

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F604014 (06/03/05)

CHARLES CALLAHAN, EMPLOYEE	CLAIMANT
SHERWIN WILLIAMS CO., SELF-INSURED EMPLOYER	RESPONDENT #1
GALLAGHER BASSETT SERVICES, TPA	RESPONDENT #1
SECOND INJURY FUND	RESPONDENT #2
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT #3

OPINION FILED AUGUST 11, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on May 16, 2008, at Jonesboro, Craighead County, Arkansas.

Claimant represented by the HONORABLE PHILLIP WELLS, Attorney at Law, Jonesboro, Arkansas.

Respondent #1 represented by the HONORABLE WILLIAM C. FRYE, Attorney at Law, North Little Rock, Arkansas.

Respondent #2 represented by the HONORABLE DAVID L. PAKE, Attorney at Law, Little Rock, Arkansas.

Respondent #3 represented by the HONORABLE CHRISTY L. KING, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above styled claim to determine the claimant's entitlement to additional workers' compensation benefits. On February 19, 2008, a pre-hearing conference was conducted in this claim, from which a Pre-Hearing of the same date was filed.

The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties contentions relative to the afore. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Charles Callahan- the claimant, and Heather Taylor, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Charles W. Callahan, the claimant, with a date of birth of January 30, 1951, is a high school graduated, whose only post-secondary training has consisted of that provided by respondent-employer. The claimant's work history following high school consisted of work in the building industry/retail outlets.

In describing the specifics of his job in the building industry, claimant's testimony reflects:

Providing materials to the job site, making estimates as far as what it would take to do the jobs, like being an estimator, delivering the items t the job site. (T. 10).

Claimant testified that the afore was a physically demanding job. The claimant was also employed at Firestone Tire for a period of time. The testimony reflects that the claimant was employed at Yale Industrial Products, a manufacturer of hoists. Claimant described the Yale Industrial Products job as one of an expedite of parts, which entailed a lot of walking and running but very little lifting or carrying. Claimant did not deem the Yale Industrial Products job as one of manual labor type job. Claimant also worked at Airatherm Manufacturing Company.

The claimant was employed by respondent-employer for twenty-six (26) years. The testimony of the claimant reflects, regarding his employment by respondent #1:

I was hired on originally as a assistant manager in Forrest City, Arkansas. I worked in that position for less than a year and was promoted to a store manager. I worked there for several years and transferred to Paragould, Arkansas, we build a new store there and I ran that store for approximately twelve years and then my position moved to Jonesboro, Arkansas as Customer Service and I was there for three years prior to my injury. (T. 10-11).

The claimant explained that as a store manager he performed the physical activities of loading and unloading trucks, loading the customer's products, mixing paint, delivering paint. Claimant added that being a store manager in a two-person store everyone worked hard. In addition to his supervisory responsibilities, claimant explained that he still had to be on the floor and do the majority of the transactions. The testimony of the claimant reflects that for 23 years he had jobs as store managers for respondent #1.

In describing his job as a customer service representative in Jonesboro, a position he held for three years prior to his compensable injury of June 3, 2005, the testimony of the claimant reflects:

Basically, the same physical activities where you have the customers tell you what they need, you mix the paint, you unloaded the trucks, you stocked shelves, wheeled the paint, that sort of thing. (T. 12).

The testimony of the claimant reflects that prior to the end of 2005, he had other health problems. The claimant has had hypertension since his late teens , age 18/19, which was controlled by medication. Claimant's testimony reflects that he has been on high blood pressure medication off and on for the last forty years. Claimant denies that his high blood pressure affected his work activity in any way. Claimant has been diagnosed with having diabetes for seven to eight years, for which he has a insulin injection regiment that he follows at home. Claimant maintains that his diagnosed diabetes has never impeded his work activities.

The claimant has in the past had stents put in his heart. Claimant testified that prior to the surgical placement of the stents he suffered from shortness of breath, lack of energy, and some chest pain. Claimant underwent the operation to implant the stents in December 2004.

Following the afore procedure, claimant testified, regarding the improvement in his quality of life:

Oh, there is a drastic improvement as far as durability, being able to go, I have more energy, my breath was fine, I no longer had chest pains, so I no longer had chest pain, so it correct that problem. I've had no followup care since then. (T. 14-15).

The claimant has a foot neuroma that required surgery by a pediatricist, Dr. Haughey. Regarding the effects of the neuroma, claimant testified that there was pain in the bottom of his foot, which slowed him down, in that he could not walk as fast as he once could. Claimant estimates that he surgical procedure was performed 6 to 8 years ago. Following the procedure, claimant testified that he had a total recovery and he no longer hurt when he walked, and his work activities were not effected.

The claimant testified that approximately six to eight years ago he was diagnosed with macular degeneration, which effects his central vision in his right eye. Claimant added that he has a wet and a dry in the left eye, however no impairment. The testimony of the claimant reflects, regarding treatment of her right eye:

I was given eye caps, it a vitamin, they tried a laser that sealed the leaking vessels off and that's what stopped that. (T. 16).

Claimant testified that he has "a little loss of central vision in the right eye". The testimony of the claimant reflects that while he wears glasses to read, he otherwise has pretty good vision. Claimant does not wear glasses to drive. Claimant maintains that he is unaware of his vision

problem affecting his ability to get a job. Claimant acknowledged that his problem with his knee and legs have resulted in “a little soreness”.

Claimant maintains that in considering all of his physical/medical problems prior to June 2005, they did not impair his ability to perform his work at respondent #1 prior to his June 3, 2005, injury. Claimant attributes any missed time from work relative to the above conditions as the product of a doctor’s appointment/visit but not for any extended period. Claimant stressed the none of the conditions prevented him from doing his job.

In describing the June 3,2005, injury in the employment for respondent #1, claimant testified:

My back starting hurting, due to some lifting and I don’t remember the exact time, or date, but made mention to a fellow worker that my back was hurting and it progressively got worse. (T. 18).

The claimant eventually under went surgery under the care of Dr. Ricca, a Jonesboro neurosurgeon, relative to his back injury. Claimant was released to return to work by Dr. Ricca in November 2006.

