NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. H203473

PATRICK AUSTEN, EMPLOYEE	CLAIMANT
LOWE'S HOME CENTERS LLC, EMPLOYER	RESPONDENT
SEDGWICK CLAIMS MANAGEMENT SERVICES INC., INSURANCE CARRIER	RESPONDENT

OPINION FILED APRIL 4, 2024

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

Claimant represented by the HONORABLE EVELYN E. BROOKS, Attorney, Fayetteville, Arkansas.

Respondents represented by the HONORABLE RANDY P. MURPHY, Attorney, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Respondent appeals an opinion and order of the Administrative Law Judge filed August 31, 2023. In said order, the Administrative Law Judge made the following findings of fact and conclusions of law:

1. The stipulations agreed to by the parties at a pre-hearing conference conducted on August 19, 2023, and contained in a pre-hearing order filed

April 21, 2019, as modified, are hereby accepted as fact.

2. Claimant has met his burden of proof by a preponderance of the evidence that he is entitled to additional medical benefits from Dr. James Blankenship for his compensable back injury.

We have carefully conducted a *de novo* review of the entire record herein and it is our opinion that the Administrative Law Judge's August 31, 2023 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.

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. 2012).

For prevailing on this appeal before the Full Commission, Claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715 (Repl. 2012). For prevailing on appeal to the Full Commission, the Claimant's attorney is entitled to an additional fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b) (Repl. 2012).

IT IS SO ORDERED.

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SCOTTY DALE DOUTHIT, Chairman

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M. SCOTT WILLHITE, Commissioner

Commissioner Mayton dissents

DISSENTING OPINION

I respectfully dissent from the majority opinion. After my *de novo* review of the file, I find that the claimant has failed to prove by a preponderance of the credible evidence that he is entitled to additional medical treatment by Dr. James Blankenship for his compensable back injury.

On July 12, 2019, the claimant suffered an admittedly compensable injury to his low back when loading a refrigerator onto the lift grate of a delivery truck. The claimant was initially seen at MedExpress in Fayetteville and was diagnosed with a muscle strain. (Resp. Ex. 1, Pp. 1-4). He was released to full duty at that time. (Resp. Ex. 1, P. 4). After continued complaints, MedExpress diagnosed the claimant with a unilateral inguinal hernia. (Resp. Ex 1, P. 10). The claimant was seen by Dr. Robert Petrino on August 12, 2019, who did not feel the claimant's pain was related to a

hernia, but rather to his low back, and referred the claimant to Dr. Luke Knox to be reevaluated. (Resp. Ex. 1, Pp. 14-16).

At the claimant's September 16, 2019 visit, Dr. Knox indicated that the claimant's active problems were:

> 1. DDD (degenerative disc disease), lumbar
> 2. Lumbar disc herniation
> 3. Lumbar foraminal stenosis
> 4. Lumbar pain
> 5. Lumbar radiculopathy
> 6. Sciatica of the right side (Resp. Ex. 1, P. 17).

Upon physical examination, Dr. Knox found tenderness at "level L1-L2 right paraspinal, but not the lumbar spine, not the left paraspinal, not the left sciatic notch and not the right sciatic notch." (Resp. Ex. 1, P. 18).

Dr. Knox ordered an x-ray of the claimant's lumbar spine as well as an MRI of the lumbar spine, noting that the claimant's pain was consistent with L1-L2 radiculopathy. (Resp. Ex. 1, P. 19). Upon reviewing the claimant's x-ray report, Dr. Knox opined that:

> Degenerative changes are noted at 3-4, 4-5 and 5-1, appearing to be worse at 4-5 and 5-1. There is no evidence of overt instability on flexion and extension views, no evidence of erosive bony abnormality and no evidence of compressive vertebral body abnormality. There are degenerative changes noted throughout the lower lumbar levels with facet settling. (Resp. Ex. 1, P. 22).

