NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. H107962

CHARLES W. AXSOM, EMPLOYEE	CLAIMANT
BAPTIST HEALTH, EMPLOYER	RESPONDENT
CLAIMS ADMINISTRATIVE SERVICES, INSURANCE CARRIER/TPA	RESPONDENT

OPINION FILED MARCH 7, 2024

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

Claimant represented by the HONORABLE EVELYN E. BROOKS, Attorney at Law, Fayetteville, Arkansas.

Respondents represented by the HONORABLE JARROD S. PARRISH, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Respondents appeal an opinion and order of the Administrative Law Judge filed August 29, 2023. In said order, the Administrative Law Judge made the following findings of fact and conclusions 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.

We have carefully conducted a *de novo* review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the decision of the Administrative Law Judge, including all findings of fact and conclusions of law therein, and adopt the opinion as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2012).

For prevailing on this appeal before the Full Commission, claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. § 11-9-715(a)(Repl. 2012). 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. 2012).

IT IS SO ORDERED.

SCOTTY DALE DOUTHIT, Chairman

M. SCOTT WILLHITE, Commissioner

Commissioner Mayton dissents

DISSENTING OPINION

I respectfully dissent from the majority opinion. After my *de novo* review of the file, I find that the claimant has failed to prove by a preponderance of the credible evidence that the medical 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.

The claimant suffered an admittedly compensable injury to his right knee on September 4, 2021, when the running board to a work van

collapsed beneath him. (Hrng. Tr, Pp. 6-7). Dr. James Tucker performed a diagnostic arthroscopy with medial meniscal repair and partial lateral meniscectomy on November 1, 2021. (Cl. Ex. 1, P. 28). The claimant asserts that his symptoms changed after surgery, leading to right foot, toe, and ankle pain. (Hrng. Tr, P. 16).

At an appointment with Dr. Tucker on November 17, 2021, the claimant advised Dr. Tucker that earlier that week he twisted his knee and felt a pop when his crutches got twisted up with a dog, and an MRI dated November 17, 2021, showed findings suspicious of a re-tear involving the inferior meniscal surface of the posterior horn. (Cl. Ex. 1, Pp. 31-33)

The claimant returned to Dr. Tucker on November 23, 2021, for a follow-up after a fall, and Dr. Tucker's 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). Dr. Tucker performed a second surgery on the claimant's knee on December 6, 2021. (Cl. Ex. 1, Pp. 38-41).

The claimant continued to complain of ongoing pain, and on February 8, 2022, reported increasing pain down the L4 dermatome/saphenous nerve distribution when something pressed against his posterior thigh. (Cl. Ex. 1, Pp. 55-58). Dr. Tucker ordered an EMG nerve study. *Id*.

Dr. Rodrigo Cayme performed a nerve study on February 21, 2022, which resulted in a report of "1. Normal electrodiagnostic study. 2. There is no electrodiagnostic evidence of a focal nerve entrapment, generalized peripheral neuropathy, or right lumbar radiculopathy." (Cl. Ex. 1, P. 63). This study was later revised to include an electrodiagnostic finding of right axonal saphenous neuropathy, but no evidence of CRPS. (Cl. Ex. 1, P. 65).

On March 16, 2022, Dr. Tucker reported that the EMG nerve conduction study showed 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).

The claimant was examined by Dr. Stephen Paulus on May 31, 2022, who opined that 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 believed that the claimant was developing Type 2 Chronic Regional Pain Syndrome. (Cl. Ex. 1, Pp. 98-102).

Dr. Tucker issued a clinic note of the same date which provided the claimant continued to suffer from saphenous neuropathy and the MRI of his

thigh showed no signs of a lesion which would increase his saphenous nerve symptoms with sitting. (Cl. Ex. 1, Pp. 103-106).

Dr. Paulus referred the claimant to Dr. Brent Walker for possible CRPS, and upon examination, Dr. Walker noted that the claimant's right knee was reddened and swollen and there was temperature asymmetry. (Cl. Ex. 1, Pp. 107-112). Dr. Walker ordered a three-phase bone scan, which revealed "relatively decreased activity on all three phases within the right foot, which may be related to disuse of the right leg." (Cl. Ex. 1, P. 113). The claimant underwent a series of lumbar sympathetic nerve blocks for the treatment of his symptoms, but they offered no relief. (Hrng. Tr, P. 19; See Cl. Ex. 1, Pp. 115, 117, 119, 128, 130, 132, 141, 143, 145; Resp. Ex. 1, P. 29). Dr. Walker opined that the claimant may be a good candidate for the UAMS CRPS program. (Cl. Ex. 1, Pp. 147-154).

On November 17, 2022, Dr. Ethan Schock assigned a 12% whole person impairment rating (30% lower extremity permanent partial impairment). (Cl. 1, P. 168).

The claimant ultimately underwent an evaluation on April 25, 2023 by Dr. Cale White and Dr. Johnathan Goree who diagnosed the claimant with CRPS of the claimant's foot per Budapest Criteria. (Cl. Ex. 1, Pp. 190-195).

