BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION
CLAIM NO. H107962

CHARLES W. AXSOM, EMPLOYEE **CLAIMANT**

v.

BAPTIST HEALTH SYSTEMS,
SELF-INSURED EMPLOYER **RESPONDENT**

CLAIMS ADMINISTRATIVE SERVICES, TPA **RESPONDNET**

OPINION FILED AUGUST 29, 2023

Hearing before Administrative Law Judge, James D. Kennedy, on the 18th day of July, 2023, in Little Rock, Pulaski County, Arkansas.

Claimant is represented by Ms. Evelyn E. Brooks, Attorney-at-Law, Fayetteville, Arkansas.

Respondents are represented by Mr. Jarrod S. Parrish, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted on the 18th day of July, 2023, to determine the claimant's entitlement to additional benefits, specifically additional medical treatment associated with complex regional pain syndrome as a result of a right knee injury. A copy of the Prehearing Order which was dated May 9, 2023, was marked "Commission Exhibit 1" and made part of the record without objection. The Order provided that the parties stipulated that the Arkansas Workers' Compensation has jurisdiction of the case and that there was an employer/employee relationship which existed on or about September 4, 2021, when the claimant suffered a compensable, work-related injury to his right knee. The respondents accepted the claim as compensable and were paying a ten percent (10%) permanent partial impairment to the claimant at the time of the hearing.

Additionally, it was stipulated that claimant's prior attorney, Mr. Andy Caldwell had a lien in regard to this claim.

The claimant's and respondent's contentions are set out in their respective responses to the prehearing questionnaire and made a part of the record without objection. The sole witness to testify was the claimant, Charles M. Axsom. The claimant submitted two (2) exhibits. "Claimant's Exhibit One" consisted of 198 pages of medical reports with an index that was admitted without objection. "Claimant's Exhibit Two" was found to not be admissible due to the fact it was furnished to the respondents within the seven-day cutoff period prior to the hearing. The exhibit was allowed to be proffered. The respondents submitted two (2) exhibits without objection, with "Respondents' Exhibit One" consisting of medical records consisting of 32 pages with an index, and "Respondents' Exhibit Two" consisting of 5 pages of forms and correspondence with an index. From a review of the record as a whole, to include medical reports and other matters properly before the Commission, and having had an opportunity to observe the testimony and demeanor of the witness, the following findings of fact and conclusions of law are made in accordance with Ark. Code Ann. §11-9-704.

FINDINGS OF FACT AND CONCLUSSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.

2. That an employer/employee relationship existed on September 4, 2021, the date that the claimant suffered a compensable injury to his right knee.

3. Respondents have accepted and are paying a ten percent (10%) permanent partial impairment to the claimant.

4. The claimant's prior attorney, Mr. Andy L. Caldwell, has filed a lien in this matter.

5. That the claimant has proven, by a preponderance of the credible evidence, that the additional medical treatment, specifically the treatment for complex regional pain syndrome is both causally related and reasonably necessary for the treatment of the work-related right knee injury.

6. If not already paid, the respondents are ordered to pay for the cost of the transcript forthwith.

REVIEW OF TESTIMONY AND EVIDENCE

The claimant, Charles Axsom, testified he would turn fifty-nine (59) years old on August 17 and had been working for the respondent since February of 2020 as a painter and also worked on wall-paper, flooring, sheet rocking, and fire proofing. He had no problem performing his work prior to September 4, 2021. On that date, he went out "fixing to head out for lunch, go back to the main hospital. That's where we clocked in and clocked out." "When I went in to get into the van, I put in, they were standing at the door and we've got that running board on the step side, and when I went up to get on it, when I put my foot on it, the running board fell." (Tr. 6, 7) He went on to state when he fell, his right knee popped and that he reported his injury. He returned to work that Tuesday and continued to climb a ladder. After the accident, he continued to work light duty from September 13th through October 19th, and then had surgery by Dr. Tucker at OrthoArkansas. He suffered from "mild pain" in his right inner knee. (Tr. 8, 9) He walked on crutches for about eight (8) months which started before the surgery. After the surgery, he testified that his symptoms changed and that "my ankle started hurting, my blood in my foot, it started out at my big toe and it progressed. It went from there to, and you know, it surged, you know, it just comes up my knee. I can't, it just does different things. But I mean, but it got worse by swelling. It got worse by the pain. It was horrible to deal

