Cite as 2023 Ark. App. 495

ARKANSAS COURT OF APPEALS

DIVISION IV
No. CV-22-781

FRANCINE CHANCE APPELLANT V. LOWE'S HOME CENTERS, LLC; AND SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. APPELLEES	Opinion Delivered November 1, 2023 APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION [NO. G702278] AFFIRMED

RITA W. GRUBER, Judge

Appellant Francine Chance suffered an admittedly compensable left leg and knee injury on April 2, 2017, and then sought additional benefits for an alleged low-back injury that was controverted by appellees. The Arkansas Workers' Compensation Commission found that she failed to prove by a preponderance of the evidence that she sustained a compensable injury to her lower back. On appeal, appellant argues that the Commission's decision is not supported by substantial evidence. We affirm.

On April 2, 2017, appellant was working at Lowe's as a floor assistant when she was injured as she was pushing a pallet cart loaded with oriented stranded board (OSB), which is an engineered wood structural panel similar to plywood. She was treated at the emergency room by Dr. James Arnold immediately after the incident where she reported acute onset of left-knee pain after she "caught her [knee] between the wound material and the metal cart."

The ER report indicated appellant was negative for back pain. X-ray imaging revealed a left tibial plateau fracture. Dr. Michael Weber performed surgery to repair the fracture the following day. Appellant had several follow-up appointments with Dr. Weber, including on June 29. The June 29 report indicates that appellant was in an advanced stage of healing, and the plan was to start physical therapy to begin "gait training, weightbearing as tolerated." At her follow up on July 27, appellant reported that she could not bear weight without severe pain. Dr. Weber suspected a soft-tissue problem, and an MRI revealed an anterior horn lateral meniscus degeneration or tear. On August 10, Dr. Weber recommended arthroscopic surgery to determine if appellant had a torn lateral meniscus.

On August 21, Dr. Weber performed surgery, which revealed a torn lateral meniscus and mild osteoarthritis of the left knee; the torn portions of the meniscus were removed. Physical therapy was recommended. Ultimately, Dr. Weber performed a left total-knee arthroplasty (knee replacement) on January 10, 2018. Appellant continued to follow up with Dr. Weber. At an office visit on February 20, appellant reported she was in "extreme" pain and still required the use of a walker. Her x-ray revealed her "components" were in the "perfect position." The plan was to discontinue physical therapy. At the March 13 follow-up, Dr. Weber told appellant her pain was out of proportion with her physical and x-ray findings, indicating she should be relatively pain-free eight weeks after surgery. After a triple phase bone scan, Dr. Weber referred appellant to a pain specialist for possible reflex sympathetic dystrophy (RSD).

Appellant saw Dr. Amir Qureshi at Arkansas Spine and Pain Center on June 6, complaining of pain in her left knee, left leg, neck, and lower back. The June 6 report also noted "sudden onset of pain," "constant pain," and "pain that radiates to the left ankle, left leg, left knee, and left thigh." Dr. Qureshi's report indicates assessments of chronic pain disorder and RSD; a left lumbar-sympathetic block was scheduled for her pain. Dr. Fren Erdem performed the block on June 13, and his report contains a diagnosis of complex regional pain syndrome (CRPS). When appellant returned to Arkansas Spine and Pain Center on July 11 for a follow-up appointment, she was seen by physician assistant Dara Mooney. The report stated that the left lumbar sympathetic block provided some relief of knee pain for around seven to ten days. The report indicated that a prescription for physical therapy would be given to correct a leg-length discrepancy and to assist with ambulation and that a second lumbar injection would be scheduled. The physical therapy prescription was for three times a week for four weeks. Appellant followed up at Arkansas Spine and Pain Cener in August and September.

On September 13, appellant saw Dr. Weber for follow-up. His assessment was probable RSD but noted that the bone scan was compatible with, but not diagnostic of, RSD. The report indicated that appellant was not satisfied with Arkansas Spine and Pain Center and that her caseworker would be contacted about switching to a different pain clinic. A report from appellant's November 20 follow-up with Dr. Weber stated that appellant continued to have substantial knee pain. The assessment was that CRPS could account for the pain, and the possibility of additional lumbar blocks would be explored.

