

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F510706

MARY A. ROBINSON,
EMPLOYEE

CLAIMANT

FAMILY DOLLAR STORES, INC.,
SELF-INSURED EMPLOYER

RESPONDENT

RISK ENTERPRISE MANAGEMENT,
TPA

RESPONDENT

OPINION FILED AUGUST 19, 2010

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

Claimant represented by the HONORABLE JEROME C. PAYNE,
Attorney at Law, Memphis, Tennessee and the HONORABLE MARC
I. BARETZ, Attorney at Law, West Memphis, Arkansas.

Respondent represented by the HONORABLE MARK ALAN PEOPLES,
Attorney at Law, Fort Smith, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law
judge's opinion filed January 14, 2010. The administrative
law judge found that additional medical treatment, including
an MRI scan of the left hip, was reasonably necessary in
connection with the claimant's compensable right foot
injury. After reviewing the entire record *de novo*, the Full
Commission reverses the administrative law judge's opinion.

The Full Commission finds that the claimant did not prove any medical treatment for her left hip was reasonably necessary in connection with the claimant's compensable injury to her right foot.

I. HISTORY

The record indicates that Mary Robinson, age 44, became employed with the respondents on August 5, 2002. Ms. Robinson's work duties involved loading boxes onto floats and delivering floats to trucks. The parties stipulated that the claimant sustained a compensable right foot injury on October 4, 2005. The claimant testified that a forklift ran over her right foot.

Dr. Riley Jones began treating the claimant on October 6, 2005:

The patient comes in today with a complaint of pain in her right foot. On 10/4/2005 she had a forklift hit her right foot....

PE: She comes in today with a dressing. We have removed the dressing and she has an 8 cm laceration on the medial aspect of the midfoot. Painful range of motion. Neurovascular exam is intact. X-RAYS show fracture at the base of the 2nd, 3rd and 4th metatarsals.

Dr. Jones diagnosed "Fracture of the base 2nd, 3rd, 4th metatarsals; rule out Lisfranc fracture."

Dr. Jones noted on October 13, 2005, "Sutures are removed. Her CT shows that she has fractures at the base of the 2nd, 3rd and 4th metatarsals. There is a partial in the ligament Lisfranc, but there is no sign of dislocation. We are going to continue to treat her non-weight bearing in her boot....Given her crutches."

Dr. Jones noted on November 22, 2005, "Her wounds look good. I am going to start her on physical therapy. X-rays show good healing. She is light duty, sedentary Monday." The claimant followed up with Dr. Jones on February 2, 2006: "She has basically full range of motion of her ankle and her forefoot. She still has a little tenderness, but there is no swelling. At this point she walks with minimal limp and I think she can do her regular duty. She is at maximum medical improvement today. X-rays show good healing of fractures....Patient is to return on an as needed basis."

Dr. Jones noted on February 9, 2006, "The patient has no permanent partial impairment based on the 5th Edition of the AMA Guides." The parties stipulated that the respondents paid temporary total disability benefits through February 9, 2006.

The claimant returned to Dr. Jones on March 23, 2006:

She states that she is having pain in the foot. She has difficulty walking and she comes in today with a markedly exaggerated gait. Examination, though, shows full range of motion of the ankle, full range of motion of the forefoot. In fact, measuring the mid foot, they measure equally. There is no sign of swelling. There is no sign of temperature change. No real tenderness such as a reflex sympathetic dystrophy. No pain to palpation. X-rays show what appears to be well healed fractures of the mid metatarsals.

Dr. Jones diagnosed "Post fracture metatarsal. At the present time I am going to put her on Naprosyn. She can do her regular duty. We will get a CT of the right foot to make sure that all fractures are healed and we will see her back after this has been done."