with." He hurt in regard to his right leg, his foot, calf, ankle, and from the bottom of his foot to his knee and sometimes to his thigh. When he sits down, it "aggravates that nerve." These symptoms have been present since the surgery. He also admitted that he had hurt his back in 2018, but he had not filed a workers' compensation claim in regard to the injury, and was not having any back trouble. He had received physical therapy and currently was seeing Doctor Christine Wagner and Doctor Robin. He ended his direct testimony by saying that he wanted to return to work and that sometimes the pain goes away for thirty (30) minutes to an hour but returns. (Tr. 10-13)

Under cross-examination, the claimant was questioned about testifying in his deposition that he had never had any problem with his right knee and his response was "I tell you, sir, I didn't remember any of that." He admitted that at the time of the deposition he provided he never had any diagnostic studies of his right knee, but since that time, his lawyer had shown him "some stuff" that he did not remember. He admitted seeing his medical records and being shown an MRI for his knee. The following questioning then occurred:

> Q: You had pain radiating down your knee in 2018 at a 9 on a 10 point scale?
>
> A: Sir, I don't remember, but if that's what it says, yes, sir.
>
> Q: The judge is going to see if it's right knee pain requiring an MRI on page 13 of your medical packet. You've seen that with your lawyer, right?
>
> A: Yes sir.
>
> Q: So when you told me at your deposition that you'd never had any right knee problems or never had any diagnostic tests, that wasn't a true statement, was it?
>
> A: Sir, I didn't remember it. I did have a mask (sic) on it, but it wasn't like this right here. I don't remember. (Tr. 14)

> Q: Okay. And we know, even from your description here today, the accident only involved your right knee, right? You said you stepped on the running board you had a twisting and popping sensation with the right knee only, right?
>
> A: Right.
>
> Q: There was no involvement involving you toes, your feet or your ankle or anything like that, is that right?
>
> A: I still stepped on my foot, but what I actually injured was my knee.
>
> Q: Yes sir. So you had no injury or symptoms in your toes or your ankle right after the accident, right?
>
> A: Right.
>
> Q: I went through your medical exhibits and I don't see mention of the words, foot, ankle, or toes or any of that until April of 2022. Did you speak that?
>
> A: Yes, sir. 2022.

The claimant also agreed there was no mention of chronic regional pain syndrome, (CRPS), until May 31 of 2022, which was nine (9) months after the accident. (Tr. 16, 17) He admitted his right foot was not injured in the accident and that he had no reason to dispute the records that Dr. Tucker placed him at MMI and released him for his right knee. (Tr. 18, 19)

On re-direct, the claimant testified that in his deposition he did not recall an MRI of his right knee. He did recall volunteering he had an injury while working for Century. In regard to his surgeries, his first one was November 1st, and the second one was December 6th. (Tr. 24, 25)

"Claimant's Exhibit Ones" initial medical consisted of a clinic note dated September 7, 2021, which provided the claimant presented to discuss concerns about his right knee which had begun on September 4, 2021. An x-ray provided for no fractures or

dislocations with mild degenerative changes. The assessment provided for a decreased range of motion and mentioned that an MRI was going to be ordered. It also provided that the claimant could return to work the following day on light duty. Crutches were prescribed. (Cl. Ex. 1, PP. 1-7)

Claimant presented to Dr. James Tucker on September 21, 2021. The report provided the claimant was to stay on crutches and that the MRI provided for a medial meniscal radial type tear, and a Velcro hinged knee brace for the MCL was ordered. (Cl. Ex. 1, PP. 8-16) A return to work slip for sedentary duty was provided. (Cl. Ex. 1, P. 17) The claimant returned to OrthoArkansas on September 26, 2021, and surgery was later performed by Dr. Tucker on November 2, 2021, for repair of the medial meniscus. (Cl. Ex. 1, PP. 18-31) An MRI dated November 17, 2021, provided for findings suspicious of a re-tear involving the inferior meniscal surface. (Cl. Ex. 1, PP. 32-33) The claimant then returned to Dr. Tucker on November 23, 2021, for a follow-up after a fall due to his crutches and the report confirmed a showing of a re-tear of his medial and lateral meniscus with a sprain of his MCL. (Cl. Ex. 1, PP. 34-37)