Claimant testified that following his release by Dr. Ricca he attempted to return to work for respondent #1:

Well, we discussed it and I was going to try to go back under a self imposed light duty, but we got approval through our division district, in Texas, Dallas. And, I was at work about an hour, and I call from Mike Cleveland, from Human Resources and they told me to go home, that they didn’t have any light duty. (T. 19-20).

As a consequence of the afore, the claimant went home.

Claimant testified that he has cooperated with the vocational specialist in an effort to find some kind of work that he could do. The testimony of the claimant reflects, regarding his actions

upon being furnished with the identity of job leads or potential employer:

I called, if it required reference from the employment security division, which most of these jobs do, I would call and talk to one or, I don't know what the term is, but we went over that and they would reference me to the job where I could go out and fill out an application or interview. (T. 20-21).

The claimant also contacted employers directly if the job did not require going through the Employment Security Division. Claimant's testimony reflects that to the best of his ability, he contacted every one of the perspective employers, whose identity was furnished to him, to see if they had a job that he could try. Claimant noted, regarding his efforts:

I filled out the applications and I had a couple of very informal Interviews and that's as far as it got. (T. 21).

Claimant's testimony reflects that nobody would hire him.

Claimant acknowledged undergoing a functional capacity evaluation. Claimant testified regarding the problems, from a physical standpoint, he has had with his back since being released by Dr. Ricca:

Well, it hurts. I am in constant pain. I have to move around, I can't stay in one position very long. If I walk sometimes if you just stub your toe, it just sends a sharp pain and it takes a couple of hours to ease back down to the normal pain. Lifting is the same way. Sometimes it doesn't hurt anymore, but sometimes it, maybe it's the wrong way that I twist, or something, but it hurts. And, it causes pain that I wouldn't want to be in front of customers, or client with, trying to perform my job doing that. (T. 22).

The testimony of the claimant reflects that the pain starts in the lower part of his back and goes down into his right hip for a short distance. Claimant's testimony reflects that the most he can sit before having to stand or change position is fifteen or twenty minutes. Claimant estimates during an average day he has to recline to take the pressure off his back:

About three, or four times a day, I'll lay in the floor, or on a hard surface. Sometimes, I can't use a recliner chair. (T. 23).

Claimant added that the duration of the laying in the floor to achieve pain relief range from ten to twenty minutes at a time.

In describing an average day since his November 2006, medical release, the testimony of the claimant reflects:

Well, I get up, six, or six thirty in the morning, I get dressed and depending on the weather, I try to walk a little bit to limber up, or loosen up. I visit with my neighbors. Sometimes I can fold clothes, sometimes I do a little dusting for my wife. And, then we progress through the day just like that. I have to take breaks and change positions. I can't stay in one position very long. (T. 24).

Claimant testified that he does not do any yard work. In elaborating of his lifting difficulties, the testimony of the claimant reflects:

I don't know. Back in March, I lifted underwear off the bathroom floor and it took a couple of weeks before the pain subsided. So, it's just now, I couldn't tell you how much I could lift without pain, or without hurting. (T. 24).

Claimant testified regarding his inability to perform a sedentary type job:

Just being sedentary, I would have to be able to move from one place to another. And, I really don't know how to explain it, other than the fact that if I'm in one position for very long, it starts a sharp pain and I have to move, I have to either walk around a little bit, or stretch out, do something to kind of take the pressure off my back. (T. 25).

Claimant's testimony reflects that as a result of his continuing back problems he had difficulty sleeping at night:

I go to bed and usually within two, or two and a half hours after I go to bed, I am awoken by either rolling over and the pain will wake me up. I'll move from one bed, to another, we have a harder bed in the spare room that I go to, or a stiff back chair, or sometimes I'll end up on the floor.

I just move from one position to another. (T. 25).

Claimant noted that the afore happens every night without medication, and results in him being tired the next day.

The claimant testified that he takes prescription pain medication in the form of Darvocet as well as the over-the-counter pain Aleve. Claimant noted that he does not take any medicine on a regular basis:

Occasionally. I don't like to take a lot of pain medication, it inhibits me fro doing a lot of other things, you can't drive, you can't, it makes you drowsy and some of it constipation. No, I don't want to get hooked on prescription pain killers. (T. 26).

The testimony of the claimant reflects that the only hobby activity he has engaged in is two (2) hours of fishing this year. Claimant is of the opinion that over the past six (6) months his condition regarding his low back has not improved, but rather stayed the same.

Claimant acknowledged that a the end of January 2007, he was diagnosed with colon cancer, for which he has undergone a treatment regiment of chemotherapy. Exploratory surgery was performed in January 2007 to determine if removal of any of the tumors could be performed and it was found that none could. The medical indicates that the claimant's condition was identified as a stage four level. At the time of the hearing claimant noted that the cancer is actually better and that the prognosis is excellent. The claimant's testimony reflects:

I had a pet scan about four weeks ago and talked to us, he called us three weeks ago and that's when he determined that we have actually seen some upper level tumors that are gone. There is no growth, there is nothing in the liver, or limp nodes, that has spread, so the chemotherapy, while it's not gotten rid of everything, it's kept everything in check. (T. 28).

The claimant has applied for and is receiving Social Security Disability. Claimant

maintains that it is his intention to continue to look for work. The claimant testified regarding his concern about his ability to work over as sustained period of time:

Well, if I go to work for someone, I've always been independent. I've always paid my way. And, I would hate to go to work, but I would try a job, but would hate to go to work knowing that I could not be an asset to the people that hired me. I guess it would be an embarrassment for me to talk my way into a job, knowing that I wasn't going to be able to perform that job day in and day out. (T. 29).

Claimant attributes his cancer to a very small role in his inability to perform work activities.

During cross-examination, the claimant testified other than the time required for chemotherapy treatments and resting, the cancer caused very few problems as far as working. Claimant has chemotherapy every other week; going for four and one-half hours the first day and wearing an infusion pump for forty-six (46) hours, at which time it is removed. Claimant estimates that he would miss two to two and a half days for work every other week, working seven to ten day over a two week period. The testimony of the claimant reflects that the chemotherapy will continue for the foreseeable future. The claimant testified that the side effects of the chemotherapy are nausea and fatigue. The testimony of the claimant reflects that he had chemotherapy on Monday, and that as of the Friday hearing he felt fine.

