BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F003087

LINDA T. MIRACLE, EMPLOYEE	CLAIMANT
MARION COUNTY RURAL SCHOOLS, EMPLOYER	RESPONDENT
RISK MANAGEMENT RESOURCES, INSURANCE CARRIER	RESPONDENT

OPINION FILED MARCH 16, 2003

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

Claimant represented by HONORABLE FREDERICK S. "RICK" SPENCER, Attorney at Law, Mountain Home, Arkansas.

Respondents represented by HONORABLE MICHAEL R. MAYTON, Attorney at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Reversed in part, affirmed in part.

OPINION AND ORDER

Both parties appeal an administrative law judge's opinion filed February 6, 2003. The administrative law judge found that the claimant "has continued to experience a left elbow and left wrist condition which is a compensable consequence of her March 10, 2000 primary injury; specifically, her left ulnar nerve condition is a direct consequence of the surgery performed by Dr. Martinson on December 21, 2000, and, according to the credible opinion of Dr. Marcia Hixson, Claimant's left elbow and left wrist condition are the sequelae of said surgery." The administrative law judge therefore found that the claimant proved she was entitled to additional medical treatment.

The administrative law judge also found that the claimant failed to prove she was entitled to "compensation for a permanent physical impairment; specifically, Claimant remains in her healing period for the consequences of her primary compensable injury and has not reached maximum medical improvement."

After reviewing the entire record *de novo*, the Full Commission finds that the claimant failed to prove that her left elbow and wrist condition is a compensable consequence of the March 10, 2000 compensable injury. We therefore reverse the administrative law judge's opinion that the claimant proved she was entitled to additional medical treatment. The Full Commission also affirms the administrative law judge's finding that the claimant failed to prove she sustained a compensable anatomical impairment, because we find that the claimant failed to establish an anatomical impairment with objective medical findings. The Full Commission therefore reverses in part and affirms in part the opinion of the administrative law judge.

I. HISTORY

The parties stipulated that Linda Miracle sustained compensable injuries to her left wrist and elbow on March 10, 2000. Ms. Miracle testified that she fell while roller skating. Dr. Thomas E. Knox evaluated the claimant on March 15, 2000:

> Miss Miracle was rollerskating when she had an accident causing a posterior dislocation of her elbow. Dr. Bufford examined her and reduced this. The reduction is quite accurate....
>
> Looking at her elbow today, there is a slight amount of ecchymosis but overall looks good. It looks like she had a little avulsion, probably her lateral collateral ligament. Everything looks stable though.

Dr. Knox treated the claimant conservatively. The claimant followed up with another orthopaedist on March 22, 2000:

> She reportedly had a fracture but I do not see one on the films today. The x-ray report sent in indicated a chip and that has apparently repositioned itself because the elbow is now in an anatomical position and the films today do not show any specific fracture abnormalities.
>
> PLAN: She was started on active and assistive exercises to begin to mobilize her elbow. She will use the splint at night and a sling during the day for additional support....

The claimant began treating with Dr. Alice M. Martinson on April 6, 2000:

> This 44 year old woman sustained a classic posterior dislocation of her left elbow when she fell while roller skating. She was reduced very shortly after injury in the Emergency Room and has been treated in a splint. She has seen Dr. Knox twice. This is a Workers' Compensation injury, and she has requested a change of physician. At the present time she complains of significant stiffness in her elbow, and she is also concerned about pain in her left wrist. She says that the pain in her wrist has been present since injury, but that initially her elbow was so painful that she didn't pay any attention to it....
>
> She has mild swelling and tenderness in the region of the distal radio-ulnar joint. She has no snuff

> box tenderness, and good active range of motion of the wrist....
>
> I reviewed x-rays of the left elbow taken on the day of injury. She has a classic posterior dislocation of the gleno-humeral joint which was concentrically reduced. There is no evidence of fracture. I obtained x-rays of her left wrist today since they had not been taken before. She has no evidence of fracture in the distal radius or any of the carpal bones. Distal radio-ulnar articulation is normal.

Dr. Martinson assessed "Status-post dislocation left elbow" and "Strain left wrist." Dr. Martinson stated, "She needs physical therapy to begin mobilizing her elbow. I reassured her that it was stable and would remain so. It is likely that she will have some mild residual loss of full extension which will not be any functional incapacity. I expect she will regain the remainder of her elbow function."