A second surgery involving the claimant's right knee occurred on December 6, 2021. (Cl. Ex. 1, PP. 38-41) The claimant then returned to Dr. Tucker for a follow-up on December 22, 2021, after an initial physical therapy treatment. The report provided that the claimant was doing okay but had an increase in pain since surgery. A new knee brace was ordered. (Cl. Ex. 1, PP. 44-50) The claimant continued to present for multiple physical therapy sessions and returned to Dr. Tucker on February 8, 2022. The major complaint at the time of the visit was continued and increasing pain down the L4 dermatome/saphenous nerve distribution and the claimant indicated this comes on when

he had something press against his posterior thigh. An EMG nerve study was recommended, as well as continued therapy. (Cl. Ex. 1, PP. 55-58)

The claimant continued to receive physical therapy and presented to Dr. Cayme at OrthoArkansas on February 21, 2022, for a nerve conduction study. The initial study provided for a normal study with no electrodiagnostic evidence of a focal nerve entrapment, generalized peripheral neuropathy, or right lumbar radiculopathy. (Cl. Ex. 1, PP. 60-64) However, a revised report of the same date provided for an abnormal electrodiagnostic study with electrodiagnostic evidence of a right axonal saphenous neuropathy. There was no electrodiagnostic evidence of a generalized peripheral neuropathy, other focal nerve entrapment, or right lumbar radiculopathy. (Cl. Ex. 1, PP. 65-66)

The claimant returned to Dr. Tucker on February 23, 2022, and also on March 16, 2022, after physical therapy. The report from March 16, 2022, provided that the EMG nerve conduction study provided no signs of nerve compression and was felt to be normal, but that the claimant continued to have dysesthesias along the saphenous nerve distribution which was aggravated by sitting in a chair. (Cl. Ex. 1, PP. 67-71)

Physical therapy regarding the right knee continued and the claimant was instructed to remain off work until further notice. (Cl. Ex. 1, PP. 74-75) The claimant was then referred to Dr. Paulus on March 28, 2022. Dr. Paulus agreed with Dr. Tucker that much of the radiating leg symptoms of the medial knee to the medial ankle fit with the saphenous nerve distribution, but by continuing to the dorsum of the foot, it was atypical for saphenous neuropathy and could represent an L5 radicular pattern. (Cl. Ex. 1, PP. 76-81)

After additional physical therapy, the claimant returned to Dr. Tucker on April 12, 2022. The report provided the claimant had a saphenous nerve injury with a positive Tinel's, with pressure against the posterior. An MRI was recommended and the claimant was again instructed to remain off of work. (Cl. Ex. 1, PP. 83-87) Two weeks later, the claimant returned to Dr. Paulus. The report provided that the claimant had presented with three (3) months of "dull, aching, throbbing" low back pain with "sharp, shooting, stabbing, tingling, numb" referral into the right leg that began after a knee surgery. The bilateral saphenous nerve conduction studies performed on March 28, 2022, revealed a significantly lower right-sided nerve amplitude in comparison to the left and Dr. Paulus opined that this was "confirmatory for saphenous neuropathy," axonal in nature. (Cl. Ex. 1, PP. 88-92) A clinic note from Dr. Tucker on the same date of April 26, 2022, provided the claimant had marked quad atrophy and was going to be placed back into therapy. (Cl. Ex. 1, PP. 93-96) An MRI of the right lower extremity provided for an unremarkable evaluation of the right thigh and showed no abnormality that could cause saphenous nerve compression. (Cl. Ex. 1, P. 97)

The claimant returned to Dr. Paulus on May 31, 2022, who opined the claimant's presentation had changed over the last month, with pain now extending into the dorsum of his foot with a new onset of vasomotor and sudomotor changes. He opined that the claimant had developed Type 2 Chronic Regional Pain Syndrome. (Cl. Ex. 1, PP. 98-102) Dr. Tucker also issued a clinic note of the same date which provided the claimant continued to suffer from saphenous neuropathy. (Cl. Ex. 1, PP. 103-106)

