

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F010031

SONDRA CLARK,
EMPLOYEE

CLAIMANT

ST. EDWARD MERCY MEDICAL CENTER,
EMPLOYER

RESPONDENT

SISTERS OF MERCY,
INSURANCE CARRIER/TPA

RESPONDENT

OPINION FILED MARCH 1, 2011

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

Claimant represented by the HONORABLE JASON HATFIELD,
Attorney at Law, Fayetteville, Arkansas.

Respondent represented by the HONORABLE RANDY P. MURPHY,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed in part,
affirmed in part.

OPINION AND ORDER

The respondents appeal and the claimant cross-appeals
an administrative law judge's opinion filed August 27, 2010.
The administrative law judge found that the claimant was
entitled to additional medical treatment. The
administrative law judge found that the claimant did not
prove she was entitled to temporary total disability
benefits after April 10, 2006. After reviewing the entire

record *de novo*, the Full Commission reverses the administrative law judge's finding that the claimant was entitled to additional medical treatment. We affirm the administrative law judge's finding that the claimant did not prove she was entitled to additional temporary total disability benefits.

I. HISTORY

The parties stipulated that Sondra Clark, now age 50, sustained a compensable injury to her lower back on May 1, 2000. The claimant testified that while lifting a patient from a wheelchair, "she fell over on me and my back arched....I heard a popping sound in my back, and then some tingling clear down my leg." A physician at Cooper Clinic reported on May 1, 2000, "X-ray of the lumbar spine shows multiple spurs but no disc herniation." The physician's diagnosis was "low back pain and muscle spasm." A lumbar CT was done on May 4, 2000, with the impression, "Very mild disc bulges at L4-5 and L5-S1. At L5-S1 there is very minimal asymmetry to the left."

Dr. Anthony L. Capocelli's impression on May 23, 2000 was "1. Bulging/Herniated disc at L4-5, L5-S1....I feel that she has a back sprain with radiculitis localized at

both the L5 and S1 levels." An MRI of the claimant's lumbar spine was taken on June 1, 2000:

There is minimal right paracentral disc herniation at the T12-L1 level and possibly the L1-L2 level as well. No significant disc bulge or protrusion at the L2-L3, L3-L4, L4-L5, or L5-S1 levels. No definite evidence of nerve root impingement radiographically. No definite left lateral disc herniation appreciated.

Impression

Minimal disc herniations at the T12-L1 and L1-L2 levels....

The impression from a lumbar spine MRI on August 14, 2000 was "Tiny disc protrusions paracentrally on the right T12-1 and L1-2. No other abnormality identified." Dr. Cappocelli stated on August 15, 2000, "there is no surgical lesions as seen on the MRI and at this point I do not think surgery would be indicated at any level." Dr. Cappocelli testified at deposition that he released the claimant to restricted work duties on September 1, 2000. Dr. Cappocelli testified that he believed the claimant had reached the end of her healing period at the time he released the claimant to return to work. A physician at Cooper Clinic Occupational Health released the claimant to restricted work on September 6, 2000.

The impression from an Electromyogram Report on September 19, 2000 was "Normal EMG and nerve conduction study of the left leg."

Dr. John R. Swicegood performed a "Left L4 plus L5 transforaminal steroid injection" on September 29, 2000.

The claimant testified that she did not work for the respondent-employer after October 2000. The claimant agreed on cross-examination that she began working at a dermatology clinic in October 2000.

Dr. Swicegood performed another epidural steroid injection on November 15, 2000. The claimant testified regarding Dr. Swicegood's injections, "The first time they did it, I did feel relief; it did help. The second time, I didn't have any relief from it."

The claimant agreed on cross-examination that she did not work at the dermatology clinic after February 2001.

Dr. Vincent B. Runnels reported on March 12, 2001, "Basically, I feel this patient has degenerative disc disease and suffered a facet strain. She has disc disease both at T12-L1 and L1-2 as well as a minor degree at 4-5 but really her back is not in that bad a shape....Surgery is certainly not indicated." Dr. Runnels noted on March 15,

2001, "I think she may be motivated now to lose some weight. I told her, in the long haul, that is going to be one of the most important things she can do." The parties stipulated that there was "no dispute over the payment of medical expenses incurred through August 3, 2001."

Dr. Runnels stated on August 15, 2001, "I think she has degenerative disc disease and a bulging disc, but it is not compressing on any nerve roots and she would not be benefitted by surgery. In addition, she has psychological problems that would not make her a good surgical candidate for a fusion. She certainly would not be benefitted by a simple discectomy. I do think, with the proper motivation, she could become gainfully employed if she restricted her lifting....I will see her back as-needed. She has a 5% permanent disability to the body as a whole."

