NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G405713

GREGORY HOLLINGSWORTH,
EMPLOYEE CLAIMANT

J B HUNT TRANSPORT SERVICE, INC.,
EMPLOYER RESPONDENT

AIG CLAIMS INC.,
INSURANCE CARRIER/TPA RESPONDENT

OPINION FILED OCTOBER 5, 2015

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

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

Respondents represented by the HONORABLE JOSEPH H. PURVIS, 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 April 28, 2015. In said order, the Administrative Law Judge made the following findings of fact and conclusions of law:

1. The claimant has proven by a preponderance of the evidence including the claimant's testimony, documentary evidence, and medical evidence that the surgery (a cervical discectomy and fusion) recommended by Dr. Knox is reasonable and necessary for the

treatment of his admittedly compensable neck injury from July 14, 2014.

2. The claimant has also proven that he is entitled to temporary total disability benefits from October 21, 2014 until a date yet to be determined.

3. Additionally, the claimant's attorney is entitled to an appropriate attorney's fee based on the above findings.

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 and adopt the April 28, 2015, 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.

SCOTTY DALE DOUTHIT, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority's opinion finding that the claimant proved that he is entitled to additional medical treatment in the form of cervical surgery with Dr. Knox, and to additional temporary total disability benefits from

October 21, 2014, through a date yet to be determined. My carefully conducted *de novo* review of this claim in its entirety reveals that the claimant has failed to prove that he is entitled to additional benefits to include medical and temporary total disability benefits.

The facts surrounding the claimant's compensable injury are undisputed. On July 14, 2014, the claimant, a truck driver for the respondent-employer, was injured when the truck he was driving rolled over as he was passing another truck. The claimant received emergency medical treatment at the emergency department of CoxHealth Monett Hospital, Monett, Missouri, where he was assessed with back pain and contusions of the face, neck, scalp, and back, with scalp and nasal lacerations. A CT scan of the claimant's cervical spine taken at the hospital revealed 1) trace degenerative retrolisthesis at C5-6; 2) mild to moderate disc height loss and spondylosis at C5-6 and C6-7; and, 3) moderate degenerative changes at C1-2. Otherwise, this study was negative for acute cervical fractures. The claimant was discharged home with medications.

On July 22, 2014, the claimant presented for follow-up care to Dr. Rebecca Lewis with QuickCare Clinics in Siloam Springs. Dr. Lewis's examination of

the claimant's cervical spine revealed "a lot of paravertebral spasm of the posterior cervical spine from the sub-occiput down to T2-T3 and the entire cervical spine." Dr. Lewis noted that the claimant had "limited range of motion in flexion/extension, right and left rotation, and side bending right and left as well." Dr. Lewis diagnosed the claimant with "right scalp laceration, now healed; staples removed, cervical whiplash with a lot of spasm noted today at the neck and upper thoracic spine, soft tissue contusions and bruising of the left thigh and laceration of the nasal ala (sic), healed with suture x1 removed today; right rib contusion of ribs 7-12." Dr. Lewis gave the claimant a Medrol Dosepak, refilled his prescription for Norco, and instructed him to follow-up with her in two weeks.

The claimant returned to the clinic on August 4, 2014. In the Plan portion of her clinic report of that visit, Dr. Lewis stated, in part, as follows:

> Today he states that he is still getting around slowly. His rib pain is much improved; however, he is beginning to have moderately severe right shoulder pain and pain down into his right arm to the elbow, coming from the right side of his neck. He states that his rotation to the right is limited as well. Most of his other injuries have resolved at this point in time, he states. In

> review of his records, the emergency room in Monet (sic), Missouri, did order a CT of the head which was normal. The CT of the facial bones did show an old nasal vomer fracture and an old orbital fracture; however, no acute findings. He also had a CT of the chest that was within normal limits and a CT of the abdomen and pelvis that was within normal limits. He had a CT of the cervical spine which showed no cervical spine fractures. He did have some retrolisthesis at C5-C6, mild to moderate disc height loss, and spondylosis at C5-6 and C6-7 which were chronic changes. He also had moderate degenerative changes at C1-2. Otherwise, unremarkable....The patient states he was terminated by JB Hunt following investigation of his wreck. He also stated at this time that he would probably be on Workers' Compensation for quite some period of time.
>
> Upon physical examination of the claimant, Dr. Lewis stated, in part, as follows:
>
> Examination of the neck reveals decreased rotation to the right. The patient has close examination of the cervical spine and there are no step-offs or deformities. On gentle feather touch palpation of the cervical spine and thoracic spine, the patient has an inappropriate withdrawal reflex and moaned, "Ow, oh, ouch" on exam. I was not able to appreciate any spasm because I really did not palpate the muscle deeply. His reflexes are brisk at the tricipital, bicipital, and brachioradialis tendons. There is no swelling or redness noted of either shoulder or forearm or around the neck area. Examination of the chest reveals no rib tenderness any

> longer. On examination of the extremities, the patient has normal strength and range of motion. Reflexes are brisk.