Dr. Jones noted on May 25, 2006, "The patient returns today. She has vague complaints, but she has no swelling. She complains of tenderness to palpation over the whole foot, but she has full plantar flexion, dorsiflexion, inversion, eversion. At this point she had a fracture. She has a lawyer and I understand they would like a rating, but based on the 5th Edition of the AMA Guides, there is nothing to rate. She is discharged to full unrestricted duty. She can take Advil as needed."

Dr. Jones reported on August 15, 2006:

On examination today the forefoot measurements are equal up and down. She is inconsistent in her

examination to touch. There are no temperature changes noted. She has full ROM in the ankle. Good eversion and inversion. She at different times is tender over the metatarsal heads and tender over the mid foot, but again, there is no swelling.

X-RAYS: show good healing of the 2nd, 3rd, and 4th metatarsal bones.

IMPRESSION/PLAN: Post fracture, healed.

PLAN: At the present time I explained to her that I don't find anything really objective here. There are multiple inconsistencies in this lady. She had three fractures, a soft tissue injury, but that's healed. She has good ROM and she walks with the most exaggerated gait that doesn't really go along with anything. So at this point I have explained to her because these were nondisplaced, she has retained all of her motion that there is no permanent partial impairment. She is at regular duty and at MMI.

Dr. W. Randy Fly examined the claimant on October 11,

2006:

She comes in today complaining primarily of pain in the plantar aspect of the foot over scar tissue along the scar on the medial aspect of the foot and stiffness in her digits....The patient states that her foot does bother her when she walks. The pain is primarily in the arc of the second metatarsal base....The patient gives no history of ankle pain, no knee or hip pain. She wears a shoe that is about one to two sizes larger than her other shoe because of the swelling in the foot and the discomfort. She has been back to her regular job without restrictions....

She has an antalgic gait on the right. She is able to get on and off the exam table without difficulty. Inspection of both lower extremities

reveals swelling in the mid-foot, forefoot region on the right. There is a little bit of swelling extending down to the digits. There is an elliptical healed skin wound about two centimeters at its apex, crescent shaped along the medial aspect of the mid-foot forefoot region extending down to just above the plantar region onto the dorsal aspect of the foot. There is thickening with mild prominence over the base of the second metatarsal phalangeal joint....

MUSCULOSKELETAL EXAM: Shows full range of motion of the hip, knee and ankle. The patient shows fairly normal heel range of motion. There is some stiffness with forefoot inversion/eversion. Primary stiffness in the right foot is in the area of the digits....The left foot shows normal flexion of the PIP and interphalangeal metatarsal phalangeal joints of the left foot. The patient has prominence with tenderness and palpable thickening over the area of the second metatarsal phalangeal joint. The patient has no instability of the forefoot.

X-RAYS: Views of the foot (3) showed degenerative changes at the second tarsal metatarsal phalangeal joints. The third and fourth fractures have healed.

Dr. Fly assessed "Osteoarthritis second metatarsal phalangeal joint. Ankylosis of the right foot lesser digits secondary to the crush injury and subsequent intrinsic muscle adhesions. Plantar great foot overall normal positioning of the foot. Metatarsal phalangeal joint stiffness secondary to crush injury of the foot, right hallux....I would recommend also that she be fitted for an extra-depth shoe with a semi-rigid insert for the forefoot

pain. I would also recommend that she utilize a steel toe shoe at work for the previous foot injury....She is to return to see me on an as needed basis. I think the patient is permanent stationary and was at maximum medical improvement at the time of her release to work from her previous treating physician. I would not place her on any impairment."

The record indicates that the claimant was fitted with bilateral orthopedic shoes on or about April 3, 2007. It was noted on June 15, 2007, "Shoes were equipped with right extended steel shank with rocker sole to prevent motion in the right foot to prevent an increase in pain due to trauma. Left shoe equipped with elevation to match rocker height. Patient was instructed to wear these shoes during all ambulatory activities and to return in two weeks for follow up appointment. Patient will need to repeat this process every year to insure proper bone and joint alignment in the right foot."