Dr. D. Luke Knox reported on September 5, 2001:

Ms. Sondra Clark was seen in the Neurosurgery Clinic on 08-28-01 for consultation of back and left leg pain....She apparently fell backward with a falling patient weighing about 200 lbs. Her back pain and leg pain seem to indicate an L5 radiculopathy. She has been through an extensive conservative trial consisting of epidural steroids, extensive pharmaceutical management, etc. She also underwent physical therapy with worsening discomfort. She also had worsening pain with chiropractic measures....

Neurologically, I thought she, indeed, had a weak extensor hallucis, slightly weak anterior tib, and a positive mild straight leg raising test. She had diminished sensation of her entire left leg. Range of motion of the back was primarily worse in extension.

I asked Sondra to redo her MRI scan of the lumbar spine and also do an LS spine series with flexion/extension views as well as get a SPECT scan of the lumbar spine. I had the opportunity to review her work-up from last year, and I agree with the previous assessments that they were relatively unrevealing. I also asked that she try to get off of most of her medications, primarily the pain medication, and she was given a prescription to start on Neurontin to see if this might help some of her discomfort. I talked to her about various treatment options, and we will entertain those again when she returns to that we can review the results of her MRI scan and further work-up.

The Full Commission filed an opinion on May 11, 2005 and found that the claimant proved she was entitled to "an LS spine series with flexion/extension views" in addition to "a SPECT scan of the lumbar spine" as recommended by Dr. Knox. The Arkansas Court of Appeals affirmed the Commission's opinion. *St. Edward Mercy Medical Center v. Clark*, CA05-785 (Ark. App. Jan. 4, 2006) (unpublished).

Dr. Knox reported on April 10, 2006:

Sondra Clark was seen in the Neurosurgery Clinic on April 10, 2006 for consultation of back and left leg pain.

As you know, Sondra is a 45-year-old, right-handed white female, who was seen by me almost six years ago for non-remitting sciatica. I had recommended that she undergo a repeat MRI scan and SPECT scan with lumbar spine films. Apparently, she got involved with a worker's compensation claim and it only came to approval recently. She continues to complain of a very characteristic L5 radiculopathy, with pain extending into the dorsum of her foot, with numbness over her great toe. It does increase with Valsalva.

Her exam, for the most part, is non-focal. She is much worse in lumbar extension at 20°. I could feel crepitus in her lumbar spine with lumbar extension. Motor exam was felt to probably be normal, although she did have diminished sensation over the L5-S1 dermatome, with paresthesias extending into S1. She had marked paraspinal muscle spasm, much worse on the left than on the right, without evidence of list....

I asked Sondra to go ahead and proceed with MRI scan of the lumbar spine. She will also complete a workup with lumbosacral spine series, with flexion and extension views....

The parties stipulated that there was "no dispute over temporary total disability benefits accruing prior to April 10, 2006."

An MRI of the claimant's lumbar spine was performed on April 13, 2006, and Dr. David A. Davis gave the following impression: "MRI study of the lumbar spine at T12-L1 and L1-L2 shows disc space narrowing and desiccation, mild annular bulging which does not appear to involve neural elements. Incidentally noted is a probable cyst arising from the

inferior pole of the right kidney measuring about 2 cm in diameter."

Dr. Knox corresponded with Dr. David Cannon on April 20, 2006: "I am referring Sandra Clark to your service. She has been followed in our clinic for the past several years. Quite frankly, she has been found to have MRI findings compatible with mild disc space changes at L4-5. She describes a classic L5 radiculopathy. I asked that she get the L4-5 Marcaine disc space injection to see if that might not offer some benefit to her persistent complaints. I will plan to follow her up after she has had a chance to complete the above."

The parties stipulated that there was "no dispute over the medical expenses incurred prior to April 20, 2006."

Dr. Knox noted on May 16, 2006, "She is currently not at maximum medical improvement. For that reason, I would be hesitant to recommend a disability rating. I suspect that I will see her after she has had a chance to complete the disc space injections."

Dr. R. David Cannon performed an L4-5 disc space injection on August 31, 2006. The claimant described her relief from Dr. Cannon's treatment as "pretty dramatic; I'd

say probably about 80 percent, 85." However, "It only lasted for a short period of time, probably - if I can remember back that far - probably four or five hours, which was what we were looking at with the novocaine."

Dr. Knox informed Dr. Runnels on September 6, 2006, "She noted marked resolution with an L4-5 Marcaine disc space injection by Dr. Cannon done last Thursday. I am inclined to recommend that she consider an anterior lumbar discectomy and fusion at L4-5....Unfortunately, her MRI scan has been misplaced. We are going to have it redone, and I will see Sondra back in clinic preoperatively....I will plan to follow her up in the future at that point when her surgery is approved by her workers' compensation carrier."

A pre-hearing order was filed on November 8, 2006. The claimant contended, among other things, that Dr. Knox continued to be her "primary care physician" for the May 1, 2000 compensable injury. The claimant contended that she was entitled to "receive compensation for Dr. Cannon's treatment, as well as her continuing treatment with Dr. Knox, including the recommended surgery. She further contends that she is entitled to receive temporary total disability benefits for her healing period."

