NOT FOR OFFICIAL PUBLICATION

ORIGINAL

IN THE COURT OF CIVIL APPEALS OF THE STATE OF OKLAHOMA

DIVISION II

PILOT TRAVEL CENTERS, LLC and ACE AMERICAN INSURANCE CO.,

Petitioners,

vs.

BRENDA STEPHENS and THE WORKERS' COMPENSATION COMMISSION,

Respondents.

Case No. 119,260

APPEAL FROM THE WORKERS' COMPENSATION COMMISSION

AFFIRMED

Cynthia J. Braly
Jenks, Oklahoma

For Petitioners

Michael R. Green
Tulsa, Oklahoma

For Respondent

OPINION BY GREGORY C. BLACKWELL, JUDGE:

The petitioners, Pilot Travel Centers LLC and Ace American Insurance Co., appeal a decision of the Workers' Compensation Commission affirming the decision of an administrative law judge that their employee, Brenda Stephens, suffered a compensable, work-related injury to her lower back and ordering treatment. On review, we find the decision of the Commission to be supported by the required substantial evidence and affirm.

BACKGROUND

According to her testimony, on February 15, 2019, Ms. Stephens was working at the Cinnabon inside her employer's facility when she felt a "pop" in her back while moving boxes of product in the walk-in freezer. She reported the injury to her supervisor, filled out an accident report, and was sent to urgent care in Atoka. She was seen by a Dr. Emerson, given a steroid injection, and ordered to return for a follow-up visit five days later. At the follow-up, Ms. Stephens received a second steroid shot and orders for physical therapy.

Ms. Stephens continued to report back pain and was referred for an MRI and underwent facet injections[1] with a Dr. Newton. [Tr p. 18]. In May 2019, Ms. Stephens filed her first record Form 3 seeking initial benefits and filed a Form 9 seeking a determination of eligibility for medical treatment. Ms. Stephens was then referred by the petitioners' adjuster to a Dr. Hahn. [Tr p. 19]. Dr. Hahn, in turn, referred Ms. Stephens to a Dr. Yates. Dr. Yates performed additional facet injections, which afforded temporary relief. As a result, Dr. Yates recommended that Ms. Stephens undergo a rhizotomy[2] at L3-4 through L5-S1.

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[1] Given the use of medical terms in this case, we will provide brief general information from outside the record in footnotes. These notes are for background information only, and have not been in any way considered as a basis for this opinion. Facet joints are small spinal joints located between and behind adjacent vertebrae. In a facet injection procedure, a mixture of anesthetic and anti-inflammatory medication is injected into the joint. Facet joint injections are a valuable tool in diagnosing facet joint pain and may provide therapeutic benefits. *See* https://www.ncbi.nlm.nih.gov/books/NBK572125/ (last accessed February 2, 2022).

[2] A rhizotomy is a minimally invasive surgical procedure to sever nerve roots in the spinal cord. The procedure is usually effective to relieve chronic back pain and muscle spasms for several years. *See* https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/rhizotomy (last accessed February 2, 2022).

In June 2019, Ms. Stephens filed a Form 9 seeking approval for a lumbar rhizotomy. Petitioners initially objected to the medical necessity of this procedure and subsequently objected more broadly to any finding of a compensable injury because they had not previously known of Ms. Stephens's prior back pain.[3] In November 2019, the ALJ ordered Ms. Stephens to submit to an independent medical examination, to be conducted by Dr. Johnathan Stone. Dr. Stone was instructed to make "specific recommendations regarding treatment that is reasonable and necessary as a result of 02-15-2019 injury," including whether Ms. Stephens needed the recommended rhizotomy "as a result of the event she was involved in on February 15, 2019." Dr. Stone was also instructed to carry out "diagnostic testing that is reasonable and necessary to respond to the issues specified in this order ... per statutory limitations" and further instructed to perform only those services expressly authorized, and to address only the issues identified by the ALJ.