Dr. Fly examined the claimant on August 22, 2007 and assessed "1. Lisfranc's arthritis, diffuse, post-traumatic. 2. Ankylosis right foot with some improvement in intrinsic muscle lesions in the foot....I explained to her that she

had a crush injury. I would refer her for chronic pain management as she may benefit from blocks."

A Human Resource Manager informed the claimant on February 4, 2008, "As of February 4, 2008 we have not heard from you despite several attempts from us to reach you, therefore your absences are being treated in accordance with the attendance policy. Failure to contact us by February 11, 2008 will result in your voluntary resignation." An April 10, 2008 Human Resources Department document stated in part, "Due to her failure to provide documentation and respond to our attempts to contact her, she was terminated from our system on 2/29/08. Mary's previous Worker's Compensation claim was settled in early 2007 at which time she returned to work full duty with no restrictions."

Dr. Sue N. Ishikawa examined the claimant on June 10, 2008 and assessed "Right foot crush injury. Right foot chronic regional pain syndrome....She was instructed on how to start desensitizing her foot. We will start her on Lyrica and send her to pain management. I discussed with them that this is not specifically an orthopaedic problem but more of a nerve problem."

The parties stipulated that a change of physician order was entered on October 16, 2008, designating Dr. Sunil Gera as the claimant's authorized treating physician. Dr. Gera consulted with the claimant on November 12, 2008:

Foot pain is sharp, aching, burning, electric shock in character, radiates from the foot to the bottom and to the ankle, circles around the foot. Pain is constantly present. Associated with numbness in left hip, right foot and toes, knee. Noticing weakness in right leg and foot....

X-rays of the knee on 01/22/2008 per report by Dr. Murrey was normal. Some exostosis from the medial femoral condyle.

Dr. Gera assessed "1. Pain foot. 2. Sympathetic mediated pain/RSD right foot....At present patient is able to wear her shoes, she is able to walk to some extent, she is somewhat functional. We will treat her with pain medication....If required we will order triple phase bone scan for RSD."

Dr. Reginald J. Rutherford performed an Independent Medical Examination on January 21, 2009 and reported in part, "Ms. Robinson suffered a crush injury to the right foot on 10/04/05. Her foot was struck by a forklift. She suffered fractures of the base of the second, third and fourth metatarsals....RSD has been raised as a possibility. To this point she has not undergone a triphasic bone

scan....Ms. Robinson requires a triphasic bone scan both lower extremities special attention directed to the right foot to further evaluate for possible RSD. She also requires EMG/Nerve Conduction Study right lower extremity to evaluate for possible neuropathic pain."

Dr. Alan M. Nadel performed electrodiagnostic testing on February 5, 2009 and concluded, "This is a normal study of the back and both legs. There is no evidence of neuropathy or lumbar radiculopathy."

Dr. Rutherford corresponded with the respondents' attorney on February 26, 2009:

Ms. Robinson has undergone a triple phase bone scan of the lower extremities and electrodiagnostic testing right lower extremity. The triple phase bone scan demonstrated mild to moderate increased activity mid foot right lower extremity and mild increased uptake knees bilaterally consistent with mild degenerative change. There was no evidence for RSD via the triphasic bone scan. There was also evidence for lumbar scoliosis. Electrodiagnostic testing of the lower extremity and lumbar spine proved normal there being no evidence of injury or dysfunction peripheral nervous system.

Dr. Rutherford answered a series of written questions and indicated that his diagnosis regarding the claimant's right foot was "Chronic pain." Dr. Rutherford stated, "I do not believe Ms. Robinson suffers from RSD and would agree

with Dr. Jones' release to regular duties circa 5-26-06 based upon lack of objective abnormality referable to her subjective complaints."