The respondents contended that "any benefits other than the plain x-ray and SPECT scan ordered by the Commission are not reasonable and necessary treatment for the claimant's compensable injury."

The parties eventually agreed to litigate the following issues:

1. The claimant's entitlement to additional medical services by Dr. Cannon and Dr. Knox after April 20, 2006, and an MRI performed on April 13, 2006.
2. The claimant's entitlement to additional temporary total disability from April 10, 2006 through a date yet to be determined.
3. Fees for legal services.
4. The respondents' entitlement to have the claimant evaluated by another neurosurgeon for a second opinion on the recommended surgery.

Dr. Knox corresponded with then-counsel for the claimant on December 13, 2006 and stated in part, "I had her undergo an MRI scan, and I had the opportunity to review Dr. David Davis' report, which does not mention anything about the L4-5 disc space changes that I had dictated previously in my reports, specifically dating back to April 20, 2006....Quite frankly, the disc space changes are better defined on her plain films, indicating slight settling, with concomitant facet settling....On September 6, 2006, I referred Ms. Clark to Dr. Dorman for a preoperative

evaluation in consideration of an anterior lumbar interbody fusion with plating. Ms. Sondra Clark is currently unable to pursue gainful employment, secondary to the pain syndrome resulting from the L4-5 disc problems, previously described."

A hearing was held on May 1, 2007. The claimant testified at that time, "I still have the tremendous pain in my lower back, around L4-L5/S1 region that radiates down my hip, through the lateral part of my hip, and then it goes down my thigh laterally to the inside of my knee and shoots out through my big toe." The claimant testified that she wanted to undergo surgery recommended by Dr. Knox. The claimant essentially testified that she was physically unable to perform any employment activity.

Dr. Knox saw the claimant on June 19, 2007 and stated in part, "I am going to have her redo her MRI scan and return to see me for preoperative consult." The claimant followed up with Dr. Knox on July 2, 2007: "I had her do an MRI scan. She does have a central disc herniation at L1-2, but I do not believe that to be the culprit of her complaints. She had previously undergone a Marcaine disc space injection by Dr. Ennis this past August/September.

This markedly improved her complaints. The disc looks so good that I want to double check the Marcaine disc space injection with Marcaine. I informed Sandi that I do not want her on any pain medications....I will plan to follow her up after she has had a chance to visit with Dr. Ennis to undergo the L4-5 disc space injection."

An administrative law judge filed an opinion on July 10, 2007. The administrative law judge found, in pertinent part:

7. The claimant has failed to prove by the greater weight of the credible evidence that the lumbar MRI performed on April 13, 2006, represented reasonably necessary medical services for her compensable injury.

8. The claimant has failed to prove ... that the medical services provided her by and at the direction of Dr. Cannon represented reasonably necessary medical services for her compensable injury.

9. The issue of whether the medical services provided and recommended to the claimant by Dr. Knox, after April 20, 2006 representing reasonably necessary medical services should be reserved for future determination upon receipt of the additional evaluation, testing, and reports herein ordered.

10. The issue of the claimant's entitlement to additional temporary total disability benefits on and after April 10, 2006, should also be reserved for future determination, upon further development of the record....

12. In order to adequately protect the interest of all parties concerned, this Commission should exercise its statutory authority to direct evaluation and testing of the claimant by a

physician of the Commission's choosing. Pursuant to the Act, the respondents are entitled to have a physician of their choosing participate in this evaluation. The appropriate medical expert to perform this and oversee this additional evaluation and testing is Dr. Thomas Glen Pait, at the University of Arkansas School for Medical Sciences in Little Rock, Arkansas.

Neither party appealed the administrative law judge's July 10, 2007 decision.

The claimant was seen at Advanced Interventional Pain & Diagnostics of Western Arkansas, a clinic with Dr. John R. Swicegood and Dr. Jared Ennis, on July 13, 2007. The record indicates that an "Evaluating Nurse" recommended a Discogram. The record indicates that the claimant underwent an "Injection of lumbar disc, Provocative discography of levels L4/L5 with Marcaine injection."

Dr. Knox saw the claimant on September 10, 2007 and noted, "she assures me that the L4-5 disc space injection afforded significant relief of the leg pain. I am going to have Sandy go through a myelogram for further evaluation to see if we may not be able to define any overt compressive pathology. I am somewhat hesitant to recommend that she consider surgery. However, if the myelogram does demonstrate significant compressive pathology, it may be worthwhile to consider cervical decompression and fusion."

A lumbar myelogram was performed on September 25, 2007, with the following conclusion: "No significant extradural defect or nerve root cutoff is identified on the myelogram. There are mild bulges at L3-4 and L4-5 on the lateral view, and also at T12-L1 and L1-2 in the lateral view. CT scan will be obtained for comparison."

