

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F800985

PATRICIA STREET, EMPLOYEE	CLAIMANT
ST. JOHN'S HOSPITAL, EMPLOYER	RESPONDENT
RISK MANAGEMENT RESOURCES, INSURANCE CARRIER	RESPONDENT

OPINION FILED JUNE 12, 2009

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

Claimant represented by the HONORABLE J. MARK WHITE, Attorney at Law, Bryant, Arkansas.

Respondents represented by the HONORABLE GUY A. WADE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The claimant appeals from the August 28, 2008 decision of an Administrative Law Judge which found that the claimant has failed to prove that she is entitled to receive any permanent partial disability benefits for permanent physical impairment from her compensable injury. After a de novo review of the record, the Full Commission reverses the Administrative Law Judge's decision and finds that the claimant is entitled to permanent partial disability benefits for the 11% anatomical impairment rating assigned by Dr. Moffitt.

The Commission has adopted the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, as the guide to be used in assessing anatomical impairment. AWCC Rule 099.34. The claimant suffers from reflex sympathetic dystrophy (RSD) in her foot; the Guides provide that RSD in the lower extremity is to be evaluated "as for the upper extremity," thus tables and sections referencing the upper extremity will be utilized herein in the absence of a specific table or section for the lower extremity.

Impairment secondary to RSD is derived by calculating the individual impairments for loss of motion, sensory deficit, and motor deficit, and then combining these individual ratings using the Combined Values Chart set forth at p. 322 of the Guides. Dr. Moffitt neither measured nor noted loss of motion, and he opined that the claimant had no "significant" motor deficit. Thus, the only specific impairment process to be considered herein is that for sensory deficit.

Impairment for sensory deficit is calculated by identifying the area of involvement, identifying the nerves that innervate the affected area, grading the severity of the sensory deficit, calculating the maximum impairment due to nerve deficit for each affected nerve,

and then multiplying that maximum impairment value by the percentage of severity of the sensory deficit.

In this case, Dr. Moffitt identified the nerves innervating the area of involvement as the sural, superficial peroneal, medial plantar, and lateral plantar nerves. He graded the severity of the sensory deficit as Grade IV, which is described by the Guides as, "Decreased sensibility with or without abnormal sensation or pain, which may prevent activity, and/or minor causalgia." "Causalgia" is defined as "the constant and intense burning pain usually seen with reflex sympathetic dystrophy (RSD) when the causative lesion involves injury to a nerve." A Grade IV deficit equates to a sensory deficit of between 61% and 80%.

For each affected nerve, Dr. Moffitt identified in his letter, the maximum impairment due to nerve deficit (1% for sensory and 2% for dysesthesia for the sural nerve, and 2% for sensory and 2% for dysesthesia for each of the remaining nerves, with each rating being to the body as a whole). These ratings are taken directly from Table 68 of the Guides. Combining these ratings using the Combined Values Chart produces a maximum rating of 15% to the body as a whole.

The maximum rating of 15% is then multiplied by the percentage of severity, which, as discussed

above, is a deficit range of 61% to 80%. This results in a final rating of between 9.15% and 12%. Dr. Moffitt assigned a final rating of 11% to the body as a whole, which is within this permissible range. Thus, given the provisions of the Guides and the mathematical calculations explained above, Dr. Moffitt's rating of 11% is entirely consistent with the Guides, and is hereby awarded by the Full Commission.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority's opinion.

The claimant sustained a compensable injury to his lower extremity. The sole issue for determination is whether the claimant is entitled to permanent partial disability benefits for a permanent physical impairment. The burden rests upon the claimant to prove all of the

facts necessary to establish both the existent and extent of permanent physical impairment. It is the duty of this Commission to determine whether any permanent anatomical impairment resulted from the injury, and, if it is determined that such an impairment did occur, the Commission has a duty to determine the precise degree of anatomical loss of use.

Ark. Code Ann. § 11-9-704(c)(1) (Repl. 2002) provides that "[a]ny determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings." Objective findings are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16)(A)(i)(Supp. 2005). The Commission is statutorily prohibited from considering complaints of pain when determining physical or anatomical impairment. Ark. Code Ann. § 11-9-102(16)(A)(ii)(a). With regard to the medical findings other than those which are specifically precluded from being considered objective, a medical finding may be considered objective only if it is the result of a diagnostic procedure which does not come under the voluntary control of the patient. Department of Parks & Tourism v. Helms, 60 Ark. App. 110, 959 S.W.2d 749 (1998).

The majority has found that the claimant sustained an 11% permanent impairment rating based upon Dr. Moffitt's assessment. In his report dated July 5, 2007, Dr. Moffitt opined that the claimant sustained an 11% whole body impairment rating as a result of her complex regional pain syndrome. In reaching this finding, Dr. Moffitt stated that the claimant was "thought to have a deficit involving both sensory and dysesthesia." After assessing the loss for sensory and dysesthesia for the sural nerve, superficial peroneal nerve, the medial plantar nerve, and the lateral plantar nerve, and multiplying these numbers by a Grade 4 (61-80% sensory deficit) as found on page 3/48 Table 11, an 11% impairment was assigned. Although loss of motion and motor deficit may also be utilized to calculate the physical impairment for reflex sympathetic dystrophy, Dr. Moffitt did not find any loss of motion or motor loss impairment involving these nerves.

