

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F004149

TERRY POTOCKI,  
EMPLOYEE

CLAIMANT

ST. EDWARD MERCY MEDICAL CENTER,  
EMPLOYER

RESPONDENT

SISTERS OF MERCY HEALTH SYSTEMS,  
INSURANCE CARRIER

RESPONDENT

OPINION FILED FEBRUARY 3, 2004

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

Claimant represented by HONORABLE GUNNER DELAY, Attorney at  
Law, Fort Smith, Arkansas.

Respondents represented by HONORABLE RANDY MURPHY, Attorney  
at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Affirmed as  
modified.

OPINION AND ORDER

The respondents appeal and the claimant cross-appeals  
an administrative law judge's opinion filed January 23,  
2003. The administrative law judge found, among other  
things, that "The claimant has proven by a preponderance of  
the evidence that she developed RSD as a result of her April  
5, 2000, right ankle fracture." The administrative law  
judge also found, "The claimant has proven by a  
preponderance of the evidence that she is entitled to a 33  
percent impairment rating for her right lower extremity as  
assessed by Dr. Heim." After reviewing the entire record de

*nov*o, the Full Commission affirms, as modified, the opinion of the administrative law judge. We find that the claimant proved she developed reflex sympathetic dystrophy as a result of her compensable injury. We find that the claimant proved she was entitled to a 23% anatomical impairment rating, as assessed by Dr. Heim.

I. HISTORY

The parties stipulated that Terry Mae Potocki, age 72, sustained a compensable injury to her right ankle on April 5, 2000. The claimant testified that she lost her balance and fell. The claimant testified that she received emergency medical treatment. The impression from an x-ray taken April 5, 2000 was "Calcaneal fracture." The parties stipulated, "Medical expenses have been paid for the treatment of the claimant's right ankle." The claimant initially treated for her injury with Dr. Joel R. Lane, Cooper Clinic Department of Orthopedics. The claimant began treating with Dr. Stephen A. Heim, Cooper Clinic, in September 2000. Dr. Heim noted on October 10, 2000, "She is wearing high top shoes and air soles and she is doing very good with her rather severe fracture....I am going to see her back in six months, at which time she will be a year

out, and at that time if her pain is severe we can consider a fusion, but hopefully that will not be necessary."

The following impression resulted from a three-phase bone scan of the ankles and feet, performed on October 18, 2000:

1. Findings which would be consistent with reflex sympathetic dystrophy involving the right ankle and foot with decrease (sic) blood flow to the right ankle and foot as well as delayed uptake in the soft tissues of the right foot and ankle.
2. Intense increased tracer activity associated with the calcaneus consistent with a fracture at this level.

Dr. John R. Swicegood noted on October 23, 2000:

Terry M. Potocki is a 69-year-old-white female who presented to my service with signs and symptoms of RSD of the right ankle and foot. She presents today for her first treatment and a series of lumbar sympathetic nerve blocks. She was started on a Clonidine topical patch to her right foot which she believes is helpful in diminishing some of the discoloration and has improved the appearance of her foot as well as perhaps some enhanced comfort....I have related to her that physical therapy, medical therapy are the hallmarks of treatment. I did order a bone scan which I reviewed with her. Unfortunately, this bone scan reveals significant blood flow lost consistent with RSD....

Right foot shows still 2+ edema. It is cool to the touch, being less than 34 degrees compared to 34 degrees on the contralateral side and stiffness and discomfort to passive range of motion maneuvers of the foot.

Dr. Swicegood's impression was "RSD of the right foot" and "Complex regional pain syndrome, type I." Dr. Swicegood's plan was "Begin her sympathetic nerve blocks."

The claimant began a regular series of treatment with Dr. Swicegood, who noted on November 6, 2000:

Terry M. Potocki is a 69-year-old-white female who presents for her sixth lumbar sympathetic nerve block. We had anticipated doing six blocks in this series and she showed marked improvement in function and appearance of her foot. She still has some discomfort, however, with weight bearing. She presents today for her last block. I have given her specific discharge instructions to continue physical therapy, medical therapy, and to follow up with Dr. Heim. If she has any relapse of pain that is suggestive of sympathetic mediated pain such as burning, changes in her skin color, appearance, health, and nourishment of her foot, to please get back in touch with us, that occasionally a supplemental series of blocks are necessary....

Dr. Swicegood's post-procedure diagnosis was "Complex regional pain syndrome, right ankle, type I."