Dr. Martinson noted on April 20, 2000 that the claimant "has been attending physical therapy and is quite pleased with her progress to date....Neurologic examination is normal in her left hand, and she has negative Tinel's and Phalen's test at the wrist and no tenderness over the ulnar nerve in the cubital tunnel. She does have some generalized tenderness in the antecubital fossa, but no Tinel's." Dr. Martinson assessed "Status-post dislocation left elbow" and continued conservative treatment.

An x-ray of the left wrist taken on June 22, 2000 showed "Normal left wrist." On July 13, 2000, however, the

claimant complained to a physical therapist of "L wrist pain and popping sensations."

Dr. Martinson noted on August 3, 2000:

> She is now about 4 ½ months post injury and has been wearing her night splint. She says that her elbow range of motion has been improving remarkably and that she is able to use her left arm in a much more comfortable fashion....
>
> She has a 12 degree flexion contracture of the left elbow with further flexion equal to the right side. She has full pronation and supination. She has a full range of motion of the wrist with no tenderness or clicking in the area of the DRUJ.

Dr. Martinson assessed "Status-post dislocation left elbow" and wrote, "The x-ray of her wrist last time showed no abnormalities whatsoever. Her range of motion is now improving quite nicely, and she should need no additional intervention. She will stop her regular physical therapy but will be seen back in physical therapy on one or two occasions to continue adjusting her night splint."

The claimant returned to Dr. Martinson on October 5, 2000:

> Her primary complaints today are of some shooting pains and tingling in her left arm. She mentioned these problems to me once before back in April, and she says that she has continued to have problems with these phenomena since then. She has not mentioned it to me on her other visits, however. Some of the tingling goes into her ring and little fingers; on other occasions she has paresthesias in the volar aspect of her forearm which reach into her thumb and index fingers....
>
> It is conceivable that she could have sustained some soft tissue trauma to her median and ulnar nerves when she dislocated her elbow that has

> produced sufficient scarring in the area so that she is continuing to be symptomatic. I will attempt to obtain some objective assessment of this problem by getting nerve conduction studies of both median and ulnar nerves across the elbow as well as across the wrist. These studies will be scheduled for this week and I will see her again next week to go over the numbers and see what a sensible course of treatment might be.

Dr. Martinson assessed "Status-post dislocation left elbow with some mild median and ulnar neuropathy." The impression from electrodiagnostic testing carried out on October 11, 2000 was "Slow conduction of L ulnar nerve across the elbow, consistent with tardy ulnar neuropathy." Dr. Martinson assessed "Left cubital tunnel syndrome" on October 26, 2000 and stated, "Although ulnar nerve problems are uncommon after dislocations of the elbow, it seems pretty clear that this problem is related to her trauma. The solution for her complaints is an anterior transposition and we discussed that in some detail today." The claimant underwent an "Anterior transposition left ulnar nerve" on December 21, 2000.

Dr. Martinson noted on February 8, 2001:

> She is now about six weeks post op anterior transposition of her left ulnar nerve. She reports remarkably gratifying relief of her pre-operative pain and paresthesias....
>
> She has a full range of motion of the forearm, wrist, and fingers. Sensation is entirely normal within the left hand and she has normal ulnar motor strength....
>
> She has responded very well to her surgical procedure, and although she still has some minor

> irritability in the area of her scar, I believe that this will subside as the scar matures. She is very happy with her surgical result and so am I. From the standpoint of her Workers' Compensation injury, I think it is fair at this time to say that she has achieved maximum medical improvement. No further treatment or follow up is necessary. Utilizing the *AMA Guidelines* (Fourth Edition) I would assign her a five percent Impairment Rating for the left upper extremity based on her mild loss of motion and minimal sensory residuals of her ulnar nerve entrapment.

Dr. Martinson assessed "Left cubital syndrome - resolving post-op."

The claimant did not again return to Dr. Martinson until October 25, 2001:

> She comes back today with about a two-month history of episodic numbness & tingling in the thumb, index, and long fingers of her left hand. Her symptoms will awaken her at night. During the day she sometimes has problems when gripping the steering wheel or holding a newspaper. She has recently noted some exacerbation of her problems while using a weed eater. She has no problems with pain, numbness, or tingling in the ring and little fingers of her left hand since undergoing anterior transposition of her ulnar nerve some ten months ago....
>
> Her symptoms and findings are those of a mild left carpal tunnel syndrome. They are of recent onset and I do not believe that they have any direct or indirect relationship to her elbow dislocation some 18 months ago. It should be noted that nerve conduction studies performed on the left upper extremity prior to her ulnar nerve transposition showed normal electrical parameters for the median nerve at the wrist. Her symptoms now are sufficiently mild that I am hopeful that they will resolve with the use of a night splint and the avoidance of the use of vibrating tools.