A CT of the claimant's lumbar spine "post water soluble contrast myelogram" was done on September 25, 2007, with the following findings:

CT lumbar spine was performed from L1 through S1. There is a small extradural defect behind the lower L1 vertebral body. This is centrally located and does compress the anterior thecal sac at this level. This does not appear to connect to the L1-2 disc space. Clinical significance is not certain. An extruded disc fragment cannot be excluded. No abnormality below the L1 level is definitely detected.

At L2-3, no abnormality is seen.

At L3-4, no abnormality is seen.

At L4-5, no abnormality is seen.

At L5-S1, no abnormality is seen.

No nerve root cutoff at the other levels is identified.

CONCLUSION:

Extradural defect behind the lower L1 vertebral body as described. An extruded disc cannot be excluded. Other abnormality also could not be excluded. Correlation with an MRI scan of the lumbar spine and lower thoracic spine at this level would be recommended for correlation. A study with and without contrast may be of value.

Dr. Knox saw the claimant on September 27, 2007 and informed Dr. Ennis, "I am about ready to convince myself that her problem is arising from the L1-2 level. I have recommended that she undergo an L1-2 Marcaine disc space injection to assess the possibility of improvement."

Dr. Ennis performed an "Injection of lumbar disc, provocative discography of levels L1/L2" on October 1, 2007. The claimant followed up with Dr. Knox on October 16, 2007: "She had marked resolution of her pain following a Marcaine disc space injection. It is my understanding that apparently there was a significant disruption of the disc on discogram done by Dr. Ennis. In the face of her marked resolution of pain, I am quite pleased to recommend that Ms. Clark consider surgical options. Unfortunately, it is going to necessitate a facetectomy and fusion with TLIF spacer implant. This will be arranged in the near future at that point when it is approved by her workers' compensation carrier."

The claimant agreed on cross-examination that she presented on her own to Dr. James B. Blankenship. Dr. Blankenship provided a Clinic Note on December 4, 2007:

Mrs. Clark is an extremely pleasant 47-year-old radiation technician. She was working at St.

Edwards when she was hurt on May 1, 2000. A patient fell on her and she was hyperextended. She had the acute onset of lower back and left groin and left anterior thigh pain....Dr. Knox offered her surgical intervention with a transforaminal interbody arthrodesis at L1-L2 with bilateral pedicular fixation. She has elected to go ahead with surgical intervention but has had some problems at least according to the patient with her Worker's Compensation carrier and she is actually seeing me today as a second opinion through her private health insurance....

IMPRESSION: I agree with Dr. Knox that the patient does have a L1-L2 lateral disk herniation in the extreme lateral disk space....I agree completely with Dr. Knox that she most certainly does have an L1-L2 disk protrusion. She also has marked disk space changes at L1-L2 as well as some fairly significant changes at T12-L1, although there is no disk herniation at this level....

I would agree with Dr. Knox that surgical intervention at the L1-L2 would be an appropriate treatment plan especially considering the fact that the patient has had significant and longstanding conservative treatment with multiple rounds of physical therapy and multiple injections. She understands after seven years the success rate of surgical intervention is not as good as it would have been originally when Dr. Knox offered her a consideration of surgery. I told her that based on the fact that she did have a positive response with her discogram and her DSI coupled with her clinical examination and her findings on MRI and myelography that I think she certainly has at least an 80% chance of improvement with surgical intervention....

It is my opinion based on a reasonable degree of medical certainty that the disk herniation that she has experienced based on the information I have been provided is directly related to her work-related injury seven years ago. I am not

really sure why there has been any question about that unless there is information that I have not been provided. The patient would undergo a lateral decompression at L1-L2 with an extreme lateral decompression and facetectomy with a PEEK implantation and unilateral pedicular fixation. She would also have an extracavity transforaminal lumbar interbody arthrodesis....

Dr. Earl Peeples corresponded with the respondents on March 27, 2008:

Sondra Clark was seen for the purpose of an independent medical examination March 27, 2008. I explained to her that the purpose of our encounter was for me to examine her and prepare a report for a third party....

Radiographs were obtained in this office. Flexion/extension views do not show any evidence of instability....

Ms. Clark had an injury in 2000 and at the time was found to have clearly pre-existing degenerative changes at T12-L1 and L1-L2. A very careful evaluation by physicians, including Dr. Knox, indicated at that time there was no surgical indication and only the presence of pre-existing degenerative disc disease.

Some six years later, she has a confusing status. Dr. Knox changed his mind on several occasions and finally he and Dr. Blankenship, on the basis of a single level discogram study, are apparently eying (sic) the L1-L2 disc as possibly causing her pain. It is by no means certain nor is there any definite proof that is causing her pain.

The discogram, a controversial procedure, was done only at a known abnormal level. No control was performed, therefore, I do not believe the discogram provides useful medical information. There may be some current symptoms coming from the

degenerative changes at either T12-L1 or L1-L2, but this degeneration pre-existed the accident and there is, to a reasonable degree of medical certainty, definitely documented in the medical record, no extrusion of disc material at the time of injury in the year 2000. Surgical treatment could be elected based on degenerative changes. I think it is unlikely to succeed as this individual has recorded history of psychological difficulties, has no recent psychological testing and has no clear-cut findings. She has been disabled for a long period of time.

