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 APRIL 12, 2010

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.

Respondent represented by the HONORABLE GUY ALTON WADE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The Arkansas Court of Appeals has remanded so that the Commission may make specific findings. *St. John's Hospital v. Street*, CA09-740 (Feb. 11, 2010). The Full Commission finds that the claimant proved she was entitled to an 11% anatomical impairment rating.

I. HISTORY

The parties stipulated that Patricia Street, age 46, sustained a compensable injury to her right foot on June 15, 2005. Ms. Street testified, "I was helping a paramedic and EMT transfer a patient to an ambulance cot for transfer out of our facility and the cot rolled up on my foot with a flaccid patient when I lifted him up to get a slideboard out from under him, and it stayed on my foot for approximately five minutes."

Dr. Dan D. Park, a podiatrist, saw the claimant on August 3, 2005:

> The patient is a 41-year-old white female who presented as a new patient with her husband, referred by Dr. Charles Horton. The patient presents for the care of a stress fracture of the right foot. She states that she started to have pain under her right heel about four months ago. The pain used to be worse early in the morning. Lately, she has been having more pain on the outside of the right ankle area. The patient works as an aide in Berryville Hospital and she used to be on her feet all day. She has been advised to rest at home until she is able to come back to work with no pain on the right foot. She presents with a copy of the report of the bone scan performed on 07/12/05....
>
> DERMATOLOGICAL: Revealed no sign of any edema or erythema. Color, temperature, and texture of the skin and toenails were within normal limits. No sign of any infection or cellulitis noted bilaterally.

> X-RAYS OF THE RIGHT FOOT:
> FINDINGS: A plantar heel spur was noted and calcification was noted at the insertion of the Achilles tendon at the posterior aspect of the right calcaneus. There was no sign of any osteolytic or osteoblastic areas noted. Joint spaces including ankle mortise were noted to be well maintained. No sign of any soft tissue abnormalities noted.
> IMPRESSION: Heel spur of the right foot, otherwise unremarkable.
>
> Upon review of the report of the bone scan performed on 07/12/05, excess activity in the region of the right calcaneus which appears to be in a focal area medially at the plantar aspect was noted.
> IMPRESSION: Findings comparable with bone bruise or minimal occult fracture.

Dr. Park assessed "1. Plantar fascitis with heel spur of the right foot. 2. Peroneal tendonitis of the right foot." Dr. Park planned conservative treatment and noted, "A report of the bone scan performed on 07/12/05 was fully reviewed with the patient which showed abnormal uptake on the medial plantar aspect of the right calcaneus....The patient understands that she may require custom made accommodative orthotics."

Dr. Jason H. Pleimann, an orthopedic specialist, provided a Second Opinion on September 14, 2005:

> This 42 year-old female comes in after having a gurney roll on her right foot while working at St. John's in Berryville on June 15th. Prior to that,

she was being followed by a podiatrist for plantar fasciitis and had at least two injections for that. Since the gurney ran over her foot, the pain in the foot has intensified and spread over the top in the dorsal and lateral aspects of the foot and ankle. She has some swelling, but not a lot. It gives her a lot of pain at night. She says even the air from the fan blowing on it causes pain. She has been doing sitting work....

PHYSICAL EXAMINATION: This is a healthy appearing female in no acute distress. Right foot shows maybe some mild swelling laterally. No gross deformity. She has significant increased pain even with light touch throughout the dorsal, lateral, and medial aspects of the foot. Less so plantarly. She is tender diffusely in the anterior and lateral ankle joint region. Attempts at motion, especially inversion, cause increased pain. She does have palpable pulses in the foot. Intact light touch sensation, but again, she is very hypersensitive.

RADIOGRAPHS: Right foot films show no evidence of any fracture or other bony abnormality. She has had a bone scan that essentially showed some uptake at the plantar fascial origin consistent with plantar fasciitis.

IMPRESSION: Right foot pain. Possible RSD.

PLAN: Her symptoms and exam are very suspicious for a complex regional pain syndrome. Certainly, it is difficult to get a good exam on her as sensitive as she is. I think the real question is whether she has any intrinsic tendon or ligament damage. All her pain is nerve mediated. I am going to start her on some Elavil and go ahead with an MRI of her ankle to rule out significant injury. I recommend that she see a pain management specialist in Springfield. In the meantime, she could be a sitting work. I anticipate the rest of her follow-up would be through pain management, but if her MRI shows any

> significant abnormalities, I will of course be happy to follow her along for that. I do believe that her current problem is related to her on the job injury dated 6/15/05, and this has probably exacerbated her plantar fasciitis as well.

Dr. Benjamin A. Lampert evaluated the claimant on November 8, 2005:

> The patient was referred by Dr. Pliemann (sic) for consultation regarding pain management options for right foot pain. The patient has been having foot pain since an ambulance cot rolled over her right foot. The pain is predominately in the metatarsal head region across her foot on the right side. She also has some pain from plantar fascitis in her heel that predated the injury....
>
> She has had a bone scan that I have been able to review which reveals a hot spot on the plantar aspect of her calcaneus and possibly in the subtalar joint. She does not seem to have any abnormalities in the metatarsal head region. Her pain ranges between 3 and 9 out of 10 in severity and walking makes her pain quite a bit worse but when she rests and she has been on light duty her pain has gotten somewhat better....
>
> She walks with an antalgic gait favoring the right side. She is significantly depressed....
>
> Examination of the lower extremities reveal good range of motion in the hips, knees, and left ankle and foot. She does have some tenderness in all the metatarsal head region in the right foot but she does not really have any hypersensitivity, color change, or edema noted....No skin lesions are noted in the upper extremities, the lower extremities, the head or back except as otherwise noted....Her foot x-rays do not appear to have any abnormalities.

Dr. Lampert's impression was "1. Possible complex regional pain syndrome, right foot. 2. Possible 'bone bruise' or foot trauma from the ambulance incident. 3. History of plantar fasciitis. 4. Major depression." Dr. Lampert planned, "I have recommended some amitriptyline which she said had helped her with her burning foot pain in the past as well. She does report some symptoms of complex regional pain syndrome with hypersensitivity, edema, color change, and temperature change at times, but they are just no (sic) evident on examination today. I have also recommended a trial of some Lexapro 10 milligrams 3 times a day. I have recommended proceeding with a lumbar sympathetic block to see if her pain is sympathetically maintained. I suspect that given some adequate rest and treatment with tricyclic antidepressants her pain should be manageable."

Dr. Lampert noted on January 25, 2006, "The patient returns today in follow up. She continues to have a dysesthetic neuropathic pain in her foot on her right side. She had two lumbar sympathetic blocks which did not result in improvement in her pain. She had perhaps 5% improvement for 4-6 hours despite a good sympathetic nerve block as

shown by vasodilation and warmth in the foot." Dr. Lampert's impression was "Complex regional pain syndrome, right foot. I have recommended conservative treatment."

The claimant followed up with Dr. Lampert on March 22, 2006:

> Examination reveals some tenderness and hypersensitivity over the dorsum of her left foot on the medial aspect over the first metatarsal. There is no color change, temperature change noted, or swelling. Review of her records indicates a bone scan not completely consistent with complex regional pain syndrome, and an MRI which reveals some arthritic changes in her foot. IMPRESSION: My impression is that she has perhaps bone trauma which is slow to heal. Anti-inflammatory drugs do help her pain quite a bit. There is not a great deal of evidence supporting complex regional pain syndrome, although she did get good temporary relief of her pain with the sympathetic block. At this point I would expect her to progress fairly rapidly over a few months with improvement of her pain. I have instructed her to take her anti-inflammatory drugs before work. We will gradually increase her work activities over the next two months. If she is not completely better, then I would consider a work hardening program.
> DIAGNOSIS: Right foot pain.