Dr. Heim reported on March 1, 2001 that he "had nothing to do with the reflex sympathetic dystrophy diagnosis and will refer this to Dr. Swicegood." The claimant testified that the respondent-employer provided medical treatment through March 2001. Ms. Potocki claimed entitlement to additional worker's compensation. The claimant contended that she was entitled to permanent partial disability and

wage-loss disability. The respondents contended that they had paid all benefits for which the claimant was entitled. The respondents contended that treatment by Dr. Swicegood was not authorized and was not reasonably necessary. The respondents contended that further medical treatment was not reasonably necessary, and that the claimant did not have a compensable reflex sympathetic dystrophy condition. The respondents contended that the claimant had not sustained a "permanent injury" as a result of her compensable injury.

The parties deposed Dr. Heim, an orthopaedic surgeon, on August 6, 2002. The respondents' attorney queried Dr. Heim:

Q. On March 1, 2001, did you have any recommendations regarding further treatment?

A. At that point, no.

Q. Okay. Was there anything else that you had to offer at that point from an orthopaedic standpoint?

A. Not at that time....

Q. On March 1, 2001, had Ms. Potocki reached maximum medical improvement?

A. Probably not.

Q. Okay. Why not?

A. She was - she wasn't even quite a year out at that time. She was -

Q. When would you expect MMI or maximum medical improvement to occur?

A. I'm sure it's occurred by now....

Q. You did release Ms. Potocki to return to work on March 1, 2001, is that right?

A. Yes....

Q. Would you have diagnosed Ms. Potocki with RSD?

A. In reviewing the bone scan and Dr. Swicegood's note, I don't have an argument with that. I had met her, you know, after the fact, after Dr. Lane had treated her. It's difficult to tell at that time if you're dealing with RSD or still the sequela of the initial injury because swelling, redness, pain, they're both symptoms of her calcaneus fracture and they can be symptoms of RSD, but I have no problem with Dr. Swicegood's diagnosis....

Q. Would you rate Ms. Potocki with any permanent impairment as a result of her calcaneus fracture?

A. She would have a permanent impairment and I could. At this point she's probably reached her MMI....

Q. What would be her permanent impairment rating as a result of the calcaneus fracture?

A. Oh, I'd have to see her and examine her foot and measure it. It'd depend on her ankle, her inversion-eversion of her subtalar joint, her ankle range of motion, you know, it would not be insignificant. Calcaneus fractures are bad, bad boys....

Q. Now, you make reference to the arthritic development in the hind foot in the joint area there. What role did that play in any problems that Ms. Potocki was having?

A. You have an articulation between the calcaneus and the talus. The talus is the top bone in your foot, the bottom bone in your ankle. The calcaneus is right below that. Obviously if you fracture one of those and disrupt it, that joint is no longer going to be congruent and now you're going to have arthritis. It'd be like having a terrible tibial plateau fracture in your knee, you're going to have arthritis in your knee. Well, she had arthritis now in her foot because of the fracture to the calcaneus.

The claimant's attorney cross-examined Dr. Heim:

Q. Now, in her case you said she would be entitled to an impairment rating for the fracture. Would she also be entitled to an impairment rating for the condition of RSD?

A. Yes, you can. You can have some dysfunction in RSD. The problem with RSD, Mr. Delay, it's harder to put a finger on it. It's this nerve dysfunction and you can't really measure it, you can't quantify it, and a lot of the problems are subjective....

Q. Based on the result of the triphasic bone scan, would you also diagnose her as having RSD?

A. I think, yes, I think I would lean, in a 50-50 setting, I would lean toward RSD, yes.

Q. What physical restrictions would you put on Ms. Potocki of a permanent nature?

A. She's going to have difficulty being on her feet all day. She's going to have difficulty on walking on uneven ground. She'll have swelling on her foot toward the end of the day. She may have to wear either a surgical stocking to keep the edema out or prop her feet up some time during the day. She'll probably have to take some type of anti-inflammatory because she's going to have some pain in that subtalar joint. She may have to wear

an insert in her shoe or like I ordered this AFO to give her some stability.

Q. In your opinion could she sit for an eight-hour day?

A. I would think so, yes.

Dr. Heim reported on August 14, 2002:

Terry presents where I have done a complete evaluation of her lower extremity. She has severe calcaneus fracture that resulted in a flattened arch, loss of Böhler's angle and also appears to have developed a complex regional pain syndrome, formally known as reflex sympathetic dystrophy. She was treated by Dr. Swicegood for this.

OBJECTIVE: Indeed, today her right foot is cooler than her right leg and from midcalf distally is cooler than her left. She has edema. She has a positive bone scan, positive for osteoporosis. The skin appears to be slightly shiner (sic) in nature than the left.

ASSESSMENT AND PLAN: I feel she has a comminuted calcaneus fracture with an overlying complex regional pain syndrome. I have recorded her measurements in dorsiflexion, plantar flexion, inversion, eversion of the subtalar joint. She walks with a cane. I also gave her a brace today. I am concerned about her stability. She said it felt very good, gave her good stability. I have included her range of motion of her ankle, her subtalar joint with the complex regional pain syndrome and would rate her at a 33% impairment to the right lower extremity resulting in a 13% impairment to the patient as a whole.

Dr. Reginald J. Rutherford independently examined the claimant on September 13, 2002:

Medical records were provided for review. Hard copy of plain radiographs of the right foot and a

triphasic bone scan both lower extremities was also provided. The bone scan was performed on October 18, 2000. This is reported as demonstrating features consistent with reflex sympathetic dystrophy as well as demonstrating intense increased activity related to calcaneal fracture. In my opinion the bone scan does not demonstrate any evidence to suggest reflex sympathetic dystrophy and would better be interpreted as demonstrating changes related to the calcaneal fracture accompanied by disuse. The latter is reflected by decreased activity on blood flow and early images involving the right foot with the picture as anticipated in RSD being increased activity on all three phases. The latter is clearly not evident. While this picture may evolve during advanced or resolving RSD, the time of this particular study referable to the injury represent (sic) a sufficient time interval for this change to have transpired....

Clinical examination revealed demonstrates mild deformity of the right ankle. Pedal pulses are palpable, symmetrical and considered normal....Right foot is slightly cool to touch compared to the left but both feet were noted to be cool rather than warm. There was no significant edema noted of the right foot, specifically there was no swelling as might be anticipated in reflex sympathetic dystrophy of moderate to severe degree....

In brief, the clinical picture as presented by Ms. Potocki is not strongly suggestive of the operant clinical diagnosis of reflex sympathetic dystrophy. Her neurological examination is clearly abnormal demonstrating diminution of the right ankle jerk, weakness of the toes right foot and blunting of pinprick sensation over the sole and to a lesser extent dorsum of the right foot. The above findings indicate injury to the peripheral nervous system in addition to her clinical fracture.

Ms. Potocki's clinical examination is not considered

supportive of the diagnosis of reflex sympathetic dystrophy. Her bone scan is not considered supportive of the diagnosis of reflex sympathetic dystrophy. In my opinion the bone scan would be best interpreted as demonstrating evidence for calcaneal fracture and disuse. Her current clinical examination clearly demonstrates evidence for injury to the peripheral nervous system. Further investigation is clearly indicated in Ms. Potocki's case. This should comprise an MRI study of the lumbar spine, MRI study of the right foot, triphasic bone scan both lower extremities specific attention directed to the foreleg and foot and EMG/Nerve Conduction Study right lower extremity. Further treatment options may not be adequately assessed at this juncture in the absence of the above diagnostic information.

The parties again deposed Dr. Heim on October 1, 2002.

The respondents' attorney queried Dr. Heim:

Q. And can you just go through and tell us what the basis of the 33 per cent impairment to the right lower extremity is?

A. Yes. The loss of Boehler's, spelled B-o-e-h-l-e-r-s, angle with a fracture of the calcaneus, the disruption of the subtalar joint, which will also affect her ankle, her instability, the need to use a cane and the need to use a brace, all of those are covered in the guide. In looking at this, whether any of her problems are due to causalgia or not really doesn't change the fact that she's lost significant motion in her ankle and her hind foot, which the subtalar joint is part of the hind foot. If you add the loss of extension and flexion of the ankle, the loss of extension, flexion, varus and valgus of the subtalar joint and include the impairment, need to use a cane and brace, which on page 78 in section three and 76 in section three, they discuss lower limb impairment and gait derangement, which she does have a gait derangement. Actually, what I did is I probably thought was fairly conservative and I feel that by using these numbers which can

be interpreted different ways, mild, moderate, severe, each degree of motion, which is very difficult to measure, can add or subtract. Probably came up with the 33 per cent there, and really I don't think I gave her anything for the causalgia.

Q. For the what, sir?

A. For the reflex sympathetic dystrophy or causalgia....

Q. Let me ask you this, Doctor. You know, the RSD aside, if you're saying that your impairment rating does not include any element of RSD -

A. It really doesn't.

Q. Okay. That's fair enough. What is your normal impairment rating for a calcaneal fracture of the ankle?

A. It's probably - the ones as severe as hers, I'd say this is very average.

Q. Okay. And it's based on loss of motion and the angle that -

A. It's loss of motion of the ankle, loss of subtalar motion, which will make it difficult to walk on uneven ground, you'll have an antalgic gait, you can be unsteady. Should your - for instance, if you have an injury to the right foot - I had this happen recently as a matter of fact - should your left slip, you can't catch yourself with your right foot. The need to perhaps use a cane and a brace, and they even - on that 376 they talk about a mild gait derangement and -

Q. Is that what you used?

A. No. This is just they talk about these....

Q. Now, did you provide or did you include in the 33 per cent to the lower extremity anything for pain?

A. No.

Q. Okay. It's all based on loss of range of motion?

A. Loss of range of motion of those two joints. I did include the fact that she would, I felt she would have to walk with a cane to be stable and I also put her in a brace that day.

Q. Okay. Let's break that down and I think we can do it by actually subtracting the cane and the brace percentages that you used. What are the percentages that you used for Ms. Potocki having to walk with a cane?

A. .... I have her 5 per cent to the lower extremity for having to use the cane.

Q. Okay. What about the brace?

A. An additional 5 per cent for having to use the brace.

Q. Okay. And would the remaining 23 per cent be for loss of motion of the two joints?

A. Correct.

The claimant's attorney cross-examined Dr. Heim:

Q. Are you familiar with the terms active range of motion versus passive range of motion?

A. Yes.

Q. And how would you define the difference in those two?

A. Active range of motion is the movement of the extremity or joint or body part provided by the

patient's own muscle and tendon unit. Passive would be when the patient is relaxed and a secondary force exerts the motion upon that....

Q. And when you noted the lack of range of motion, was that your own manipulation or were you asking Ms. Potocki to simply move her foot?

A. No, on her it was my manipulation.

Q. Okay. And that's what your calculations of the loss of range of motion were based on?

A. Yes.

After a hearing before the Commission, the administrative law judge filed an opinion on January 23, 2003. The administrative law judge found, "The claimant has proven by a preponderance of the evidence that she developed RSD as a result of her April 5, 2000, right ankle fracture." The administrative law judge found that the claimant was entitled to medical treatment for her reflex sympathetic dystrophy. The administrative law judge found, "The claimant is to return to Dr. Swicegood for an evaluation to determine if she is entitled to an impairment rating for her RSD. Once Dr. Swicegood's report is received a determination as to whether this claimant is entitled to wage loss will be made." Finally, the administrative law judge found, "The claimant has proven by a preponderance of the evidence that she is entitled to a 33 percent impairment

rating for her right lower extremity as assessed by Dr. Heim. Dr. Heim, in his deposition, has stated and explained that he used objective medical evidence of this claimant's serious fracture in determining the degree of impairment to her right lower extremity."

The respondents appealed to the Full Commission, and the claimant filed a notice of cross-appeal. On February 11, 2003, the claimant filed a Motion To Remand. The claimant stated that the Full Commission should remand to the administrative law judge "to make a specific finding as to whether the claimant is entitled to wage loss disability." The respondents requested that the Full Commission deny the motion. The Full Commission filed an Order on March 12, 2003. The Full Commission noted, "Dr. Swicegood has apparently declined to perform the evaluation requested by the Administrative Law Judge." The Full Commission held in abeyance the claimant's motion pending our *de novo* review.

## II. ADJUDICATION

### A. Causation

The claimant bears the burden of proving that she is entitled to benefits, and she must sustain that burden by a preponderance of the evidence. Dalton v. Allen Eng'g Co.,

66 Ark. App. 201, 989 S.W.2d 543 (1999). Causal connection is generally a matter of inference, and possibilities may play a proper and important role in establishing that relationship. Osrose Wood Preserving v. Jones, 40 Ark. App. 190, 843 S.W.2d 875 (1992). 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). The determination of whether a causal connection exists is a question of fact for the Commission. Jeter v. B.R. McGinty Mechanical, 62 Ark. App. 53, 968 S.W.2d 645 (1998).

In the present matter, the Full Commission affirms the administrative law judge's finding that the claimant suffered reflex sympathetic dystrophy as a result of her compensable injury. The record indicates that the claimant fractured her calcaneus, or heel bone, as a result of the stipulated April 5, 2000 compensable injury. The first treating orthopedic specialist, Dr. Lane, opined in July 2000 that the claimant's bone fracture had "essentially healed." The claimant began treating with another orthopaedist, Dr. Heim, in September 2000. Dr. Heim's report did not expressly agree with Dr. Lane that the claimant's fracture had healed. A bone scan taken in

October 2000, apparently arranged by Dr. Swicegood, showed "Findings which would be consistent with reflex sympathetic dystrophy." We note that the result of the bone scan is objective evidence of reflex sympathetic dystrophy, although the claimant does not have to support a continuing need for medical treatment with objective findings. Chamber Door Industries, Inc. v. Graham, 59 Ark. App. 224, 956 S.W.2d 196 (1997).

Dr. Swicegood reported edema and coolness in the claimant's right foot in October 2000, and this report of course constitutes additional objective findings. Dr. Swicegood's impression was "RSD of the right foot" and "Complex regional pain syndrome." Dr. Swicegood began a course of pain management in 2000. The record does not clearly show whether or not the respondents paid for Dr. Swicegood's treatment. The claimant's testimony indicated that the respondents did not formally controvert additional medical treatment until March 2001. The respondents subsequently contended that Dr. Swicegood's treatment was "unauthorized," although they have abandoned that argument on appeal to the Full Commission.

Based on the preponderance of evidence before us, the Full Commission affirms the administrative law judge's

finding that the claimant's reflex sympathetic dystrophy condition was compensable. Dr. Heim testified that he didn't "have an argument" with Dr. Swicegood's diagnosis of RSD. Dr. Heim in fact testified, "I would lean toward RSD, yes." Dr. Rutherford, a neurologist, did not expressly agree with the diagnosis of reflex sympathetic dystrophy, but he did not discount it either. Dr. Rutherford stated, "the clinical picture ... is not strongly suggestive of the operant clinical diagnosis of reflex sympathetic dystrophy." We also note Dr. Rutherford's report of "injury to the peripheral nervous system in addition to her clinical fracture." Even if the preponderance of evidence did not show that the claimant had sustained reflex sympathetic dystrophy as a result of her compensable injury, the evidence clearly showed that the claimant required additional medical treatment as a result of her compensable injury. The employer must promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a). In the present matter, we find that the claimant proved by a preponderance of the evidence that she was entitled to all of the medical

treatment provided by Dr. Lane, Dr. Heim, and Dr. Swicegood.

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. Weber v. Best Western of Arkadelphia, Workers' Compensation Commission F100472 (Nov. 20, 2003). Pursuant to Ark. Code Ann. §11-9-522(g), the Commission has adopted the Guides to the Evaluation of Permanent Impairment (4<sup>th</sup> ed. 1993), published by the American Medical Association for assessing anatomical impairment. Any determination of the existence or extent of physical or mental impairment shall be supported by objective and measurable physical findings. Ark. Code Ann. §11-9-704(c)(1). To the extent that they allow subjective criteria for establishing an impairment rating, the Guides must yield to the statutory definition of anatomical impairment as established by the Arkansas General Assembly. Rizzi v. Sam's Wholesale Club, WCC E515370 & E112991 (April 1, 1999).

In the present matter, the Full Commission agrees with the respondents that the claimant is not entitled to an impairment rating for her diagnosed reflex sympathetic dystrophy. The respondents argue that the instant case

"falls squarely within" the case of Wal-Mart Stores, Inc. v. Connell, 340 Ark. 475, 10 S.W.3d 882 (2000). In Connell, the Supreme Court of Arkansas held that substantial evidence did not support the Commission's award of permanent partial disability benefits and wage-loss disability benefits, "because we agree with appellant that these disability benefits may not be awarded absent a finding of a specific percentage of permanent physical impairment." The claimant in Connell had sustained a compensable injury to her right knee and was thereafter assigned an 8% impairment rating to her right lower extremity. Connell was subsequently diagnosed with reflex sympathetic dystrophy. An administrative law judge awarded the claimant a permanent partial disability attributable to her reflex sympathetic dystrophy. The Full Commission affirmed as modified, reducing the claimant's rating attributable to RSD.

The sole point before the Supreme Court was "whether the Commission erred by awarding Connell permanent partial-disability benefits and wage-loss disability benefits, related to her RSD, in the absence of a permanent anatomical-impairment rating." The Commission had determined that Connell had suffered some permanent impairment, although the "extent or degree" of such

impairment "could not be calculated in accordance with Arkansas statutory requirements." The Commission then went on to award the claimant wage-loss disability in excess of her incalculable permanent physical impairment. The Court cited Ark. Code Ann. §11-9-522(b)(1), which provides for awarding wage-loss disability "in excess of the employee's percentage of permanent physical impairment." The Court held:

Here, the Commission never determined Connell's percentage of permanent physical impairment attributable to her RSD, acknowledged that it lacked a statutory basis to make a specific impairment rating in this case, and yet made an award for permanent partial-disability benefits and wage-loss benefits....We find that the statutory barriers that prevented the Commission from assigning a specific impairment rating and foreclosed an award of permanent benefits were nothing less than fatal to Connell's claim for wage-loss disability benefits. Accordingly, we reverse the Commission's award of permanent partial-disability benefits and wage-loss disability benefits.

The Full Commission subsequently found that there was no evidence to assign an impairment rating for reflex sympathetic dystrophy under the Guides in Henderson v. Riverside Furniture, Workers' Compensation Commission F104235 (June 3, 2003), citing Connell, *supra*. In the present matter, we likewise agree that there is no criteria in the Guides for assigning a permanent impairment rating

for the claimant's reflex sympathetic dystrophy. The Full Commission therefore does not affirm the administrative law judge's finding that the claimant should present to Dr. Swicegood for an evaluation of permanent impairment attributable to the claimant's RSD. And of course, Dr. Swicegood has in any event declined to perform such an evaluation.

However, the Full Commission finds that the claimant sustained anatomical impairment in the amount of 23% to her right lower extremity as a result of the claimant's compensable injury. The record indicates that 23% of Dr. Heim's impairment rating was based on passive range of motion, was based on objective findings, and was not related to the claimant's reflex sympathetic dystrophy. The Court of Appeals has held that "passive" range of motion can constitute an objective medical finding for purposes of assigning permanent impairment. See, Hayes v. Wal-Mart Stores, 71 Ark. App. 207, 29 S.W.3d 751 (2000). In the present matter, Dr. Heim testified that 23% of his rating was based on the physician's manipulation and was not under the voluntary control of the claimant. We find that the claimant's compensable injury was the major cause of her 23% anatomical impairment, pursuant to Ark. Code Ann.

§102(4)(F)(ii)(a). The claimant's injury to her right lower extremity was a scheduled injury. A claimant who has sustained a scheduled injury but is less than permanently and totally disabled is not entitled to wage-loss disability. Maxey v. Tyson Foods, Inc., 66 Ark. App. 301, 991 S.W.2d 624 (1999). The instant claimant does not contend that she is entitled to permanent and total disability, and the record does not show that she is entitled to same.

### III. CONCLUSION

Based on our *de novo* review of the entire record, the Full Commission affirms the administrative law judge's finding that the claimant proved by a preponderance of the evidence that she developed reflex sympathetic dystrophy as a result of her compensable injury. We find that the claimant proved she was entitled to the medical treatment provided by Dr. Lane, Dr. Heim, and Dr. Swicegood. We find that the claimant proved she was entitled to a 23% anatomical impairment rating as assigned by Dr. Heim, and that the claimant's compensable injury was the major cause of her 23% anatomical impairment. Because the claimant is not entitled to wage-loss disability for her scheduled injury, the Full Commission denies the claimant's pending

motion for remand to the administrative law judge on the wage-loss issue. The claimant's attorney is entitled to fees pursuant to Ark. Code Ann. §11-9-715(a) (Repl. 1996). For prevailing on appeal to the Full Commission, the claimant is entitled to an additional fee of \$250 pursuant to Ark. Code Ann. §11-9-715(b) (2) (Repl. 1996).

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

Commissioner Turner concurs in part and dissents in part.

CONCURRING AND DISSENTING OPINION

\_\_\_\_\_I concur with the finding in the principal opinion that claimant suffers from reflex sympathetic dystrophy or complex regional pain syndrome, which is a compensable consequence of the admittedly compensable injury to her right foot. Contrary to the usual and expected opinion of Dr. Reginald Rutherford, the overwhelming evidence indicates that claimant has suffered neurological damage to, or malfunction of, her sympathetic nervous system as a result of the compensable injury. Even Dr. Heim described Dr. Rutherford as "pretty bold" in formulating his opinion.

I also concur with the finding that claimant is entitled to benefits for a permanent anatomical impairment

of at least 23 percent to the body as a whole. We cannot, and should not, accept respondents' invitation to arbitrarily disregard or ignore Dr. Heim's testimony that this rating is based on passive range of motion.

Finally, I must respectfully dissent from the finding that benefits for a permanent anatomical impairment can never be assigned for reflex sympathetic dystrophy or similar nervous system abnormalities. This issue presents a medical question best left answered by the medical profession. Admittedly, this Commission has on several occasions denied a request for such benefits on a finding that the rating did not comply with the criteria set forth in the Guides. However, that is not to say that medical evidence could never be developed to support such an award. Accordingly, I would remand this matter to the Administrative Law Judge to appoint a physician to determine the extent, if any, of claimant's permanent anatomical impairment as a result of the injury to her nervous system.

For the foregoing reasons, I concur in part and respectfully dissent in part.

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SHELBY W. TURNER, Commissioner

Commissioner McKinney concurs in part and dissents in part.

CONCURRING AND DISSENTING OPINION

I respectfully concur in part and dissent in part from the majority opinion. Specifically, I concur in the reduction of the claimant's permanent impairment rating to not include any impairment for the RSD. However, the claimant, in my opinion, is not entitled to any permanent impairment. I must dissent from the finding that the claimant proved by a preponderance of the evidence that she developed reflex sympathetic dystrophy as a result of her compensable April 5, 2000, right ankle fracture. In my opinion, the claimant has failed to meet her burden of proof.

The claimant has the burden of proving by a preponderance of the credible evidence that medical treatment is reasonable and necessary. Norma Beatty v. Ben Pearson, Inc., Full Workers' Compensation Commission, Feb. 17, 1989 (D612291); B.R. Hollingshead v. Colson Caster, Full Workers' Compensation Commission, Aug. 27, 1993 (D703346). In workers' compensation cases, the burden rests upon the claimant to establish his claim for compensation by a preponderance of the evidence. Kuhn v. Majestic Hotel,

50 Ark. App. 23, 899 S.W.2d 845 (1995); Bartlett v. Mead Container Board, 47 Ark. App. 181, 888 S.W.2d 314 (1994).

When an employee is determined to have a compensable injury, the employee is entitled to medical and temporary total disability benefits. Ark. Code Ann. § 11-9-102(5)(F)(i)(Repl. 2002). Benefits are not payable for a condition which results from a non-work-related independent intervening cause following a compensable injury which causes or prolongs disability or need for treatment Ark. Code Ann. § 11-9-102(5)(F)(iii)(Repl. 2002). "The test for determining whether a subsequent episode is a recurrence or an aggravation is whether the subsequent episode was a natural and probable result of the first injury or if it was precipitated by an independent intervening cause." Georgia Pacific Corp. V. Carter, 62 Ark. App. 162 969 S.W.2d 677 (1998). Whether there is a causal connection between an injury and a disability and whether there is an independent intervening cause are questions of fact for the Commission to determine. Oak Grove Lumber Co. V. Highfill, 62 Ark. App. 42 968 S.W.2d 637 (1998).

In my opinion, the claimant cannot prove by a preponderance of the medical evidence that she has a compensable RSD injury. The claimant was examined by

Dr. Reginald Rutherford, who authored a report dated September 13, 2002. In that report, Dr. Rutherford concluded that the claimant did not suffer from RSD. His report states, in relevant part:

The bone scan was performed on October 18, 2000. This is reported as demonstrating features consistent with reflex sympathetic dystrophy as well as demonstrating intense increased activity related to calcaneal fracture. In my opinion the bone scan does not demonstrate any evidence to suggest reflex sympathetic dystrophy and would better be interpreted as demonstrating changes related to the calcaneal fracture accompanied by disuse.

. . .

Clinical examination revealed demonstrates mild deformity of the right ankle. Pedal pulses are palpable, symmetrical and considered normal. Superficial veins are prominent both lower extremities. Right foot is slightly cool to touch compared to the left but both feet were noted to be cool rather than warm. There was no significant edema noted of the right foot, specifically there was no swelling as might be anticipated in reflex sympathetic dystrophy of moderate to severe degree. There was no mechanical hyperesthesia or allodynia identified. There was no asymmetry of hair or nail growth in comparing the feet and no asymmetry in sweat pattern on examination of the feet.

. . .

Ms. Potocki's clinical examination is not considered supportive of the diagnosis of reflex sympathetic dystrophy. Her bone scan is not considered supportive of the diagnosis of reflex sympathetic dystrophy. In my opinion he bone scan

would be best interpreted as demonstrating evidence for calcaneal fracture and disuse.

Although Dr. John Swicegood made the diagnosis of RSD, a close examination of Dr. Heim's testimony establishes that he never unequivocally agreed with that diagnosis. In his initial deposition of August 6, 2002, Dr. Heim testified that he would defer to Dr. Swicegood for the diagnosis of RSD. Dr. Heim was clear that he could not diagnose RSD "with certainty", but stated that it was a "very difficult" condition to diagnose.

In his deposition of October 1, 2002, Dr. Heim made it clear that he was not choosing one side or the other with regard to the RSD debate:

Q. Dr. Rutherford felt like that Ms. Potocki's problems were more related to the fracture accompanied by disuse as opposed to RSD and you're giving some credence to that in your rating?

A. Not really. I really wouldn't argue with him and I wouldn't necessarily agree with me. As we stated earlier - as we stated in the previous disposition, it is a poorly understood phenomenon. There is a vasoconstrictive and vasodilatative in a state of causalgia. You can have an initial bone phase that has decreased vascularity. Now, he took that and hung his hat on that stating that because of that he didn't think she has an RSD. I think that's a pretty bold statement especially when you talk about the coolness of the skin above the ankle. She had no fracture above the ankle, so what would - there would certainly be no injury above the ankle and why would there be a change in

the variation, the temperature variation of the skin above the ankle, and the other thing is he freely admits in there that perhaps some of the numbness may be due to injury to the nerves, and he goes over this litany of how to diagnose that. Usually the nerve arteries run in conjunction, and if you have a nerve injury, why could you not have an arterial injury which would also decrease blood flow and make your bone scan run cooler?

Q. Right.

A. So, I'm not disputing him. It's a difference of opinion, and if you ask 10 people, you may get five on each side.

Q. Right. Well, let me just say this. Dr. Swicegood, of course, has made the diagnosis of RSD?

A. He felt it was and I don't disagree with him.

Q. And we talked in your deposition before and you candidly admitted it is a difficult diagnosis?

A. It is very difficult.

Q. And I think you said it was in the 50/50 range, and I just kind of want to cut to the chase, you're kind of in the middle as far as -

A. There's not a test you can draw. What it is, it's a compilation of tests and then you give your best estimate, but no one's right and no one's wrong.

After conducting a de novo review of the record, I find that the claimant does not have RSD, and such a finding is contrary to the weight of the credible medical evidence.

I also find that the claimant is not entitled to any permanent impairment. The Workers' Compensation Law is clear that an impairment rating must be supported by objective findings and that range of motion tests are not objective findings. Ark. Code Ann. §11-9-102(16)(A). Dr. Heim testified that a 23% impairment rating was assigned to the claimant based upon lack of range of motion of the ankle and subtalar joints. Dr. Heim testified:

Q. And what you're telling us now, if I understand it correctly, when you're putting her through the paces for the clinical examination as far as a loss of range of motion, you have to believe her?

A. Yes.

Q. Okay. And you rely on what she's telling you insofar as how -

A. To a certain extent there is some - I guess it would be available, I mean, it would be - it could happen with someone as large as me if you tried to bend my elbow and I didn't want you to bend it, you couldn't bend it. But it have a pretty (sic) idea of practicing 15 years whether somebody is -

Q. Right.

A. - trying to embellish their symptoms.

Dr. Heim again conceded that part of the test was subjective.

The 23% impairment rating is based upon range of motion tests, which are subjective in nature. The claimant should not be awarded permanent partial disability benefits in the amount of 23%. Dr. Heim explained:

Q. All right, sir. And you can just go through and tell us what the basis of the 33 per cent impairment to the right lower extremity is?

A. Yes. The loss of Boehler's spelled B-o-e-h-l-e-r-s, angle with a fracture of the calcaneus, the disruption of the subtalar joint, which will also affect her ankle, her instability, the need to use a cane and the need to use a brace, all of those are covered in the guide. In looking at this, whether any of her problems are due to a causalgia or not really doesn't change the fact that she's lost significant motion in her ankle and her hind foot, which the subtalar joint is part of the hind foot. If you add the loss of extension and flexion of the ankle, the loss of extension, flexion, varus and valgus of the subtalar joint and include the impairment, need to use a cane and a brace, which on page 78 in section three and 76 in section three, they discuss lower limb impairment and gait derangement, which she does have a gait derangement. Actually, what I did is I probably thought was fairly conservative and I feel that by using these numbers which can be interpreted different ways, mild, moderate, severe, each degree of motion, which is very difficult to measure, can add or subtract. Probably came up with the 33 per cent there, and I really don't think I have her anything for the causalgia.

Therefore, for all the reasons set forth herein, I must respectfully concur in part and dissent in part from the majority opinion.