Dr. Lewis stated her impression of the claimant's condition as follows:

> IMPRESSION: Rollover motor vehicle accident on July 15, 2014 with reported increase in right-sided neck pain and right upper arm and shoulder pain
> Inappropriate pain response to gently (sic) touch of the cervical spine.

Dr. Lewis's ordered an MRI scan of the claimant's cervical spine to "clarify" his reported complaints. Further, she noted that the claimant had "some chronic ongoing degenerative changes in the neck that were there long before his wreck."

An MRI scan of the claimant's cervical spine taken on August 13, 2014, revealed the following findings:

> The cervical spine demonstrates a normal lordotic curvature. The vertebral body heights are well maintained and demonstrate normal signal. The visualized soft tissues of the posterior cranial fossa are unremarkable. The visualized soft tissues of the neck are felt to be within normal limits.
>
> At C2/C3, no evidence of disc bulge, neural foraminal narrowing, or central canal stenosis is identified.

At C3/C4, no evidence of disc bulge, neural foraminal narrowing, or central canal stenosis is identified.

At C4/C5, minimal bilateral uncovertebral disc osteophyte complex is seen with mild bilateral facet degenerative changes present creating mild bilateral neural foraminal narrowing. No central canal stenosis is identified.

At C5/C6, mild to moderate diffuse disc osteophyte complex is seen with a right lateral disc osteophyte complex identified. There is moderate right and mild neural foraminal narrowing. No central canal stenosis is identified.

At C6/C7, there is mild diffuse disc osteophyte complex seen with a moderate right lateral disc osteophyte complex identified, creating moderate right foraminal narrowing. No central canal stenosis is identified.

C7/T1, no evidence of disc bulge, neural foraminal narrowing, or central canal stenosis is identified.

IMPRESSION:
Degenerative changes are seen within the cervical spine most pronounced at the levels of C5/C6 and C6/C7 where there is mild to moderate diffuse disc osteophyte complex at these levels with a moderate right lateral disc osteophyte complex present creating moderate right neural foraminal narrowing. There is no acute central canal stenosis seen.

The claimant presented to Dr. Lewis in follow-up on August 18, 2014. According to Dr. Lewis, the claimant suffered from "persistent cervical strain on the right and left," with "degenerative joint disease of the cervical spine with osteophyte formation, multiple levels." In conclusion of her report of that date, Dr. Lewis noted as follows:

> PLAN: The patient will be referred to a neurosurgeon for a second opinion. We did discuss the findings of the MRI at great length and a diagram was made for him of his degenerative changes of the cervical spine. He did state that his pain did not begin whatsoever until after he had the accident and he never had any reports of any history of an injury to his cervical spine previously. He does state that he is going to obtain the services of an attorney to clarify these issues for him. At this time, I am going to defer his treatment to a neurosurgeon who can possibly explain to him better than I did what degenerative changes of the cervical spine involve. This is a final report on this injury.

Dr. Lewis released the claimant to return to work on that date with no restrictions.

On October 21, 2014, the claimant presented to Dr. Knox at the Northwest Arkansas Neurosurgery Clinic. In his comprehensive report of that visit, Dr. Knox noted, among other things, that the claimant's cervical

spine was normal to inspection. More specifically, Dr. Knox noted that the claimant's cervical spine was normal to palpation without muscle spasm, tenderness, or set-offs; he had active range of motion; normal muscle strength, and; normal reflexes with flexion and extension. Dr. Knox further noted nerve and spinal cord tension-compression, and intense neck pain with *Spurling's Maneuver*. The claimant's thoracic, lumbar, and sacral spine examinations were normal on inspection as to palpation, range of motion, muscle strength and tone, and stability. Dr. Knox assessed the claimant with cervical degenerative disc disease, herniated disc, radiculopathy, stenosis, and spondylosis without myelopathy.

A CT scan of the claimant's cervical spine conducted on January 16, 2015, revealed the following findings:

> There is good contrast in the thecal sac. There is mild degenerative disc disease at C5-C6 and C6-C7 with disc space narrowing and with some anterior and posterior osteophyte formation. There is no significant disc bulge and no disc protrusion or canal stenosis.

The radiologist reading this scan, Dr. David Phelan, gave his impression of these findings as follows:

1. Negative for evidence of disc protrusion or canal stenosis.
2. Mild degenerative disc disease at C5-C6 and C6-C7.

In a clinic report generated on January 20, 2015, Dr. Knox stated that upon reviewing the radiologist's report of the claimant's recent CT scan he was "more impressed than their report." According to Dr. Knox, this study showed a "distinctly significant" compressive pathology at the C5-6 level on the right, with a significant component of compression at the C6-7 level bilaterally. In addition, Dr. Knox stated the post-CT myelogram demonstrated significant neuroforaminal encroachment at C5-6 and C6-7 levels on the right. Dr. Knox recommended an anterior cervical discectomy and fusion at C5-6 and C5-7 in order to address these findings.

The deposition of Dr. Knox was taken twice during the course of this claim. In his first deposition taken on January 5, 2015, Dr. Knox agreed that diagnostic studies performed at the time of the claimant's compensable accident showed pre-existing disc degeneration throughout the claimant's cervical spine, more profound at levels C5-6 and C6-7. Dr. Knox stated without equivocation, however, that it was his opinion that the claimant's motor vehicle accident of July,

2014, was causing the claimant's symptoms, as opposed to a degenerative process. Dr. Knox stated that the basis for this opinion was the claimant's lack of cervical complaints prior to this accident. More specifically, Dr. Knox stated: "No. It was the accident in July - - as I see it, it was his accident in the middle of July causing his current symptoms." Dr. Knox agreed that the claimant's underlying degenerative process was not caused by his motor vehicle accident, and he later conceded that the claimant's current symptoms are a product of both his underlying degeneration and his accident. When questioned about the degenerative findings on the claimant's MRI and CT studies, Dr. Knox stated: "[V]ery often times as good as our MRI scans or CAT scans are, there are findings, specifically in surgery or automatically, where we see that the disc is injured resulting in more impingement despite the fact that we read it out as degenerative in nature, but there can be a small disc herniation from the acute injury." Dr. Knox generally discredited the radiologists's readings of the claimant's first diagnostic studies, stating generally that a radiologist has "no clue" what the claimant's problems are, and that he should "not be used as an individual to document" the claimant's problems. "Well, the radiologist has no business

attributing his problem," Dr. Knox added, "he's a radiologist, he just looks at x-rays, he doesn't look at the patient." Rather, in Dr. Knox's opinion, the claimant's treating physicians should be the ones interpreting the claimant's diagnostic studies in order to "define his treatment plan."

I note that Dr. Knox's first deposition was taken prior to the claimant's myelogram with CT scan, in part, to determine the reasonable necessity of these studies. In Dr. Knox's second deposition, which was taken on January 27, 2015. Dr. Knox stated that when the claimant presented to him on January 20, 2015, to review the findings of his recent myelogram and CT scan, he expected to see negative results due to all the "plus/minus" findings from earlier diagnostic testing. Dr. Knox found, however, that the claimant's myelogram was positive for "extrinsic compression of the nerve root," which Dr. Knox stated could have been related to his degenerative disc disease. "My contention," Dr. Knox stated, "is that even though you have this degenerative phenomenon, you can have a small disc herniation that can escape notice on the MRI scan, CAT scan, post-myelogram CAT scan." When asked what the source of the claimant's nerve root impingement was, Dr. Knox replied, "I would be hard-pressed to say for

absolute certain if it is a disc herniation versus a disc degenerated spur. It could be either."

Dr. Knox agreed that the claimant should be symptomatic with any nerve root impingement. When questioned about his initial examination of the claimant's cervical spine on October 21, 2014, wherein Dr. Knox found normal muscle strength, reflexes, and sensation, without spasm on palpation, Dr. Knox stated, "Wouldn't you expect, it's always good when you find it, it would - - I don't know if you have to expect it, but, yes, you would like to see it." Although Dr. Knox could not definitively state whether the claimant's nerve impingement was from degeneration or his accident, he stated that the claimant's described pain is consistent with the area of impingement.