On June 15, 2022, the claimant was referred by Dr. Paulus to Dr. Brent Walker, for possible complex regional pain syndrome of his lower extremity. Dr. Walker noted

that the claimant's right knee was reddened and swollen and that there was a temperature asymmetry and consequently, he ordered a triple phase bone scan in regard to possible complex regional pain syndrome of the right lower extremity. (Cl. Ex. 1, PP. 107-112) The bone scan was performed on June 21, 2022, and it provided that there was decreased activity on all three (3) phases within the right foot which could be related to the disuse of the right leg. It also noted that although rare, this pattern had also been described with complex regional pain syndrome. (Cl. Ex. 1, PP. 113-114) The claimant received a sympathetic nerve block administered by Dr. Walker on June 28, 2022, on July 5, 2022, and also on July 12, 2022. (Cl. Ex. 1, PP. 115-120) Claimant then returned to Dr. Walker on July 15, 2022, who assessed him with complex regional pain syndrome of the right lower extremity. Complex regional pain syndrome has an uncertain progress and can possibly reactivate months and even years after the initial insult. (Cl. Ex. 1, PP. 121-127) The claimant received additional right lumbar sympathetic blocks by Dr. Walker, based upon the diagnosis of complex regional pain syndrome of the lower extremity on August 4, 9, and the 16, of 2022. (Cl. Ex. 1, PP. 128-133) Dr. Walker issued a clinical note on August 25, 2022, which provided the claimant was returning after six (6) lumbar sympathetic nerve blocks and was seeing an improvement over the last three (3) injections and no longer had a generalized pain, but had a more specific pain into the web of his toes and dorsum of his foot, with continued pain in his right knee and with a decreased range of motion. (Cl. Ex. 1, PP. 134-140)

The claimant returned for additional sympathetic nerve blocks on August 30, September 6 and the 13, of 2022. (Cl. Ex. 1, P. 141-146) On September 23, 2022, Dr. Walker issued an additional clinic note which provided the claimant might be a good

candidate for a referral to UAMS and their CRPS program. He opined that it was his opinion that the claimant would not respond to any additional sympathetic nerve blocks. (Cl. Ex. 1, PP. 147-154) Another clinic note was issued by Dr. Walker on October 21, 2022, which again provided under assessment for the diagnosis of complex regional pain syndrome of the right lower extremity. (Cl. Ex. 1, PP. 155-163)

The claimant was then seen by Dr. Ethan Schock on November 17, 2022, with a clinic addendum issued on February 27, 2023, which provided that the opinion he issued was limited to the orthopedic related issues of the right knee and the neurologic/complex regional pain syndrome involving the right knee and the lower extremity diagnosis. He opined the claimant had reached MMI with respect to his right knee work-related injury and found a twelve percent (12%) whole person permanent partial impairment. On February 27, 2023, Dr. Schock issued an addendum which provided he saw no way to modify his November 17, 2022, assessment based upon the question of "chronic chondromalacia." (Cl. Ex. 1, PP. 163a-168)

On December 15, 2022, Dr. Wagner issued a clinic note which provided the claimant was seen for management of his right lower extremity complex regional pain syndrome. Unfortunately, he was in the chronic phase. Symptoms were starting to radiate to the mid-thigh level and he had not heard about a second opinion with UAMS. He had been assessed with complex regional pain syndrome of the right lower extremity and his work restrictions were continued. (Cl. Ex. 1, PP. 169-180) An OrthoArkansas clinic note dated December 15, 2022, again made an assessment of complex regional pain syndrome of the right lower extremity. (Cl. Ex. 1, PP. 181-189)

Finally, claimant was seen by Dr. Cale White and Dr. Jonathan Goree on April 25, 2023. The report provided that the right lower extremity pain was consistent with complex regional pain syndrome and the plan called for a DRG stimulator assessment, a pre-operative neuropsych evaluation, a preoperative MRI, and counseling on smoking cessation. (Cl. Ex. 1, PP. 190-195)