On February 1, 2019, Dr. Gordon Newbern performed an independent medical examination (IME) upon Dr. Weber's referral. Dr. Newbern's report stated that appellant was being seen for an IME of her "painful left leg and knee replacement." The injury was described as having occurred when "boards came off a lumber cart which caused the cart to be thrown into her knee." Dr. Newbern's assessment was that appellant appeared to have CRPS affecting her left knee and leg. He recommended aggressive treatment and evaluation with Southern Regional Anesthesiology Consultants, indicating that lumbar blocks could improve and control her pain.

On April 24, May 1, and May 8, appellant received left lumbar sympathetic blocks for her CRPS at Arkansas Specialty Surgery Center—the first two given by Dr. Gary Frankowski and the third by Dr. Brent Walker. Appellant saw APRN Nicholas Fazio on July 24 at Southern Regional Anesthesiology Consultants. The chief complaint was noted as "left leg pain." His impression was CRPS of the lower left extremity and posttraumatic osteoarthritis, and he recommended continuation of another series of lumbar sympathetic blocks. Dr. Weber agreed with the treatment plan. Appellant received three left lumbar sympathetic blocks in August performed by Dr. Frankowski. At her follow-up with Dr. Walker on August 28, Dr. Walker assessed CRPS of the lower left extremity and recommended three more lumbar sympathetic blocks, which were administered in September by Dr. Frankowski.

On October 7, appellant went for a follow-up appointment with Elizabeth Jarvis, APRN, who works with Dr. Walker at Southern Regional Anesthesiology Consultants. Appellant's chief complaint was left leg pain. Jarvis recommended additional lumbar blocks,

and three more blocks were administered. Appellant was seen again by Jarvis on November 27, who noted that the blocks were helping and more would be scheduled. The clinic note also stated that an MRI had been approved, indicating that appellant had reported numbness in her left toes and left leg and was concerned that there is something going on in her spine that could be causing the numbness because she was "thrown in the air and landed on her tailbone."

The MRI performed on November 29 revealed "multilevel disc bulges with facet hypertrophy and prominence of the of the posterior epidural fat resulting in varying degrees of spinal canal and neural foraminal narrowing," with the spinal-canal narrowing being most severe at L3–L4 and L4–L5. The MRI also revealed "central/right paracentral disc herniation at L5–S1." Appellant continued to receive left lumbar sympathetic blocks. Dr. Frankowski's procedure notes from December 17 and December 31 indicate appellant was receiving them to address the CRPS in the lower left extremity. At a January 14, 2020 appointment, Dr. Walker noted that appellant had around 30 percent relief for about four days following the last injection, and she was concerned that "this may be due to her back." Dr. Walker's procedure note indicated that the MRI showed a bulging disc at L4–L5, and he planned "to add a little extra steroid to perhaps help a bulging disc." On January 28, appellant received a left L4–L5 transforaminal epidural steroid injection performed by Dr. Frankowski for symptoms consistent with radiculopathy, noting evidence of degenerative changes and neural foraminal stenosis.

Appellant saw Jarvis again on February 11, reporting a chief complaint of RSD in her lower left extremity as well as lumbar spine pain. The plan was to schedule a series of lower lumbar sympathetic blocks. Dr. Frankowski's March 24 and April 7 procedure notes indicated appellant had recurrent symptoms consistent with CRPS of the lower left extremity. Dr. Walker's procedure note from appellant's April 21 left lumbar sympathetic block noted the chief complaint as low-back pain. Appellant returned to see Jarvis again on May 6, at which time appellant requested a left transforaminal L4–L5 epidural steroid injection because it gave her better relief. At the next follow-up with Jarvis on June 3, appellant reported intense pain and tenderness in her back between her tailbone and her waist. The plan was to schedule another left transforaminal L4–L5 injection because it gave her 90 percent relief in January and to refer her for a surgical evaluation of her back.

On July 13, 2020, appellant saw Dr. Jared Seale on a referral from Dr. Frankowski, who, along with Dr. Walker, had performed most of the injections. The x-rays of appellant's spine revealed normal lordosis, facet arthropathy, and no spondylolisthesis. Dr. Seale reviewed the MRI of appellant's lumbar spine. His reading revealed mild to moderate central stenosis and lateral recess stenosis at L3–L4 and L4–L5 with moderate central stenosis, moderate to severe lateral recess stenosis bilaterally at L4–L5, and diffuse degeneration. The report noted that appellant had significant stenosis and subjective complaints of symptoms that match this more on the left side. Dr. Seale discussed with appellant that much of her pain could be due to her asymmetric gait and favoring the left knee. He thought that decompression was warranted given the significant stenosis, and appellant requested surgical

intervention. Dr. Seale recommended a minimally invasive left laminectomy at L3–L4 and L4–L5 for her back pain. His report further stated:

> The patient's MRI does not show disc protrusion or fracture. There are signs of degeneration and stenosis which is pre-existing. There are no objective findings of acute injury. However, the patient's symptoms began on and after the work injury. The patient has no history of pain in the low back or down the leg prior to the work injury. Therefore, it is within a reasonable degree of medical certainty that at least 51% of the patient's current symptoms are directly related to [her] work injury.