After reviewing Dr. Moffitt's July 5, 2007, report and analyzing the impairment rating he assigned, it is patently obvious that this rating is based solely upon subjective complaints of pain, numbness, and abnormal feelings or sensations that involve the affected portion of the claimant's leg. Chapter 15 of the *AMA Guides* labeled Pain specifically states that

"pain is subjective, and its presence cannot be validated or measured objectively" and that "impairment due to pain has not been well defined." These complaints not only include the impermissible use of pain in assessing an impairment rating, but also rely solely upon subjective findings wholly within the claimant's voluntary control. While the claimant did possess objective findings sufficient to warrant a finding of a compensable injury such as skin discoloration, edema, and temperature change, these findings are not utilized to assess permanent impairment as they are clearly transitory. The only findings relied upon by Dr. Moffitt to reach a finding of impairment were sensory deficit and syesthesia, which the AMA Guides specifically classifies as "subjective." AMA Guides 3.2k. Just because the Commission finds an injury compensable does not necessarily mean that the injured employee is also entitled to a permanent impairment rating. See A.C.A. § 11-9-102(4)(A)-(B), (F)(ii) (Supp. 2007). Thus, while the claimant has objective findings sufficient to find the compensability of her injury, these findings were not present when she was examined by Dr. Moffitt on July 5, 2007, after she had reached maximum medical improvement.

In a recent Court of Appeals opinion, the Court noted that the General Assembly charged the Commission with adopting an impairment guide and that pursuant to this directive the Commission adopted the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993). In affirming our reduction of a 10% anatomical impairment rating to an 8% anatomical impairment rating the court stated;

We hold that it was not error for the Commission to reduce appellee's impairment rating from 10 percent to 8 percent based on the evidence presented. The two competing alternatives here are found in Table 75, page 3/113 of the *AMA Guides*. Section IV(C) of that table provides for an 8 percent impairment for single-level cervical spinal fusion *without* residual signs or symptoms, and section IV(D) assigns a 10 percent rating for single-level cervical fusion *with* residual signs or symptoms. The controversy relates to Mr. Leach's radiculopathy, and the Commission indicated that it could not rely on subjective signs or symptoms to increase the impairment.

Prior to the fusion surgery, Mr. Leach was diagnosed with radiculopathy. This diagnosis was based on objective studies, and in particular a December 8, 2004, medical report documented that a nerve conduction study showed an acute right C7 radiculopathy. However, following the C6-7 fusion surgery on January 13, 2005, there was an absence of medical evidence demonstrating that radiculopathy was

still present. In fact, in the subsequent medical reports authored by his surgeon, Dr. Joseph Hudson, Dr. Hudson made no mention of radiculopathy but reported that Mr. Leach was doing very well and that his fusion was progressing nicely. Dr. Hudson released him to work on April 1, 2005. Although Mr. Leach testified that, after returning to work after the surgery, he was in a considerable amount of pain, **Ark.**

Code Ann. § 11-9-

102(16)(A)(ii)(Repl. 2002) provides that complaints of pain cannot be considered when determining physical impairment. And while Mr. Leach is

correct that Dr. Shrader indicated in his report that radiculopathy was a residual sign increasing the rating to 10 percent pursuant to the *AMA Guides*, Dr. Shrader never examined Mr. Leach and his opinion was limited to his evaluation of the prior medical records. Because Mr. Leach failed to establish, post-operatively and objectively, the presence of radiculopathy or any other residual sign or symptom independent of his continuing pain, there was substantial evidence to support the 8 percent impairment awarded by the Commission pursuant to section IV(C) of Table 75 of the *AMA Guides*.

Enterprise Products Co. v. Leach, ___ Ark. App. ___, ___ S.W.3d ___ (opinion delivered March 4, 2009) (emphasis added).

A.C.A. § 11-9-102(16)(A)(ii) provides; "When determining physical or anatomical impairment, neither a physician, any other medical provider, an administrative

law judge, the Workers' Compensation Commission, nor the courts may consider complaints of pain." Thus, when this section is applied, I cannot find that the sensory and dysesthesia deficits may be considered in rendering a permanent anatomical impairment rating.

Claimant argues in her brief that this claim is akin to Brock v. Swift-Eckrich, Inc., 63 Ark. App. 118, 975 S.W.2d 857 (1998), in which the Court of Appeals held that an impairment rating based upon neuropsychological testing which relied upon subjective responses was compensable. However, unlike the claimant in Brock who also had objective evidence of brain damage via CT scans, the objective findings of injury for the claimant in the present claim are all transitory and were not present at the time she was evaluated for impairment. Thus, unlike the claimant in Brock, the claimant in the present claim does not present with any permanent objective findings to support the existence of a permanent impairment rating.

Accordingly, based upon my de novo review of the entire record, without giving the benefit of the doubt to either party, and strictly construing the workers' compensation statute as we are constrained to do, I find that the claimant has failed to prove by a preponderance of the evidence that she sustained a

physical impairment rating which is supported with objective medical findings. Therefore, for all the reasons set forth herein, I must respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner