

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F508325

JANICE K. SWAFFORD, EMPLOYEE	CLAIMANT
POCAHONTAS PUBLIC SCHOOLS, A SELF-INSURED EMPLOYER	RESPONDENT
RISK MANAGEMENT RESOURCES, TPA	RESPONDENT

OPINION FILED DECEMBER 3, 2007

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

Claimant represented by HONORABLE JOHN BARTTELT, Attorney at Law, Jonesboro, Arkansas.

Respondent represented by HONORABLE MICHAEL E. RYBURN, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal a decision of the Administrative Law Judge filed on February 5, 2007, finding that the claimant sustained a compensable right carpal tunnel injury which resulted in a compensable consequence injury in the form of left carpal tunnel syndrome; that the treatment rendered by Dr. Tuck relative to the left upper extremity was reasonable and necessary; and that the respondents were responsible for all reasonable hospital and medical expenses arising out of the specific incident injury

of July 27, 2005, including the compensable consequence injury of the left carpal tunnel syndrome. Respondents do not appeal the finding that the treatment rendered by Drs. Rebecca Barrett-Tuck, J.D. Bonner and Demetrius Spanos while reasonable and necessary in connection with the right upper extremity, was not authorized. Based upon our de novo review of the entire record, and without giving the benefit of the doubt to either party, we find that the claimant has failed to meet her burden of proof with regard to whether carpal tunnel release surgery was reasonable and necessary and with regard to whether the claimant's compensable injury resulted in a compensable consequence injury to the left upper extremity. Therefore, we find that the decision of the Administrative Law Judge should be and hereby is reversed.

The claimant sustained a compensable injury to her right upper extremity on July 27, 2005, when her arm was slammed and pinned to the desk as she was releasing the handle on a dolly. This injury was readily accepted as compensable by respondents and benefits have been paid. Upon sustaining her injury, the claimant was seen by the company

physician, Dr. Alexander Baltz, and diagnosed with a right wrist and elbow contusion. The claimant was placed in a wrist brace and advised to use ice and take Ibuprofen for pain. X-rays did not reveal any fractures. The claimant was placed on light duty work with limited use of the right hand. As claimant continued to complain of pain, she was referred to Dr. R. Edward Cooper, Jr., an Orthopaedic Specialist, whom she saw for the first time on August 16, 2005. Dr. Cooper noted "significant tenderness over the ligaments surrounding the basilar joint of the right thumb and pain with basilar joint stress test." Again, x-rays did not demonstrate any evidence of fracture or dislocation. The claimant was placed in a thumb spica splint to immobilize the basilar joint and was kept on light duty. By September 13, 2005, the claimant reported to Dr. Cooper that the pain was more centralized over the radia-carpal joint and that she develops numbness and swelling whenever she lets her right hand hang down. Dr. Cooper ordered an MRI at that time. The MRI revealed soft tissue edema at the basilar joint indicative of a ligamentous injury. Dr. Cooper

referred the claimant to Dr. Michael Moore, a hand subspecialist at that time.

Dr. Moore first saw the claimant on October 11, 2005. After reviewing the claimant's medical records and diagnostic films, as well as physically examining the claimant, Dr. Moore noted that her subjective symptoms outweighed her objective findings. Possibly suspecting Reflex Sympathic Dystrophy, Dr. Moore ordered a triphasic bone scan and a referral to Dr. Reginald Rutherford, a neurologist, to conduct a nerve conduction and EMG study. Dr. Moore outlined a treatment plan for a Functional Capacity Evaluation if the test results were negative, or for further treatment by either Dr. Rutherford or himself if the test results revealed an abnormality.

The claimant was examined by Dr. Rutherford on November 3, 2005. Dr. Rutherford noted that the claimant's triphasic bone scan revealed evidence of Reflex Sympathetic Dystrophy of the right hand. In addition, the nerve conduction study and EMG revealed mild carpal tunnel syndrome on the right and moderate carpal tunnel syndrome on

the left. As the Reflex Sympathetic Dystrophy represented the claimant's "dominant clinical problem at present" Dr. Rutherford set out to treat this condition prior to addressing the carpal tunnel syndrome. Dr. Rutherford referred the claimant to Dr. Kenneth Rosenzweig with Arkansas Speciality Pain Management Center for a series of stellate ganglion blocks. In a follow-up appointment with Dr. Rutherford on November 16, 2005, he noted that the claimant was responding to the treatment for her RSD. By January 4, 2005, Dr. Rutherford noted that the claimant's hand remained improved and that she no longer needed the structured injection treatment; however, he did continue the claimant on her Neurontin and Clonidine patch. A follow-up triphasic bone scan was conducted which revealed "significant improvement in her RSD." Dr. Rutherford released the claimant to return to Dr. Moore for follow-up treatment on the claimant's bilateral carpal tunnel syndrome. As the claimant's left carpal tunnel was more severe than the right, Dr. Rutherford recommended, and

Dr. Moore agreed, that surgery should be limited to the left hand.

The claimant returned to Dr. Moore on February 7, 2006. Dr. Moore discussed treatment options with the claimant which included splinting, injection and splinting, or carpal tunnel surgery. The claimant declined surgical treatment for her left hand at that time.

The claimant returned to Dr. Rutherford on March 16, 2006, to follow-up on her RSD treatment. The claimant reported to Dr. Rutherford that when she discontinued use of Neurontin she noticed an increase in her RSD symptoms; thus Dr. Rutherford continued her on this medication therapy. Dr. Rutherford also ordered a Functional Capacity Evaluation. The FCE performed by Rick Byrd generated an invalid profile for the claimant as she only passed 17 out of 49 consistency measures. This report indicated that the claimant put forth an unreliable effort and demonstrated inappropriate pain behavior. With regard to reliability, Mr. Byrd specifically noted:

Ms. Swafford exhibits full AROM of the fingers, wrist, elbow and shoulder of

the RUE yet during formal testing exhibited the inability to reach overhead and also the inability to reach out in front of her body with her arm extended.