It is my opinion, to a reasonable degree of medical certainty that there is no specific traumatic lesion attributable to the incident at work documented in this chart. There are degenerative changes clearly pre-existing the incident at work documented. Future treatment may be elected for those, but there was no treatment recommended in the year 2000 for any traumatic abnormality and I do not believe further treatment is work related treatment. It would be related to her chronic degenerative changes.

It is of utmost importance that the physicians very carefully select a procedure to be performed for very definite pathology. I do not see any evidence that documents nerve root compression in any of the studies. Elective fusion for long standing two level degenerative changes at the thoracolumbar junction in a population that has this history is, I think, an unpredictable recommendation. Even Dr. Knox has vacillated as to the cause of her pain.

Pain is not a ratable condition. There is no definite extrusion of disc material or other material definitely related to the 2000 incident as shown on the studies in 2000 and 2001. It would be inappropriate to make a rating secondary to progressive changes and attribute them to an incident in 2000. I believe prior to any consideration for elective surgical intervention

for the degenerative changes at T12-L1 and L1-L2, MMPI testing by an individual unassociated with treatment, such as Dr. Winston Wilson of Little Rock, would be appropriate....

It should be emphasized that there is no evidence of spinal instability or of neurological deficit. These are the conditions which require surgical intervention. They are absent from the records in 2000 and 2001 and from her current records and exam....

Dr. Blankenship stated in part on April 2, 2008, "I have had the benefit of reviewing Dr. Earl Peeple's Independent Medical Evaluation....Dr. Knox and I both agree that she is at the point where the only potential option that she has is surgical intervention....In summary after reviewing the Independent Medical Evaluation, my opinion is still the same....I concur with Dr. Luke Knox that surgical intervention would be an appropriate treatment modality for this patient at present. It appears that the independent medical evaluation that was performed on the patient was weighted heavily with the idea that had been obtained prior to completion of the examination that surgical intervention would not be warranted."

Dr. Gary T. Souheaver evaluated the claimant and provided a Neuropsychology Report on April 30, 2008. Dr. Souheaver's impression was "1. Somatization Disorder, with

moderate to severe anxiety, and secondary depression. 2. Mild cognitive disorder, from #1."

Dr. Blankenship referred the claimant to Dr. Cara R. Hartfield, a clinical psychologist, for a Psychological Evaluation. Dr. Hartfield's diagnostic impression on June 19, 2008 was "Pain Disorder Association with both Psychological Factors and a Medical Condition. Generalized Anxiety Disorder....Mrs. Clark would benefit from cognitive behavioral therapy to teach her ways to respond to stress and worry in ways that do not intensify her pain."

A pre-hearing order was filed on August 11, 2009. The claimant contended that she "sustained a compensable injury while working for the respondents on or about May 1, 2000. At that time, the claimant was lifting a patient while in the course and scope of her employment when she injured her back and neck. There have been multiple recommendations for further testing that have been controverted by the respondents. Additionally, the respondents have failed to pay medical bills."

The respondents contended that the claimant was not entitled to any additional benefits.

The parties agreed to litigate the following issues:

1. The claimant's entitlement to additional medical services from July 2007 through the present by Dr. Knox, Dr. Blankenship, Dr. Ennis, Dr. Hartfield, and Dr. Swicegood.
2. The claimant's entitlement to additional temporary total disability benefits from April 10, 2006 through a date yet to be determined.
3. Fees for legal services.

The claimant was x-rayed in Dr. Knox's clinic on September 15, 2009:

Six-view lumbar spine study demonstrating five non-rib-bearing lumbar vertebrae with well-visualized pedicle architecture throughout the lower thoracic and lumbar spine. There is a rather high lumbosacral junction relative to the intercrystal line, marked disc space changes noted at T12, L1, and L2 without evidence of overt instability, well-maintained sagittal balance. No evidence of spondylo defect. There are vascular clips in the right upper quadrant.

The claimant followed up with Dr. Knox on September 15, 2009: "She has not been seen for a couple of years. She continues to be plagued with back and left leg pain....I recommended that she go ahead and redo her MRI scan for follow up. Her plain films do demonstrate significant disc space changes noted throughout the thoracolumbar junction."

Dr. Knox reported on October 8, 2009, "Sandi Clark was seen in the Neurosurgery Clinic on October 8, 2009 for follow up. Again, she has back and left leg pain. I am convinced that it is the L4-5 level....Unfortunately, Dr.

Ennis did an L1-2 Marcaine disc space injection almost two years ago that afforded tremendous benefit to her complaints. That really confuses me because now I am not so convinced it is the L4-5 facet arthropathy vs. the L1-2 disc. I have recommended that Sandi undergo both an L1-2 Marcaine disc space injection to assess the reversible effects of complete pain resolution for four to six hours vs. a facet injection at L4-5 on the left and/or disc space injection at L4-5." Dr. Ennis performed an "Injection of lumbar disc/discography of levels L1/L2" on October 19, 2009. Dr. Ennis performed a "Facet Nerve Block, Lumbar" on October 23, 2009.