The claimant's testimony at the hearing before the commission on February 2, 2015, reflects that he was asymptomatic for cervical pain prior to his compensable injury and that he had no prior treatment for his cervical issues prior to that incident. The claimant alleges that he cannot bend his neck to the right or to the left, and that bending his neck backwards causes him severe pain. The claimant has not worked since the July, 2014, injury, and he claims that he no longer works as a truck driver, which I note had been his

primary source of employment for over three decades prior to his accident.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. § 11-9-508(a)(Supp. 2009). However, injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. *Owens Plating Co.v. Graham*, 102 Ark. App. 299, 284 S.W.3d 537 (2008). What constitutes reasonable and necessary treatment is a question of fact for the Commission. *Id.; Anaya v. Newberry's 3N Mill*, 102 Ark. App. 119, 282 S.W.3d 269 (2008). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze both the proposed procedure and the condition it is sought to remedy. *Deborah Jones v. Seba, Inc.*, Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553). Also, the respondent is only responsible for medical services which are causally related to the compensable injury. Treatments to reduce or alleviate symptoms resulting from a compensable injury, to maintain the level of healing achieved, or to prevent further deterioration of the damage produced by the compensable

injury are considered reasonable medical services. *Foster v. Kann Enterprises*, 2009 Ark. App. 746, 350 S.W.2d 796(2009).

The compensability of the claimant's injury is undisputed. Therefore, it is not necessary that we establish that the claimant's allegedly asymptomatic cervical degenerative disc disease is a compensable consequence of that injury. Rather, the question is whether the cervical surgery proposed by Dr. Knox is reasonably necessary for the treatment of that condition. Here, I find that it is not.

In his medical reports and deposition testimony, Dr. Knox has stated that the claimant's current cervical symptoms are the result of the claimant's compensable accident. Dr. Knox admits, however, that the claimant's underlying degenerative condition pre-existed the claimant's 2014 injury. Furthermore, Dr. Knox agrees that it is questionable as to whether his finding of a nerve impingement in the claimant's cervical spine is degenerative or acute in etiology. In addition, Dr. Knox admits that the cervical surgery he proposes for treatment of the claimant's condition is solely for the purpose of relieving the claimant's pain, which the doctor acknowledges is not verifiable by objective medical

testing. Rather, even Dr. Knox concedes that the claimant's reported pain is purely subjective.

Numerous objective studies performed during the course of the claimant's medical treatment have resulted in no acute findings. And, while Dr. Knox may discount these findings because they were read by the radiologists overseeing the performance of these tests, I do not. Rather, I find Dr. Knox's demeaning characterization of a radiologist's role in the diagnostic process baseless, especially in view of the fact that it is commonly known that reading and interpreting the results of imaging in order to advise the treating physician of these findings is part-and-parcel of a radiologist's primary responsibilities.

Furthermore, I find that the consistency of diagnostic studies showing no objective basis for the claimant's alleged complaints of debilitating pain is also consistent with Dr. Lewis's conclusion that the claimant was engaging in symptom magnification upon her examination of the claimant contemporaneously with his accident. I addition, I find that the claimant's reported prediction early on in his treatment that he "would probably be on Workers' Compensation for quite some period of time" is troubling, in that there was no prognosis at the time indicating the anticipated length

of the claimant's recovery. Therefore, the claimant's prediction of his recovery time was not backed by any medical evidence or opinion. The claimant's noted symptom magnification combined with his statement to Dr. Lewis concerning a prognosis that had not been medically made leads me to find that the claimant lacks credibility. And, while I do not completely discredit Dr. Knox's opinion that the claimant could have nerve impingement that may or may not be causally related to his compensable injury, this much is clear: it has been the opinion of three different doctors of radiology reading three separate diagnostic studies on three separate occasions that the claimant has no objective findings of acute injury that could account for his subjective complaints of pain. Therefore, we are left to determine whether the claimant's allegedly asymptomatic pre-existing condition has become symptomatic as a result of his compensable injury enough to warrant Dr. Knox's proposed surgical procedure. Due to the claimant's lack of credibility, I find that the claimant's subjective complaints of pain form an insufficient basis upon which establish a need for this proposed treatment. Therefore, I find that the claimant has failed to prove by a preponderance of the evidence that the additional medical treatment he seeks in the

form of cervical surgery is reasonably necessary for the treatment of his compensable injury, and that this treatment should be denied.

With regard to additional temporary total disability benefits, I find that the claimant has failed provide sufficient proof in the way of medical evidence or otherwise showing that he is unable to work, as he claims, as a result of his compensable injury. Further, since I find that the claimant is not credible, I further find that an award of temporary total disability cannot be based solely on his testimony that he is unable to work. Dr. Lewis released the claimant to return to work without restrictions on August 18, 2014. Therefore, I find that the claimant has failed to prove that he is unable to work as a result of his 2014 compensable injury, and that additional temporary total disability benefits after August of 2014 should be denied. Accordingly, I respectfully dissent from the majority's opinion.

KAREN H. McKINNEY, Commissioner