ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
JUDGE DAVID M. GLOVER

DIVISION III

CA08-706

December 3, 2008

HOME DEPOT and SEDGWICK CLAIMS MANAGEMENT APPELLANTS	APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION [F501680]
V.	
KIMBERLY BRASEL APPELLEE	AFFIRMED

In this workers' compensation case, appellee, Kimberly Brasel, sustained a compensable back injury on December 21, 2004, while working for appellant Home Depot. She received conservative treatment for her injury. When it was not successful in alleviating her pain, she sought additional medical treatment, including surgery for her back, and additional temporary-total disability benefits. Following a hearing, the ALJ concluded that appellee was entitled to additional medical treatment but not to additional TTD benefits. The Commission affirmed. Appellants bring this appeal from the decision awarding additional medical treatment. Appellee does not appeal the TTD denial. We affirm.

Point of Appeal

There is no substantial evidence that the surgery recommended by Dr. James Blankenship is reasonably necessary or related to the appellee's 2004 injury.

Standard of Review

In *Williams v. Johnson Custom Homes*, ____ Ark. ____, ____, ____ S.W.3d ____,____ (Oct. 23, 2008), our supreme court explained:

> In appeals involving claims for workers' compensation, this court views the evidence in a light most favorable to the Commission's decision and affirms that decision if it is supported by substantial evidence. Substantial evidence exists if reasonable minds could reach the Commission's conclusion. The issue is not whether the appellate court might have reached a different result from the Commission, but rather whether reasonable minds could reach the result found by the Commission. If so, the appellate court must affirm the Commission's decision.

Appellants contend that the Commission's award of additional medical treatment should be reversed for two reasons: 1) the Commission failed to recognize that the proposed surgery was for S1 radiculopathy and that there was no evidence demonstrating a surgical problem at L4-5, where the compensable injury occurred, 2) the Commission erred in finding surgery to be reasonably necessary, in the absence of any evidence that the surgery had a bona fide expectation of benefitting the appellee beyond the consistent relief she had obtained through conservative means. We disagree.

1) Relationship of S1 Radiculopathy to the L4-5 Injury

The gist of appellants' first argument involves a battle among competing doctors' opinions about appellee's need for surgery. Appellee's initial 2004 compensable injury was located at L4-5. Appellants contend that her current problems are S1 radiculopathy,

which are not related to the 2004 injury; yet the S1 radiculopathy would be the focus of the surgery. Drs. William Kendrick, Richard Kyle, and David Cannon did not recommend surgery for appellee. Dr. James Blankenship did. Appellants contend that "[a]t most, Dr. Blankenship can only conjecture that the Appellee's L4-5 radiculopathy is somehow reaching two levels below to cause S1 nerve impingement—two years after her original injury." His testimony is instructive.

Dr. Blankenship's deposition was given on June 28, 2007. He explained that he is board certified in neurosurgery, spine surgery, and pain medicine. The most pertinent part of his testimony follows:

> The L5 nerve root and the S1 nerve root are the two most common nerve roots that can cause deep buttock pain. As far as specifically determining which nerve, you have to couple your examination with the patient's complaints and an MRI. When you've been doing it 20 years, you can get a pretty good idea what disc is painful and what's causing a hip to hurt, although not always. Discography is a test that can help with that by using some different objective findings still relying on subjective complaints when you inject the disc. I conducted an MRI on Ms. Brasel in 2007, but she hasn't had any discography. From the MRI that I read in 2007, she did have a disc pathology at L4-5.
>
> Part of my physical examination indicated an absent ankle reflex, which is also a radicular or a neurological deficit. The ankle reflex is also the same thing as the achilles reflex. It is a function of the S1 nerve root. If she is indicating posterior hip pain on the left, as well as absent ankle reflex on the left, that tends to indicate that the compromise of the nerve root is probably more likely the S1 nerve root as opposed to the L5 nerve root. I don't think there's any doubt it's the S1 nerve root. Sometimes even well-trained neurosurgeons don't know where the nerves go. *The S1 nerve root, the nerve root itself, is in the spinal canal at the level of the L5-S1 disc space, but in the thecal sac it resides laterally in the lateral recess. I had to become board-certified in pain management to learn from our noninvasive doctors what we should be taught in our training that with lateral recess stenosis, <u>you can get radicular pain in an S1 distribution at the 4-5 level</u>. It explains a lot in patients that we've always wondered about why they're hurting at a certain level.*

In this lady's situation I felt like she had compression of her L5 nerve root in the canal, the S1 nerve root and also a lateral recess, and then she also had a lateral compression of the L4 nerve root which is where her numbness was coming from. It is correct that the S1 nerve root controls the achilles reflex. There was no disc pathology at L5-S1 that I felt was causing the impingement of the nerve root or the stenosis of the foramen. At the L5-S1 level she didn't have any significant disc space pathology on my dictation of her MRI that was read on March 12 of this year.

As far as the claimant having facet arthropathy in L4-5 and L5-S1, I didn't dictate anything on her plain films or on her MRI. I don't see anything on either of Dr. Morse's MRI interpretations that indicated she had any facet arthropathy. Facet arthropathy is a degenerative change.