The respondents' attorney corresponded with Dr. Sunil Gera on March 20, 2009:

For purposes of the record in this claim, I need to confirm the contents of your telephone conversation with nurse case manager Chandra Thomas. Based on Ms. Thomas' report to me, I understand you stated the following with respect to his patient:

1. That you have reviewed the IME report of Dr. Reginald Rutherford and that you agree with his conclusions.
2. That your most recent examination of Ms. Robinson was inconsistent with RSD.
3. That Ms. Robinson was quite functional during your most recent evaluation of her.
4. That you are discharging Ms. Robinson from further care with your clinic.

Dr. Gera initialed a space under the sentence, "I agree with statements 1 through 4 set forth in this letter."

A pre-hearing order was filed on June 29, 2009. The claimant contended, among other things, that she had "previously been approved for an independent medical examination treatment by Dr. Fly. Neither he, nor her prior physician, identified her pain injury and nerve problems, which have been identified by Dr. Ishikawa of Campbell Clinic which were caused by this injury....she requires a

change of physician to a pain management expert at this time and that additional medical benefits are sought."

A hearing was scheduled on the issues of additional medical benefits, additional temporary total disability benefits, and fees for legal services.

Dr. Tewfik E. Rizk saw the claimant on July 9, 2009:

This pt. is a 43-year old female who is here today complaining of right hip pain and left hip pain.

Pt. related her symptoms to injury on Oct. 1, 2005. She was working on a forklift which passed over her right foot. Pt. went to the ER and later she was seen by Dr. Riley Jones and she was found to have a fracture of her foot. Pt. had tube placed and later she received therapy and then she went back to work after about 6 weeks and she started on light duty. Pt. stated that she was able to do it for a short period of time but her pain was usually increased after one hour and if she walks for a long time or stands for a long time she will have pain of her right foot....Pt. stated that she has started to favor her left lower extremity in doing things and she will put her weight on it while she is standing and that will start to cause a problem with her left hip so pt. is here today complaining of left hip and right foot....

Bone and joint examination showed full range of movement in both upper extremities. Lower extremities evaluation showed painful range of movement of the right ankle, mainly on internal and external rotation. Pt. also has scar on the medial side of the right ankle which was tender to palpation at the edges. Pt. left leg circumference was ½ inch more than the right side. Pt. left hip evaluation showed painful range of

motion of the left hip as well as localized tenderness but no apparent shortening....

Dr. Rizk's impression was "1. Post-traumatic synovitis of the right ankle with status-post fracture. 2. Possible avascular necrosis of the left hip/secondary osteoarthritic changes....We will proceed with xray evaluation and pt. was started on Ultram prn for pain until I see her again."

The claimant followed up with Dr. Rizk on September 14, 2009: "Pt. stated that she had her xrays done and Ultram is just helping a little. Pt. xray evaluation was discussed....We will proceed with MRI evaluation of the left hip to rule out avascular necrosis and also we will get triple bone scan for possible RSD. We will continue her present medication."

Dr. Rizk noted on October 8, 2009, "Pt. records were reviewed. Pt. had triple phase nuclear bone scan done on 2/5/09 and findings showed no abnormal findings suggesting reflex sympathetic dystrophy. Pt. radiological evaluation showed osteo-arthritic changes of the spine and pt. had EMG-NCV study which was normal and did not show evidence of neuropathy or radiculopathy at the lumbar spine level....Pt. was advised to get her MRI of the hip done and meanwhile we will continue her present medication."

Dr. Rizk corresponded with the claimant's attorney on October 15, 2009:

Thank you for your inquiry. I reviewed this patient's record and I examined her on 7/9/09, on 9/14/09 and 10/8/09. Reports of these visits are enclosed.

It is my clinical impression that most probably this patient has avascular necrosis of her left hip.

It is my opinion that her present condition is directly related to her injury on October 1, 2005.

Patient has not reached maximum medical improvement yet and she will need to have an MRI done of her hip to determine further management....

A hearing was held on October 22, 2009. At that time, the claimant reserved the issue of additional temporary total disability benefits. The claimant testified that she had walked with a limp since the compensable injury. The claimant testified, "I have problems with my left hip - the pain, the soreness, where I can't rest on it. I can't even sleep on that side, cause it's pain - pains so."

