record, I must respectfully dissent from the majority opinion, because I find that the claimant has proven by a preponderance of the evidence that medical treatment recommended by Dr. Covington, including a single level fusion at L4-5, is reasonably necessary for his compensable injury. I would award the claimant medical benefits, to include the treatment recommended by Dr. Covington.

For the foregoing reasons, I must respectfully dissent from the majority opinion.

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PHILIP A. HOOD, Commissioner