The literature is absolute now that there is no radiographic test that can be done to determine whether a facet joint, or zygapophyseal joint, is painful or not, other than injecting the joint and seeing if the pain gets better. That's the only diagnostic test that's ever been shown in the literature in randomized control studies. Abnormalities on plain x-rays, on CT scans, MRIs, bone scans are the worst in the world. Seeing abnormalities in those only means that there's an abnormality on the x-ray. *It doesn't mean that's what's causing the patient's pain.* I don't recall whether I appreciated whether she had any facet arthropathy. If Dr. Cannon did a trigger point injection, he wasn't overly suspicious of her facet joint being the pain generator or he would have injected them.

(Emphasis added.)

Dr. Blankenship explained that in his opinion appellee did not present with any significant diagnostic dilemma whatsoever; that to differentiate between discogenic pain and zygapophyseal joint pain is a very difficult diagnostic process; that one starts by examining the patient; that in most patients who have disc pain, they hurt more in flexion (forward); and that with joint pain, they hurt more with extension or bending backwards. He acknowledged that more than one doctor suspected the facet joint or the zygapophyseal joint as being the source of appellee's pain. But, he stated that fact did not

present to him a situation where there is uncertainty as to the source of the pain as opposed to it being purely discogenic; that it did not change his opinion in this situation; that he has a lot of respect for Dr. Cannon; that he was sure Dr. Cannon would say, "If Dr. Blankenship thinks it's the disc, it's probably the disc."; that Dr. Cannon's exact statement in his notes was, "I believe most of the pain is coming from either the facet arthropathy/spondylosis or disc degeneration."; that that statement "pretty much covers 360 degrees all the way around the spine"; that an abnormal x-ray, when it comes to the zygapophyseal joint, has been shown in the literature, unequivocally, to have absolutely no correlation with that joint being painful or not; that the same is true with bone scans and MRIs; and that the only test that has ever been shown to be diagnostic for z-joint/facet pain is to inject the joint and see if the patient gets better.

Dr. Blankenship gave his opinion that neither the facet joint nor the zygapophyseal joint were the source of the claimant's pain. He stated that he does not subject all of his patients to z-joint injection, discography, and ESI; that if he is having trouble making a diagnosis, then those are very useful tools, but if he does not suspect that is an etiology for their pain, he is not going to subject them to an invasive procedure just because of "what, if, and maybe." Dr. Blankenship said that with his examination and what he had documented in the chart, he had no doubts about what was causing her pain, and that the z-joints were not one of the possibilities that even came into his mind as being part of her problem.

Dr. Blankenship further explained:

> *Ruling out that there wasn't any uncertainty with respect to the joint versus the disc being the pain, there was no uncertainty as to which disc level was the source of the pain, L4-5 versus L5-S1, given that she had an absent achilles reflex. With respect to what led me to pick one disc level over the other, the first thing is that on the MRI that I looked at in March of ths year, the only disc that I saw any pathology was the L4-5 disc. I've already testified as to how you can have an S1 radiculopathy with an L4-5 disc compression if you have lateral recessed stenosis as a result of it. There's no mystery there. The disc at L5-S1 didn't show any pathology.* The S1 nerve root was well visualized, it wasn't under any compression, so I didn't have any doubts that disc was not causing her problem. The other thing is that we have some beautiful studies that were actually published about a year ago that showed that there was a time period where some people thought that doing discography on patients that had fairly normal-appearing disc on MRI could turn up a disc that was painful and pathologic, even if the MRI looked okay. The retrospective study that was done by the American Association of Neurosurgeons that was actually done with neurosurgeons and orthopedists showed that if you're doing discography on a level that looks good on MRI, thinking that's a painful disc, you're going to be very disappointed in your outcome if you wind up doing surgery on them. You need to have an abnormal disc on MRI. If you do perform discography and it correlates, then you have a good clinical finding to talk to your patient about.

(Emphasis added.)

Dr. Blankenship testified that time is the most critical thing that he weighs in making the determination of whether to offer the patient surgery or just continue some conservative treatment. He stated that the majority of people who rupture discs in their back get over that pain in a period of time; that one month minimum, preferably two months, and after three months "we start to get into a period of that magical three to six months that if they're not getting any better, surgery is a very reasonable thing because after six months people develop chronic pain." He said that six months was an arbitrary figure, but it is the figure that pain-management literature uses to differentiate between acute, subacute, and chronic pain. Dr. Blankenship stated that he likes to see patients who had some conservative treatment during that period of time; that he likes to see that they

had some type of medical treatment with either anti-inflammatory medication or steroids. He said that at some point, the amount of time has been so extreme that it is very unlikely that they are going to get better with any type of continued conservative treatment; that he believes appellee has been hurting for a year and a half or two years; and while you do not want to do things too soon, you certainly do not want things to drag out to where you develop chronic-pain syndrome where your brain is rewired to where you will not get better. He stated that if he thought appellee's report of improvement in her radicular symptoms over a two-year period through something as mundane as home exercises and over-the-counter medication was an indicator that more focused conservative treatment would be a first option of attack in treating her overall condition, he would have offered her that when he saw her in March of 2007. He testified that the fact her radicular pain got better was more of a determination of the time; that she originally was having pain going all the way down her leg and that it got better; and that it had to do with the fact that some time went by and it got better.

