ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
WENDELL L. GRIFFEN, JUDGE

DIVISION II

CA06-135

September 20, 2006

AREA AGENCY ON AGING
RISK MANAGEMENT RESOURCES
SECOND INJURY FUND
APPELLANTS

V.

PHILLIP ROGERS
APPELLEE

AN APPEAL FROM ARKANSAS WORKERS' COMPENSATION COMMISSION [F210164]

AFFIRMED

Area Agency on Aging and its carrier, Risk Management Resources, appeal from a decision of the Workers' Compensation Commission, which determined that Phillip Rogers was entitled to additional medical treatment for an admittedly compensable back injury. They argue that the Commission's finding that appellee's most recent treatment was reasonable and necessary for the treatment of his compensable injury is not supported by substantial evidence. We affirm.

Appellee suffered a compensable injury on August 29, 2002, while working for the Area Agency on Aging. He was helping a client walk from the van to her patio when the client slipped. Appellee caught her and heard a pop in his back. At the hearing before the Administrative Law Judge (ALJ), he testified that he felt immediate pain and had never previously suffered from that type of pain in his life. Appellee presented to the Scott County Medical Clinic, where Dr. Nathan Bennett assessed him with low-back strain. Dr. Bennett prescribed medication and recommended that appellee rest and apply heat to his back.

Appellee returned to Dr. Bennett on September 5, 2002, where he was diagnosed with a compression fracture at T12. Appellee was referred to orthopaedic surgeon Claude Martimbeau, who ordered an MRI. His impression was of a mild anterior wedge compression deformity at L1, a small disc protrusion at L5-S1, disc bulging at L4-5 and L3-4, and a small synovial cyst on the left at L2-3. A bone scan on October 30, 2002, showed a compound fracture at T12. Doctors recommended a vertebroplasty for compressed vertebras at T12-L1 or L1-L2,[1] but appellants controverted the treatment. In an opinion dated June 27, 2003, the ALJ found that appellee was entitled to the vertebroplasty. The decision was not appealed and became a final order. Appellee was referred to Dr. Arthur Johnson, who performed a kyphoplasty (a procedure essentially the same as a vertebroplasty) on October 1, 2003.

Appellee again presented to Dr. Johnson, complaining that he still had back pain. In a February 26, 2004, letter, Dr. Johnson wrote:

> [Appellee] still continues to have pain and it is thought that his pain is probably discogenic in nature. Therefore a discogram of L3-4, L4-5, and L5-S1 was ordered in order to determine if the pain is coming from these areas that are not associated with his previous injury at T12 and L1.

In a letter dated March 30, 2004, Dr. Johnson stated that appellee had reached maximum medical improvement from the L1-2 compression and assessed an impairment rating of twelve percent to his body as a whole. Appellants accepted the rating and began paying benefits. Appellee was also placed on a lifting restriction of no more than twenty pounds on an occasional basis and no more than seven to fifteen pounds on a frequent basis. The record also contains a statement, which contained two "check boxes," signed by Dr. Johnson and dated July 19, 2004. Dr. Johnson checked the option reading:

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[1]Because of differences in the way some doctors count vertebras, certain medical reports referred to the compression fractures as being at T12-L1, where others refer to them being at L1-2.

> I, Dr. Arthur Johnson, being the treating physician of Phillip Rogers do state with reasonably medical certainty that: . . .
>
> In my opinion the major cause of Phillip Rogers current need for medical treatment in regards to his lumbar spine, as of this date, and his continued disability is most probably the result of his on the job injury with the Area Agency on Aging on August 29, 2002.

Dr. Johnson underlined the word "probably," and wrote after the paragraph, "Not a 100% certain [sic]. Patient continues to have pain in his back since the injury of 8-29-02." Appellee underwent a transforaminal lumbar interbody fusion at L4-5 and L5-S1 on July 26, 2004.

On cross-examination at the hearing, appellee testified that he had triple bypass surgery in 1997. He also had an abdominal aortic aneurysm repaired in 1993. He stated that he never had any back problems before August 29, 2002. He was presented medical records from 1996 showing that he had acute lumbosacral strain injury in persistent low-back pain, but he stated that the medical records did not refresh his memory regarding back problems before August 2002. The record also contains a medical report dated April 4, 1993, which notes, "Mild degenerative changes of the lumbar spine are incidentally noted."[2]

The ALJ found that the medical services rendered to appellee by Dr. Johnson represented reasonable and necessary medical services for appellee's August 29, 2002, compensable injury. While the ALJ was reluctant to afford credit to Dr. Johnson's "checkbox" report, he found Dr. Johnson's opinion to be supported by appellee's testimony as well as tests soon after appellee's injury showing evidence of discal defects in the involved area and records showing that appellee had no continuing back difficulties after a previous October 1996 episode. Appellants appealed to the Commission, which affirmed the

[2]Also in the record was the deposition testimony from orthopedic surgeon William Abraham regarding the appropriateness of the vertebroplasty procedure. Neither party references this deposition, nor is it mentioned in the opinions of the ALJ or the Commission. Accordingly, that testimony is not recounted here.

opinion of the ALJ. In addition to Dr. Johnson's medical reports of February 26, March 30, and July 19, 2004, the Commission also considered Dr. Johnson's deposition testimony, which was not entered into evidence before the ALJ but was included as part of appellee's brief before the Commission without objection from appellants, wherein Dr. Johnson stated his belief that appellee's lumbar-spine injuries were the result of his August 2002 injury.