Dr. Stone examined Ms. Stephens and identified the following abnormalities in his report:

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[3] Ms. Stephens had previously presented to Atoka Choctaw Nation Health Center in 2017 with complaints of lower back pain. She was given home exercises and medication. Ms. Stephens returned in December 2017 with complaints of low back pain radiating into her neck after cleaning a client's house and further made reference of having to stand for long periods of time at her job. Ms. Stephens returned twice more with similar complaints, the last being in March 2018, with complaints of left lower back pain and a urinary tract infection. No treatment recommendations were made in regards to her low back at any of these visits and she had not sought any treatment for back pain from March 2018 until the incident under review here. For a time, the petitioners were not aware of this prior history because at her deposition in August 2019, Ms. Stephens stated she could not recall if she "ever injured [her] lower back" before the incident in question. At trial, Ms. Stephens testified that she did not consider this prior incident to be an "injury" in the same sense that she was injured now. She stated: "I hadn't hurt my back like this. I have had a pulled muscle ... but I have never injured my lower back." [Tr. 23].

Gait and Station: antalgic gait and poor sitting posture with slumped shoulders and ambulates with no assistive devices.[4]

Lumbar Spine: Inspection: lordosis. Bony Palpation of the Lumbar Spine: tenderness of the transverse process on the right at L 5 and the transverse process on the left at L 5 and no tenderness of the spinous process. Soft Tissue Palpation on the Right: tenderness of the paraspinal region at L 5 and the iliolumbar region. Soft Tissue Palpation on the Left: tenderness of the paraspinal region at L 5 and the iliolumbar region. Active Range of Motion: pain with motion, worse with extension (and worse with facet loading maneuvers).[5]

Dr. Stone made the following assessments:

Brenda Stephens has chronic low back pain, consistent with facet mediated pain after work injury.

1. Low back pain
M54.5: Low back pain

2. Displacement of lumbar intervertebral disc without myelopathy
M51.26: Other intervertebral disc displacement, lumbar region[.]

He stated that he had considered the following records for his medical evaluation:

(1) Office note from Dr. Gaylan Yates from October 22, 2019 where he recommends bilateral L4-5 and L5-S1 facet joint nerve radiofrequency ablation (RFA), or rhizotomy;

(2) IME from Dr. Aaron McGuire recommending the lumbar RFA;

(3) Facet joint injection procedure reports from Dr. Yates at the bilateral L4-5 and L5-S1 levels;

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[4] Antalgic gait refers to an abnormal pattern of walking secondary to pain that ultimately causes a limp. *See* https://www.ncbi.nlm.nih.gov/books/NBK559243/ (last accessed February 9, 2022).

[5] Lumbosacral facet loading during a physical exam has been used to diagnose facetogenic pain. This maneuver is performed by having the patient extend and rotate the spine. This serves to increase pressure on the facet joints thus eliciting a pain response. *See* https://www.ncbi.nlm.nih.gov/books/NBK441906/ (last accessed February 9, 2022).

(4) Physical therapy notes;

(5) Lumbar MRI report noting multilevel disc desiccation, disc bulges and facet hypertrophy in the lumbar spine with varying degrees of central and foraminal stenosis; and,

(6) Office note from Dr. Michael Hahn from May 6, 2019.

In response to the specific questions posed by the ALJ's order, Dr. Stone replied:

> In my medical opinion, [Ms. Stephens] had two successful lumbar facet joint injections, but the relief was only temporary. I agree with Dr. Gaylan Yates, and would recommend that she have the lumbar facet medial branch RFA (rhizotomy) to help provide longer lasting pain relief for her.

Petitioners objected that Dr. Stone's report was incompetent. The ALJ concluded in her order that:

> From review of the record as a whole, including medical reports, documents and other matters properly before the Commission, and having an opportunity to hear testimony of [Ms. Stephens] and observe her demeanor, the following findings of fact and conclusions of law are made in accordance with 85A O.S. §72:
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> I am most persuaded by Dr. Stone's medical report and deposition testimony, which is most consistent with my findings of fact in this claim regarding the alleged mechanism of injury. After assigning weight and credibility to all evidence submitted, I find Ms. Stephens has proven by a preponderance of the evidence she sustained a compensable injury to her LUMBAR SPINE on February 15, 2019.