The parties deposed Dr. Rizk on December 10, 2009. The respondents' attorney questioned Dr. Rizk:

Q. What is avascular necrosis?

A. Avascular necrosis is a phenomenon which happened if you disturb the circulation around the hip joint, and what would happen here is the

circulation slow (sic) down gradually, and when it slowed down gradually, the head of the femur itself, which is a piece of bone, will start to get softer because there is no nutrition going to it....

Q. What are the causes of avascular necrosis?

A. You can have it from trauma. You can have it from large doses of steroids treatment, cortisone treatment. You can have it by sudden change in the pressure around the human body like people diving deep for a long time. They can have that, and this is the most - three things which is very common.

Q. One of the things you mentioned was that trauma. Would that usually be trauma to the hip area itself?

A. Trauma to the hip area, yeah, either direct or indirect. The fact is the trauma affecting the joint, around the joint. For example, you can slide and twist your hip. That's the trauma that can cause avascular necrosis, or you can hit the hip directly cause avascular necrosis, or you can fall from four or five feet, straighten your leg, and your leg is straight transmitting all the trauma to the hip joint, that can cause avascular necrosis.

Q. What is your understanding of Ms. Robinson's work injury? What part of her body did she injure?

A. According to the history she gave me, if you allow me to look back here -

Q. Absolutely.

A. And she was working on October 1st, 2005, and she was working on a forklift which passed over her right foot, and then she went to the ER, saw Dr. Riley Jones, and it's my understanding at that

time that she forklift passed on her foot, and she tried to pull herself and, you know, apparently injured her lower extremity as a whole.

Q. It was your understanding she injured her entire lower extremity?

A. Yeah, I mean, traumatically, if you have somebody step on your leg and your foot, what are you going to do? You are trying to get your foot out....

Q. You are not saying that the trauma to her foot would have caused the avascular necrosis to her hip, are you?

A. Not direct trauma to the foot but the indirect trauma which happened to the hip at that point.

Q. And that's speculation on your part, right?

A. That's right, yeah....

The claimant's attorney questioned Dr. Rizk:

Q. Okay. And now - and so that I'm clear on this - and I think Mr. Peoples asked you - the lack of - the running over the foot and then that foot having a history of, let's say, swelling and that sort of thing, that would not in and of itself - swelling to a right foot, could that cause lack of blood supply and the problems with the left hip or - I mean, first of all, let me just ask you that. Could something like that cause it?

A. Well, as I said, you know, the main issue here is trauma to the hip.

Q. Okay.

A. The causative trauma to the hip, if that was injury to the foot leading to the hip, that's how it works.

Q. Okay. And that's what I'm trying to - and that's what I thought you said.

A. Yeah.

Q. So that, in other words, in her process of trying to avoid the injury or to get away from the pressure of the forklift or the sliding down or whatever, that's what would have caused the injury to the left hip. Are - am I correct about that?

A. Yeah, yeah.

An administrative law judge filed an opinion on January 14, 2010. The administrative law judge found that additional medical treatment, include an MRI scan of the left hip, was reasonably necessary in connection with the claimant's compensable injury to her right foot.

The respondents appeal to the Full Commission.

II. ADJUDICATION

The employer shall 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) (Repl. 2002). The claimant must prove by a preponderance of the evidence that she is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton*

v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In the present matter, an administrative law judge essentially found that the claimant's left hip complaints were caused by the compensable injury to the claimant's right foot. The administrative law judge therefore found that claimant was entitled to medical treatment for her left hip, including an MRI scan. The Full Commission reverses these findings. The parties stipulated that the claimant sustained a compensable right foot injury on October 4, 2005. The claimant testified that a forklift ran over her right foot. Dr. Jones, the treating physician, reported that the claimant had sustained a laceration of the right foot along with nondisplaced fractures of the 2nd, 3rd, and 4th metatarsals. The claimant was treated conservatively for the compensable injury to her right foot. Dr. Jones reported on February 2, 2006 that the claimant had full range of motion of her ankle and forefoot, that there was no swelling, and that X-rays showed good healing. Dr. Jones returned the claimant to regular duty work. The respondents paid temporary total disability benefits through February 9, 2006.