Claimant acknowledged that one of the physicians he was following his injury of June 2005, was Dr. Gera. Claimant confirmed that in an October 25, 2005, he relayed a history to Dr. Gera of pain for the last year which started in one leg and goes down both legs, with a dull, aching and burning sensation. (T. 42). Claimant acknowledged that one of the diagnoses that Dr. Gera though he had was diabetic neuropathy in his legs.

Following the back surgery under the care of Dr. Ricca, the claimant testified regarding

his symptoms:

It still hurt. There were day where it hurt as badly as before the surgery and there were other days that it didn't. (T. 43-44).

Claimant acknowledged that in an April 12, 2006, report, that Dr. Ricca relayed that he thought that the claimant's insulin dependent diabetes was a significant risk for neuropathic pain and probably one of the causes for neuropathic pain. (T. 44).

Claimant testified that at the time he applied for work at the various places he does not believe that the cancer ever came up. Claimant acknowledged that prior to June 2005, he had a sore back occasionally. Claimant concedes that he had gone to a chiropractor off and on. A 2004 entry in the records of the chiropractor reflects that the claimant complained of his right hip hurting. While acknowledging back pain for about twenty (20) years, claimant added that the same was not consistent, but occasional and bought on by exertion and activities. Claimant concedes that he now has pain with exertion on his hip and back.

Claimant acknowledged that he has macular degeneration in both eyes, with the right eye being worse than the left eye. The testimony of the claimant reflects that the symptoms of watering and hazy in the right eye have been consistent throughout the last seven to eight years. In describing the impact of the symptoms on the central vision of the right eye, claimant explained:

Okay. If, I close my left eye and look you right in the face, I can see the perimeter of your face and shoulders, but maybe couldn't make out your facial features. (T. 33-34).

Claimant testified regarding his coping mechanism with respect to his right eye:

You adapt to it, because your peripheral vision is fine and you just have to tilt your head or, something and the left eye will actually take over and you won't even notice the blur. (T. 34).

Claimant's testimony reflects that if his blood sugar gets out of control and very high it causes blurriness of vision. Claimant noted that eating sweets and fried foods causes his blood sugar to be very high.

The testimony of the claimant reflects that at the time his cardiac difficulty was diagnosed he relayed symptoms of increased fatigue, dizziness and visual disturbance. Claimant underwent the EKG in August 2004. In December 2004, claimant underwent the placement of stents due to blockage in his heart. Claimant noted that the morning following the afore procedure there was a drastic improvement in his symptoms. Claimant concedes that during a February 2005, visit to the cardiologist he relayed that he was still having shortness of breath with exertion, however the fatigue was better. Claimant testified that hard work, get shortness of breath.

The testimony of the claimant reflects that when he returned to his eye doctor in November 2004, there was a cataract over the right eye which caused him to have a translucent blur. Dr. Landry performed the claimant's cataract surgery. Claimant acknowledged that he could not read very well due to the vision difficulty.

In January 2005, claimant was taking Lotrell for his blood pressure, Plavic for his heart, Bytorn and Metatopral as well as insulin for his diabetes and baby aspirin for his heart. Of the

afore medications, claimant testified that he is presently only taking Lowetal and insulin.

The testimony of the claimant reflects that following his June 3, 2005, injury he returned to his eye doctor and that the vision in his right eye was worse. Claimant acknowledged that in August 2006, he was relaying that he could not see well enough to read a newspaper. Claimant maintains that the afore is not the case presently. Claimant testified that he went to the eye doctor to get new glasses a few months earlier. Regarding the present status of the macular degeneration, the testimony of the claimant reflects:

It actually has improved with the medication and the chemo. It a medicine called Labastin, that they market under a different name, and they have injected into people with severe macular degeneration. Because, I was taking it and the chemo actually improved my vision. (T. 40).

Claimant testified that he does not remember having problems which would cause him to return to his cardiologist on December 6, 2005. Claimant attributes the afore visit to a six-month followup. Claimant testified that he was not aware that his heart was functioning at 55%.

Claimant acknowledged that Dr. Haughey noted the he was having pain in both legs for about a year, which was period to the June 2005, work-related injury. The testimony of the claimant reflects that when the neuroma was removed from his foot he was not told that it was related to his diabetes.

The claimant disputes that the functional capacity evaluation is an accurate assessment of his physical capabilities, explaining:

No, sir. I did that on a one time basis. I don't think I could consistency or constantly perform those functions. (T. 46).

The testimony of the claimant reflects that he based his restrictions on how he felt and what he felt he could perform physically. Claimant concedes that there a quite a few jobs that he could

possibly do, “if you based it on a two hour test”, the FCE.

The claimant testified that he requested that Dr. Ricca send him for the FCE because he wanted to return to work respondent #1. Claimant added that he thought that maybe the company would allow him to return work, but it did not.

The testimony of the claimant reflects that in applying for Social Security Disability benefits, he listed everything that was wrong, to included his diabetes, his heart complaint, and macular degeneration, but noted that the back was the primary reason.

The claimant testified regarding his job with respondent #1 that he did management, daily operations, maintaining inventory, paper work, some of which was done on computer.

Regarding the computer work, the claimant’s testimony reflects:

Sherwin Williams computers you could say were job specific, if I wanted to look up a customers name, I could just pit in two letters and it would bring up the customer list. Inventory was done by scanning systems where you didn’t have to read the numbers. (T. 49).

Claimant acknowledged having some skills in customer services, as reflected in the report of the vocational rehabilitation report, as well as retail management, supervision, and inventory control. Claimant disputes that he would be an excellent candidate for a job at a home improvement store in the paint department, explaining:

No, sir. Not because of the constant movement, twisting, bending, sometimes weight has nothing to do with the pain, it’s just the way that I move. And, different things, I don’t feel like I could put in an honest eight hour day. (T. 52).