Ms. Swafford demonstrates inappropriate lifting as she exhibited the ability to only lift 1 lbs. with RUE. Ms. Swafford also demonstrated inappropriate effort related to her LUE as she decreased (sic) 6 lbs. as too heavy. Her effort was minimal with lifting. Later during testing, she exhibited the ability to lift an unmarked 5 lbs. weight with the RUE and then again declined to lift a 1 or 2 lb. marked weight, stating that these were too heavy.

Ms. Swafford demonstrates a normal arm swing while walking throughout testing, yet when tested for walking in a timed formal situation, she then placed her RUE against her body and guarded the extremity. After formal test, she again had normal arm swing. This is an indication of inappropriate illness responses.

Ms. Swafford exerted minimal forces isometrically and had very high C.V.'s with all repetitive trial testing. Her grip and pinch strength levels were 0 lbs. at times this indicates inappropriate effort and a direct manipulation of the testing procedure.

Ms. Swafford also exhibited the ability to lift her purse and then she placed it on her right shoulder to carry out of

this clinic. The abilities she demonstrated during testing would not have allowed her to lift this purse and she would not have placed it on her right shoulder.

After reviewing the result of the FCE, Dr. Rutherford found the claimant to be at maximum medical improvement and released her to return to work without any restrictions and without a permanent impairment rating.

The claimant went on her own to see Dr. Rebecca Barrett-Tuck, a neurosurgeon in Jonesboro, Arkansas. After detailing the nature of her injury, the claimant provided Dr. Tuck with the following treatment history:

...Since that time she has had pain that involves the wrist, the hand, the elbow, the shoulder, and the trapezius region on the right in association with numbness and tingling involving her whole hand and weakness of the hand. She has been treated for reflex sympathetic dystrophy, Dr. Ken Rosenswag (sic) in Little Rock has apparently given her three or four superior ganglion sympathetic blocks, however she cannot determine whether or not the procedures were helpful. She does feel that the pain seems to have worsened recently and wonders if it is possibly because she has not had a block in awhile. There are some job duties that have been a major

problem for her since the strength in her hand is simply not there and she has some much pain that she also is limited in her grip. She has not had her shoulder, neck, or elbow evaluated. She did have plain films and MRI of the hand and wrist.

With regard to her examination of the claimant, Dr. Tuck questioned whether the claimant's decreased grip strength was true weakness or guarding. Dr. Tuck ordered additional testing of the claimant's cervical spine and shoulder, as well as a new EMG/NCV of the upper extremities.

The claimant was examined by Dr. Demetrius Spanos, a neurologist, on May 9, 2006. In addition to recommending nerve conduction studies of the right upper extremity, Dr. Spanos also recommended that the claimant discontinue use of Neurontin which was previously prescribed by Dr. Rutherford. In its place, Dr. Spanos recommended Effexor and Cymbalta. The NCV of the right upper extremity conducted by Dr. Spanos revealed "moderately severe carpal tunnel syndrome and entrapment of the ulnar nerve across the elbow."

Upon examining the claimant's NCV results, Dr. Tuck opined that the claimant's conditions are work related. In this regard, Dr. Tuck wrote, "Most likely she was developing carpal tunnel syndrome from her work, then the accident that occurred has rapidly increased the progression on the right." Dr. Tuck recommended right carpal tunnel release and right ulnar nerve decompression under general anesthesia.

Respondents obtained a second opinion from Dr. Randy R. Bindra a hand and upper extremity specialist with UAMS College of Medicine Department of Orthopaedic Surgery. Dr. Bindra examined the claimant on July 10, 2006. Dr. Bindra obtained the following medical history:

This lady works as a janitor in Pocahontas Public Schools and has worked on this job for about 15 years. She had a work-related injury on 7/27/05. She had place a cable(sic) onto a dolly and was pushing it. When she arrived at a door that required it to be open, she lowered the dolly and then she released the lever of the dolly. Her right distal forearm just proximal to the wrist got pinned under the dolly. She stated that she developed secondary bruising distal to her elbow and just proximal to her forearm. She then appears to have

developed significant pain and, at some point, was diagnosed to have complex regional pain syndrome around October 2005. She tells me she was under treatment of this by Dr. Rutherford and, by February 2006, was told that the pain syndrome had settled and it was clear apparently by a second bond scan. She was then released from the clinic. At that time, she was diagnosed to have mild carpal tunnel syndrome. She then sought an independent opinion by an outside physician who also diagnosed carpal tunnel syndrome and recommended surgery. She was referred by Workman's Compensation Commission to see Dr. Moore, hand surgeon, as well as Dr. Rutherford. They repeated nerve conduction studies; noted the carpal tunnel was mild and did not feel it needed surgical intervention. In addition, this lady has had Functional Capacity Evaluation that showed significant inconsistency. Hence, she has been referred here for further evaluation.

Dr. Bindra reviewed the claimant's medical records as well as the diagnostic test results. Upon examination of the claimant's right upper extremity Dr. Bindra noted:

...there are no external scars noted. I did not localize any tender spots. This lady did have positive provocative tests for carpal tunnel syndrome. Examination of the cubital tunnel was normal. The ulnar nerve was normally palpable at the

elbow. On testing sensation to do a detailed sensory examination, there was significant inconsistency. Hence, a detailed sensory examination or two-point discrimination could not be achieved.

Dr. Bindra opined that the claimant sustained a forceful soft tissue injury to the right wrist and thumb. With regard to the diagnosis of carpal tunnel syndrome, Dr. Bindra wrote:

In September 2005, this lady began to complain of numbness in her hand, and it is likely that she began to develop symptoms of mild carpal tunnel syndrome. Although she does have evidence of bilateral carpal tunnel syndrome which may be constitutional, in this case, her symptoms of carpal tunnel syndrome in the right hand appear to have started only after the injury and about two months after the injury. As it was documented, she did have significant swelling around the base of her thumb. It is quite possible the carpal tunnel symptoms were brought on by her injury and the subsequent swelling around the wrist and hand area.

Noting the claimant's documented inconsistency on her Functional Capacity Evaluation as well as during the sensory examination he conducted himself, Dr. Bindra opined

that the claimant has a functional overlay to her symptoms. Dr. Bindra thus agreed with Dr. Moore that carpal tunnel release surgery would have a guarded prognosis and that her pain may not necessarily improve with surgery. Dr. Bindra offered the claimant the option of steroid injections to relieve her pain. Dr. Bindra explained in his July 31, 2006 report that if the claimant received improvement from the injection and splinting, then he would be able to determine how much of the claimant's symptoms were coming from the carpal tunnel syndrome. Specifically, Dr. Bindra noted, "If the injection and splinting fail to resolve her symptoms then it would be clear that her symptoms are not arising from the carpal tunnel syndrome and she has a chronic pain problem in her right upper extremity which, without any definable cause, this has a poor prognosis and will not improve..."

Dr. Bindra saw the claimant in follow-up on August 11, 2006, at which time the claimant advised that the injections and splinting did not make any changes in her symptoms whatsoever. Upon examination, the claimant was

reluctant to move or use her right upper extremity, although Dr. Bindra noticed that the claimant involuntarily seemed to move her arm while talking without any significant problems. With regard to her condition and treatment plan, Dr. Bindra stated in his August 31, 2006, report:

I explained to this lady that it is unlikely that she has carpal tunnel syndrome, as she has not responded to the steroid injections or to other modalities of treatment. She has right upper extremity pain of unknown origin. Unfortunately, her prognosis is poor, as there are inconsistencies in her examination. I suggested to her that if she finds the pain is severe, she needs to be on a chronic pain medicine program and possibly should consider intervention of a psychologist to help her deal with this problem better as there is certainly no surgical cure for her problem....

Despite the advise from Dr. Moore and Dr. Bindra that surgery on her right wrist was contraindicated, the claimant returned to Dr. Tuck who performed surgery on the claimant's right wrist on August 24, 2006. A thorough review of the operative report fails to disclose any obvious findings during surgery indicative of carpal tunnel

syndrome. Nevertheless, Dr. Tuck decompressed both the median and ulnar nerves. In a follow-up report dated September 6, 2006, Dr. Tuck noted that the claimant has done well following surgery, but that she does not use her right hand much. On September 7, 2006, Dr. Tuck performed left carpal tunnel release on the claimant. The last medical report from Dr. Tuck in the record is dated October 9, 2006, in which she noted that the claimant's right carpal tunnel release and ulnar nerve release was "absolutely fantastic" but that she was continuing to have pain and swelling on the left side.

The issues for determination at the hearing held December 1, 2006, were whether the surgeries performed by Dr. Tuck were reasonable and necessary in relation to the claimant's compensable right arm injury; whether the claimant sustained a compensable consequence injury to her left upper extremity; and whether the respondents are liable for medical treatment provided by unauthorized treating physicians. As previously noted, the Administrative Law Judge found that the medical treatment rendered to the

claimant under the care of Drs. Rebecca Barrett-Tuck, J.D. Bonner, and Demetrius Spanos, was not authorized. The claimant has not appealed this finding. Although the respondents are not liable for unauthorized medical treatment, it must still be determined whether the treatment was reasonable and necessary to determine whether the respondents are liable for benefits for any period of temporary disability in connection with the surgeries. It must also be determined whether the claimant sustained a compensable consequence injury to her left upper extremity.

In finding that the claimant's left carpal tunnel syndrome is a compensable consequence of the claimant's specific incident right upper extremity injury, the Administrative Law Judge found that "...the reliance on the left arm in continuing discharge of her job duties rapidly increased the progression on the left. Accordingly, the left carpal tunnel syndrome is a compensable consequence of the claimant's compensable right upper extremity injury." We find that the reasoning employed by the Administrative Law Judge to reach his conclusion is flawed.

The claimant must prove by a preponderance of the evidence that he sustained a "compensable consequence" pursuant to all of the statutory elements of compensability. Jones v. B.A.E. Sys., Full Commission Opinion filed May 6, 2004 (F001696); Atchison v. John P. Marinoni Const. Co., Full Commission Opinion filed September 19, 2001 (E616344). The burden of proof rests upon the claimant to prove the compensability of her claim. Ringier America v. Comles, 41 Ark. App. 47, 849 S.W.2d 1 (1993). There is no presumption that a claim is compensable, that the claimant's injury is job-related or that a claimant is entitled to benefits. Crouch Funeral Home v. Crouch, 262 Ark. App. 417, 557 S.W.2d 392 (1977); O.K. Processing, Inc. v. Servold, 265 Ark. 352, 578 S.W.2d 224 (1979). The party having the burden of proof on the issue must establish it by a preponderance of the evidence. Ark. Code Ann. § 11-9-704(c)(2) (Repl. 1996). In determining whether a claimant has sustained her burden of proof, the Commission shall weigh the evidence impartially, without giving the benefit of the doubt to either party. Ark. Code Ann. § 11-9-704; Wade v. Mr. C Cavanaugh's, 298

Ark. 363, 768 S.W.2d 521 (1989); and Fowler v. McHenry, 22 Ark. App. 196, 737 S.W.2d 663 (1987).