The claimant returned to Dr. Jones on March 23, 2006 with continued complaints of pain in her right foot. Dr. Jones noted, however, that the claimant walked with "a markedly exaggerated gait." Dr. Jones' examination of the claimant's foot was normal, with full range of motion, no sign of swelling, no temperature change, no tenderness or pain to palpation. Dr. Jones also noted that X-rays showed "what appears to be well healed fractures of the mid metatarsals." Dr. Jones reported on August 15, 2006:

There are multiple inconsistencies in this lady. She had three fractures, a soft tissue injury, but that's healed. She has good ROM and she walks with the most exaggerated gait that doesn't really go along with anything. So at this point I have explained to her because these were nondisplaced, she has retained all of her motion that there is no permanent partial impairment. She is at regular duty and at MMI.

Dr. Fly examined the claimant on October 11, 2006 and noted that the claimant complained of pain in her right foot. Dr. Fly's assessment included osteoarthritis in the claimant's right foot, and he recommended that the claimant be fitted with an extra-depth shoe. Like Dr. Jones, Dr. Fly found the claimant to be at maximum medical improvement. The record indicates that the claimant was fitted with bilateral orthopedic shoes in April 2007. Dr. Fly saw the

claimant in August 2007 and recommended pain management for the claimant's right foot.

The claimant subsequently treated with Dr. Ishikawa, Dr. Gera, and Dr. Rutherford. Dr. Ishikawa opined that the claimant was suffering from a nerve problem in her right foot. Dr. Gera's assessment included reflex sympathetic dystrophy of the right foot. Dr. Rutherford examined the claimant in January 2009 and arranged additional diagnostic testing. Dr. Rutherford stated on February 26, 2009, "The triple phase bone scan demonstrated mild to moderate increased activity mid foot right lower extremity and mild increased uptake knees bilaterally consistent with mild degenerative change. There was no evidence for RSD via the triphasic bone scan....Electrodiagnostic testing of the lower extremity and lumbar spine proved normal there being no evidence of injury or dysfunction peripheral nervous system." Dr. Gera indicated that he agreed with Dr. Rutherford's conclusions.

Dr. Rizk saw the claimant beginning July 9, 2009 and gave the following impression: "1. Post-traumatic synovitis of the right ankle with status-post fracture. 2. Possible avascular necrosis of the left hip/secondary osteoarthritic

changes." Dr. Rizk subsequently recommended an MRI evaluation of the claimant's left hip. Dr. Rizk reported on October 15, 2009, "It is my clinical impression that most probably this patient has avascular necrosis of her left hip. It is my opinion that her present condition is directly related to her injury on October 1, 2005."

When the primary injury is shown to have arisen out of and in the course of the employment, the employer is responsible for every natural consequence that flows from that injury. *McDonald Equip. Co. v. Turner*, 26 Ark. App. 264, 766 S.W.2d 936 (1989). The basic test is whether there is a causal connection between the two episodes. *Jeter v. B.R. McGinty Mech.*, 62 Ark. App. 53, 968 S.W.2d 645 (1998). The determination of whether the causal connection exists is a question of fact for the Commission to determine. *Carter v. Flintrol, Inc.*, 19 Ark. App. 317, 720 S.W.2d 337 (1986).

