NOT DESIGNATED FOR PUBLICATION

ARKANSAS COURT OF APPEALS

DIVISION III
No. CA08-111

JANICE SWAFFORD APPELLANT V. POCAHONTAS PUBLIC SCHOOLS and Risk Management Resources APPELLEES	**Opinion Delivered** October 1, 2008 APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION [NO. F508325] REVERSED AND REMANDED

JOSEPHINE LINKER HART, Judge

Appellant, Janice Swafford, appeals from the Arkansas Workers' Compensation Commission's denial of benefits. The Commission found that appellant (1) failed to prove that she developed left carpal tunnel syndrome as a compensable consequence of her specific-incident right-arm injury; and (2) failed to prove that the right carpal tunnel release and ulnar nerve decompression were reasonable and necessary in connection with her specific right-arm injury. We reverse and remand.

Appellant injured her right arm at work on July 27, 2005, when her arm was pinned between a desk and a dolly she was using to move the desk. This injury was accepted as compensable. Appellant was diagnosed as having a right wrist and elbow contusion, was given a right wrist brace, and was placed on light duty with limited use of the hand. She continued working on light duty, using only her left hand, with her right arm in a wrist brace. Appellant, however, continued to have pain in her right arm. On October 11, 2005, she was seen by Dr.

Michael Moore, who sent her to be evaluated by Dr. Reginald Rutherford. Dr. Rutherford ordered testing, and an EMG/NCV report dated November 3, 2005, showed that she had bilateral carpal tunnel syndrome with mild changes on the right and moderate changes on the left. Dr. Rutherford also noted that appellant "also reports that by virtue of partial immobilization of her right hand she has been required to use her left hand more than normal with resultant numbness of her left hand." He also treated appellant for reflex sympathetic dystrophy (RSD) in her right hand.

On January 19, 2006, after concluding that her RSD had improved, Dr. Rutherford returned appellant to Dr. Moore for treatment of her left and right carpal tunnel syndrome, but he wrote that "[i]f surgery is considered I would recommend that this be limited to the left hand." On February 7, 2006, Dr. Moore spoke with appellant about treatment options, and appellant concluded that her left-hand symptoms did not warrant surgical treatment. On March 16, 2006, Dr. Rutherford ordered a functional capacity evaluation (FCE). On March 27, 2006, appellant underwent the FCE. According to the FCE report, appellant "put forth totally unreliable effort and demonstrate[d] inappropriate pain behaviors." On April 13, 2006, Dr. Rutherford wrote that appellant was at maximum medical improvement with no recommended workplace restriction and no recommended permanent partial impairment rating.

On April 21, 2006, appellant went to another physician, Dr. Rebecca Barrett-Tuck, who ordered an EMG/NCV. The May 10, 2006, EMG/NCV study by Dr. Demetrius Spanos indicated that appellant had moderately severe carpal tunnel syndrome of the right

upper extremity and entrapment of the ulnar nerve across the elbow. She returned to Dr. Barrett-Tuck on May 24, 2006, who recommended a right carpal tunnel release and right ulnar nerve decompression, with a left carpal tunnel release when she recovered from the right release.

On June 8, 2006, Dr. Moore opined that if appellant "does require right carpal tunnel surgery, it is my opinion her prognosis would be guarded," and that her "left carpal tunnel syndrome is not related to the injury [that] occurred to her right hand and arm." Dr. Moore referred her back to Dr. Rutherford. A June 8, 2006, EMG/NCV test by Dr. Rutherford showed "right carpal tunnel syndrome of mild degree." Dr. Rutherford wrote that this was "unchanged from prior study." He also stated that her ulnar nerve was normal and there was no evidence of cubital tunnel syndrome. He opined that "[p]resent study would favor continued conservative management referable to carpal tunnel syndrome."

Appellant was then evaluated by Dr. Randy R. Bindra on July 10, 2006, who injected her right carpal tunnel and fitted her with a splint. He noted that she had positive provocative tests for carpal tunnel syndrome, her cubital tunnel was normal, and her ulnar nerve was normally palpable at the elbow. He concluded that "[i]f the injection and splinting fail to resolve her symptoms then it would be clear that her symptoms are not arising from the carpal tunnel syndrome and she has a chronic pain problem in her right upper extremity which, without any definable cause, this has a poor prognosis and will not improve." He also noted that appellant had inconsistencies on her functional capacity evaluation and during his sensory examination of her. He stated that it was possible that she had a "functional overlay to her

symptoms" which was "common in patients who have chronic pain." Thus, he agreed with Dr. Moore that her prognosis was guarded because persons with chronic pain did not necessarily improve after surgery. She was again evaluated by Dr. Bindra on August 11, 2006, and appellant told him that her symptoms had not changed. He explained that it was unlikely she had carpal tunnel syndrome and that there was no surgical cure for her problems.