The Commission has the authority to accept or reject medical opinion and the authority to determine its medical soundness and probative force. Green Bay Packing v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 692 (1999). The Commission need not base a decision on how the medical profession may characterize a given condition, but rather primarily on factors germane to the purposes of workers' compensation law. Tyson Foods, Inc. v. Watkins, 31 Ark. App. 230, 792 S.W.2d 348 (1990). As our Supreme Court has stated:

The Commission has never been limited to medical evidence only in arriving at its decision as to the amount or extent of a claimant's injury. Rather, we wrote that the Commission should consider all competent evidence, including medical, as well as lay testimony and the testimony of the claimant himself. Further...while medical opinions are admissible and frequently helpful in workers' compensation cases, they are not conclusive.

A.G. Weldon v. Pierce Brothers Construction, 54 Ark. App. 344, 925 S.W.2d 179 (1996).

Medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. Ark. Code Ann. § 11-9-102(16) (B). Where a medical opinion is sufficiently clear to remove any reason for the trier of fact to have to guess at the cause of the injury, that opinion is stated within a reasonable degree of medical certainty. Huffy Service First v. Ledbetter, 76 Ark. App. 533, 69 S.W.3d 449 (2002), citing Howell v. Scroll Tech., 343 Ark. 297, 35 S.W.3d 300 (2001). A medical opinion based solely upon claimant's history and own subjective belief that a medical condition is related to a compensable injury is not a substitute for credible evidence. Brewer v. Paragould Housing Authority, FC Opinion filed Jan. 22, 1996 (E417617). No matter how sincere a claimant's beliefs are that a medical problem is related to a compensable injury, such belief is not sufficient to meet the claimant's burden of proof. Killenberger v. Big D Liquor, Full Commission Opinion August 29, 1995 (E408248 & E408249).

The claimant testified that after sustaining her right wrist injury, she returned to work on light duty

performing left-handed work only. Claimant described this work to include straightening up the desks in the classrooms, dust mop, sweep, and cleaning restrooms. It was during this time period that the claimant contends she started to develop problems with her left hand.

Upon first reporting to Dr. Baltz on July 27, 2005, the claimant did not complain of left arm pain. In fact, the only diagnosis was directly related to the claimant's specific incident of being struck on the right upper extremity. After the claimant's right upper extremity complaints did not subside, the claimant was eventually referred to Dr. Edward Cooper, a local Neurologist, who diagnosed a basilar joint injury of the right thumb. Dr. Cooper eventually referred the claimant to Dr. Michael Moore, a noted hand specialist in Little Rock, Arkansas, noting in his September 21, 2005 report, "We will refer her to the hand subspecialist to try to see if they can elucidate the etiology and specifically what is going on. Certainly her symptoms have been out of proportion for the objective injury and it is difficult to say what is the

cause." When the claimant was first examined by Dr. Moore on October 11, 2005, the claimant did not provide a history of any left upper extremity problems. Dr. Moore focused on the claimant's subjective symptoms in her right upper extremity which he noted "outweigh her physical findings." Based upon his examination of the claimant, Dr. Moore suspected that she suffered from Reflex Sympathetic Dystrophy as he ordered a triphasic bone scan to rule out such a diagnosis, and referred her to Dr. Reginald Rutherford for diagnostic testing.

The first complaint of left hand problems noted in the record is seen in Dr. Rutherford's November 3, 2005, EMG Report in which he recorded a history of: "Ms. Swafford also reports that by virtue of partial immobilization of her right hand she has been required to use her left hand more than normal with resultant numbness of her left hand." The EMG/Nerve Conduction Studies revealed the presence of mild carpal tunnel syndrome on the right and moderate carpal tunnel syndrome on the left. However, Dr. Rutherford explained that the claimant's Reflex Sympathetic Dystrophy

as confirmed through the triphasic bone scan was the claimant's dominant clinical problems which would be treated first. After medication and injection therapy, the claimant's RSD significantly improved as noted by a repeat triphasic bone scan in January of 2006. At that time, Dr. Rutherford referred the claimant back to Dr. Moore for treatment of her carpal tunnel syndrome. In referring the claimant back to Dr. Moore, Dr. Rutherford specifically noted that any surgery to address the claimant's carpal tunnel syndrome should be limited to the left upper extremity.

In her return visit to Dr. Moore on February 7, 2006, Dr. Moore discussed the claimant's options for treatment of her left carpal tunnel syndrome. The claimant turned down the offer of surgery on her left arm at that time. In addition, Dr. Moore recommended a Functional Capacity Evaluation. Interestingly, when the claimant sought medical treatment from Dr. Tuck after being released by Dr. Rutherford, the claimant did not provide a history of any left hand or arm complaints during her first visit with

Dr. Tuck on April 21, 2006. When Dr. Tuck referred the claimant to Dr. Spanos for testing, the claimant advised Dr. Spanos that she was diagnosed with bilateral carpal tunnel syndrome, but she did not provide a history of left arm complaints. Nevertheless, Dr. Spanos did not recommend nerve conduction studies of the left upper extremity. With regard to the right carpal tunnel syndrome, Dr. Spanos opined that "this may have been aggravated by the apparent entrapment of her wrist between the dolly handle and the corner of the desk." After testing, Dr. Spanos concluded that the claimant had moderately severe carpal tunnel syndrome of the right upper extremity as well as ulnar nerve entrapment.

