IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Union County and PCOMP, Petitioners	:	
v.	:	No. 600 C.D. 2013
	:	SUBMITTED: July 19, 2013
Workers' Compensation Appeal Board (Feaster), Respondent	:	

BEFORE: **HONORABLE BONNIE BRIGANCE LEADBETTER,** Judge
HONORABLE P. KEVIN BROBSON, Judge
HONORABLE JAMES GARDNER COLINS, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
JUDGE LEADBETTER **FILED: November 7, 2013**

Employer Union County petitions for review of the order of the Workers' Compensation Appeal Board (Board) affirming the grant of Dorothy Feaster's petition to review compensation benefits whereby the description of Feaster's work-injury was expanded to include "RSD of the left foot."[1] Employer argues on appeal that the Board erred in affirming the expanded description of Feaster's work injury because (1) the American Medical Association (AMA) and

[1] The Board also affirmed the Workers' Compensation Judge's denial of Employer's modification petition. Employer has not challenged that portion of the order on appeal.

the International Association for the Study of Pain (IASP) no longer recognize RSD as a valid diagnosis, and (2) Feaster does not satisfy either the AMA's or IASP's diagnostic criteria for complex regional pain syndrome I.[2] Discerning no error, we affirm.

Only a brief review of the underlying facts is necessary in order to address the arguments on appeal. Feaster sustained a work-related low back injury necessitating various medical treatment, including two back surgeries. The parties eventually stipulated to the injury as a "herniated disk at L5-SI, status post surgery X2," and "residual S1 radiculopathy." Due to subsequent symptoms in her left foot, Feaster filed a petition seeking to expand the description of her injury to include, *inter alia*, RSD in that appendage. Employer denied that she suffered from the condition and the matter was litigated before a workers' compensation judge (WCJ).

---

[2] According to WebMD:

> Reflex sympathetic dystrophy syndrome (RSDS), also known as complex regional pain syndrome, is a rare disorder of the sympathetic nervous system that is characterized by chronic, severe pain. The sympathetic nervous system is that part of the autonomic nervous system that regulates involuntary functions of the body such as increasing heart rate, constricting blood vessels, and increasing blood pressure. Excessive or abnormal responses of portions of the sympathetic nervous system are thought to be responsible for the pain associated with [RSDS].

WebMD at http://www.webmd.com/brain/reflex-sympathetic-dystrophy-syndrome. The online medical resource also discusses complex regional pain syndrome (CRPS), stating in part:

> [CRPS], also called [RSDS], is a chronic pain condition in which high levels of nerve impulses are sent to an affected site. Experts believe that CRPS occurs as a result of dysfunction in the central or peripheral nervous systems.

Id. at http://webmd.com/pain-management/guide/complex-regional-pain-syndrome.

In support of her petition, Feaster presented the deposition testimony of her treating family physician, Domenick Ronco, D.O. Dr. Ronco testified, in pertinent part, that he is familiar with RSD or complex regional pain syndrome and he has diagnosed and treated numerous patients with the condition. After reviewing her medical history following the work injury, her current symptoms and treatment, as well as notes from a consulting neurologist, Dr. Ronco opined that Feaster suffered from RSD. He noted that his diagnosis was consistent with the diagnoses of a former physician in his office who treated Feaster as well as the consulting neurologist. Dr. Ronco specifically noted that RSD is another name for complex regional pain syndrome. Importantly, the doctor opined that Feaster's negative bone scan and EMG study, the latter which suggested possible early polyneuropathy, did not alter his opinion that Feaster suffered from RSD. He further stated that a positive bone scan, specific findings on an EMG, and hair and nail changes are not required for a diagnosis of RSD. On cross-examination, Dr. Ronco indicated that he was not familiar with the AMA criteria for a diagnosis of RSD or complex regional pain syndrome.[3]

In opposition, Employer presented the deposition testimony of Alan VanSant, M.D., a physician specializing in physical medicine and rehabilitation, who performed an independent medical exam on Feaster. Dr. VanSant opined that Feaster did not suffer from RSD or chronic regional pain syndrome because he saw no objective evidence of the condition when he examined her nor when he reviewed her diagnostic tests. Rather, Dr. VanSant attributed Feaster's symptoms to residual S1 radiculopathy. In response to counsel's question regarding whether

[3] Employer's counsel was apparently referring to criteria set forth in the AMA "Guides to the Evaluation of Permanent Impairment."

he was familiar with any of the organizations establishing diagnostic criteria for RSD or chronic regional pain syndrome, the doctor replied that: "[T]he diagnostic findings and the thinking on CRPS has evolved over the years [and that] he [relies] on the American Medical Association Guide to Impairment, Sixth Edition, which lists - - - you need certain subjective complaints, which she has, but then you need the objective findings which she does not have." Deposition of Alan VanSant, M.D. at 30.

Based upon Dr. Ronco's testimony, which the WCJ found credible, the WCJ found that Feaster suffers from work-related RSD. Accordingly, the WCJ granted Feaster's petition and expanded the description of her injury to include RSD of the left foot. The Board affirmed and this appeal followed.