The results of the claimant's MRI showed:

> L4-5: Diffuse disc bulge asymmetric to the right and bilateral facet arthropathy results in mild

> bilateral lateral recess narrowing and moderate bilateral foraminal narrowing.
>
> L5-S1: Diffuse disc bulge asymmetric to the right and bilateral facet arthropathy results in severe right foraminal stenosis and moderate left foraminal narrowing. There could be impingement upon the exiting right L5 nerve root. (Resp. Ex. 1, P. 23).
>
> Impression: Lower lumbar predominant spondylosis, worst at L4-5 and L5-S1 levels. There is severe right sided foraminal stenosis at L5-S1 level, which could result in impingement upon the existing L5 nerve root. (Resp. Ex. 1, P. 23).

These results showed, "[n]o canal, lateral recess, or foraminal narrowing" at the L1-L2 level. *Id*. However, upon reviewing the MRI, Dr. Knox determined that the claimant has a "foramenal disc at L1-2 on the rt will get started pain management/foraminal selective nerve block L1-2 on right." (Resp. Ex. 1, P. 27). Dr. Knox referred the claimant to Camp Interventional Pain Associates and released him to work without limitations, full duty (Resp. Ex Pp. 27-31).

After his first visit with the claimant on October 22, 2019, Dr. Nicholas Camp at Camp Interventional Pain Associates noted that "[a]n MRI to the lumbar spine performed recently was revealing for disc protrusions, primarily at the right L1-2 level" and reported that he "opened the patient's MRI today during our visit and discussed, in detail, this patient's underlying pathology and our treatment approaches available to

address this pain . . . Will schedule for a right L1/2 selective nerve root block with fluoroscopy." (Resp. Ex. 1, Pp. 31-36). The claimant received nerve blocks by Dr. Camp on November 5 and November 19, 2019 (Resp. Ex. 1 Pp. 37-44). The claimant followed up with Dr. Knox on December 9, 2019, reporting 75% improvement. (Resp. Ex. 1, P. 45.) Dr. Knox's report indicated that there were "[d]egenerative changes noted at L4-L5 and L5-S1. Right L1-L2 lateral bulging disc affecting the Right L1 nerve," and Dr. Knox referred the claimant for "evaluation of extreme lateral disc herniation at L1-2 on the right." (Resp. Ex. 1, P. 47).

On December 18, 2019, the claimant saw Dr. Brandon Evans who recommended that the claimant continue with non-surgical measures due to the improvement he had shown until that point in time. Dr. Evans stated in his report:

> 37-y/o male with history of L1 radiculopathy that is improved with therapies. He how has symptoms of radiculopathy that suggest a lower nerve root compression as it is located in lateral thigh. Overall, his symptoms have improved with the recent injections. I reviewed his MRI and showed and explained my impression. There is a far lateral disc at L1-2 that was likely the source of his original symptoms. The radicular pain has resolved from this and he is left with numbness. I explained that this could be permanent but the fact it is no longer painful suggests it is no longer being injured from the disc fragment, thus surgery would not likely convey any more benefit and only add risk. Related to his new symptoms, this too appears to be improving

> and more tolerable. On his MRI there is disc protrusion at L4-5 and L5-S1 that narrows the neural foramen. This MRI was done prior to his new symptoms, so it is limited in this regard. His new symptoms do not extend below the knee so it is difficult to delineate which nerve root is symptomatic on clinical exam. However, at this time, I encouraged him to continue with the nonsurgical treatments as he has improved and surgery would add significant long term risk given his age. I recommend he try to get a selective right L4-5 foraminal injection to see his this helps more with his residual symptoms.

On June 2, 2020, the claimant underwent an additional MRI, which revealed:

> L1-L2: There is a diffuse disc bulge asymmetric to the right. There is no central canal stenosis. There is no facet osteoarthritis. There is mild right neural foraminal stenosis.
> . . .
> L4-L5: There is diffuse disc bulge. There is no central canal stenosis. There is moderate bilateral facet osteoarthritis. There is mild-to-moderate left neural foraminal stenosis.
>
> L5-S1: There is diffuse disc bulge. There is no central canal stenosis. There is mild bilateral facet osteoarthritis. There is moderate bilateral neural foraminal stenosis. The disc bulge also minimally impinges on the bilateral S1 nerve roots.
>
> Impression: 1. Degenerative disc and joint disease with varying degrees of neural foraminal stenosis as described above. Disc bulge at L5-S1 minimally impinges on the bilateral S1 nerve roots. (Resp. Ex. 1, Pp. 174-175).

After continuing treatment, the claimant obtained a third MRI on June 14, 2021, which showed:

> There is degenerative disc signal throughout the lumbar spine . . . There is multilevel discogenic and facet degenerative changes that will be discussed on a level by level basis:
> . . .
>
> L1-L2: No central canal or neural foraminal narrowing.
> . . .
>
> L4-L5: Mild diffuse disc bulge and early facet hypertrophy resulting in mild effacement of the thecal sac and mild bilateral neural foraminal narrowing.
>
> L5-S1: Minimal diffuse disc bulge and mild facet hypertrophy resulting in mild effacement of the intrathecal sac, moderate right neural foraminal narrowing, and mild left neuroforaminal narrowing.
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> Impression:
>
> 1. Mild degenerative changes of the lumbar spine worst in the lower lumbar spine. At L5-S1, there is minimal diffuse disc bulge and mild facet hypertrophy resulting in mild effacement of the anterior thecal sac, moderate right neural foraminal narrowing, and mild left neuroforaminal narrowing.
>
> 2. Mild degenerative disc signal involving all 5 intervertebral discs of the lumbar spine. (Reps. Ex. 1, P. 234).

The claimant underwent a fourth and final MRI on August 15, 2022, which showed "[m]ild multilevel spondylosis, as above. No high-grade

canal stenosis at any level" (Resp. Ex. 1, P. 280). This is noted to being similar to the claimant's September 2019 MRI results. (Resp. Ex. 1, P. 279).

Throughout his treatment, two doctors – Dr. Kenneth Tonyman and Dr. James Blankenship – offered the claimant very invasive surgeries to relieve his symptoms. Neither appear to indicate the relationship between the claimant's L4-5/L5-S1 complaints and his work-related injury.

The respondents obtained an additional opinion from Dr. Owen Kelly, a board-certified orthopedic surgeon, regarding the Dr. Blankenship's contention that an anterior arthrodesis at L4-5/L5-S1 is reasonable and necessary. Dr. Kelly opined that:

> L1-L2:
> Mr. Austen's complaint was localized to the L1-L2 level with a documented lateral disc herniation affecting L1. He underwent treatment and management at that level including selective nerve root blocks. His findings including the groin pain are consistent with that dermatome distribution. There did not appear to be right hip pathology noted to explain his symptoms. The L1-L2 pathology (lateral disc herniation) appeared to be work related.
>
> L4-S1:
> Mr. Austen has objective findings of degenerative disc disease/ multilevel spondylosis at L4-S1 which includes disc narrowing/ desiccation, hypertrophy and neuroforaminal narrowing. These findings are consistent with degeneration not an isolated event. The medical documentation, physical

> exam findings and diagnosis isolate the injury at the L1-L2 segment. The L4-S1 findings do not appear to be related to injury.
>
> TREATMENT:
> The L1-L2 treatment which included medicinal treatment, injections/ blocks, and the previously mentioned surgical intervention at that level are related.
>
> Although there is documented pathology at L4-S1, the treatment would be related to the degenerative disc disease. This would include the medicinal treatment, therapy, injections, and the arthrodesis/ fusion at L4-S1. This is supported by the provided medical documentation at Northwest Arkansas Neurosurgery clinic and including the MRI imaging. (Resp. Ex. 1., Pp. 295-300).

The sole question here is whether the claimant is entitled to additional medical treatment related to his compensable low back injury. Ark. Code Ann. § 11-9-508(a) (Repl. 2012) requires an employer to provide an employee with medical and surgical treatment "as may be reasonably necessary in connection with the injury received by the employee." The claimant has the burden of proving by a preponderance of the evidence that the additional treatment is reasonable and necessary. *Nichols v. Omaha Sch. Dist.*, 2010 Ark. App. 194, 374 S.W.3d 148 (2010).