The claimant returned to Dr. Tuck on May 24, 2006, for follow-up. With regard to the test results, Dr. Tuck opined:

The studies confirm moderately severe carpal tunnel syndrome on the right as well as ulnar neuropathy on the right. She has symptoms consistent with both. It is my feeling that these are work related conditions. Most likely she was developing carpal tunnel syndrome from her work, then the accident that

occurred has rapidly increased the progression on the right. She has also had progressive carpal tunnel syndrome on the left.

After performing right carpal tunnel release surgery on August 24, 2006, the claimant returned to Dr. Tuck for the same procedure for her left arm. However, at no time did Dr. Tuck ever offer an opinion that the left carpal tunnel syndrome was in any way related to her specific incident injury of the right arm.

With regard to causation, a review of Dr. Bindra's Independent Medical Examine is enlightening. As noted above, Dr. Bindra performed a thorough examination of the claimant as well as of her medical records and diagnostic tests. Dr. Bindra noted that the claimant's right sided carpal tunnel syndrome complaints did not start until about two months after her specific injury. Dr. Bindra opined that it was quite possible that these symptoms "were brought on by her injury and the subsequent swelling around the wrist and hand area." With regard to the left carpal tunnel syndrome, Dr. Bindra merely noted that she had "evidence of bilateral

carpal tunnel syndrome which may be constitutional.” Dr. Bindra did not recommend surgery for the carpal tunnel syndrome in light of the claimant’s documented inconsistency on the FCE and during his examination. After injecting the claimant’s right carpal tunnel with Depo-Medrol on July 10th, the claimant returned to Dr. Bindra on August 11, 2006, complaining that the injection did not provide any relief. As this is not only a treatment of carpal tunnel syndrome, but also a means of diagnosis, Dr. Bindra opined that the claimant’s failure to obtain any relief from this treatment indicated that “it is unlikely that she has carpal tunnel syndrome...” Accordingly, Dr. Bindra diagnosed the claimant with right upper extremity pain of unknown origin, and explained that her prognosis is poor given the inconsistencies in her examination.

Dr. Bindra’s only comments regarding the claimant’s left carpal tunnel syndrome was that it may be constitutional. Dorland’s Medical Dictionary 26th Edition defines constitutional as “affecting the whole constitution of the body; not local.” Constitution is thus defined as

"the make-up or functional habit of the body, determined by the genetic biochemical, and physiologic endowment of the individual, and modified in great measure by environmental factors." Dr. Bindra did not elaborate on what, if any, environmental factors, modified the claimant's make-up or functional habit of the body. Accordingly, without resorting to impermissible conjecture and speculation, the only conclusion that can be drawn from Dr. Bindra's comments regarding the left carpal tunnel syndrome is that it is specifically related to the claimant's make-up and functional habit of the body. Dr. Bindra never commented about the work or other environmental factors that might play into this diagnosis, thus it would be impermissible to read anything more in to his opinion. Conjecture and speculation, even if plausible, cannot take the place of proof. Ark. Dept. of Correction v. Glover, 35 Ark. App. 32, 812 S.W.2d 692 (1991). Dena Construction Co. v. Herndon, 264 Ark. 791, 575 S.W.2d 155 (1970). Arkansas Methodist Hospital v. Adams, 43 Ark. App. 1, 858 S.W.2d 125 (1993).

The only link between the claimant's work and her left carpal tunnel syndrome is seen in the history the claimant provided to Dr. Rutherford during his initial examination. The claimant advised Dr. Rutherford that the extra work with her left arm during light duty for her right arm injury resulted in numbness of her left hand. No physician has offered an opinion with regard to the causation of the claimant's left carpal tunnel syndrome. At best, Dr. Bindra opined that the claimant's bilateral carpal tunnel syndrome may be constitutional. Without any evidence as to the interplay of any environmental factors which Dr. Bindra may have been aware, the only logical conclusion that can be drawn is that he was merely referring to her physical make-up. Thus, the record is devoid of any credible medical opinion establishing a causation between the claimant's compensable right carpal tunnel syndrome from a specific incident injury and her subsequent development of left carpal tunnel syndrome. While the claimant testified that she had to use her left arm more during her light duty assignments, this is insufficient evidence to arise to a

preponderance of the evidence to find that the left carpal tunnel syndrome arose out of the claimant's employment and was not just the result of her physical make-up.

Accordingly, we find that the claimant has failed to prove by a preponderance of the evidence that she developed left carpal tunnel syndrome as a compensable consequence of her specific incident right arm injury.

Finally, with regard to the recommendation by Dr. Tuck that the claimant undergo right carpal tunnel release and ulnar nerve decompression, we find that the claimant has failed to prove by a preponderance of the evidence that such treatment is reasonable and necessary in connection with her compensable injury. The record reveals that the claimant underwent these procedures on August 24, 2006, and that she has received adequate relief from the surgery. However, as Dr. Tuck was not an authorized treating physician the respondents are not liable for the medical care provided at her direction. Nevertheless, the issue of whether the care was reasonable and necessary is relevant to

determine whether the respondents are liable for any period of disability associated with this unauthorized treatment.

Neither Dr. Rutherford nor Dr. Moore recommended right carpal tunnel release. Dr. Rutherford had just successfully treated the claimant for Reflex Sympathetic Dystrophy of the right upper extremity. As such he did not recommend invasive treatment for the mild carpal tunnel. Likewise, Dr. Moore, who would stand to benefit financially from operating on the claimant, also concluded that the claimant's condition did not warrant surgery on the right upper extremity. Given the EMG/Nerve Conduction Studies, Dr. Moore offered to operate on the claimant's left upper extremity as the left side revealed moderate carpal tunnel syndrome findings while the right only revealed mild findings. However, the most telling opinion with regard to whether surgery on the claimant's right upper extremity was reasonable and necessary is Dr. Bindra's Independent Medical Examination report. Dr. Bindra's physical examination produced significant inconsistent findings. Accordingly, he determined that the claimant may have functional overlay to

her symptoms. Dr. Bindra thus opined "that surgery for carpal tunnel syndrome will have a guarded prognosis as the patient's chronic pain did(sic) not necessarily improve after surgery." Dr. Bindra recommended a steroid injection into the claimant's right carpal tunnel to relieve her symptoms. As Dr. Bindra explained in his follow-up report, since this injection did not provide the claimant with any relief, "...it is unlikely that she has carpal tunnel syndrome..."