Regarding the functional capacity evaluation, claimant credibly testified:

I understand. But, on a day by day basis, I don’t feel like I can perform those functions constantly. (T. 52).

The claimant continues to attribute his inability to perform the jobs identified to the residual of his back injury, rather than the chemotherapy that he is undergoing. (T. 53).

The vocational rehabilitation counselor did not recommend any delivery jobs because of the claimant's vision. Claimant's testimony reflects that he drives everyday and that he had no problem with his vision as far as driving. Claimant concedes that he informed the vocational rehabilitation consultant that he tries to limit his driving to areas that he is familiar at night.

Claimant acknowledged being provided with information by Ms. Taylor, the vocational rehabilitation consultant, about some free computer classes. Claimant added, however:

The computer skills that I lack are keyboarding. Typing, I believe there was a vocational school in Walnut Ridge that had some computer training, but there again I would need more typing skills than I would computer skills. (T. 53-54).

Claimant denies that fact that he has the problem with his right eye causes him some problem with typing, adding that he just never had the ability to type. Claimant concedes that he responded that his vision would present a problem to him driving to Walnut Ridge to check into the training regarding computer skills. Claimant elaborated regarding the afore:

I should have elaborated more on that statement. The driving it hurts, going you know, I don't care to drive for long distances. But, as far as seeing, I can see pretty well. (T. 55).

During further cross-examination, the claimant acknowledged that there were a number of pre-existing condition that he experienced prior to the June 3, 2005, compensable injury, however except for doctors' visits and the two (2) week period following the placement of the heart stents he has worked full duties for respondent #1. Claimant denies that he was treated as handicapped worker by respondent #1 during his employment with same. Claimant's testimony

also reflects that supervisory personnel of respondent #1 was aware of his diabetes, macular degeneration as well as his occasional visits to the chiropractor for back pain. The testimony of the claimant also reflects that respondent #1 was aware of the nerve surgery he had on both his feet.

The testimony of the claimant reflects that even with the above pre-existing conditions he was able to perform his full duties in the employment of respondent #1. The claimant's testimony reflects that his regular job duties entailed lifting paint cans that weighed as much as 95 lbs, as well as bending, twisting, stooping, and squatting. The testimony of the claimant also reflects that on occasions, during his employment with respondent #1, he delivered paint to job sites, factories or where ever the customer required it.

Claimant continues to possess an unrestricted drivers' license. Accordingly, the claimant was able to drive a vehicle, load and unload paint where needed prior to the June 3, 2005, compensable injury. Claimant was not provided an anatomical impairment rating for any of his pre-existing conditions by a physician prior to June 3, 2005, or since. Likewise, claimant's testimony reflects that he had not been provided with any permanent physical restrictions by a physician relative to his pre-existing conditions prior to the June 3, 2005, compensable injury or since.

The claimant's testimony reflects that the rating provided by Dr. Ricca is solely for the two level fusion in the low back relative to the June 3, 2005, compensable injury. Dr. Ricca has assessed a 17% impairment rating, however respondent #1 has accepted a 13% impairment. Claimant testified that he is uncertain if the 13% impairment rating has been paid.

In describing the results he achieved from the two level lumbar fusion, claimant testified

that it did not make his life any better. Claimant attributes the source of his present pain to the site of the injury and surgery in the treatment of same. Claimant provided a reliable effort during the functional capacity evaluation. Claimant testified that the functional capacity evaluation was focus on her activity abilities relative to his low back. The testimony of the claimant reflects that he has not been placed under any physical restrictions by his heart doctor relative to the stents placement.

Claimant is of the opinion that if he was able to find an employer that would allow him to work four (4) ten-hour days, his chemotherapy treatment would not present a problem to him returning to work. The testimony of the claimant reflects that the two-level lumbar fusion and residuals therefrom would prevent him from working a four(4) day ten-hour work week.

Claimant's testimony reflects that the first time he heard of the diagnosis of diabetic neuropathy was from Dr. Gera, which was after the June 3, 2005, compensable back injury. The claimant testified that it is his understanding that the EMG study performed by Dr. Chan at the request of Dr. Gera ruled out the presence of neuropathy.

Claimant confirmed that although he had a number of pre-existing conditions he never applied for Social Security Disability prior to the June 3, 2005, compensable back injury because they were not preventing him from working. Claimant asserts that as far as he knows he is receiving Social Security Disability benefits based on his low back condition alone.

Claimant assesses the type to work he performed during his twenty-six year work history with respondent #1 as physically heavy type work. Claimant estimates that in the twenty years preceding his June 3, 2005, compensable back injury he went to the chiropractor less than ten (10) times. Claimant noted that his chiropractic treatment was not a regular thing or occurrence.

The testimony of the claimant reflects that the chiropractic treatment accomplished the purpose of the visit. Claimant's testimony reflects that prior to the June 3, 2005, compensable back injury he had not undergone diagnostic test on his back in the form of a CT scan, MRI scan, or mylogram.

The testimony of the claimant reflects that following the June 3, 2005, injury he went to a chiropractor before going to a specialist. The claimant was referred by the chiropractor to a medical specialist. Claimant had never been referred by the chiropractor to a medical doctor during past visits prior to June 3, 2005.

Claimant asserts that neither his general eyesight or any of his other pre-existing conditions prevented him from performing his job duties with respondent #1 prior to the June 3, 2005, compensable back injury. The claimant re-affirmed the answers to the interrogatories as being accurate to the best of his knowledge.

Claimant denied that he chose to retire from his employment with respondent #1. When questioned regarding whether he had a choice of going on long term disability or retirement claimant respondent:

Sherwin Williams didn't give me a choice

I retired. January the 31st of 07.

We have what you call a pension investment program where I bought stock and I just rolled that over into a investment and I've not touched any of that money right now. (T. 71-72).

With respect to the testimony of Rita Callahan, the claimant's wife, the parties stipulated that called as a witness that her testimony would corroborate that of the claimant.

During the course of his May 7, 2008, deposition, claimant described his change in job

position in 2003 from store manager to customer service specialist as a demotion as well as a reduction in earnings, however it was at his request. Claimant explained:

I just didn't really want the responsibility of manager, of store manager, but I still wanted to sell paint. (R2,X1, p. 8).