Dr. Martinson assessed "Mild left carpal tunnel syndrome."

The respondents controverted additional medical treatment after October 25, 2001.

The claimant's personal physician, Dr. Robert Ahrens, referred the claimant to Dr. Marcia L. Hixson, who examined the claimant on March 13, 2002:

> She is a forty-seven year old woman who fell at work on her job on 3-10-00 landing on her outstretched left hand. At that time, she sustained an elbow dislocation. She had a closed reduction of the elbow and subsequently developed problems with the ulnar nerve which was transposed anteriorly. Ms. Miracle continues to complain of aching pain in the left wrist and in the left ring finger as well as pain and hypersensitivity in the elbow. She states that her hand still becomes numb and tingly and that she has problems with grip strength especially picking up objects in the left hand. These symptoms are severe enough that she has not been able to return to work....
>
> She has full range of motion of the left wrist, but there is a click and some crepitance on the ulnar aspect of the wrist....Review of the outside x-rays show (sic) a posterior lateral elbow dislocation that has been reduced and which does not have any associated fractures. The plain x-ray of the wrist shows a VISI deformity consistent with a mid-carpal ligament injury....
>
> Ms. Miracle appears to have no sequelae from the actual elbow dislocation, however she has signs of persistent ulnar nerve compression at the elbow associated with the anterior transposition. She also has sustained an injury to the left wrist. This most likely occurred when she fell two years ago. She denies any other injuries before or since that accident to the left wrist. My recommendation is that she have the transposed ulnar nerve neurolysed and probably a more complete release of the nerve. This is most likely responsible for the majority of her pain. The ligament injury to the wrist can only be solved at this point by a 4-corner arthrodesis. Generally this type of wrist pain is not severe. I would recommend that she wait on this type of

> surgery to see how much of the pain resolves with the ulnar nerve treatment. Ms. Miracle was given a prescription for Neurontin to take for the nerve related pain. She will give me a call if she decides to schedule surgery.

Ms. Miracle claimed entitlement to additional worker's compensation. The claimant contended that she was entitled to additional medical treatment, including additional surgery as recommended by Dr. Hixson. The respondents contended that "the only compensable injury sustained by the claimant was an injury to her elbow; that there are no objective medical findings of an injury to the claimant's wrist."

The administrative law judge found, "the Claimant has proven by a preponderance of the evidence that she has sustained a compensable specific incident injury to her left wrist and left elbow on March 10, 2000, and that at the time of the hearing herein, she has continued to experience a left elbow and left wrist condition which is a compensable consequence of her March 10, 2000 primary injury; specifically, her left ulnar nerve condition is a direct consequence of the surgery performed by Dr. Martinson on December 21, 2000, and, according to the credible opinion of Dr. Marcia Hixson, Claimant's left elbow and left wrist condition are the sequelae of said surgery." The administrative law judge found that the claimant proved she was entitled to medical treatment provided by Dr. Hixson.

The administrative law judge also found, "the Claimant failed to prove by a preponderance of the evidence that she is entitled to compensation for a permanent physical impairment; specifically, Claimant remains in her healing period for the consequences of her primary compensable injury and has not yet reached maximum medical improvement."

Both parties have filed notices of appeal to the Full Commission.

II. ADJUDICATION

A. Causal connection

Causal connection is generally a matter of inference, and possibilities may play a proper and important role in establishing that relationship. Osmose Wood Preserving v. Jones, 40 Ark. App. 190, 843 S.W.2d 875 (1992). The determination of whether a causal connection exists is a question of fact for the Commission to determine. Jeter v. B.R. McGinty Mechanical, 62 Ark. App. 53, 968 S.W.2d 645 (1998). The basic test is whether there is a causal connection between the two episodes. Air Compressor Equip. v. Sword, 69 Ark. App. 162, 11 S.W.3d 1 (2000).

In the present matter, the Full Commission reverses the administrative law judge's finding that the claimant continues to experience a left elbow and wrist condition which is a compensable consequence of the claimant's compensable injury. The claimant fell on her left arm on

March 10, 2000. The claimant suffered a posterior dislocation of her left elbow, which dislocation was "reduced." Dr. Martinson began treating the claimant on April 6, 2000, noting "significant stiffness in her elbow, and she is also concerned about pain in her left wrist." Along with "dislocation left elbow," Dr. Martinson assessed "Strain left wrist." In August 2000, Dr. Martinson assessed "Status-post dislocation left elbow" and noted, "The x-ray of her wrist last time showed no abnormalities whatsoever."