After weighing the opinions of Dr. Rutherford, Dr. Moore, and Dr. Bindra, we find their opinions carry more weight than that of Dr. Tuck. First, we note that Dr. Rutherford is a neurologist that conducts diagnostic testing, and both Dr. Moore and Dr. Bindra are orthopaedic surgeons specializing in the hand and upper extremity, while Dr. Tuck is a neurosurgeon, a speciality that does not normally treat carpal tunnel syndrome. Second, there is no evidence that Dr. Tuck had the benefit of the claimant's complete medical treatment records when she examined and operated on the claimant. Dr. Tuck ordered her own diagnostic tests which

were quite different from those ordered and reviewed by Drs. Rutherford, Moore and Bindra. Most notably, Dr. Rutherford conducted his own diagnostic testing, while Dr. Tuck referred the claimant to Dr. Spanos for testing. Dr. Spanos did not even conduct a comparison test of the claimant's left upper extremity and he even noted in his report a finding of 5/5 strength of the claimant's left upper extremity. After conducting the EMG/Nerve Conduction study Dr. Rutherford found the claimant had mild carpal tunnel syndrome on the right. Given the claimant's specific injury and Reflex Sympathetic Dystrophy, Dr. Rutherford concluded that the claimant's symptoms on the right were not severe enough to warrant surgery. Dr. Moore agreed. Moreover, it is noted that the claimant's subjective testing of the right upper extremity was often equivocal with regard to a positive diagnosis of carpal tunnel syndrome. However, the most telling of all with regard to whether right carpal tunnel release was reasonable and necessary is Dr. Bindra's provocative diagnostic test of injecting steroids into the claimant's right upper extremity which did not provide the

claimant with any relief. Had the claimant truly suffered from carpal tunnel syndrome the steroids would have provided at least some relief from her pain. As it did not, Dr. Bindra explained to the claimant that she more than likely did not have carpal tunnel syndrome.

In light of Dr. Bindra's testing for carpal tunnel syndrome which failed to disclose the existence of this condition, we cannot find that carpal tunnel release surgery is reasonable and necessary. Furthermore, as Dr. Bindra noted in his examination of the claimant, her ulnar nerve was normally palpable at the elbow. Furthermore, the EMG/ Nerve Conduction Study performed by Dr. Rutherford did not reveal any latency of the ulnar nerve. Therefore, we find that decompression of this nerve was not necessary. In reaching this finding, we further note that Dr. Tuck's operative report does not disclose any findings of carpal tunnel syndrome or ulnar nerve entrapment. We further note that although the claimant contends that she received some benefit from this surgery, the finding of functional overlay by Dr. Bindra may account for this placebo type relief.

Accordingly, we find that the claimant has failed to prove by a preponderance of the evidence that surgery for carpal tunnel release of the right and ulnar nerve decompression was reasonable and necessary in connection with the claimant's specific incident injury to his right upper extremity.

For those reasons set forth herein, we find that the decision of the Administrative Law Judge must be and hereby is reversed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority's opinion finding the claimant failed to meet her burden of proof that surgery for carpal tunnel release of the right

and ulnar nerve decompression was reasonable and necessary in connection with the claimant's specific injury to her right upper extremity and that the claimant's compensable injury did not result in a compensable consequence injury to the left upper extremity. Based upon a de novo review of the record in its entirety, I find the medical treatment the claimant received from Drs. Bonner, Barrett-Tuck, and Spanos was reasonable and necessary medical treatment related to her compensable injuries to both her right and left arm. Specifically, the respondent is liable for the unauthorized medical treatment the claimant received to her left arm because the respondent had controverted that claim in its entirety. Likewise, I find the claimant established by a preponderance of the evidence that she is entitled to temporary total disability benefits for the work she missed while undergoing treatment at the direction of Dr. Barrett-Tuck. As such, I must respectfully dissent.

In finding that the surgical treatment that Dr. Barrett-Tuck performed on the claimant's right arm was not reasonable and necessary, the Majority is relying

primarily on the treatment records of Drs. Rutherford and Moore and the opinion of Dr. Randy Bindra, an orthopedist with the UAMS College of Medicine, who evaluated the claimant at the request of the respondent. However, I find that the Majority draws several conclusions from those physician's reports which are in error.

It is true that when Dr. Moore initially saw the claimant on October 11, 2005, he stated that the claimant's, "subjective symptoms" seem to outweigh her physical findings. However, that statement was made in connection with an x-ray of the claimant's hand and before she had undergone any tests for carpal tunnel syndrome or ulnar nerve entrapment. Dr. Moore also stated that her clinical history and physical examination were consistent with the right hand and arm pain she was complaining about. Because of the claimant's symptoms, Dr. Moore directed the claimant to undergo an EMG study. He next saw the claimant on February 7, 2006, and in a report of that date, specifically stated that he had discussed surgical treatment with the claimant for her left carpal tunnel syndrome. He also noted

that she did have right carpal tunnel syndrome, as well as reflex sympathetic dystrophy. Obviously, at this time, Dr. Moore no longer felt that her subjective complaints were outweighed by the physical evidence, in that, he had physical evidence substantiating the existence of carpal tunnel syndrome.