During the deposition claimant attributed his permanent total disability status to June 3, 2005, compensable injury in the employment of respondent #1. Claimant testified that he was aware of his health problems/conditions - - high blood pressure, diabetes, the placement of stents in his heart, macular degeneration - - prior to his compensable injury, however they did not prevent him from performing his regular job duties.

Claimant noted that he was released to light duty work by Dr. Ricca, however after reporting to respondent #1 and working for a period of one hour in accordance with the light duty release he was contacted by supervisory personnel of respondent from Cleveland and directed to go home. Claimant testified that he was told that it would set a bad precedent if he was allowed to come back and work at light duty. (R2,X1, p. 13).

Claimant maintains that at the time he was released as having reached maximum medical improvement he was told by his doctor, Dr. Ricca, that he was permanently disabled. In addition to providing him a rating of 17%, claimant maintains that Dr. Ricca, his treating neurosurgeon, told him that he would never be able to do the work that he had previously done.

In explaining the September 2006, release by Dr. Ricca to return to light duty work, the testimony of the claimant reflects that he requested the release. Claimant added that the light duty release was approved through his local store manager, the district manager and through the Dallas division, however it was later vetoed by the Cleveland office. Claimant conceded that the

diabetes may impede his healing.

During the May 2008, deposition, claimant testified that he had followed up on the jobs identified by Ms. Taylor, a vocational rehabilitation counselor. Claimant noted that most of them are referred through the Paragould Employment Security Division. Claimant's testimony reflects that he telephoned the afore to get a reference. Claimant added that they, the local ESD, had a listing or a copy of his impairment and qualifications. Claimant testified that several of the prospective employers informed him that he was not qualified to do what the employer required. Claimant also acknowledged at the time of the May 7, 2008, deposition that he had compiled a list of employers and the results of his contacts with them.

The testimony of the claimant reflects that he cited the necessity of driving and his vision as considerations for his lack of interest in receiving training in computer skills, along with the fact that he could not type. (R2X1, p.17). Claimant conceded the vision difficulty brought on by the macular degeneration adversely affects his driving and use of computer. (R2X1, p. 17-18).

Claimant denied that his chemotherapy treatment relative to his stage four colon cancer made him unable to perform any job functions. Claimant concedes it would be difficult to find an employer to suit his need to be off work for several days every other week due to residuals of the chemotherapy treatment.

The claimant testified that he has been receiving Social Security Disability benefits since November 2006. At the time of the May 7, 2008, deposition claimant was receiving \$1,700.00, monthly in Social Security Disability benefits.

The claimant testified during the May 7, 2008, deposition that prior to June 3, 2005, he had not been given a permanent anatomical impairment relative to either his high blood pressure,

diabetes, the stents in his heart, the surgery for the neuroma of both feet, or provided permanent physical restrictions regarding the afore. The claimant was off work for less than two (2) weeks in connection with the stents placement. Following the foot surgery, which was necessitated by the neuroma brought on by prolonged walking on concrete, claimant wore plastic boots for about four weeks until the stitches healed. Claimant did not file a workers' compensation claim regarding the feet complaints.

The claimant testified that he has had macular degeneration for "a few years" and that up until the time of his June 3, 2005, compensable back injury, had an unrestricted driver's license. Claimant testified that there was nothing about his vision that caused him to feel as though he was handicapped while working for respondent #1. Claimant denied that he had received a permanent anatomical impairment rating relative to his eye condition prior to June 3, 2005.

There is testimony in the May 7, 2008, deposition to reflect that the claimant last took a physical in April 1998. Claimant acknowledged seeing a chiropractor, Dr. Bibb, for a stiff neck after the June 3, 2005, compensable low back injury. Claimant does not feel that the neck complaint was a product of or part of the June 3, 2005, low back work-related injury.

In the discharge of his employment duties with respondent #1, the claimant engaged in the physical activities of repeated bending and twisting, lifting weights up to 95 pounds, squatting and stooping. The claimant testified that most of the jobs identified by the vocational rehabilitation counselor, Ms. Taylor, required the afore physical maneuvers/activities.

Claimant asserts that at the time he requested the release to return to work from Dr. Ricca in September 2006, he requested a light duty release. Claimant explained that he felt that if he could return to light duty, in time as his back progressed he was hopefully that he could work

into a full duty status. Claimant maintains that respondent #1 did not have light duty work available. The testimony of the claimant reflects that after he was directed to go home pursuant to the direction of the Cleveland office of respondent #1 in September 2006, he was again taken off work by Dr. Ricca. The claimant was directed by Dr. Ricca to remain off work from October 9, 2006 through October 23, 2006. Claimant estimates that he only work for an hour following the September 2006, release by Dr. Ricca, and that he did not work between September 11, 2006, and October 9, 2006.

The claimant consistently maintained during the May 7, 2008, that what prevents him from working in the pain in his back, which he attributes to the June 3, 2005, compensable back injury. The testimony of the claimant reflects whether he has some type of neuropathic pain in his leg or foot he still could not work because of the back pain alone, which was bought on by the injury at respondent #1. Claimant denies that he has pain in his feet, noting he only has pain in his back and down his right hip.

Ms. Heather Taylor, a vocational rehabilitation counselor in the employment of Systematic Corporation, has an undergraduate degree in social work and a masters degree in rehabilitation counseling both from Arkansas State University. Ms. Taylor was requested to perform a vocational rehabilitation evaluation on the claimant by the third party administrator for respondent #1. In performing an evaluation, Ms. Taylor testified that she looks at the medical information as it relates to the work related injury and receives/reviews the functional capacity evaluation. Ms. Taylor also meets with the individual.

In the instant claim, Ms. Taylor testified that received and reviewed the claimant's functional capacity evaluation and reviewed the medical information relative to the June 3, 2005,

work-related injury. Thereafter Ms. Taylor met with the claimant. Ms. Taylor testified that she went over the results of the functional capacity evaluation with the claimant. In explaining the importance of the FCE, from a vocational expert point of view, Ms. Taylor's testimony reflects:

Well, I rely on physician information and other medical information to give me an objective meaning of what a individual can do from a physical standpoint. (T. 75).