The ALJ concluded that Ms. Stephens had sustained a compensable injury and ordered the petitioners to provide Ms. Stephens with reasonable and necessary medical treatment with Dr. Yates for her lumbar spine, including the recommended rhizotomy. The Commission affirmed this order, and the petitioners timely appealed.

STANDARD OF REVIEW

It is settled that "the law in effect at the time of the injury controls both the award of benefits and the appellate standard of review where workers' compensation is concerned." *Graham v. D&K Oilfield Services, Inc.*, 2017 OK 72, ¶9, 404 P.3d 863. Because Ms. Stephens's date of injury was in February 2019, the Administrative Worker's Compensation Act (AWCA), governs the law applicable to this matter, including our standard of review. *Brown v. Claims Mgmt. Res., Inc.*, 2017 OK 13, ¶ 9, 391 P.3d 111.

Pursuant to the AWCA, appellate review here is governed by 85A O.S.Supp.2014, § 78(C), under which this Court may modify, reverse, remand for rehearing, or set aside a Commission's order if it was, as relevant here, "[c]learly erroneous in view of the reliable, material, probative and substantial competent evidence." Regarding this standard, the Supreme Court has stated:

> The language of this provision is similar to that used by this Court concerning its review of factual matters in other administrative proceedings. *See Okla. Dept. of Public Safety v. McCrady*, 2007 OK 39, ¶ 10, 176 P.3d 1194 (order subject to reversal if agency's findings were clearly erroneous in view of the reliable, material, probative and substantial competent evidence); *Dugger v. State ex rel. Okla. Tax Com'n*, 1992 OK 105, ¶ 9, 834 P.2d 964.
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> Accordingly, on issues of fact, the Commission's order will be affirmed if the record contains substantial evidence in support of the facts upon which it is based and the order is otherwise free of error.

Brown, ¶ 11. The Supreme Court has defined "substantial evidence" in administrative proceedings as follows:

> Substantial evidence is more than a scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.... It must be enough to justify, if the trial were to a

> jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury.

Cox Oklahoma Telecom, LLC v. State ex rel. Oklahoma Corp. Comm'n, 2007 OK 55, 164 P.3d 150, n. 57 (*quoting NLRB v. Columbian Enameling & Stamping Co.*, 306 U.S. 292, 300, 59 S.Ct. 501, 505 (1939)) (quotations removed).

However, resolution of a pure issue of law, such as the construction of a statute, requires *de novo* review. *Arrow Tool & Gauge v. Mead*, 2000 OK 86, ¶ 6, 16 P.3d 1120.

ANALYSIS

Though set forth as two separate propositions, the petitioners make in effect one claim of error: that there was no "objective medical evidence," as that phrase is statutorily defined, that the injury in question was compensable.

The argument stems, promisingly, from the statutory text. Section 2 of the relevant statutes require that "[a] compensable injury shall be established by medical evidence supported by objective findings as defined in paragraph 30 of this section." 85A O.S.Supp.2017, § 2(9)(c).[6] "Objective findings" are then defined as "those findings which cannot come under the voluntary control of the patient." *Id.* § 2(31). Petitioners take from this requirement and definition that a doctor, such as Dr. Stone here, is not permitted to take a patient's report of their own pain into account when determining the cause of an injury, whether the expres-

[6] The reference to paragraph 30 in the 2017 version the statute is clearly an error. The statute was amended in 2019 to correctly identify paragraph 31.

sions of pain occur during the course of a physical examination or not. Petitioners conclude that, because Dr. Stone's opinion was based entirely (so they claim) on Ms. Stephens' expression of pain, it is not valid under the statute. Petitioners' conclusion is based on two fundamental errors.