Dr. Lampert stated on May 17, 2006, "My impression is that she has mild complex regional pain syndrome and right lower extremity bone pain." Dr. Lampert noted on August 16, 2006, "Her gait is still a little antalgic, but she can walk....DIAGNOSIS: Complex regional pain syndrome, lower

extremity." The claimant followed up with Dr. Lampert on November 16, 2006:

> PHYSICAL EXAMINATION: Reveals no difference in the appearance of either foot. She has good vascular flow and pulses in both feet with good range of motion of the tibiotalar and subtalar joints. There is some tenderness across the tarsal metatarsal joints predominantly in the area where the cart rolled over her foot....

Dr. Lampert's impression was "1. Right foot pain. 2. Right sacroiliac joint pain. 3. Major depression."

Dr. Lampert noted on February 15, 2007, "Examination reveals both feet are warm and symmetrical with good blood flow. She has no hypersensitivity to light touch. No edema is noted." Dr. Lampert noted on May 9, 2007, "Examination reveals a bluish tint and slight edema in the right foot with allodynia and hyperesthesia. IMPRESSION: 1. Complex regional pain syndrome, right lower extremity....I think at this point she is at maximum medical improvement....We will send her for a rating."

Dr. Gary L. Moffitt provided an independent medical evaluation on June 14, 2007:

> Ms. Street is a 43 year old female. While at work on the 15th of June 2005 she sustained an injury to her right foot. A gurney that was carrying a rather heavy patient rolled over her foot. She sustained an injury to her foot and subsequently

has been diagnosed with a complex regional pain syndrome involving this foot. This condition has been characterized as being mild. She is currently being followed by a pain management specialist....She is not interested in having any further procedures.

Currently she states that her foot feels like a "sponge" and that it feels as if somebody has stepped on it. She notices that it is worse after she has been on it for 5-6 hours....She tries to keep it warm. She notices worsening of her symptoms with light touch or if she steps in certain ways. Sometimes she notices a limp. Also, sometimes the foot will turn different colors and be blotchy....

Examination of the foot reveals no definite swelling. The coloring is the same compared to the other foot. The temperature of the foot on the right is 87.1 degrees and 88.3 on the left. She complains of mild tenderness to light and medium touch along the dorsal aspect of the mid and forefoot. She is able to move her toes and her ankles. She does have altered sensation to pin prick along the mid and forefoot both along the dorsal and plantar surface in the lateral and medial aspect too. She is walking with a slight limp.

Her records that have been provided have been reviewed in their entirety.

Diagnosis is contusion of the foot with the development of a complex regional pain syndrome. I do feel that she is at the point of maximum medical improvement. Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, she is thought to have an improvement of sural nerve as well as the superficial peroneal, the medial plantar, the lateral plantar, the saphenous, the deep femoral and the medial calcaneal. She is thought to have a Grade IV sensory deficit of these nerves and is not thought

> to have a significant motor deficit. Utilizing Table 68 on page 3-89, she is thought to have a deficit involving both sensory and dysesthesia. For the sural nerve she is thought to have a 1% whole body sensory deficit and 2% dysesthesia deficit. For the superficial peroneal she is thought to have a 2% sensory and a 2% dysesthesia deficit. For the medial plantar nerve she is thought to have a 2% sensory and a 2% dysesthesia impairment. These numbers are combined and she is found to have an 11% whole body impairment rating....

The parties stipulated that the claimant's healing period ended on or about June 15, 2007.

A pre-hearing order was filed on April 22, 2008. The claimant contended, among other things, that she sustained a compensable injury to her right foot on June 15, 2005. The claimant contended that "as a compensable consequence of her June 15, 2005 compensable injury, she developed complex regional pain syndrome (RSD) in her right lower extremity." The claimant contended that she was entitled to "permanent partial disability benefits for the permanent impairment rating of 11% to the body as a whole assigned by Dr. Gary Moffitt."

The respondents contended, among other things, that the claimant's permanent partial disability rating was "not due to claimant's injury or supported by a sufficient basis."

The parties agreed to litigate the following issues:

1. The claimant's entitlement to permanent partial disability for permanent physical impairment.
2. Appropriate attorney's fee.

A hearing was held on June 9, 2008. The claimant described the condition of her foot: "It has its days where it turns blue and swells. It's got to the point that sometimes it doesn't want to flex. I can be walking along and the foot doesn't go with me." The claimant testified that she suffered from pain "Across the top of the foot where the ambulance cot stayed at....It burns and occasionally shooting pain."