The respondents submitted two (2) exhibits which were admitted into the record without objection. The first exhibit consisted of 32 pages of medical reports with an index. An MRI of the lumbar spine dated June 21, 2012, provided the claimant had narrowed disc spaces at the L3-4 and at the L4-5 disc space with a right paracentral disc herniation slightly indenting the thecal sac and abutting the right S1 nerve root. (Resp. Ex. 1, P. 1) A second lumbar spine MRI was taken on April 9, 2014, which provided for development of disc degeneration with left paracentral disc protrusion at the L2-3, with no change of the left disc protrusion at L3-4. Additionally, there was no change in the right paracentral disc protrusion at L5-S1 with minimal mass affect on the right S1 nerve root. There was no change in the right posterolateral annual tear with a small protrusion at L4-5. (Resp. Ex. 1, PP. 2-3)

A chart note dated April 21, 2014, by Dr Regan Gallaher provided for right hip arthropathy and lumbar radiculopathy. (Resp. Ex. 1, P. 4) A myelogram dated June 6, 2014, provided for a L2-3 left subarticular disc protrusion contracting and posterior deviating the descending left L3 nerve roots. An L2-3 left foraminal disc protrusion contacted the exiting left L3 nerve roots with mild left neural foraminal narrowing. L3-4 foraminal disc protrusions contacted the exiting left L3 nerve roots without neural foraminal narrowing. (Resp. Ex. 1, PP. 5-7)

The records also provided that on December 31, 2014, the claimant presented to the ER at Baptist Medical Center for alcohol detoxification and had presented to the ER intoxicated with elevated liver enzymes and back pain. (Resp. Ex. 1, PP. 8-10). A report by Dr. Jacob Abraham dated August 18, 2015, provided the claimant had lumbar spondylosis, lumbosacral and thoracic radiculitis, and lumbar disc disruption. In addition, a letter from Dr. Jack Cates addressed to Dr. Timothy English dated October 1, 2015, provided the claimant suffered from a right hand that was dry and flakey. (Resp. Ex. 1, P. 12)

An MRI of the claimant's right knee dated May 12, 2016, provided for mild medical osteoarthritis with no evidence of acute internal derangement. (Resp. Ex. 1, P. 13) The respondents also provided a chart note from Dr. Joshua Garner dated November 7, 2018. The note provided for vertebral subluxation complex. (Resp. Ex. 1, PP. 14-18) An EMG nerve conduction study dated February 21, 2022, was previously reviewed in the claimant's documentary evidence. (Resp. Ex. 1, PP. 19-20)

An Impairment Evaluation Summary dated January 11, 2023, was also made part of the record which provided the claimant had a "4% Whole Person, 10% Lower Extremity impairment due to a loss of motion and also a 4% Whole Person, 10% Lower Extremity impairment when rated using a diagnosis based impairment approach." The report also provided that the claimant had a documented surgical and/or medical history which indicated a diagnosis-based impairment was applicable. (Resp. 1, PP. 21-25)

Finally, an IME from Dr. Carlos Roman discussed the various treatments and diagnoses the claimant received from multiple doctors, as well as his past history of neuropathy and general and severe osteoarthritis. He opined that the claimant did not fit

the criteria for complex regional pain syndrome. (Resp. Ex. 1, PP. 26-28) Additionally, in a clinic note for the claimant dated April 5. 2023, Dr. Roman opined that the bone scan would not in any way conclude complex regional pain syndrome. He also opined that the lovera procedure for the right knee pain was indicated for severe osteoarthritic patients contemplating a right total knee arthroplasty and/or post arthroplasty surgeries and the claimant did not fit the criteria for an lovera knee procedure. (Resp. Ex. 1, PP. 29-30)

The respondents second exhibit consisted of an AR-C Form filed on September 30, 2021, which provided the claimant had suffered injuries to his right knee and other body parts. (Resp. Ex. 2, P. 1) The AR-2 form filed by the respondents provided the respondents had accepted the compensability of the right knee and that all benefits due had been or were in the process of being paid. (Resp. Ex. 2, P. 2) Additionally, attorney Andy Caldwell, claimant's previous attorney, asserted a lien pursuant to Ark. Code Ann. §16-22-304 after the claimant informed him he no long wanted Mr. Caldwell to represent him. (Resp. Ex. 2, P. 3) Finally, the respondents provided a list of available jobs that were forwarded to the claimant. (Resp. 2, P. 4)