The claimant followed up with Dr. Knox on November 11, 2009: "She reports a 40% improvement with her L1-2 injection but 100% improvement with her L4-5 facet injections. I spoke with Dr. Ennis. I would certainly like to see Sandi avoid surgical avenues. She is to undergo a facet rhizotomy." Dr. Ennis performed a Pain Clinic Procedure on November 24, 2009: "Fluoroscopically directed Radiofrequency Median Branch Neurolysis (Destruction of paravertebral facet joint nerve(s)) 1st nerve and 2nd nerve, Lumbar, median

branch facet nerve 3 and 4, bilateral. Facet levels denervated: L4/5."

A hearing was held on May 11, 2010. The claimant testified that her low back and left leg pain had worsened. The claimant testified that she had not undergone low back surgery. The claimant testified that a treating physician had recommended an "internal pacemaker" for the claimant's back.

An administrative law judge filed an opinion on August 27, 2010. The administrative law judge found that liability for Dr. Blankenship's evaluation of the claimant "was established by the prior final Opinion and Order of July 10, 2007. This determination is res judicata and the respondent is liable for the expense of the evaluation by Dr. Blankenship, subject to the medical fee schedule." There is no support in the record for this finding, because the administrative law judge's July 10, 2007 opinion did not mention Dr. Blankenship at all and instead explicitly designated Dr. T. Glenn Pait to perform additional evaluation and testing. The record does not indicate that Dr. Pait ever examined the claimant. Further, the claimant testified that she presented on her own to Dr. Blankenship,

and Dr. Blankenship noted that the claimant was seeing him "through her private health insurance." Nevertheless, the respondents do not appeal the administrative law judge's finding that they are liable for the expense of Dr. Blankenship's evaluation. Nor do the respondents appeal the administrative law judge's finding that the respondents are liable for the psychological evaluation provided by Dr. Hartfield.

The administrative law judge otherwise essentially found that the claimant was entitled to additional treatment with Dr. Knox and Dr. Ennis. The administrative law judge found that the claimant was not entitled to temporary total disability benefits after April 10, 2006. The respondents appeal to the Full Commission and the claimant cross-appeals.

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. 1996). The claimant must prove by a preponderance of the evidence that

she 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. *Wright Contracting Co. v. Randall*, 12 Ark. App. 358, 676 S.W.2d 750 (1984).

In the present matter, the Full Commission finds that the claimant did not prove medical treatment provided by Dr. Knox and Dr. Ennis after July 2007 was reasonably necessary in connection with the claimant's compensable injury. The parties stipulated that the claimant sustained a compensable injury to her lower back on May 1, 2000. An x-ray on May 1, 2000 showed "multiple spurs but no disc herniation." A lumbar CT on May 4, 2000 showed mild disc bulges at L4-5 and L5-S1. Dr. Capocelli's impression on May 23, 2000 was "back sprain with radiculitis localized at both the L5 and S1 levels." The impression from a lumbar MRI taken on June 1, 2000 was "Minimal disc herniations at the T12-L1 and L1-L2 levels." A lumbar MRI on August 14, 2000 showed "tiny disk protrusions paracentrally on the right T12-1 and L1-2. No other abnormality identified." Dr. Capocelli reported on August 15, 2000, "there is (sic) no surgical lesions as seen

on the MRI and at this point I do not think surgery would be indicated at any level." Additionally, the impression following an Electromyogram Report in September 2000 was "Normal EMG and nerve conduction study of the left leg."

Dr. Runnels examined the claimant and reported in March 2001, "Basically, I feel this patient has degenerative disc disease and suffered a facet strain. She has disc disease both at L12-L1 and L1-2 as well as a minor degree at 4-5 but really her back is not in that bad a shape....Surgery is certainly not indicated." The parties' stipulations indicated that the respondents initially paid for the claimant's medical treatment through August 3, 2001. On August 15, 2001, Dr. Runnels again opined that surgery would not benefit the claimant.

Dr. Knox began treating the claimant on August 28, 2001 and subsequently reported, "I asked Sondra to redo her MRI scan of the lumbar spine and also do an LS spine series with flexion/extension views as well as get a SPECT scan of the lumbar spine." The Full Commission filed an opinion on May 11, 2005 and found that the claimant was entitled to "an LS spine series with flexion/extension views" and "a SPECT scan of the lumbar spine" as recommended by Dr. Knox. After the

Court of Appeals affirmed the Full Commission's finding, the claimant resumed treating with Dr. Knox on April 10, 2006. Dr. Knox recommended another MRI scan of the claimant's lumbar spine.