What constitutes reasonably necessary treatment is a question of fact for the Commission. *Gant v. First Step, Inc.*, 2023 Ark. App. 393, 675 S.W.3d 445 (2023). In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, the

Commission analyzes both the proposed procedure and the condition it sought to remedy. *Walker v. United Cerebral Palsy of Ark.*, 2013 Ark. App. 153, 426 S.W.3d 539 (2013).

It is within the Commission's province to weigh all the medical evidence, to determine what is most credible, and to determine its medical soundness and probative force. *Sheridan Sch. Dist. v. Wise*, 2021 Ark. App. 459, 637 S.W.3d 280 (2021). In weighing the evidence, the Commission may not arbitrarily disregard medical evidence or the testimony of any witness. *Id*. However, the Commission has the authority to accept or reject medical opinions. *Williams v. Ark Dept. of Community Corrections*, 2016 Ark. App. 427, 502 S.W. 3d 530 (2016). Furthermore, it is the Commission's duty to use its experience and expertise in translating the testimony of medical experts into findings of fact and to draw inferences when testimony is open to more than a single interpretation. *Id.*

In the present case, the ALJ disregards the opinions of Dr. Knox, Dr. Camp, Dr. Evans, Dr. Boris, and Dr. Kelly in finding in favor of the claimant. In doing so, the ALJ states:

> From the records and the testimony, I am satisfied that claimant injured his back at L4-S1 in July 2019. It is a bit puzzling how the four MRIs claimant has undergone have shown different results at his L1-L2 level. That is, however, largely irrelevant to the issue of the reasonableness of Dr. Blankenship's recommendations, which is for surgery at the L4-S1 level. Claimant was understandably

> reluctant to undergo a major surgery such as has been suggested to him but has reached the point that it seems to be his only option. (Op., P. 10).

The four MRIs the claimant has undergone all result in the conclusion that the claimant's L4-S1 symptoms are degenerative in nature and therefore not work related.

Throughout the claimant's records, there are repeated objective findings of pathology at L1-L2, namely an "extreme lateral disc herniation at L1-2 on the right," which had largely resolved by December 2019. (Resp. Ex. 1, P. 47; Cl. Ex. 1, P. 3). Each MRI the claimant has undergone that indicates any findings of a diffuse disc bulge between L4-S1 describes them as "mild" or "minimal." (Resp. Ex. 1, P. 234). The "[d]isc bulge at L5-S1 minimally impinges on the bilateral S1 nerve roots." (Resp. Ex. 1, P. 174).

There are no objective findings to indicate that this diffuse disc bulge is the source of the claimant's pain. In fact, by the claimant's own reports, nerve blocks at L1-L2 consistently relieved the claimant's pain between 75% and 80%. (Resp. Ex. 1, Pp. 52, 62). The primary concern throughout the claimant's treatment was the disc bulge at L1-L2 because no practitioner believed L4-S1 to be the source of the claimant's work-related pain until the claimant treated with Dr. Blankenship in 2022. The only doctor suggesting that the claimant's L4-S1 issues are related to his 2019 injury is also the sole doctor seeking to perform surgery—Dr. Blankenship. It is

unreasonable to presume that only one doctor is correct when no fewer than four others somehow missed the mark with the same level of access to the claimant's medical records and the claimant himself. Dr. Kelly's findings summarize this point clearly:

> The L1-L2 treatment which included medicinal treatment, injections/ blocks, and the previously mentioned surgical intervention at that level are related.
>
> Although there is documented pathology at L4-S1, the treatment would be related to the degenerative disc disease. This would include the medicinal treatment, therapy, injections, and the arthrodesis/ fusion at L4-S1. This is supported by the provided medical documentation at Northwest Arkansas Neurosurgery clinic and including the MRI imaging. (Resp. Ex. 1., P. 300).

Accordingly, for the reasons set forth above, I must dissent.

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MICHAEL R. MAYTON, Commissioner