In reviewing decisions from the Workers' Compensation Commission, we view the evidence and all reasonable inferences deducible therefrom in the light most favorable to the Commission's decision and affirm if that decision is supported by substantial evidence. *Smith v. City of Ft. Smith*, 84 Ark. App. 430, 143 S.W.3d 593 (2004). Substantial evidence is evidence that a reasonable mind might accept as adequate to support a conclusion. *Williams v. Prostaff Temps.*, 336 Ark. 510, 988 S.W.2d 1 (1999). The issue is not whether the reviewing court might have reached a different result from the Commission; if reasonable minds could reach the result found by the Commission, we must affirm the decision. *Minnesota Mining & Mfg. v. Baker*, 337 Ark. 94, 989 S.W.2d 151 (1999). We only review the findings of the Commission and not those of the ALJ. *Logan County v. McDonald*, 90 Ark. App. 409, — S.W.3d — (2005).

Appellants argue that the Commission's finding that Dr. Johnson's treatment of appellee's lumbar spine was reasonable and necessary to treatment of appellee's compensable injury is not supported by substantial evidence. They contend that appellee's injuries to his lumbar spine are a result of degenerative disease and are unrelated to his compensable injury to his T12-L1. Workers' compensation law provides that an employer shall provide the medical services that are reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a) (Repl. 2002); *Stone v. Dollar Gen. Stores*, 91 Ark. App. 260, — S.W.3d — (2005). The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. *Stone*

v. Dollar Gen. Stores, *supra*. The Commission has the duty of weighing medical evidence, and the resolution of conflicting evidence is a question of fact for the Commission. *Id.*

Many of appellants' arguments challenge the Commission's conclusion that appellee's injury to his lumbar spine was the result of the August 2002 accident; however, in every case, appellants either misinterpret the evidence or would have this court ignore its deferential standard of review in workers' compensation cases. First, appellants note Dr. Bennett's October 1, 2002, review of appellee's CT scan, where he noted moderate spinal canal stenosis in appellee's lumbar spine, and rely on Robert Berkow, M.D., *The Merck Manual*, 14th ed. (1982), p. 1240, to argue that his injury was caused by osteoarthrosis, Paget's disease, or spondylolisthesis. However, this is merely an alternate interpretation of that medical record, an interpretation that the Commission was not obligated to accept. Further, appellants fail to identify any medical evidence showing that appellee was diagnosed with any of those diseases.

Second, appellants note that Dr. Martimbeau conducted an MRI on October 10, 2002, and referenced the compression fracture at appellee's L1 but did not reference any other areas of appellee's lumbar region. They also note that the bone scan conducted October 30, 2002, references only the injury at T12. Appellants argue that Dr. Martimbeau disregarded the degenerative changes at L3-4 and L5-S1 as unrelated to appellee's compensable injury. However, this is rank speculation. We have no way of knowing why Dr. Martimbeau did not discuss the injuries to appellee's L3-4 or L5-S1. Even if we were to conclude that these records constitute evidence that appellee's lumbar injuries are unrelated to his injuries at T12, the evidence merely contradicts Dr. Johnson's opinion that appellee's lumbar injuries are related to the August 2002 accident. Assuming such a contradiction, it would be within the province of the Commission to resolve the conflict in the medical evidence, and there would be no error in doing so in favor of Dr. Johnson's opinion. *See Stone v. Dollar Gen. Stores*,

supra.

Next, appellants challenge Dr. Johnson's opinion. They identify Dr. Johnson's February 26, 2004, letter, where he wrote that a discogram would need to be performed to determine whether the pain coming from appellee's lumbar area, which was not associated with appellee's injury at T12-L1. They argue that the note states outright that the lumbar region was not associated with appellee's injuries. This is simply inaccurate. Dr. Johnson's letter merely stated his desire to perform additional tests to determine the etiology of appellee's pain in that region. Further, in his deposition testimony, Dr. Johnson clarified his opinion that the August 2002 accident caused two separate spinal injuries. Appellants also attempt to undermine the checkbox report by arguing that it does not distinguish between appellee's injury at T12-L1 and his injuries at L3-4 and L5-S1. While the form could have been more clear, the Commission could properly infer that Dr. Johnson was referring to appellee's injuries at L3-4 and L5-S1, as those were the injuries that he was treating at the time he submitted that opinion.

Finally, appellants argue that the Commission places substantial weight on evidence that appellee had no disc defects in his lumbar region prior to August 2002. They identify the April 4, 1993, medical report noting the mild degenerative changes in appellee's lumbar spine and argue that this record, along with Dr. Bennett's October 1, 2002, medical note and the surgical report from appellee's final procedure listing his diagnosis as "degenerative fibrocartilage," show that appellee had defects in his lumbar region prior to the August 2002 accident. However, the Commission only noted that none of Dr. Johnson's opinions showed that appellee's lumbar injuries preexisted the August 2002 accident. The Commission apparently found Dr. Johnson's opinion to be persuasive, and appellants failed to present any persuasive reason why that opinion should be disregarded on appeal to this court.

Appellee presented substantial evidence that he was entitled to additional medical

treatment for injuries to his lumbar spine. Accordingly, we affirm.

Affirmed.

ROBBINS and CRABTREE, JJ., agree.