Dr. Davis' interpretation of a lumbar MRI performed April 13, 2006 was "MRI study of the lumbar spine at T12-L1 and L1-L2 shows disc space narrowing and desiccation, mild annular bulging which does not appear to involve neural elements." Dr. Knox informed Dr. Cannon on April 20, 2006, "She describes a classic L5 radiculopathy." Dr. Knox recommended injection treatment. The parties stipulated that there was "no dispute over the medical expenses incurred prior to April 20, 2006." Dr. Knox saw the claimant on September 6, 2006 and recommended a discectomy and fusion at L4-5. Dr. Knox saw the claimant on June 19, 2007 and recommended yet another MRI scan.

The parties have agreed to litigate the issue of the claimant's entitlement to additional medical treatment beginning in July 2007. The evidence does not demonstrate that medical treatment provided to the claimant beginning in July 2007 was reasonably necessary in connection with the claimant's May 1, 2000 compensable injury to her lower back.

The record before the Commission shows that the claimant suffered from pre-existing degenerative disc disease and suffered a facet strain, as reported by treating physician Dr. Runnels in March 2001. The record does not demonstrate that discography, injections, additional diagnostic treatment, or any other medical procedures recommended by Dr. Knox or Dr. Ennis beginning in July 2007 were reasonably necessary in connection with the compensable facet strain suffered by the claimant on May 1, 2000. There is not even a scintilla of evidence before the Commission which demonstrates that the "Destruction of paravertebral facet joint nerves" as administered by Dr. Ennis in November 2009 was reasonably necessary in connection with the May 1, 2000 compensable injury. We recognize that the claimant has occasionally reported temporary improvement at various times after undergoing injection treatment by various physicians. Nevertheless, the claimant testified at the latest hearing that her low back and left leg pain had worsened rather than improved. The evidence simply does not demonstrate that medical treatment provided after July 2007 was reasonably necessary in connection with the instant claimant's May 1, 2000 compensable injury.

Dr. Knox and Dr. Blankenship have previously recommended surgical treatment for the claimant's thoracic and/or lumbar spine. The claimant testified at hearing that placement of an "internal pacemaker" had been recommended for her lower back. The evidence does not demonstrate that the claimant proved she was entitled to surgical treatment or placement of any device into her back. 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). The Full Commission attaches significant probative weight to the opinions of Dr. Capocelli and Dr. Runnels. Dr. Capocelli stated on May 23, 2000 that the claimant had sustained a back sprain. Dr. Capocelli opined in August 2000 that there were "no surgical lesions as seen on the MRI and at this point I do not think surgery would be indicated at any level." Dr. Runnels reported in March 2001 that the claimant had degenerative disc disease and that surgery was "certainly not indicated." Dr. Peeples independently evaluated the claimant on March 27, 2008. Dr. Peeples opined that surgery was not likely to succeed in improving the claimant's physical condition. Dr. Peeples stated, "I

do not believe further treatment is work related treatment. It would be related to her chronic degenerative changes." The Full Commission finds in the present matter that Dr. Peeples' opinion is credible, is consistent with the opinions of Dr. Capocelli and Dr. Runnels, and is entitled to significant probative weight.

The Full Commission finds in the present matter that the opinions of Dr. Capocelli, Dr. Runnels, and Dr. Peeples are entitled to greater evidentiary weight than the opinions of Dr. Knox and Dr. Blankenship. The claimant did not prove by a preponderance of the evidence that she was entitled to surgery or placement of any internal device into her body. The claimant did not prove that any medical treatment provided after July 2007 was reasonably necessary in connection with the May 1, 2000 compensable injury.

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). Ark. Code Ann. §11-9-102(13) (Repl. 1996) defines "healing period" as "that period for healing of an injury resulting from an

accident." The healing period continues until the employee is as far restored as the permanent character of her injury will permit, and if the underlying condition causing the disability has become stable and if nothing in the way of treatment will improve that condition, the healing period has ended. *Carroll General Hospital 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 for the Commission. *Id.*

An administrative law judge found in the present matter, "10. The claimant has failed to prove that she has been rendered temporarily totally disabled, as a result of the effects of her compensable injury, on and after April 10, 2006." The Full Commission affirms the administrative law judge's finding that the claimant did not prove she was entitled to additional temporary total disability benefits after April 10, 2006. Dr. Capocelli testified that he released the claimant to restricted work as of September 1, 2000 and that the claimant had reached the end of her healing period as of that date. We attach significant probative weight to Dr. Capocelli's opinion. The parties' stipulations indicated that the respondents paid temporary

total disability benefits through April 10, 2006. Dr. Knox stated on May 16, 2006 that the claimant was "currently not at maximum medical improvement." The Commission has the authority to accept or reject a medical opinion and the authority to determine its medical soundness and probative force. *Green Bay Packing v. Bartlett*, 67 Ark. App. 332, 999 S.W.2d 692 (1999). In the present matter, the evidence does not corroborate the opinion of Dr. Knox that the claimant had not reached maximum medical improvement in May 2006 for the compensable facet strain as described by Dr. Runnels in 2001. The Full Commission finds that the instant claimant did not prove she remained within a healing period or was totally incapacitated from earning wages after April 10, 2006.

