ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
LARRY D. VAUGHT, JUDGE

DIVISION I

CA06-131

September 13, 2006

DONNA KEY

APPELLANT

V.

OWENS CORNING CORP. and
CROCKETT ADJUSTMENT

APPELLEES

APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION
[NO. F108142]

AFFIRMED

Donna Key argues that the Arkansas Workers' Compensation Commission erroneously denied her permanent-impairment and wage-loss benefits resulting from a compensable injury she sustained at her workplace—Owens Corning Fiberglass Corporation. Specifically, Key argues that she is entitled to an additional whole-body impairment rating of seven percent (and an additional seven percent—over and above the impairment rating—for wage-loss benefits) based on her diagnosis of reflex sympathetic dystrophy (RSD). This impairment entitlement claimed by Key is over and above the fourteen percent previously accepted and paid by Owens.

In support of her argument, Key notes that she sustained a compensable injury to her right foot and ankle on July 10, 2001, while descending stairs in the course and scope of her

employment with Owens (where she had been employed for eleven years).[1] Thereafter, she came under the care of several physicians for the treatment of her compensable injury, beginning with Dr. Michael Wolfe. On July 26, 2001, Dr. Wolfe opined that Key had sprained her ankle, and he released her to light-duty work. However, Key's symptoms reportedly persisted, so she returned to Dr. Wolfe, who prescribed physical therapy.

Key also had an MRI, which was conducted on August 24, 2001. The MRI revealed "[p]ossible inflammatory type changes in [Reed's] subcutaneous tissues both medial and laterally." A bone scan of Key's feet and ankles, conducted on August 31, 2001, subsequently revealed mild arthritic changes, with "no evidence of [RSD] on the right."

After this scan, Key initiated treatment with her family physician, Dr. Joe Paul Alberty, who examined her and referred her to Dr. John Swicegood. On November 2, 2001, a three-phase bone scan of Key's ankles and feet revealed findings consistent with RSD, which has been defined as a type of chronic pain syndrome. *See generally Wal Mart Stores, Inc. v. Connell*, 340 Ark. 475, 10 S.W.3d 727 (2000). In response to this finding, Dr. Swicegood administered a series of right lumbar sympathetic nerve-block injections, as well as a percutaneous sympathetic radio-frequency neurotomy. However, these procedures reportedly failed to provide Key with lasting relief from her symptoms.

A second MRI of Key's right foot and ankle, conducted on December 21, 2001,

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[1]The fact that Key fell and sustained an injury to her right foot and ankle is undisputed. Owens only disputes Key's entitlement to an additional whole-body impairment rating of seven percent (and the resulting wage-loss benefits).

showed moderate diffuse soft-tissue edema around the right ankle but no focal abnormality. A functional-capacity evaluation, conducted on December 28, 2001, indicated that Key was capable of working a job that required no more than thirty minutes of prolonged standing and thirty minutes of prolonged sitting, with minimal lifting at waist level. On January 16, 2002, Dr. Keith Holder released Key to limited work hours with certain restrictions. However, Key did not return to work, and she was referred to Dr. Ackerman for further evaluation and treatment.

During her examination on March 17, 2002, Dr. Ackerman observed decreased flexion of Key's right ankle, tenderness, temperature changes between her lower extremities, and discoloration of both feet. Although these symptoms are consistent with RSD, Dr. Ackerman did not observe any muscle wasting, hypersensitivity to touch, or excessive sweating (hyperhidrosis), which are also common symptoms of RSD. Uncertain about the etiology of Key's symptoms, Dr. Ackerman ordered another EMG/NCE, with laser Doppler study. In the meantime, Dr. Ackerman diagnosed Key with neuritis, and he opined that her condition had been caused by either a "tarsal tunnel syndrome and/or a ligamentous injury." Indeed, in his October deposition, Dr. Ackerman agreed that Key's problems at the time of her March 17 examination were attributable to the tenosynovitis.

Key's laser Doppler test indicated that her sympathetic nervous system was intact and that she did not have RSD. Also, her nerve-conduction study was negative, and it indicated no abnormalities in her lower extremities and no evidence of radiculopathy or neuropathy.

In subsequent examinations, Key continued to present to Dr. Ackerman with varying—and sometimes inconsistent—symptoms. Dr. Ackerman explained this phenomenon was due to the fact that RSD is dynamic in nature and that its symptoms can vary from examination to examination. However, Dr. Ackerman also stated that variation of symptoms is also common with other neurological conditions, such as neuritis.

Dr. Ackerman eventually referred Key to Dr. Steven Kulik. On May 16, 2002, Dr. Kulik noted some swelling, tenderness, and limited ankle motion in Key's lower-right extremity. Dr. Kulik diagnosed Key with a right-peroneal tear, for which he administered a peroneal injection. On May 22, 2002, Dr. Ackerman agreed with Dr. Kulik that Key's symptoms were not caused by RSD. On July 19, 2002, Dr. Kulik performed a tenosynovectomy of the peroneal tendons of Key's lower-right extremity, with a grove deepening removal of extostosis from the distal posterolateral fibula.

After her surgery, Key sought follow-up treatment with Dr. Robert Thompson, who ordered additional x-rays. These films revealed a visible normal bone structure bilaterally with no evidence of radiculopathy or punctate changes that might be expected with RSD. Thereafter, Key returned to Dr. Ackerman on October 9, 2002. During that examination, Dr. Ackerman noted no difference in the temperature between Key's right and left legs (a symptom of RSD). Although Dr. Ackerman did note some swelling in both of Key's feet, he found no hypersensitivity, excessive sweating, discoloration, or hair changes—all consistent with RSD. However, Dr. Ackerman noted that Key demonstrated "global pain," which is

consistent with RSD. Ultimately, Dr. Ackerman—once again—diagnosed Key with neuritis, and he ordered another three-phase bone scan, which according to Key's medical record was never done.

On December 11, 2002, Dr. Kulik opined that Key had reached maximum-medical improvement, and he released her to return to a sedentary job with standing, walking, climbing, and lifting restrictions. In addition, Dr. Kulik assigned Key a fourteen-percent impairment rating to her lower extremity based on her surgically repaired torn peroneal tendon. Thereafter, Owen paid permanent-disability benefits based on this fourteen-percent rating.

Key returned to Dr. Ackerman on February 11, 2003, at which time he noted symmetrical temperature, but some swelling, discoloration, and excessive sweating bilaterally. Dr. Ackerman suspected that Key's neuritis had spread to her opposite extremity. He also noted that "RSD has been ruled out." In a later examination, Dr. Ackerman reported that Key displayed some sensitivity to touch but that there was no temperature difference between her extremities and no sweating. Dr. Ackerman recommended installation of a dorsal column stimulator, which Key refused. In subsequent examinations, Dr. Ackerman noted an absence of symptoms consistent with RSD, and following his examination of Key on January 14, 2004, he stated that he was unsure as to the proper diagnosis—neuritis or RSD.

On March 10, 2004, Dr. Ackerman opined that Key had reached the end of her healing

period and that she could return to sedentary work. On May 24, 2004, Dr. Ackerman assigned Key a seven-percent impairment rating to her body as a whole—based on the diagnosis of RSD.

After considering the evidence presented by Key, the Commission concluded that she had failed to prove by a preponderance of the evidence that she was entitled to a whole-body impairment rating of seven percent and wage loss in the amount of an additional seven percent over and above the seven percent whole-body impairment rating previously awarded. Specifically, the Commission found that the permanency of Key's condition was questionable; that a patient with neuritis would display many of the same symptoms as seen with RSD; that Key's obesity could have been the source of some of her symptoms; and that Key had not proven by objective criteria that she suffered a permanent disability. It is from this decision that Key appeals.

When reviewing decisions from the Commission, we view the evidence and all reasonable inferences deducible therefrom in the light most favorable to the findings of the Commission, and we must uphold those findings unless there is no substantial evidence to support them. *Rice v. Ga. Pac. Corp.*, 72 Ark. App. 148, 35 S.W.3d 328 (2000). In cases where a claim is denied because a claimant fails to show entitlement to compensation by a preponderance of the evidence, the substantial-evidence standard of review requires that we affirm if a substantial basis for the denial of relief is displayed by the Commission's opinion. *Id*.

A determination of the existence or extent of physical impairment must be supported by objective and measurable physical findings. *Kimbrell v. Ark. Dep't of Health*, 66 Ark. App. 245, 989 S.W.2d (1999). Objective findings are statutorily defined as "those findings [that] cannot come under the voluntary control of the patient." Ark. Code Ann. § 11-9-101(16) (Repl. 2002). The Commission cannot consider complaints of pain when determining physical or anatomical impairment. *Id*. The Commission has the authority and the duty to weigh medical evidence to determine its medical soundness and the authority to accept or reject medical evidence. *Mack v. Tyson Foods, Inc.*, 28 Ark. App. 299, 771 S.W.2d 794 (1989). Pursuant to Ark. Code Ann. § 11-9-522 (Repl. 2002), the Commission must adopt an impairment-rating guide to be used in the assessment of anatomical impairment, and the Commission has adopted the *American Medical Association Guides to the Evaluation of Permanent Impairment* (AMA Guides) to be used in this assessment. *See* Arkansas Workers' Compensation Commission Rule 34.

Further, the Commission is authorized to decide which portions of the medical evidence to credit and to translate this medical evidence into a finding of permanent impairment using the AMA Guides. *Avaya (Lucent Techs.) v. Bryant*, 82 Ark. App. 273, 105 S.W.3d 811 (2003). Physical impairments occur when an anatomical or physiological abnormality permanently limits the ability of the worker to effectively use part of the body or the body as a whole. In considering such claims, the Commission must first determine whether the evidence shows the presence of an abnormality that could reasonably be

expected to produce the permanent-physical impairment alleged by the injured worker. *Crow v. Weyerhaeuser Co.*, 46 Ark. App. 295, 880 S.W.2d 320 (1994).

Based on the review standards set forth above, we are satisfied that a substantial basis exists for the Commission's ultimate conclusion that Key failed to prove by a preponderance of the evidence that she was entitled to an additional whole-body impairment rating and wage-loss benefits Key's RSD diagnosis was questionable. Specifically, the evidence showed that a patient with neuritis would display many of the same symptoms as seen with RSD. Further, there was evidence presented that Key's obesity could have been the source of some of her symptoms. Finally, we agree with the Commission that Key failed to carry her burden in order to establish a valid wage-loss claim, based on the multiple references in the record to Key's ability to return to work.

This evidence, when viewed with all reasonable inferences deducible therefrom in the light most favorable to the findings of the Commission, is sufficient to support a conclusion that Key failed to carry her requisite burdens in establishing her entitlement to additional permanent-impairment and wage-loss benefits. Accordingly, the decision of the Commission is affirmed.

Affirmed.

HART and NEAL, JJ., agree