An administrative law judge filed an opinion on August 28, 2008. The administrative law judge found that the claimant did not prove she was entitled to a permanent physical impairment rating. The administrative law judge therefore denied and dismissed "the present claim for permanent partial disability benefits attributable to permanent physical impairment."

The claimant appealed to the Full Commission. The Full Commission reversed the administrative law judge's opinion and found that the claimant was "entitled to permanent partial disability benefits for the 11% anatomical impairment rating assigned by Dr. Moffitt."

The respondents appealed to the Arkansas Court of Appeals. The Court of Appeals has remanded so that the Commission may make specific findings.

II. ADJUDICATION

Permanent impairment, which is usually a medical condition, is any permanent functional or anatomical loss remaining after the healing period has been reached. *Ouachita Marine v. Morrison*, 246 Ark. 882, 440 S.W.2d 216 (1969). Act 796 of 1993, as codified at Ark. Code Ann. §11-9-102(4)(F)(ii)(Repl. 2002), provides:

> (a) Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment.
> (b) If any compensable injury combines with a preexisting disease or condition or the natural process of aging to cause or prolong disability or a need for treatment, permanent benefits shall be payable for the resultant condition only if the compensable injury is the major cause of the permanent disability or need for treatment....
> (14)(A) "Major cause" means more than fifty percent (50%) of the cause.
> (B) A finding of major cause shall be established according to the preponderance of the evidence[.]

Preponderance of the evidence means evidence of greater convincing force and implies an overbalancing in weight. *Barre v. Hoffman*, 2009 Ark. 373, ___ S.W.3d ___.

Any determination of the existence or extent of physical impairment shall be supported by objective and

measurable physical or mental findings. Ark. Code Ann. §11-9-704(c)(1)(B)(Repl. 2002). Ark. Code Ann. §11-9-102(16)(Repl. 2002) provides:

> (A)(i) "Objective findings" are those findings which cannot come under the voluntary control of the patient.
> (ii) 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; for the purpose of making physical or anatomical impairment ratings to the spine, straight-leg-raising tests or range-of-motion tests shall not be considered objective findings.
> (B) Medical opinions addressing compensability and permanent impairment must be stated within a reasonable degree of medical certainty[.]

There is no requirement that medical testimony be based solely or expressly on objective findings, only that the medical evidence of the impairment be supported by objective findings. *Wal-Mart Assocs. Inc. v. Ealey*, 2009 Ark. App. 680; *Singleton v. City of Pine Bluff*, 97 Ark. App. 59, 244 S.W.3d 709 (2007). The Commission is not limited to medical evidence only in arriving at its decision as to the amount or extent of permanent partial disability suffered by an injured employee as a result of injury. *Hickman v. Kellogg, Brown & Root*, 372 Ark. 501, 277 S.W.3d 591 (2008), citing *Wilson & Co. v. Christman*, 244 Ark. 132, 424 S.W.2d

863 (1968). It is the duty of the Commission to translate the evidence on all issues before it into findings of fact. *Gencorp Polymer Products v. Landers*, 36 Ark. App. 190, 820 S.W.2d 475 (1991).

In the present matter, the Full Commission finds that the clamant proved by a preponderance of the evidence that she sustained an 11% anatomical impairment rating as assessed by Dr. Moffitt. The parties stipulated that the claimant sustained a compensable injury to her right foot on June 15, 2005. There are a number of objective medical findings in the record which support an award of 11% permanent physical impairment. For instance, a bone scan in August 2005 showed excess activity in the claimant's calcaneus (heel bone) which was consistent with a bone bruise. Dr. Lampert noted in November 2005 that the bone scan had shown a "hot spot" in the claimant's calcaneus. Dr. Lampert opined in March 2006 that the claimant had suffered from bone trauma which was slow to heal. Dr. Lampert described "a bluish tint and slight edema" in the claimant's right foot in May 2007. All of these findings were objective and could not come under the claimant's voluntary control. The evidence also demonstrates that

these objective medical findings were causally related to the claimant's compensable injury rather than a pre-existing degenerative condition.