Based on our *de novo* review of the entire record, the Full Commission reverses in part and affirms in part the administrative law judge's opinion. The Full Commission finds that the claimant did not prove by a preponderance of the evidence that she was entitled to treatment, diagnostic testing, injections, or any other procedures from Dr. Knox or Dr. Ennis after July 2007. Treatment provided by Dr. Knox and Dr. Ennis beginning in July 2007 was not reasonably

necessary in connection with the claimant's May 1, 2000 compensable injury. The claimant did not prove she was entitled to temporary total disability benefits after April 10, 2006. The claimant did not prove by a preponderance of the evidence that she remained in a healing period or was totally incapacitated from earning wages on or after April 10, 2006. The instant claim for additional benefits is denied and dismissed.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. McKINNEY, Commissioner

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

CONCURRING AND DISSENTING OPINION

I must respectfully concur, in part, and dissent, in part, from the majority opinion. I agree with the majority that the claimant has not met her burden of proving entitlement to additional temporary total disability benefits. However, I must dissent from the majority opinion regarding additional reasonably necessary medical treatment. The parties have stipulated that the claimant sustained a

compensable injury to her lower back on May 1, 2000. The majority now concludes that the claimant's need for treatment is not due to her compensable injury, but due to a pre-existing condition. Not only is it a little late in the game in this case to now deem the claimant's compensable injury a "pre-existing condition", even if the claimant did have medical findings evidencing a pre-existing lower back condition, the evidence of record would also suggest that the claimant aggravated the pre-existing condition during the lifting incident at work on May 1, 2000. The employer takes the employee as it finds him, and employment circumstances that aggravate pre-existing conditions are compensable. Heritage Baptist Temple v. Robison, 82 Ark. App. 460, 120 S.W. 3d 150 (2003); Pearline Williams v. L&W Janitorial, Inc. 85 Ark. App. 1, 145 S.W. 3d 383 (2004). Simply put, the majority cannot avoid the question of reasonably necessary medical treatment for the claimant's lower back injury by stating that the claimant's need for treatment is due to a pre-existing condition, not the compensable injury, without addressing the question of whether or not the claimant's compensable injury is an aggravation of a pre-existing condition.

After a de novo review of the record, I find that since the parties have stipulated to a compensable injury, the question of aggravation vs. new injury does not even have to be addressed. The claimant has a compensable lower back injury. The question the majority should be focusing on is whether or not the treatment the claimant has received from and at the direction of her treating physician Dr. Luke Knox, since July 2007, has been reasonably necessary medical treatment. The Workers' Compensation Act requires employers to provide such medical services as may be reasonably necessary in connection with an employee's injury. Ark. Code Ann. § 11-9-508(a) (Repl. 2002); American Greeting Corp. v. Garey, 61 Ark. App. 18, 963 S.W. 2d 613 (1998). Injured employees must prove that medical services are reasonably necessary by a preponderance of the evidence; however, those services may include that 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. Ark. Code Ann. § 11-9-705(a) (3) (Repl. 2002); Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911

S.W.2d 593 (1995); and See Artex Hydroponics, Inc. v. Pippin, 8 Ark. App. 200, 649 S.W.2d 845 (1983).

The problem in this case is that Dr. Knox has been unable to accurately diagnose the claimant's condition. It is undisputed that the claimant is in pain. The question for Dr. Knox seems to be whether the pain is being generated from the L4-L5 level of the claimant's spine or the L1-L2 level. All of the treatment provided to the claimant by Dr. Knox and Dr. Ennis since July 2007 has been geared to accurately diagnosing her condition in order to treat her pain. Treatment designed to accurately diagnose the nature and extent of a compensable injury is reasonably necessary medical treatment under the workers' compensation act. Pain treatment is reasonably necessary medical treatment under the workers' compensation act. I believe the majority is simply frustrated that it is taking so long to accurately diagnose the claimant's condition. But just because the claimant has a difficult to diagnose condition does not mean that the majority can simply say that the claimant does not have a compensable injury and that the treatment she has been receiving since July 2007 has not been reasonably necessary, when she has a stipulated compensable injury, and

when the treatments she has been receiving so clearly meet the case law definition of reasonably necessary medical treatment. There is no requirement in workers' compensation law that the claimant must have a simple injury.

Unfortunately for this claimant, her injury is hard to diagnose. In my opinion, the question of whether the claimant has an L4-L5 injury or and L1-L2 injury was best answered by the claimant in her hearing testimony. It is both. And the treatment she has received for both disc levels from and at the direction of Dr. Knox since July 2007 has been reasonably necessary medical treatment.

For the aforementioned reasons I must concur, in part, and dissent, in part, from the majority opinion.

PHILIP A. HOOD, Commissioner