In the present matter, the claimant did not prove that there was a causal connection between her October 4, 2005 compensable foot injury and Dr. Rizk's October 2009 diagnosis of avascular necrosis of the claimant's left hip. The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative

value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). Dr. Rizk expressly opined at deposition that the cause of the claimant's avascular necrosis was "indirect trauma which happened to the hip" at the time of the compensable injury to the claimant's foot on October 4, 2005. Dr. Rizk's opinion in this regard is entitled to no probative weight. There is no evidence before the Commission demonstrating that the claimant sustained any direct or indirect trauma to her left hip at the time of the right foot injury. Nor did any other examining physician, including Dr. Jones, Dr. Fly, Dr. Ishikawa, Dr. Gera, or Dr. Rutherford, opine that the claimant had sustained direct or indirect trauma to her left hip at the time of the compensable right foot injury. The preponderance of the evidence of record does not corroborate Dr. Rizk's statement with regard to the claimant's left hip, "It is my opinion that her present condition is directly related to her injury on October [4], 2005." There is no evidence in the present matter demonstrating that the claimant's left hip condition was related to her right foot injury.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove her

left hip condition was a natural consequence flowing from the claimant's October 4, 2005 compensable injury to her right foot. The claimant did not prove that there was a causal connection between her left hip condition and her right foot injury. The Full Commission finds that the claimant did not prove additional medical treatment for her left hip, including an MRI recommended by Dr. Rizk, was reasonably necessary in connection with the compensable injury to the claimant's right foot. We reverse the administrative law judge's award of additional medical treatment for the claimant's left hip.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

After my de novo review of the entire record, I must respectfully dissent from the majority opinion. I would award the claimant additional medical benefits for the treatment of her hip as a compensable consequence of the

original compensable injury, including in MRI of her right hip.

The majority determined that the claimant failed to prove a causal connection between the October 4, 2005 compensable injury and the claimant's avascular necrosis of the left hip. Dr. Rizk stated that the cause of this condition was indirect trauma to the hip suffered at the time she was struck by the forklift. The majority found that there was no evidence of any trauma, direct or indirect, to the claimant's hip at the time of the incident. The majority also relied upon the fact that no other doctor opined that she sustained trauma to her hip. The majority concluded by stating that there was no evidence relating the condition of her hip to the compensable injury. I disagree.

The claimant was injured on October 4, 2005 when a forklift ran over her right foot. She testified that when the forklift ran over her foot, it took her by surprise, and she could not maintain her balance. She was unable to stand and went to the ground on her left side. The forklift apparently weighed at least five thousand pounds, if not more. Despite the apparent healing of her foot injury, the claimant suffered extended pain and difficulties with her

right foot which altered her gait, exacerbating her pain in her left hip. Her physicians stated that her gait did not conform to the foot problems she had experienced. In November 2008, the claimant presented to Dr. Gera with pain in her right foot, knee and hip. This was the first time hip pain was mentioned in the medical records. Eventually, the claimant saw Dr. Rizk in July 2009. His impression was that the claimant had possible avascular necrosis in her left hip.

Dr. Rizk felt that having the forklift run over her foot caused sufficient trauma to her hip to trigger the onset of avascular necrosis. He explained that avascular necrosis does not have an immediate onset, but develops over time as blood flow is diminished to the hip bone due to damage to the blood vessels as a result of the trauma. He also stated he saw this problem on a daily basis and that surgery would correct it.

It requires no speculation to conclude that the claimant sustained trauma to her body, including her right leg and her hips when her foot was run over by a five thousand pound forklift. The fact that no other doctor opined that she sustained trauma during the incident is

indicative of the nature of avascular necrosis. She was asymptomatic as the condition developed, so whether she sustained trauma to her hip was not an issue until those symptoms developed, in November 2008. Dr. Rizk stated clearly that the presence of avascular necrosis was "directly related" to her October 2005 work injury.

I find that the claimant's hip pain is causally related to her work-related injury in October 2005, that she is entitled to an MRI to conclusively evaluate her for avascular necrosis, and that treatment for her hip pain is reasonable and necessary treatment of her compensable injury.

For the foregoing reasons, I must respectfully dissent from the majority opinion.

PHILIP A. HOOD, Commissioner