On August 24, 2006, appellant underwent right carpal tunnel release and right ulnar nerve decompression that was performed by Dr. Barrett-Tuck. The doctor's postoperative diagnosis was right carpal tunnel syndrome and right ulnar nerve entrapment. The doctor performed a left carpal tunnel release on September 7, 2006, with a postoperative diagnosis of left carpal tunnel syndrome.

At the hearing, appellant testified that after her July 27, 2005, injury, her right arm was in a wrist splint when she worked, and she worked only with her left hand. Her job duties required her to straighten desks, clean restrooms, sweep, dust, and use a dust mop. She testified that because of the strain of working only with her left hand, she had severe pain in her wrists going up to her elbow. She further testified that she did this at least four hours a day. She stated that she told Dr. Rutherford about her problem with her left hand, that it was severely bothering her and she could not perform some of her janitorial duties. She testified that she was pleased with the results from the surgery to her right arm, as she did not have very much pain and she had a better grip, whereas before the surgery she could not grip. She stated, however, that she was not 100%.

With regard to her left arm, the Commission found that appellant failed to prove by

a preponderance of the evidence that she developed left carpal tunnel syndrome as a compensable consequence of her specific-incident right-arm injury. The Commission concluded that "the record is devoid of any credible medical opinion establishing a causation between [appellant's] compensable right carpal tunnel syndrome from a specific incident injury and her subsequent development of left carpal tunnel syndrome." Further, the Commission wrote that while appellant "testified that she had to use her left arm more during her light duty assignments, this is insufficient evidence to arise to a preponderance of the evidence to find that the left carpal tunnel syndrome arose out of [appellant's] employment and not just the result of her physical make-up."

Appellant argues in part that the Commission misstated the law when it denied benefits based on appellant's failure to provide medical evidence on causation. We observe that if an injury is compensable, then every natural consequence of that injury is also compensable. *Air Compressor Equip. v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000). The basic test is whether there is a causal connection between the two episodes. *Id.* Objective medical evidence, however, is not essential to establish the causal relationship between the injury and work-related accident. *Wal-Mart Stores, Inc. v. VanWagner*, 337 Ark. 443, 990 S.W.2d 522 (1999).

In making its decision, the Commission did not follow our supreme court's statement in *VanWagner* that medical evidence is not essential to establish the causal relationship between the injury and work-related accident. Rather, the Commission found no evidence of causation because it concluded that appellant's testimony alone—unsupported by medical

evidence—could not constitute evidence of causation. Accordingly, we reverse and remand for the Commission to reconsider its decision in light of *VanWagner*.[1]

With regard to her right arm, the Commission concluded that appellant failed to prove by a preponderance of the evidence that the right carpal tunnel release and ulnar nerve decompression were reasonable and necessary in connection with her compensable injury.[2] The Commission wrote that Dr. Barrett-Tuck's "operative report does not disclose any findings of carpal tunnel syndrome or ulnar nerve entrapment." Further, while acknowledging that the record showed that appellant received adequate relief from the surgery, the Commission observed that "the finding of functional overlay by Dr. Bindra may account for this placebo[-]type relief." Appellant challenges on appeal the Commission's finding that appellant's right-arm surgery was not reasonable and necessary.

An employer must promptly provide for an injured employee such medical and surgical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a) (Supp. 2007). What constitutes reasonable and necessary treatment is a question of fact for the Commission. *Gansky v. Hi-Tech Eng'g*, 325

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[1]We note that Dr. Moore opined that her left carpal tunnel syndrome was not related to the injury that occurred to her right hand and arm. This opinion—whatever it meant—was not discussed or relied upon in the Commission's decision. It is the Commission's duty to use its expertise in translating evidence of medical experts into findings of fact. *Hill v. Baptist Medical Center*, 74 Ark. App. 250, 57 S.W.3d 735 (2001).

[2]While appellant did not appeal to the Commission or this court the ALJ's finding that the surgery was unauthorized, we must still determine whether the surgery was reasonably necessary for the purposes of determining whether appellant may seek temporary total disability benefits. *See Byars Const. Co. v. Byars*, 72 Ark. App. 158, 34 S.W.3d 797 (2000).

Ark. 163, 924 S.W.2d 790 (1996).

The Commission wrote that Dr. Barrett-Tuck's operative report does not disclose any findings of carpal tunnel syndrome or ulnar nerve entrapment. The report, however, offers both as the post-operative diagnosis. While the Commission weighs medical evidence, it may not arbitrarily disregard evidence. *Hill v. Baptist Medical Center*, 74 Ark. App. 250, 57 S.W.3d 735 (2001). Furthermore, while the Commission acknowledged that the record showed she received adequate relief from the surgery, it also noted that this was a placebo-type relief. There is no evidence, however, that her relief was a placebo-type relief. Post-surgical improvement is relevant in determining whether surgery is reasonably necessary. *Id*. Again, the Commission may not arbitrarily disregard evidence. Accordingly, we reverse and remand. *See id*. (reversing and remanding where the Commission arbitrarily ignored evidence of post-surgical improvement and disregarded evidence of a herniation).

Reversed and remanded.

GRIFFEN and HUNT, JJ., agree.