Moreover, in assessing a permanent anatomical impairment rating as of June 14, 2007, Dr. Moffitt reported, "The temperature of the foot on the right is 87.1 degrees and 88.3 on the left." The decreased temperature in the claimant's right foot, shown at the end of her healing period, was an explicit objective medical finding not within the claimant's voluntary control. Dr. Moffitt assigned an 11% whole-body impairment rating based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 4th Ed. Dr. Moffitt's reliance on the 4th Edition of the Guides was proper based on the relevant provisions of Act 796 of 1993. *See* Ark. Code Ann. §11-9-521(h)(Repl. 2002); *Workers' Compensation Laws And Rules, Rule 099.34*.

In our previous opinion awarding an 11% permanent physical impairment rating, the dissent argued that Dr. Moffitt's assessment from the Guides was based on subjective criteria and thus improper as a basis for permanent anatomical impairment. Nevertheless, if the Guides do not

contain an express method of rating an injury that is compensable pursuant to Arkansas law, then the Commission must adopt a reasonable method of doing so. *See Singleton v. City of Pine Bluff*, 102 Ark. App. 305, ___ S.W.3d ___ (2008); *Rutherford v. Mid-Delta*, 102 Ark. App. 317, ___ S.W.3d ___ (2008). The dissent asserted in the present matter that the sensory deficits, dysesthesia deficits, and dysesthesia impairment noted by Dr. Moffitt were complaints of pain which could not be relied upon to assess a permanent impairment rating. Even if the deficits noted by Dr. Moffitt were solely related to complaints of pain, which Dr. Moffitt did not state, Dr. Moffitt's assessment of permanent impairment was still supported by objective and measurable physical findings. These objective findings, as we have noted, included the abnormal bone scan which was consistent with a bone bruise, the "hot spot" shown on the bone scan, the bluish tint and edema noted in the claimant's right foot, and the decreased temperature shown in the claimant's right foot at the time of maximum medical improvement. We also find that Dr. Moffitt's assessment of 11% anatomical impairment was stated within a reasonable degree of medical certainty.

Based on our *de novo* review of the entire record, and in accordance with the mandate from the Arkansas Court of Appeals, the Full Commission finds that the claimant proved she sustained a permanent anatomical impairment in the amount of 11%. We find that the June 15, 2005 compensable injury was the major cause of the claimant's permanent anatomical impairment. We find that the determination of 11% whole-body impairment was supported by objective and measurable physical findings not within the claimant's voluntary control. We find that the 11% whole-body impairment rating assessed by Dr. Moffitt was stated within a reasonable degree of medical certainty. The Full Commission therefore reverses the administrative law judge's opinion. The claimant's attorney is entitled to fees for legal services pursuant to Ark. Code Ann. §11-9-715(a)(Repl. 2002). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to an additional fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b)(Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

This matter is currently before the Full Commission on remand from the Arkansas Court of Appeals. The Court remanded this case for the Full Commission to make specific findings regarding whether or not there were objective findings to support the claimant's permanent anatomical impairment award of 11%. Pursuant to the remand, I find there are no objective findings to support the permanent anatomical impairment rating.

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 11% permanent anatomical impairment rating was 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 reached a finding of impairment were sensory deficit and sysesthesia, 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 radiculapathy 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, 2009 Ark. App. 148,S.W.3d 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. The pin prick test is a test used to elicit a pain response. Therefore, it is a purely subjective test and can bot be relied upon to support a permanent anatomical impairment rating. Even if it were an objective test, it cannot be relied upon pursuant to the provisions of Ark. Code Ann. § 11-9-102(16)(A)(ii)(a) in the assessment of a permanent anatomical impairment rating.

This matter is clearly distinguishable from 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 permanent anatomical 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 anatomical 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 permanent anatomical impairment rating which is supported with objective medical findings. Accordingly, the previous decision of the Commission awarding an 11% permanent anatomical impairment rating should be reversed on remand from the Court. Therefore, for those reasons set forth above, I respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, COMMISSIONER