Ms. Taylor testified that it was her understanding from the FCE that the claimant could perform in the medium work category which entails lifting 20 to 50 pounds on an occasional basis and 10 to 10 to 25 pounds on a frequent basis.

Ms. Taylor testified that she did discuss the claimant's other health conditions, to include diabetes, his heart stents, macular degeneration, cataracts, and his colon cancer. Ms. Taylor's testimony reflects, with regard to the claimant's colon cancer, that it is her understanding that he is currently taking chemotherapy treatments and will be for an indefinite time period. Ms. Taylor testified that from the standpoint of the absenteeism factor the chemotherapy treatment causes difficulty in returning the claimant to gainful employment, explaining:

Well, I've asked employers how that would effect this employment and that would be a great barrier, because he would have to be absent from work every other week for at least two, or three days every other week. (T. 76-77).

Ms. Taylor testified that the claimant's former employment position as a paint department supervisor is classified in the light category, however because he was required to lift 80 to 90 pounds, it would actually be considered heavy. Ms. Taylor's testimony reflects that the claimant has transferrable skills that would be helpful in returning to the work place to include retail management, supervision, leadership, inventory control, budgeting, customer service and sales.

Ms. Taylor added that the claimant's job as a paint department supervisor is skilled. Ms. Taylor testified, regarding the claimant:

Well, because of all of the skills that I just listed, he has a endless transferable skills that he could utilize as far as going into a different job. (T. 77-78).

Ms. Taylor noted that the claimant's transferable skills in customer service and as a paint department supervisor would be compatible with employment at Lowe's, Home Depot, Sears, Ace, Wal-Mart and National Home Centers. Ms. Taylor observed that employment in another home improvement store was within the FCE so long lifting was not required.

Ms. Taylor's testimony reflects that based on all the information she came up with some jobs that she felt were available to the claimant. Ms. Taylor compiled her first grouping of jobs that she felt was within the functional restriction in February 2008, noting that a lot of the jobs were through the Arkansas Work Force, which is a resource that she frequently utilize. Ms. Taylor explained, regarding the afore:

It's through the Employment Security Division, it's called the Work Force Center, it's basically a free job service. A lot of employers advertise their job openings with the Work Force Center and you just basically have to register with the Center in order to apply. (T. 80).

Ms. Taylor testified that the claimant expressed an interest in gaining some more computer skills and she provided him information about the Adult Education Center in Walnut Ridge which offered basic keyboarding, Microsoft Word, Excel, introduction to computers, e-mail, internet and basic skills.

Regarding the jobs identified and furnished to the claimant, Ms. Taylor testified that in talking with the claimant she was informed that he had applied for the jobs, however had not

received a job offer. Ms. Taylor acknowledged that the claimant relayed to her his physical restrictions and limitations. Ms. Taylor added, however, that when she did find/identify a job she made sure that it was within the functional capacity evaluation. In reports of February 6, 2008; February 14, 2008; and March 24, 2008, the claimant was provided with a list of jobs by Ms. Taylor. Ms. Taylor testified that if job placement assistance was not successful she would not have recommended anything further. (T. 83). With respect to the claimant wanting retraining in computers, Ms. Taylor testified:

Well, he could certainly do it, but I would recommend it to be short term in nature, simply because of his age. (T. 83-84).

The testimony of Ms. Taylor reflects that she has placed a number of people back in the work force in the medium category. Ms. Taylor's testimony further reflect that with the claimant's abilities and education level he should be able to return to some type of gainful employment.

During cross-examination, Ms. Taylor acknowledged that it was her job to provide assistance to see if there was a suitable job for the claimant to get back into the work force. In accordance with the afore, Ms. Taylor reviewed the claimant's medical records, his functional capacity evaluation, and also had an opportunity to talk the claimant in his home. Ms. Taylor's testimony reflects that it was the claimant's responsibility to contact prospective employers and put in job applications. In following up with the claimant Ms. Taylor testified it was her impression/understanding that the claimant was following up on the jobs identified/furnished. Ms. Taylor also testified that the claimant was cooperative in doing a diligent and good faith effort to try find employment. (T. 85).

Ms. Taylor testified that is her understanding that the functional capacity evaluation is a

one time evaluation on which the participant goes and lifts objects and lifts weights and does things to see what type of weight he can lift. Ms. Taylor agrees that the FCE report reflects that the claimant gave a very good effort on the evaluation. The testimony of Ms. Taylor reflects that she accepts the results of the FCE as “the medical opinion”. (T. 86). Ms. Taylor concedes that FCE is not performed by a medical doctor. Ms. Taylor was questioned specifically regarding the utilization of the one time functional capacity evaluation results:

Q. And, is it your testimony here today that Mr. Callahan can lift twenty to fifty pounds occasionally and ten to twenty-five pounds frequently and possibly up to ten pounds regularly?

A. It’s not my opinion of what he can, or can’t do physically, I relied on the FCE.

Q. You’re taking this FACE [FCE] to be what Mr. Callahan can, or can’t do on a daily basis?

A. Yes.

Q. And, you did read in the Functional Capacity Evaluation that after he was lifting these objects he was suffering a great deal of pain; you read that?

A. Yes.

Q. And, were you aware of the fact that Doctor Ricca his surgeon that he felt like he should only return to lite [light] duty?

A. I don’t know if I remember that.

Q. If, there is a medical report from Doctor Ricca has been admitted in this case, would you except [accept] Doctor Ricca’s opinion as the neurosurgeon that he should return to lite [light] duty work?

A. Yes.

Q. And, yet when you were looking for work, you did not use the lite [light], you used the medium on the FCE?

A. Actually, I used medium, lite [light] and sedentary. As they would all be within the FCE. (T. 87-88).

Ms. Taylor acknowledged, based on the claimant's testimony of having to recline for up to four times a day because of lower back pain, that there are very few employers that will allow an employee to lay down on the job. Further, Ms. Taylor conceded that if the claimant required a period of time to lay down during the day he would not be able to do any of the jobs identified/provided to him.