DISCUSSION AND ADJUDICATION OF ISSUES

In the present matter, the parties stipulated the claimant sustained a compensable injury on September 4, 2021. The claimant is therefore not required to establish "objective medical findings" in order to prove that he is entitled to additional benefits. *Chamber Door Indus., Inc. v Graham*, 59 Ark. App. 224, 956 S.W.2d 196 (1997)

However, when assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze the proposed procedure and the condition that it is sought to remedy. *Deborah Jones v. Seba, Inc*., Full Workers'

Compensation filed December 13, 1989. (Claim No. D512553). The respondent is only responsible for medical services which are causally related to the compensable injury. Treatments to reduce or alleviate symptoms resulting from a compensable injury, to maintain the level of healing achieved, or to prevent further deterioration of the damage produced by the compensable injury are considered reasonable medical services. *Foster v. Kann Enterprises*, 2009 Ark. App. 746, 350 S.W.2d 796 (2009). Liability for additional medical treatment may extend beyond the treatment healing period as long as the treatment is geared toward management of the compensable injury. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 180 S.W.3d 31 (2004).

The claimant bears the burden of proof in establishing entitlement to benefits under the Arkansas Workers' Compensation Act and must sustain that burden by a preponderance of the evidence. *Dalton v. Allen Engineering Co*., 66 Ark. App 260, 635 S.W.2d 543. Injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. *Owens Plating Co. v. Graham*, 102 Ark. App 299, 284 S.W. 3d 537 (2008). What constitutes reasonable and necessary treatment is a question of fact for the Commission. *Anaya v. Newberry's 3N Mill*, 102 Ark. App. 119, 282 S.W.3d 269 (2008).

The claimant was injured when he stepped on the running board of a vehicle and the running board collapsed. The testimony provided he worked the remainder of September 4, 2021, and worked light duty from September 13 through October 19, 2021. The claimant was treated by Dr. James Tucker who ordered an MRI and who diagnosed a medial meniscal radial tear and performed the initial surgery to repair the medial meniscal tear on November 2, 2021. After the surgery, the claimant was placed on

crutches and fell due to the crutches, which caused a reinjury of his medial meniscus and lateral meniscus and also a sprain of his MCL. Dr. Tucker performed a second surgery to repair the additional injuries on December 6, 2021. The follow-up by Dr. Tucker provided that the claimant was doing "okay" but was having increased pain after the surgery, with increased pain down the L4 dermatome/saphenous nerve distribution, and the claimant indicated that the pain came on if something pressed on his exterior thigh. An EMG nerve study by Dr. Cayme provided in a revised report an abnormal electrodiagnostic study with electrodiagnostic evidence of a generalized peripheral neuropathy, other focal nerve entrapment, or right lumbar radiculopathy. The claimant continued with physical therapy and continued with dysesthesias along the saphenous nerve distribution, which was aggravated by sitting in a chair.

The claimant continued to complain and was eventually referred to Dr. Paulus who agreed with Dr. Tucker that much of the radiating leg symptoms of the medial knee to the medial ankle fit with the saphenous nerve distribution, but by continuing to the dorsum of the foot was atypical for saphenous neuropathy. A bilateral saphenous nerve conduction was performed on March 28, 2022, which revealed a significantly lower right-sided nerve amplitude in comparison to the left and Dr. Paulus opined that this was "confirmatory for saphenous neuropathy." He also noted quad atrophy. On May 31, 2022, Dr. Paulus opined that the claimant had developed Type 2 Chronic Regional Pain Syndrome. Dr. Tucker also issued a clinic note on the same date which provided that the claimant continued to suffer from saphenous neuropathy.