The final time the claimant saw Dr. Moore was on June 8, 2006. In a report of that date, Dr. Moore once again discusses the possibility of carpal tunnel surgery, this time on her right and left hand. While Dr. Moore felt that the claimant's prognosis of the right carpal tunnel syndrome would be "guarded", he did not rule out the possibility. He also acknowledges that the claimant did have left carpal tunnel syndrome. He then went on to state that he did not believe that this was the result of the claimant's accident on July 27, 2005. This latter statement is, in fact, correct. The claimant never asserted that her left carpal tunnel syndrome was due to the accident of July 27, 2005. Rather, her contention was that left carpal tunnel syndrome was probably present to some extent prior to that date and

the extensive use of her left hand and arm while on one-handed duty *following* the accident of July 27, 2005, caused a rapid acceleration of the carpal tunnel syndrome until surgical treatment of that condition became a necessity.

The claimant saw Dr. Randy Bindra, at the direction of the respondent, on July 10, 2006. In his report of July 31, 2006, he outlines his findings and recommendations regarding the claimant's condition. Dr. Bindra did not state that the claimant did not have carpal syndrome, nor that surgery for that condition was inappropriate. In his report under the heading of Assessment, he made the following comment:

"Based upon the patient's history that has been provided, it appears that the patient did have significant forceful injury to the area of her right wrist and thumb. All her initial examination findings indicated she had soft tissue swelling around her right thumb and subsequent MRI scan also showed fluid around it suggesting she may have sustained a significant soft tissue injury around her right wrist and thumb. In September 2005, this lady began to complain of numbness in her hand, and it is likely that she began to develop symptoms of mild carpal tunnel syndrome. Although she does have evidence of

bilateral carpal tunnel syndrome which may be constitutional, in this case, her symptoms of carpal tunnel syndrome in the right hand appear to have started only after the injury and about two months after the injury. As it was documented, she did have significant swelling around the base of her thumb. It is quite possible the carpal tunnel symptoms were brought on by her injury and the subsequent swelling around the wrist and hand area.

Her carpal tunnel is mild and subsequent nerve conduction studies have not shown any deterioration." (Emphasis added).

As is apparent from reviewing Dr. Bindra's statements, he obviously agrees that the claimant has carpal tunnel syndrome, and he specifically related it to her job-related accident of July 27, 2005. In the next portion of his report titled "Plan", he discusses the claimant's treatment options. He does not state that the claimant should not undergo surgery. Instead, he stated: "Thus, I agree with Dr. Moore that surgery for carpal tunnel syndrome will have a guarded prognosis as the patient's chronic pain did not necessarily improve after surgery." (This a somewhat curious statement, in that, the claimant had not yet had any

surgery on her arm). He goes on to suggest to the claimant that she undergo injection therapy with steroids in an attempt to improve her condition as a less invasive alternative to surgery. Dr. Bindra administered these injections to the claimant, which provided her no relief.

After a follow up examination of the claimant on August 11, 2006, Dr. Bindra opined that since the claimant had not responded to the injection therapy, she was a poor candidate for surgery and should not undergo it.

Interestingly, this date was less than two weeks before the claimant underwent carpal tunnel surgery on her right wrist which resulted in substantial improvement. I believe that the more successful surgical treatment performed by Dr. Tuck is ample refutation of Dr. Bindra's conclusion regarding possible surgical treatment of the claimant's injuries.

Much is also made by Drs. Moore, Rutherford, and Bindra about the functional capacity exam the claimant underwent in March 2006. However, I fail to see why any significant weight should be given to the result of this examination. It is apparent from subsequent events that the

claimant was still well within her healing period when she underwent this examination, at the direction of Dr. Rutherford. I believe that the test given to the claimant was clearly premature because, as indicated by subsequent events, the claimant was still within her healing period when she underwent it. Functional capacity exams are intended to be an indicator of an individual's vocational ability after they have reached the end of their healing period and when they are no longer undergoing active medical treatment. Neither was the case for the claimant. Dr. Rutherford apparently referred her to this FCE because he had completed her treating her for reflex sympathetic dystrophy. However, as subsequent diagnostic testing, including that of Dr. Rutherford later indicated, the claimant was still suffering from carpal tunnel syndrome in both wrists, as well as in an as yet undiscovered ulnar nerve entrapment. In fact, tests show that the claimant's carpal tunnel syndrome was getting progressively worse in both wrists. For example, the claimant's right carpal tunnel syndrome was described as being mild in the early NCV's

performed in November of 2005. However, by the time Dr. Spanos examined the claimant in May 2006, his results indicated that the claimant's right carpal tunnel syndrome had become moderately severe. Given that the claimant was still suffering from nerve entrapments at three joints, as well as related pain, numbness, and loss of use, it is not surprising that she was unable to successfully complete a number of tasks involved in the functional capacity exam. Her steadily worsening conditions certainly account for the inconsistent results found by the FCE examiner. It also calls into question the conclusion that the claimant was exaggerating her symptoms or was suffering from some type of psychological overlay. In fact, it is readily apparent that the claimant's ongoing, deteriorating physical condition needed a more proactive treatment regimen than that being followed by her current treating doctors. It was not until the claimant began seeing Dr. Barrett-Tuck that she received any successful treatment.