Ms. Taylor's testimony reflects that she deferred to the FCE rather than the claimant's assessment of his physical limitations and restrictions. Ms. Taylor testified:

When identifying a job, I relied on the FCE. (T. 89).

Ms. Taylor acknowledged that the claimant did "mention" that he had to spend a considerable amount of time reclining because of back pain when she met with him. The testimony of Ms. Taylor reflects that she did not take the afore into account when identifying/providing jobs to the claimant since they are subjective complaints, but rather she relied on the FCE.

During further cross-examination, Ms. Taylor confirmed that she did not take into consideration any of the claimant's pre-existing conditions in her job search recommendation, with the exception of shying away from driving due to the claimant's eyes. Ms. Taylor testified that based on the claimant's testimony regarding driving to deliver paint to customers in his employment with respondent #1, it does not sound as though he had any problem being able to drive.

Ms. Taylor testified that she met with the claimant on two (2) occasions. During the in-person interviews claimant relayed complaints regarding pain in his low back which necessitates

him reclining several times during the day. The duration of each meeting with the claimant was between one and one-half to two hours. In the instant claim, the duration of the claimant's functional capacity evaluation was one day. Ms. Taylor testified regarding her knowledge of a functional capacity evaluation covering multiple days:

I think, I've heard from physical therapist that it is to get a better measure over several days so they can factor in like a five day work week.

That's why sometimes they do it over multiple days as opposed to one, to get a better understanding of what they can do say in a eight hour work period. (T. 92-93).

The claimant's medical history pre-dating his June 3, 2005, compensable back injury is extensive. The earliest medical record addressing the claimant's vision difficulty contained in the record is a January 10, 2000, report of Dr. John L. Elfervig with Eye Surgery Center of Arkansas pursuant to a referral of Dr. Kye Layton, O.D. Thereafter the claimant was seen in follow-up treatment by Dr. Elfervig on February 11, 2000, April 14, 2000, and August 23, 2002. (R1#1, p. 5-8). In a November 12, 2004, interoffice memo to Dr. Robert J. Landry, Dr. Elfervig noted of the claimant:

Mr. Callahan will be a new patient to you. I have not seen him in 2 -1/2 years. He has a history of a hereditary type macular degeneration and could very well be a Stargardt's variant. He is also diabetic, but has not evidence of diabetic retinopathy. His blood sugar does fluctuate and I suspect that his progressive cataract is a function of his diabetes.

Today, I can barely visualize the posterior pole and peripheral retina. He has a marked progression of his cataract in the right eye in my notes of August in 2002, his vision was finger count in his right eye. The left eye was 20/25. When I saw him the last time in the year 2000, his right eye was 20/80, the left eye was 20/25.

* * *

His left eye is showing some early lenticular changes. His macular degeneration to me does not look all that different, although he is having a little more trouble reading, but looking back through this chart, he does have big swings in his vision, because in the year 2000, at one time, he was reading 20/200 and then when I saw him in 2002, the left eye that was reading 20/200 was then reading 20/50. Today, his left eye is reading 20/70. (R1X1, p. 27).

A December 1, 2004, chart note of Dr. Landry reflects that the claimant was seen with a chief complaint of loss of vision in the right eye. The chart note reflects under the history of present illness that the claimant complained of being unable to see well enough to read for the past four (4) years. Following his examination of the claimant Dr. Landry's impression was that of visually significant cataract in the right eye, for which extraction was planned with IOL implant.

On August 2, 2006, the claimant was seen by Dr. Thomas M. Stank with a chief complaint of loss of vision in the left eye. The claimant provided a history to Dr. Stank of being unable to see well enough to read the newspaper for the past three months. Following an examination cataract extraction was recommended. (R1X1, p. 50).

A July 31, 2003, Initial Evaluation of the claimant at Northeast Arkansas Clinic by Dr. Kevin D. Ganong, pursuant to a referral of Dr. Albert Fonticiella, for evaluation of the claimant's diabetes recites history of the claimant's diabetes two years earlier. The history also noted that the claimant had been treated for hypertension since about the age of 20. The report reflects that the claimant had undergone a cardiac catheterization which showed some partial blockages. Following his examination Dr. Ganong assessed the claimant with uncontrolled diabetes. The claimant's insulin dose was increased to 40 units at breakfast and 30 units at supper. (R1X1, p.9-11).

On August 25, 2004, the claimant was referred by Dr. Fonticiella to Dr. Nuri Akkus with Cardiology Associates of NEA. The office noted of the referral reflects that the claimant had complaints of heaviness to chest, dyspnea with exertion, with burning sensation to the throat with exertion, increased fatigue, dizziness and visual disturbance. Following the examination of the claimant Dr. Akkus opined that the claimant had typical symptoms of angina with regional wall motions abnormality in the echocardiogram with low ejection fraction. (R1X1, p. 16-18). On December 23, 2004 the claimant was admitted to Regional Medical Center in Paragould and underwent the placement of stents. Claimant was discharged on December 24, 2004. (R1X1, p. 34-35).

On April 4, 2006, the claimant underwent surgery under the care of Dr. Gregory F. Ricca for the diagnosed bilateral herniated nucleus pulposus at L3-4 and L4-5, growing out of the compensable June 3, 2005, compensable injury. (CX. #1,p. 11-13). On August 30, 2006, the claimant underwent a functional capacity evaluation. (CX #1, p. 36-42). When seen in follow-up on September 11, 2006, Dr. Ricca noted of the claimant:

Mr. Callahan returns for f/u of FCE. He very much wants to RTW. He states that he would rather hurt at work than hurt at home. His FCE had excellent effort including pulling some chest muscles. Mr. Callahan's best effort put him in the Medium Work Category. Exerting 20-50#s occasionally, 10-25#s frequently, and up to 10#s constantly. A letter from Kay Reneau, HR Administrator for Sherwin Williams on 5/12/6 states that he is required to lift up to 25-50#s frequently and 75-100#s occasionally. Mr. Callahan states that his district manager said that he must be able to RTW Full duty. (CX #1, p. 43).