Dr. Paulus then referred the claimant to Dr. Brent Walker, who noted that the claimant's right knee was reddened and swollen and who ordered a triple phase bone

scan in regard to possible complex regional pain syndrome of the right lower extremity. On July 15, 2022, Dr. Walker assessed the claimant with complex regional pain syndrome of the right lower extremity. The report also provided that complex regional pain syndrome had an uncertain progress and could reactivate months and even years after the initial insult. Dr. Walker recommended that the claimant was a candidate for the UAMS program for chronic regional pain syndrome.

The claimant was also seen by Dr. Cale White and Dr. Jonathan Gores on April 25, 2023, and their report also provided that the right lower extremity pain was consistent with complex regional pain syndrome and their plan called for a DRG stimulator assessment.

An IME by Dr. Carlos Roman discussed the various treatments and diagnoses that had been provided by the above doctors and he opined that the claimant had a past history of neuropathy with general and severe osteoarthritis and the claimant did not fit the criteria for complex regional pain syndrome and further, the bone scan would not in any way conclude complex regional pain syndrome. He also opined that the claimant did not fit the criteria for the initial right knee surgery. (Iovera procedure per Dr. Roman)

Questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. *Powers v. City of Fayetteville*, 97 Ark. App. 251, 248 S.W.3d 516 (2007). Where there are contradictions in the evidence, it is within the Commissions' province to reconcile conflicting evidence and to determine the true facts. *Cedar Chem. Co. v. Knight*, 99 Ark. App. 162, 258 S.W.3d 394 (2007). The Commission has authority to accept or reject a medical opinion and to determine its medical soundness and probative force. *Oak Grove Lumber Co. v. Highfill*,

62 Ark. App. 42, 968 S.W.2d 637 (1998). However, the Commission may not arbitrarily disregard the testimony of any witness. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004).

In workers' compensation law, the employer takes the employee as he finds him and employment circumstances that aggravate pre-existing conditions are compensable. *Heritage Baptist Temple v. Robinson*, 82 Ark. App. 460, 120 S.W. 3d 150 (2003). The parties agreed the claimant suffered a compensable injury to his right knee from a work-related injury. The claimant clearly suffered from some arthritic issues prior to the work-related accident, as do most people who are approximately fifty-five (55) years of age. It is also noted that the testimony of the claimant had various discrepancies between statements during his deposition and later testimony. However, with that said, there were various objective findings regarding the right knee, which included a nerve conduction study that provided electrodiagnostic evidence of right saphenous neuropathy, a positive Tinel's, quad atrophy, findings of a reddened and swollen right knee with temperature asymmetry, and a triple phased bone scan that provided for decreased activity in all three phases of the right foot which could be caused by lack of use but also by a rare pattern of complex regional pain syndrome.

Here it is clear that the medical opinions by treating physicians Dr. Paulus, Dr. Walker, Dr. White, and Dr. Gore, and the referral to complex regional pain syndrome by Dr. Schock and Dr. Wagner, are in direct opposition to the opinion issued by Dr. Roman. It is also noted that Dr. Roman's opinion is apparently also in direct opposition to Dr. Tucker's original treatment of the claimant in regard to his surgeries. It is within the Commission's province to reconcile conflicting evidence, including the medical evidence.

Williams v. Ark. Dept. of Community Corrections, 2016 Ark. App. 427, 502 S.W.3d 534. The Commission has the duty of weighing medical evidence, and the resolution of conflicting evidence is a question of fact for the commission. It is well settled that the Commission has the authority to accept or reject medical opinions and the authority to determine their medical soundness and probative force. Considering the Commission's fact-finding authority, and weighing the findings of multiple doctors, many who are specialized in their area of practice, there is no alternative but to find that the opinions of Dr. Paulus, Dr. Walker, Dr. White, and Dr. Goree are found to be controlling.

After reviewing all of the evidence, without giving the benefit of the doubt to either party, there is no alternative but to find that the claimant has satisfied his burden of proof to prove, by a preponderance of the credible evidence, that the medical treatment he requested, specifically treatment associated with complex regional pain syndrome is both causally related and reasonably necessary for the treatment of the compensable work-related right knee injury and that he is entitled to the same.

IT IS SO ORDERED.

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JAMES D. KENNEDY
Administrative Law Judge