After another MRI in August, appellant returned to Dr. Seale on October 7. Dr. Seale's records indicate that the new MRI, which was a better quality, showed less significant stenosis at L3–L4 and that appellant reported a doctor had told her "this was preexisting." The record further stated that appellant's degenerative changes were definitely preexisting but she had no history of back pain prior to the work injury. Dr. Seale's recommendation based on the new MRI was to only decompress the left L4–5 level.

At appellees' request, orthopedic surgeon Dr. Owen Kelly performed a review of appellant's medical records up to May 2020. Dr. Kelly opined that appellant could not receive much benefit from continued treatment and that a final impairment rating should be completed. This opinion related to appellant's knee. After receiving Dr. Seale's reports from July 2020, Dr. Kelly issued an additional opinion on August 4. He stated that he reviewed appellant's records and did not note any complaints of back pain as it relates to her initial work injury, and Dr. Seale's notes confirm that her problems are preexisting and that there is no evidence of acute injury. Dr. Kelly opined that it would be difficult to associate the "back pain/complaints" with the injury since the findings appear to be preexisting. As

to the rating concerning appellant's knee, Dr. Kelly assessed a 20 percent whole-person rating and a 50 percent lower-extremity rating.

Appellant filed a claim for additional workers' compensation benefits arising out of the April 2, 2017 incident. A hearing was held on January 18, 2022, to determine whether appellant sustained a compensable injury to her lower back and was therefore entitled to related medical treatment. The parties introduced the medical records and the review by Dr. Kelly, and appellant testified. Appellant, who was sixty-seven at the time of the hearing, testified that she and another employee were trying to push a metal pallet stacked full of OSB to a truck to unload it when the "OSB took off." She stated that she was told this action "threw [her] back about 30 feet in the air when the cart hit her." She said she hit the concrete and landed on her tailbone. Appellant indicated she had used a walker since the injury. In regard to her back pain, appellant stated on cross-examination that she had no problems with her back prior to the injury. She had tried to return to work at Lowe's since the injury, but it had lasted only three days, and she had not worked anywhere else. Appellant testified that she had been on "pain medicine, opioids" from the time she had the initial surgery until after her knee-replacement surgery. She stated that she had not complained about back pain because she could not "feel it" until after she "got off the opioids."

The administrative law judge found that appellant had proved by a preponderance of the evidence that her back condition was causally related to her compensable leg and knee injury. Appellees appealed to the full Commission. The Commission reversed, finding that

appellant had failed to prove by a preponderance of the evidence that her back condition was causally related to her compensable leg and knee injury. This appeal followed.

Arkansas Code Annotated section 11-9-508(a) requires an employer to provide an injured employee such medical services as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a)(1) (Supp. 2023). When the primary injury is shown to have arisen out of and in the course of employment, the employer is responsible for any natural consequence that flows from that injury. *Nichols v. Omaha Sch. Dist.*, 2010 Ark. App. 194, 374 S.W.3d 148. However, for this rule to apply, the basic test is whether there is a causal connection between the injury and the consequences of such. *Id.* The burden is on the employee to establish the necessary causal connection. *Id.* The determination of whether a causal connection exists between two episodes is a question of fact for the Commission. *Ingram v. Tyson Mexican Original*, 2015 Ark. App. 519.

We review the Commission's decision in the light most favorable to its findings and affirm when the decision is supported by substantial evidence. *Dodson v. Valley Behav. Health Sys.*, 2022 Ark. App. 128. Substantial evidence is evidence that a reasonable mind might accept as adequate to support a conclusion. *Id.* The Commission has the duty to make determinations of credibility, to weigh the evidence, and to resolve conflicts in medical testimony and evidence. *Id.* If reasonable minds could reach the result found by the Commission, the appellate court must affirm. *Id.*

For reversal, appellant argues that the Commission's determination that her current back problems were not causally related to her compensable knee injury is not supported by

the evidence. The crux of appellant's argument is that her altered gait associated with the condition of her left leg and knee worsened her back condition to the extent surgery was recommended.[1] Appellant relies on Dr. Seale's report from her July 13, 2020 visit.