He further explained that physical therapy for people who have traumatic injuries to their back and ruptured discs and discogenic back pain is not going to bear fruit very often; that if he thought there was even a reasonable chance that it would have helped her, he would have had her on aggressive physical therapy. Dr. Blankenship testified that if appellee was showing improvement, albeit gradual and slow improvement through home exercises and over-the counter medication, "with respect to whether surgery could truly be considered reasonably necessary at this time, I would assume the fact that I have four

board certifications hanging on my wall, and I'm the only physician in Arkansas that is board-certified by the American Board of Neurosurgery, the American Board of Spine Surgery, and the American Board of Pain Medicine, that if I made the offer it was reasonable." He further explained, "If I didn't think surgery was reasonably necessary over a treatment modality like more focused physical therapy, true physical therapy, or medication or a combination of both, I wouldn't have offered it to her as a treatment option."

With respect to whether functional capacity is something he looks at when making a determination of whether surgery is reasonably necessary, Dr. Blankenship said he always tells his patients that when they get to a point where, in his opinion, the conservative treatment has been adequate, and it has failed, it then gets down to a situation of whether they are hurting bad enough that they are not able to do things that they want to do or need to do, then they need to consider having surgery.

Dr. Blankenship explained that he is extremely conservative about operating on people and that he has a reputation of being an extremely conservative surgeon. However, he testified that in a situation where he has someone who has been hurting for two years and she has had an appropriate trial of home exercises, which over that period of time has as much benefit as focused physical therapy, it is a totally different story than if somebody has been hurting for a month.

With respect to the L4-5 disc pathology, Dr. Blankenship acknowledged that he had said there was some paresthesias in the L4 dermatome that he felt was correlative to

that disc abnormality; that the L4 dermatome is on the front part of the side of the leg and actually in some people can extend down below the knee in the front part of the shin; that paresthesias or numbness is always a difficult thing to correlate with the cause because there are a a lot of different things that can make your leg numb, and a pinched nerve in the back is not the most common thing that can make your leg numb in any location; that he would never offer surgery to anybody just because they have some numbness in their leg; and that her numbness was not critical to him, it was just part of the overall picture. He stated that he still feels that her deep buttock pain is radicular and a different root entirely than the L4 nerve root that was giving her some of her paresthesias.

Finally, Dr. Blankenship gave his opinion that with her diminished ankle reflex on the left-hand side and the marked degree of lateral recess stenosis that she had from the disc at L4-5, he thinks it is the S1 nerve root in the thecal sac at that level that's causing her deep buttock pain; that you can get deep buttock pain from the L5 nerve root, but the S1 nerve root is the one that you really look at the most because the gluteal musculature has the majority of its innervation from the S1 nerve root; and that *"if I've got to look at the overall picture and tell you what I think is causing her deep buttock pain, then I would tell you it's the lateral recessed stenosis of the S1 nerve root at the L4-5 level."* (Emphasis added.)

The Commission has the duty of weighing the medical evidence as it does any other evidence. *Jones v. Wal-Mart Stores*, 100 Ark. App. 17, 262 S.W.3d 630 (2007). The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has the force and effect of a jury verdict. *Id.* In opposition to the

opinion of the other three treating physicians, Dr. Blankenship adequately explained how the original L4-5 injury could be causing the problems at L5-S1. He adequately differentiated his opinion and the basis for it from the other doctors' opinions. Thus, reasonable minds could agree with the Commission's decision. Accordingly, there is substantial evidence to support the Commission's conclusion that appellee established that additional medical treatment was connected to her original compensable injury.

2) Reasonable Necessity of Surgery

In response to appellants' second argument, our 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 (Supp. 2007). The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. *Jones*, *supra*. What constitutes reasonably necessary medical treatment is a question to be determined by the Commission. *Id*.

Dr. Blankenship's testimony clearly constitutes substantial evidence to support the Commission's conclusion that appellee proved the proposed medical treatment was reasonably necessary. For example, he stated that time is the most critical thing that he weighs in making the determination of whether to offer the patient surgery or just continue some conservative treatment. Dr. Blankenship said that the majority of people who rupture discs in their back get over that pain in a period of time; that one month minimum, preferably two months, and after three months "we start to get into a period of

that magical three to six months that if they're not getting any better, surgery is a very reasonable thing because after six months people develop chronic pain." He further explained that at some point, the amount of time has been so extreme that it is very unlikely that they are going to get better with any type of conservative treatment that you continue; that he believes appellee has been hurting for a year and a half or two years; and while you do not want to do things too soon, you certainly do not want things to drag out to where you develop chronic pain syndrome where your brain is rewired to where you will not get better.

Viewing the evidence in the light most favorable to the Commission's decision, we conclude that Dr. Blankenship's opinion was not based on conjecture and that reasonable minds could reach the same result as the Commission. Accordingly, we affirm.

Affirmed.

ROBBINS and HEFFLEY, JJ., agree.