Dr. Carlos Roman performed an independent medical examination on January 30, 2023, and determined:

> It is my assessment per Budapest Criteria, he does not have Complex Regional Pain Syndrome…By Budapest Criteria, the tone, color and temperature was not compatible with complex regional pain syndrome of the right lower extremity. This bone scan, again, indicates the foot, not the knee, again an atypical and unusual pattern, but not correlative with complex regional pain syndrome and the location of the pooling was not relative to the knee where the pain is. The bone scan does not in any way conclude complex regional pain syndrome. It is quite contrary. Obviously the radiologist reading the scan would not be aware if it was a knee or a foot, but the bone scan does not indicate complex regional pain syndrome. (Resp. Ex. 1, Pp. 26-30).

There was no mention of chronic regional pain syndrome (CRPS) until May 31 of 2022, which was ten (10) months after the claimant's accident. (Hrng. Tr, Pp. 16-17).

The respondents have accepted and are paying a ten percent (whole body) impairment rating. An administrative law judge determined that the claimant met his burden of proving that he is entitled to additional medical treatment for CRPS related to his September 2021 compensable injury. Respondents appeal.

Arkansas Code Annotated section 11-9-508(a) (Repl. 2012) requires an employer to provide an employee with medical and surgical treatment "as may be reasonably necessary in connection with the injury received by the employee." The claimant has the burden of proving by a preponderance of the evidence that the additional treatment is reasonable and necessary. *Nichols v. Omaha Sch. Dist.*, 2010 Ark. App. 194, 374 S.W.3d 148 (2010).

What constitutes reasonably necessary treatment is a question of fact for the Commission. *Gant v. First Step, Inc.*, 2023 Ark. App. 393, 675 S.W.3d 445 (2023). In assessing whether a given medical procedure is reasonably necessary for treatment of the compensable injury, the Commission analyzes both the proposed procedure and the condition it sought to remedy and the respondent is only responsible for treatment causally related to the compensable injury. *Walker v. United Cerebral Palsy of Ark.*, 2013 Ark. App. 153, 426 S.W.3d 539 (2013). Treatments to reduce or alleviate symptoms resulting from the 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).

The Commission has authority to accept or reject medical opinion and to determine its medical soundness and probative force. *Gant v. First Step, Inc.,* 2023 Ark. App. 393, 675 S.W.3d 445 (2023). Furthermore, it is the Commission's duty to use its experience and expertise in translating the testimony of medical experts into findings of fact and to draw inferences when testimony is open to more than a single interpretation. *Id.*

The claimant alleges that he is entitled to additional medical treatment for complex regional pain syndrome (CRPS).

Dr. Carlos Roman conducted an IME on January 30, 2023, and opined that, "[b]y Budapest Criteria, he does not fit criteria for complex regional pain syndrome, again, also been refractory to sympathetic blocks, those are both therapeutic and diagnostic in scope." (Resp. Ex. 1, P. 28). Dr. Roman's report included the findings that:

- Sympathetic tone is normal and symmetric.
- No excess swelling in the right leg compared to the left.
- No gross temperature differential.
- Color is appropriate.
- No skin breakdown issues.

(Resp. Ex. 1, Pp. 26-30).

On February 21, 2022, the claimant underwent a nerve conduction study which resulted in a report of "1. Normal electrodiagnostic study. 2. There is no electrodiagnostic evidence of a focal nerve entrapment, generalized peripheral neuropathy, or right lumbar radiculopathy." (Cl. Ex. 1, P. 63). This study was later revised to include an electrodiagnostic finding of right axonal saphenous neuropathy, but no evidence of CRPS. (Cl. Ex. 1, P. 65).

A June 21, 2022, three-phase bone scan revealed "relatively decreased activity on all three phases within the right foot, which may be related to disuse of the right leg." (Cl. Ex. 1, P. 113). "Typical pattern for complex regional pain syndrome is going to be increased activity in all three phases, the flow, the pool, and the delay." (Resp. Ex. 1, P. 29). Decreased activity as seen in the claimant's scan would be a "rare atypical pattern." *Id*.

> By Budapest Criteria, the tone, color and temperature was not compatible with complex regional pain syndrome of the right lower extremity. This bone scan, again, indicates the foot, not the knee, again an atypical and unusual pattern, but not correlative with complex regional pain syndrome and the location of the pooling was not relative to the knee where the pain is. The bone scan does not in any way conclude complex regional pain syndrome. It is quite contrary. Obviously the radiologist reading the scan would not be

> aware if it was a knee or a foot, but the bone scan does not indicate complex regional pain syndrome. *Id*.

The claimant did not respond to the typical treatments for CRPS. (Hrng. Tr, P. 19; *See* Cl. Ex. 1, Pp. 115, 117, 119, 128, 130, 132, 141, 143, 145; Resp. Ex. 1, P. 29). No fewer than nine lumbar block injections which provided no long-term relief. *Id*.

The medical records are clear that the claimant has failed to prove by a preponderance of the evidence that he suffers from CRPS. The claimant's bone scan was negative for any indication of CRPS, and the results of the claimant's nerve conduction study showed no evidence of CRPS.

Dr. Ramon was unequivocal in his medical opinion that despite years of investigation by OrthoArkansas, there is no evidence of CRPS by the Budapest Standard and the claimant is not entitled to additional medical treatment for this claim.

Accordingly, for the reasons set forth above, I must dissent.

MICHAEL R. MAYTON, Commissioner