On appeal, Employer argues that it was error to expand Feaster's injury to include RSD because that condition is no longer accepted as a valid diagnosis. Employer contends that the medical profession had become skeptical of the diagnosis of RSD because it was overused and lacked specific diagnostic criteria. According to Employer, the AMA and IASP have abandoned RSD as a condition or diagnosis in favor of complex regional pain syndrome, types I and II, and have tightened the criteria necessary for diagnosis. Employer suggests that Dr. Ronco's diagnosis of RSD is incompetent because it no longer has general acceptance in the medical field, and that contrary to Dr. Ronco's belief, RSD is not another name for chronic regional pain syndrome. In making this argument, Employer refers to the "general acceptance" test for novel scientific evidence first

set forth in *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).[4] This argument lacks merit.

First, the record is completely devoid of any evidence, let alone competent, credited evidence, that RSD is no longer a valid diagnosis. Dr. VanSant certainly did not testify that RSD is no longer recognized by the general medical community, only that the thinking on chronic regional pain syndrome has evolved and he personally refers to the criteria set forth in the American Medical Association Guide to Impairment, Sixth Edition. Moreover, there is ample evidence in the record that the doctors in Feaster's immediate medical community, including a consulting neurologist, view RSD as a valid diagnosis and continue to diagnose patients with the condition; the WCJ obviously credited this evidence.[5]

---

[4] We note generally that the test or standard set forth in *Frye* is applied in Pennsylvania. *See Grady v. Frito-Lay, Inc.*, 576 Pa. 546, 556-57, 839 A.2d 1038, 1044-45 (2003).

[5] Employer cited to the AMA and IASP as authority for its contention that the medical community became skeptical of RSD as a diagnosis and no longer recognizes it. Although Section 306(a.2) of the Workers' Compensation Act, Act of June 2, 1915, P.L. 736, added by the Act of June 24, 1996, P.L. 350, *as amended*, 77 P.S. § 511.2, directs that the AMA's "Guides to the Evaluation of Permanent Impairment" shall be used in determining a claimant's degree of impairment due to a compensable injury, we are aware of no authority which declares the AMA the final, controlling authority in the diagnosis of medical conditions and the practice of medicine. Indeed, according to its website, the AMA is a dues-based voluntary organization comprised of physicians, residents and medical students. Membership benefits include: "Build your knowledge and keep it current. Full access to AMA publications . . . Share your perspective and make a difference. . . . Gain expert support to help you with your practice and your career. Enjoy special savings on insurance, financial services, medical supplies, travel and more." Further, the organization describes its physician resources as follows: "From billing and reimbursement resources to guides for advancing your career; from patient education materials to clinical practice standards. What you need to know—all in one place." *See generally* http://www.ama-assn.org. Employer's brief even acknowledges that other medical organizations, such as the IASP, have developed their own criteria to aid in diagnosing specific medical conditions.

Second, the *Frye* standard is not relevant in this context. As our Supreme Court noted in *Grady v. Frito-Lay, Inc.*: "The *Frye* test . . . is part of [Pennsylvania Rule of Evidence 702 and under *Frye*,] novel scientific evidence is admissible if the methodology that underlies the evidence has general acceptance in the relevant scientific community." 576 Pa. at 555, 839 A.2d at 1043-44. Thus, the proponent of scientific evidence must demonstrate that the "methodology an expert used is generally accepted by scientists in the relevant field as a method for arriving at the conclusion the expert will testify to at trial." *Id.* at 558, 839 A.2d at 1045. Moreover, the proponent of the evidence is not required to prove that the scientific community has also generally accepted the expert's conclusions. *Id.* Here, not only is novel scientific evidence not involved, but the methodology employed for diagnosis is not novel either. *E.g., Tucker v. Comm. Med. Ctr.*, 833 A.2d 217, 223-24 (Pa. Super. 2003). Both medical experts used a common approach to diagnose the condition in Feaster's foot: physical exam, review of medical records, including reports of other physicians, and personal training and experience. Dr. Ronco's failure to use diagnostic criteria advocated by either the AMA or IASP goes to the weight and credibility of his opinion, not its competency.

Based upon our conclusion above, we need give little discussion to Employer's second argument, that Feaster's failure to satisfy the AMA's diagnostic criteria for complex regional pain syndrome precludes the diagnosis from being included in the description of the work injury. As already stated, this is a consideration for the WCJ in deciding the weight and credibility of the competing medical testimony. Similarly, we reject Employer's various contentions attempting to undermine Dr. Ronco's opinion as these are factors that also address

the weight and credibility of his opinion. It is well settled that the WCJ is the ultimate fact-finder in workers' compensation proceedings and has exclusive authority over the weight and credibility of evidence; this includes the power to accept or reject the testimony of any witness, including physicians, in whole or in part. *Channellock, Inc. v. Workers' Comp. Appeal Bd. (Reynolds)*, 72 A.3d 731, 741 (Pa. Cmwlth. 2013). The WCJ's findings are binding on appeal when supported by substantial evidence of record. *Id.* The WCJ's finding that Feaster's injury included RSD is supported by substantial, competent and credited evidence of record. Accordingly, the finding is binding. The Board did not err in affirming the WCJ's decision and order.

Accordingly, we affirm.

BONNIE BRIGANCE LEADBETTER,
Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Union County and PCOMP, Petitioners	:	
v.	:	No. 600 C.D. 2013
Workers' Compensation Appeal Board (Feaster), Respondent	:	

O R D E R

AND NOW, this 7th day of November, 2013, the order of the Workers' Compensation Appeal Board in the above-captioned matter is hereby affirmed.

BONNIE BRIGANCE LEADBETTER,
Judge