In my opinion, the medical record clearly establishes that the medical treatment the claimant received

from Dr. Barrett-Tuck was reasonable and necessary. Objective, diagnostic testing undeniably establishes that the claimant was suffering from bilateral carpal tunnel syndrome as early as November 2005. As the Majority is fully aware, carpal tunnel release surgery is a commonly prescribed method of treatment for this condition. However, Dr. Rutherford diagnosed (possibly erroneously) that the claimant was suffering from reflex sympathetic dystrophy in her right arm and began treating her for that. Dr. Moore, an orthopedic surgeon, consistently deferred to Dr. Rutherford to treat her right arm problem because of this diagnosis. While he was aware that she had left carpal tunnel syndrome, he seemed uninterested in treating her for that since the respondent had not accepted that as a compensable injury. Further, the claimant's ulnar nerve entrapment was undiagnosed by any of the claimant's initial treating physicians until she underwent the nerve conduction studies of her elbow administered by Dr. Spanos.

While it is true that the claimant's treatment from Dr. Barrett-Tuck for her right arm problems were

unauthorized, it is readily apparent that her treatment of both her right and left arm was reasonable and necessary. As the claimant testified to, the carpal tunnel release and ulnar decompression on her right arm was successful and significantly alleviated her symptoms. There is nothing experimental, unusual, or in any other way inappropriate in the treatment carried out by Dr. Barrett-Tuck. Furthermore, as noted above, all of the doctors who saw the claimant, including Dr. Bindra, were of the opinion that the claimant had right carpal tunnel syndrome based upon positive NCV tests. While it is true that none of them diagnosed her as suffering from ulnar nerve entrapment, it was not until the claimant came under the treatment of Dr. Barrett-Tuck that this condition was discovered. It is, therefore, my conclusion, based upon a review of all of the claimant's medical records, that the bilateral carpal tunnel releases and the ulnar nerve decompression performed by Dr. Barrett-Tuck were all reasonably necessary.

The next issue is the compensability of the claimant's left carpal tunnel syndrome injury. The Majority

determined this was not a compensable consequence of her right arm injury of July 27, 2005. However, the claimant's testimony reflects that her left wrist had not begun hurting until she was released to return to work with the restriction that she was limited to one arm duty. This restriction required her to perform her already hand-intensive job of mopping, dusting, sweeping, using floor buffers, and related activities with only one hand. Obviously, this type of activity, which is stressful enough using two hands, was simply too much strain on the claimant's left wrist. In fact, this condition was directly alluded to by Dr. Rutherford, one of the physicians chosen by the respondent, in his report of April 3, 2005. In that report he stated: "Miss Swafford also reports that by virtue of partial immobilization of her right hand, she has been required to use her left hand more than normal which has resulted in numbness of her left hand." Dr. Barrett-Tuck also addressed this situation in her report of May 24, 2006, noting: "Most likely she was developing carpal tunnel syndrome from her work, then the accident that occurred has

rapidly increased compression on the right. She also has progressive carpal tunnel syndrome on the left."

In my opinion, the evidence is overwhelming that the claimant sustained a job-related carpal tunnel injury to her left wrist. Dr. Barrett-Tuck reached that conclusion after examining the claimant and discovering the nature of her work. Even Dr. Rutherford made the correlation between the increased job-related stress placed upon the claimant's left wrist while under her restricted-duty job and her resulting symptoms. Likewise, the existence of left carpal tunnel syndrome has been repeatedly verified by documented nerve conduction velocity tests.

I believe that the Majority's finding that the claimant does not have carpal tunnel syndrome in her left wrist is unfounded and is completely without merit. The existence of the carpal tunnel is a medically-documented fact that is beyond dispute. Further, all of the other factors which are known facts, point to the conclusion that the claimant developed left carpal tunnel syndrome as a result of her job-related activities. Specifically,

increased stress placed on her left wrist and hand because of increasing work duties requiring her to mop, sweep, lift, carry, and operate equipment using her left hand only. The development of symptoms of carpal tunnel syndrome directly correlate to the increased job duties. Therefore, I find the claimant has met her burden of establishing a compensable carpal tunnel injury to her left wrist.

The final issue is the respondent's liability for the medical treatment the claimant received from, or at the direction of, Dr. Barrett-Tuck and Dr. Spanos to her left wrist. In arguing that this treatment was unauthorized, I believe that the Majority is confusing the injuries the claimant sustained on her right arm with those to her left arm. The Administrative Law Judge found that the claimant, in seeking treatment from Dr. Barrett-Tuck for her compensable right arm injury, went to an unauthorized physician and, accordingly, treatment so received is not the liability of the respondent. However, the respondent has controverted in its entirety her claim for benefits associated with her left carpal tunnel syndrome. That issue

is clearly delineated in the Administrative Law Judge's Prehearing Order dated September 26, 2006, when the issues are shown to be: "compensability (left CTS-medical and temporary total disability benefits)." It is a long held rule that where a respondent controverts a claimant's entitlement to benefits, the change of physician rules do not apply and the claimant may seek medical treatment from any other provider for all of the treatment so long as the treatment is reasonable and necessary. Sanyo Manufacturing Corporation v. Farrell, 16 Ark. App. 59, 696 S. W. 2d 779 (1985).

I believe the Majority errs in finding that the treatment the claimant received from Dr. Barrett-Tuck and Dr. Spanos for her left carpal tunnel syndrome was not reasonable and necessary medical treatment. Since the respondent controverted her entitlement to benefits for this condition, I believe that there is no question as to authorization. The respondent is simply liable for the treatment the claimant received for this condition.

In summary, I find the medical treatment the claimant received from Drs. Bonner, Barrett-Tuck, and Spanos was reasonable and necessary medical treatment related to her compensable injuries to both her right and left arm. Specifically, the respondent is liable for the unauthorized medical treatment the claimant received to her left arm because the respondent had controverted that claim in its entirety. Likewise, I find the claimant established by a preponderance of the evidence that she is entitled to temporary total disability benefits for the work she missed while undergoing treatment at the direction of Dr. Barrett-Tuck.

For the aforementioned reasons, I must respectfully dissent.

PHILIP A. HOOD, Commissioner