The petitioners' first error is to interpret § 2 as prohibiting a doctor from relying on any and all reports of pain in order to make their diagnosis. Contrary to this reading, however, § 2 only prohibits consideration of those expressions of pain that "come under the voluntary control of the patient." Petitioners argue that this limitation applies to *all* expressions of pain, but we think this is a significant misreading. An expression of pain may be voluntary or involuntary.[7] In this case, Dr. Stone conducted a physical manipulation of Ms. Stephens and determined she had "pain with motion, worse with extension (and worse with facet loading maneuvers)." A doctor may consider, consistent with § 2, a patient's expressions of pain made during a physical examination, and the opinion resulting from the examination is objective medical evidence under the statute.[8]

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[7] The distinction often arises in the context of hearsay and its exceptions. *See, e.g., Sw. Bell Tel. Co. v. Nelson*, 1963 OK 172, ¶ 21, 384 P.2d 914, 919 ("It is a well settled general rule that, where the bodily or mental feelings of a person are to be proved, the usual and natural expressions and exclamations of such person which are the spontaneous manifestations of pain, and naturally flow from the pain being suffered by him at the time, are competent and original evidence, which may be testified to by any party in whose presence they are uttered.") (overruled on other grounds) (quotations omitted)). By contrast, a patient's *recitation* of pain experienced in the past is under the patient's control, and thus cannot be the *sole* basis of a finding of a compensable injury.

[8] Of course, a patient may for various reasons attempt to express a feeling of pain when that patient feels none. However, absent extraordinary circumstances, the ACWA places the decision as to whether or not a patient's expression of pain is genuine, initially, in the discretion of the examining doctor. There is nothing in the statute that prohibits a physician from considering credible expressions of pain in their diagnosis. By contrast, "*complaints* of pain" may not be considered "[w]hen determining *permanent disability*." 85A O.S. Supp.2017, § 2(31)(a)(2)(a) (emphasis supplied). In the proceedings below, the petitioners

Second, we are not persuaded by the petitioners' argument that the IME and the ALJ considered *only* Ms. Stephens' complaints of pain in reaching their opinion and judgment. The ALJ specifically stated that she had reviewed "the record as a whole, including medical reports, [and] documents" in making her decision. Dr. Stone specifically listed five documents authored by other treating physicians and one by a physical therapist that he had considered in arriving at his opinion. All agree that Ms. Stephens has a spinal condition that requires treatment.[9] These reports are substantial enough to support a finding that a rhizotomy procedure was medically indicated and necessary. The only question here is, therefore, whether there was substantial evidence that Ms. Stephens' need for surgical intervention was caused or exacerbated by her employment.

We find substantial evidence in the record that Ms. Stephens' previous back pain had resolved prior to the accident. She demonstrated a history of seeking treatment whenever she experienced back pain, seeking treatment four times in the space of seven months between August 2017 and March 2018. She did not seek treatment again until the work incident of February 15, 2019, by which time she had been at her employment for six months working an average of

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argued that this provision was relevant in this case despite the fact that Ms. Stephens was seeking treatment, not an award of permanent disability. The argument appears to have been abandoned on appeal.

[9] Dr. Gillock was hired by the petitioners to perform an additional evaluation after the IME's report proved unfavorable to them. Dr. Gillock opined that Ms. Stephens suffered from a degenerative disk condition that had not been exacerbated by her employment. He did not, however, opine whether treatment is needed or not, but only that treatment is not needed for any work-related injury. [Record 141].

thirty-nine hours a week and had apparently performed the same stock-rotating maneuver without incident as part of her job duties.

We find substantial evidence that Ms. Stephens was not in need of medical or surgical intervention prior to the work-related incident of February 15, 2019, and that she was in such need after the incident. Pursuant to 85A O.S. § 2(9)(a), "compensable injury" means damage or harm to the physical structure of the body ... of which the major cause is either an accident, cumulative trauma or occupational disease arising out of the course and scope of employment." A preexisting condition is not compensable unless a physician clearly confirms an identifiable and significant aggravation to that condition was incurred in the course and scope of employment. 85A O.S.Supp.2017, § 2. In this case, we find substantial evidence supporting the ALJ and Commission's decision that a compensable injury occurred in the course and scope of employment.

AFFIRMED.

WISEMAN, P.J., and RAPP, J., concur.

March 23, 2022