However, the claimant returned to Dr. Martinson in October 2000, complaining of "shooting pains and tingling in her left arm....Some of the tingling goes into her ring and little fingers; on other occasions she has paresthesias in the volar aspect of her forearm which reach into her thumb and index fingers." Subsequent diagnostic testing showed "Slow conduction of L ulnar nerve across the elbow, consistent with tardy ulnar neuropathy." Dr. Martinson wrote, "Although ulnar nerve problems are uncommon after dislocations of the elbow, it seems pretty clear that this problem is related to her trauma." Dr. Martinson performed an "Anterior transposition left ulnar nerve" in December 2000. The claimant subsequently reported complete relief of her symptoms. Dr. Martinson therefore pronounced maximum medical improvement, assigned an impairment rating, and released the claimant on February 8, 2001.

The claimant returned to Dr. Martinson on October 25, 2001, complaining of "a two-month history of episodic numbness & tingling in the thumb, index, and long fingers of her left hand....*She has recently noted some exacerbation of her problems while using a weed eater* (our emphasis)." Dr. Martinson diagnosed mild carpal tunnel syndrome and stated that the claimant's symptoms "are of recent onset and I do not believe that they have any direct or indirect relationship to her elbow dislocation some 18 months ago." The respondents controverted additional medical treatment after Dr. Martinson's October 25, 2001 report.

The Full Commission recognizes that Dr. Hixson began treating the claimant in March 2002 and that Dr. Hixson opined that the claimant's left wrist "most likely occurred when she fell two years ago." However, the Commission has the duty of weighing medical evidence and, if the evidence is conflicting, its resolution is a question of fact for the Commission. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). It is within the Commission's province to weigh all of the medical evidence and to determine what is most credible. Minnesota Mining & Mfg. v. Baker, 337 Ark. 94, 989 S.W.2d 151 (1999). The preponderance of evidence in the instant matter supports the respondents' position that the claimant was not entitled to additional medical treatment after October 25, 2001. Dr.

Martinson, the primary treating physician, reviewed an x-ray and reported on April 6, 2000, "She has no evidence of fracture in the distal radius or any of the carpal bones. Distal radio-ulnar articulation is normal." This report shows that there was no bony injury to the claimant's wrist when she dislocated her elbow in March 2000. Another x-ray in June 2000 showed "normal left wrist," Dr. Martinson subsequently noting, "The x-ray of her wrist last time showed no abnormalities whatsoever." After the ulnar nerve transposition, Dr. Martinson pronounced maximum improvement and released the claimant on February 8, 2001.

The claimant returned to Dr. Martinson on October 25, 2001 with only "a two-month history of episodic numbness" in her left hand. Dr. Martinson diagnosed carpal tunnel syndrome and explicitly stated that the claimant's symptoms "were of recent onset and I do not believe that they have any direct or indirect relationship to her elbow dislocation some 18 months ago." The evidence does not show that the claimant's carpal tunnel symptoms in October 2001 and following were causally related to the claimant's March 2000 compensable injury. Nor does the record indicate that the "VISI deformity" reported by Dr. Hixson in March 2002 was a causal result of the claimant's March 2000 compensable injury. Nor does the October 2001 report of an "exacerbation" following use of a weed eater indicate that

the claimant had sustained a recurrence of her compensable injury. The Full Commission expressly attaches significant and controlling weight to the opinion of the primary treating physician, Dr. Martinson, that the claimant’s symptoms as reported on October 25, 2001 and following were not related to the claimant’s compensable injury. We therefore reverse the administrative law judge’s finding that the claimant proved she was entitled to additional medical treatment as recommended by Dr. Hixson.

B. Anatomical impairment

An injured worker must prove by a preponderance of the evidence that she is entitled to an award for a permanent physical impairment. Ark. Code Ann. § 11-9-522(g) directed the Commission to adopt an impairment rating guide to be used in assessing anatomical impairment. The Commission thus established Rule 34 and adopted the Guides to the Evaluation of Permanent Impairment (4th ed. 1993) published by the American Medical Association. Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical findings. Ark. Code Ann. §11-9-704(c)(1)(B). To the extent that they allow the use of subjective criteria for establishing an impairment rating, the Guides must yield to the statutory definition of anatomical impairment. Rizzi v. Sam’s

Wholesale Club, Workers' Compensation Commission E515370 & E112991 (April 1, 1999).