In that report, Dr. Seale states that it was discussed that "a lot of her pain could be due to the asymmetric gait and favoring the left knee." Dr. Seale indicated there were signs of degeneration and stenosis that were preexisting and no objective findings of acute injury, but he noted that appellant's "symptoms began *on and after* the work injury." Because appellant had "no history of pain in the low back or down the leg prior to the work injury," Dr. Seale concluded that it was "within a certain degree of medical certainty that at least 51% of [appellant's] current symptoms were directly related to her work injury." Appellant contends that appellees did not refute her testimony or the reports and opinions offered by her doctors. She states that if the condition necessitating surgery was preexisting, appellees failed to refute the opinion offered by Dr. Seale that it was aggravated by the accident and subsequent issues of altered gait. Appellant's contention, however, ignores Dr. Kelly's opinion.

In its conclusion that appellant failed to prove her back issues were a "natural consequence" of the April 2, 2017 compensable injury or an aggravation of a preexisting

[1]Appellant does not appear to challenge the portion of the Commission's decision that there was no proof of a specific-incident injury to her back on April 2, 2017. In this portion of the Commission's decision, it noted that the record did not corroborate appellant's testimony that she was thrown "30 feet in the air" and that there was no evidence that supported a statement in Dr. Walker's notes that appellant injured her tailbone.

degenerative condition, the Commission conducted a thorough review of the medical records and testimony. The Commission relied on Dr. Newbern's February 1, 2019 record that indicates it had been twenty-one months since appellant's injury and one year since her left total knee replacement, and she appeared to have CRPS affecting her left knee and leg. The Commission specifically mentioned that Dr. Newbern did not opine that appellant had sustained an injury to her back as a result of the left knee injury. The Commission further stated that the record did not demonstrate that the "multilevel disc bulging" reported on the November 2019 MRI was causally related to the "altered gait." The Commission noted that Dr. Kelly opined that appellant should receive a permanent-impairment rating with respect to her left knee injury but did not opine that appellant also had a back injury that was causally related to her knee injury.

Dr. Kelly performed a review of appellant's medical records, including Dr. Seale's records. Dr. Kelly's report stated that in his review of the medical records, he had "not noted any complaints of back pain in the record as it related to her initial work injury." He further stated that Dr. Seale's notes confirm that her back problems were preexisting, and there was no evidence of acute injury. Dr. Kelly concluded that it would be "difficult" to associate appellant's back pain with the injury because the findings are preexisting.

Although appellant contends that appellees failed to refute Dr. Seale's opinion, the Commission found that Dr. Kelly's opinions were entitled to significant evidentiary weight. In addition, the Commission found that Dr. Seale's conclusion was not supported by the record. The Commission here was confronted with opposing medical opinions, and it is

within the Commission's province to reconcile conflicting evidence, including the medical evidence. *See, e.g.*, *Lowe's Home Ctrs., Inc. v. Robertson*, 2019 Ark. App. 24, 567 S.W.3d 899. The Commission has the duty to weigh medical evidence, and the resolution of conflicting evidence is a question of fact for the Commission. *Id.* It is well settled that the Commission has the authority to accept or reject medical opinion and the authority to determine its medical soundness and probative force. *Id.* Here, the Commission's opinion evaluates and discusses all the relevant evidence, and no evidence was arbitrarily disregarded. This appears to be a classic "dueling-doctors" case in which this court is bound by the Commission's findings.

Our standard of review requires that we view the evidence and all reasonable inferences in the light most favorable to the Commission and affirm if substantial evidence supports the decision. *Dodson*, *supra.* The issue is not whether we would reach a different result but whether reasonable minds could reach the result found by the Commission. If reasonable minds could reach the result found by the Commission, we must affirm. Under the particular facts of this case, we cannot say that fair-minded persons with the same facts before them could not have reached the conclusions arrived at by the Commission.

Affirmed.

HARRISON, C.J., and HIXSON, J., agree.

Gary Davis, for appellant.

Anderson, Murphy & Hopkins, L.L.P., by: *Randy P. Murphy*, for appellants.