The administrative law judge found in the present matter, "the Claimant failed to prove by a preponderance of the evidence that she is entitled to compensation for a permanent physical impairment; specifically, Claimant remains in her healing period for the consequences of her primary compensable injury and has not yet reached maximum medical improvement." In her notice of appeal, the claimant states that she disagrees with the administrative law judge's finding that the claimant is not entitled to compensation for a permanent physical impairment.

Whether an employee's healing period has ended is a factual determination to be made by the Commission. Ketcher Roofing Co. v. Johnson, 50 Ark. App. 63, 901 S.W.2d 25 (1995). The Full Commission first finds that the instant claimant reached the end of her healing period for the compensable injury no later than February 8, 2001, when Dr. Martinson pronounced maximum medical improvement. We therefore do not affirm the administrative law judge's determination that the claimant remained within her healing period. The Full Commission also notes that Dr. Martinson assigned a 5% rating on February 8, 2001. This impairment rating was based on "mild loss of motion and minimal sensory residuals of her ulnar nerve entrapment." "Loss of motion"

and "sensory residuals" are subjective findings which cannot be used for purposes of assigning permanent anatomical impairment. Ark. Code Ann. § 11-9-704(c)(1)(B). The Commission may assess its own impairment rating rather than rely solely on our determination of the validity of a rating assigned by a physician. Polk County v. Jones, 74 Ark. App. 159, 47 S.W.3d 904 (2001). The ratings in the Guides related to the ulnar nerve, as found at Table 15, p. 54 and following, are based on exclusively subjective criteria. The claimant cannot rely on subjective criteria to establish entitlement to an anatomical impairment rating. The Full Commission therefore affirms the administrative law judge's finding that the claimant failed to prove she was entitled to compensation for a permanent physical impairment, but our decision is based on the lack of objective medical findings to support an award of permanent physical impairment.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant failed to prove she was entitled to additional medical treatment for her compensable injury after October 25, 2001. We therefore reverse the administrative law judge's finding that the claimant was entitled to the treatment recommended by Dr. Hixson. The Full Commission also finds that the claimant failed to prove she was entitled to compensation for a permanent physical impairment. We therefore affirm, on

separate grounds, the administrative law judge's finding that the claimant failed to prove she was entitled to compensation for permanent physical impairment. This claim is denied and dismissed.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. McKINNEY, Commissioner

Commissioner Turner dissents.

DISSENTING OPINION

I must respectfully dissent from the opinion of the majority denying additional medical treatment and benefits for permanent anatomical impairment.

It must be remembered that the parties stipulated that claimant sustained injuries to her elbow and left wrist. Claimant has consistently complained of pain in her left wrist since the date of the compensable accident. Dr. Martinson noted that "the pain in her wrist has been present since injury, but that initially her elbow was so painful that she didn't pay any attention to it." The majority points out that Dr. Martinson did not believe claimant's wrist symptomatology was related to the elbow dislocation. Apparently, neither does Dr. Hixson. The wrist problem is a separate condition, which was caused by the work-related fall in March 2000.

The majority also states that x-rays showed "no bony injury to the claimant's wrist." However, I note that Dr. Hixson has not opined that claimant sustained a bony injury to the wrist. Dr. Hixson diagnosed "a VISI deformity consistent with a mid-carpal ligament injury."

I disagree with the majority's finding that claimant is not entitled to any additional medical treatment for the compensable injuries. Dr. Hixson reported that claimant "has signs of persistent ulnar nerve compression at the elbow associated with the anterior transposition," which was the original surgery performed by Dr. Martinson. There is certainly no justification for denying additional medical treatment for the persistent complaints involving the elbow.

Finally, the majority seems to attribute much weight to Dr. Martinson's one comment on October 25, 2001, that claimant "recently noted some exacerbation of her problems while using the weedeater." I simply point out that this notation was made at least seven months after Dr. Hixson's evaluation of claimant. In other words, claimant was having significant problems and surgery had been recommended many months before claimant mentioned the use of a weedeater. It should not be surprising that most any activity would cause an "exacerbation" of her symptoms.

In my opinion, the majority's determination that claimant is not entitled to any benefits for permanent

anatomical impairment is premature. Since claimant is still obviously within her healing period, a determination of the extent of her permanent disability cannot be made at this time.

For the foregoing reasons, I must respectfully dissent.

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SHELBY W. TURNER, Commissioner