The September 11, 2006, chart note reflects diagnoses of the claimant's complaints as low back pain and lumbar radiculitis. The afore chart note further reflects, in pertinent part:

I talked at length with Mr. Callahan, his wife and his new case manager, Monica Fraser, RN and reviewed all of the above as well as the various options. Mr. Callahan wants to RTW and try. His FCE says that he cannot meet the full duty requirements. We agreed that he will engage in aggressive home exercise the next few weeks and then try to RTW on 9/25/6. I will see him in 6 wks for f/u. . . . (CX #1, p. 43).

The claimant was seen in follow up by Dr. Ricca on October 23, 2006. The chart note relative to the October 23, 2006, visit reflects, in pertinent part:

Mr. Callahan states that he cannot tolerate work. His first week back to work he worked 30 hrs and the second week he worked 14 hours. He had to take a lot of Vicoden. During that time he had fever, sweating and glucose up to 400. It took him 1.5 weeks to get over 2 wks of work. In the past we discussed facet blocks and facet rhizotomy. (CX. #1, p. 44).

On October 26, 2006, the claimant underwent diagnostic facet blocks at L2-3 right and L5-S1 right under the care of Dr. Ricca. (CX #1, p. 45).

The claimant was seen by Dr. Ricca on November 13, 2006, in follow-up to the facet blocks. The office note relative to the visit reflects, in pertinent part:

Mr. Callahan states that the lumbar facet blocks L3-4 and L4-5 were of no help. Mr. Callahan is taking Tylenol #3 11 tabs bid but not everyday, Naproxen 500 mg daily, and Lyrica 75 mg daily. He continues to have prominent pain. . . . Mr. Callahan tolerates Tylenol #3 well. He only takes Naproxen once daily because it causes nausea.

* * *

Exam is unchanged: Mr. Callahan appears to be in pain. He ambulates with a stiff low back. His incision is well healed.

Dx:
Lumbar Radiculitis 724.4
Lumbar Postlaminectomy Syndrome 722.83

Discussion:
I talked at length with Mr. Callahan, his wife and his case worker and reviewed all of the above as well as the various options. This included

the various nonsurgical options. I recommended that we work on medication adjustment. . . . We agreed to add Ultram, change From Napoxen to Relafen, and add Xanax. Mr. Callahan will use Ultram as a first line drug and use Tylenol #3 for breakthrough pain. In the future we will consider either increasing or stopping his Lyrica. I also discussed MMI. I will provide an impairment rating once Mr. Callahan is stabilized on his medications I will release him from my care. (CX #1, p. 46).

A January 5, 2007, office visit by the claimant to Dr. Ricca reflects that the claimant had not returned to work but would retire on January 31, 2007. The office note further reflects that the claimant would continue regular follow-up with Dr. Fonticiella. (CX. #1, p. 47).

On February 4, 2007, Dr. Ricca authored a report reflecting the claimant's impairment rating. The February 4, 2007, report reflects, in pertinent part:

Mr. Charles Callahan is a patient of mine who developed severe LBP and bilateral posterior LE pain in the Spring of 2005. His job required carrying heavy buckets of paint and straining his low back. This resulted in large bilateral disc ruptures at Lumbar 3-4 and Lumbar 4-5 that ultimately required surgery.

Mr. Callahan had a Posterior Lumbar Interbody Fusion at Lumbar 3-4 and Lumbar 4-5 on 4/4/6. He had very large bilateral disc ruptures at these levels as well as calcification of the posterior longitudinal ligament that was fused with the dura. Mr. Callahan suffers from chronic Low Back Pain and pain into his lower extremities. He carries a diagnosis of Lumbar Poslaminectomy Syndrome. He has tried to work but is unable to because of marked low back pain and right lower extremity pain.

I last saw Mr. Callahan on 1/5/7 and released him from my care at that time. . . .

I followed the AMA Guides to the Evaluation of Permanent Impairment, Forth Edition, from the American Medical Association.

Table 75 on page 3/113. section IV. Part D (Single level fusion with or without decompression with residual signs or symptoms). Lumbar. Mr. Callahan receives a 12% impairment of the whole person.

Section IV. Part E. 1. adds 1% for a second level.

Please note that the AMA Guides to the Evaluation of Permanent Impairment does not address Mr. Callahan's inability to work or engage in normal daily activities. It does not consider the ongoing symptoms that significantly interfere with Mr. Callahan's ability to enjoy life. This also affects his family. The AMA Guides to the Evaluation of Permanent Impairment also does not address Mr. Callahan's need for chronic pain medication and physician follow-up. Mr. Callahan may need a dorsal column stimulator for management of his chronic low back pain and right lower extremity pain. This would require an additional surgery that, according to the AMA Guides would increase his impairment rating another 1%.

This, based on my review of Mr. Callahan's records and my review of the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, from the American Medical Association Mr. Callahan receive **at least a 17% partial impairment of the whole person.** (CX. #1, p. 48-49).

In a February 26, 2007, correspondence to the nurse case manager Dr. Ricca elaborated on the claimant's impairment rating:

This letter to try to help clarify my impairment rating of Mr. C. Callahan. In my letter of February 4, 2007, I listed the ratings as recommended by the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, from the American Medical Association (referred to as "the Guide"). The total for the surgery he has had thus far is 13% according to the Guide.

Mr. Callahan may need a Dorsal Colum Stimulator Placed that would give an additional 1% impairment. The total thus would then be 14% partial impairment of the whole if he were to have one more lumbar surgery.

I also stated:

"the AMA Guides to the Evaluation of Permanent Impairment does not address Mr. Callahan's inability to work or engage in normal daily activities. It does not consider the ongoing symptoms that significantly interfere with Mr. Callahan's ability to enjoy life. This also affects his family. The AMA Guides to the Evaluation of Permanent Impairment also does

not address Mr. Callahan's need for chronic pain medication and physician follow-up."

Because of the above I believe that the Guide does not adequately address Mr. Callahan's particular problems. I believe that the Guide is just that, a guide. I have never heard or read that the Guide is an absolute authoritative document and that it accurately accounts for all problems a person may have. In fact, in the case of Mr. Callahan, I think the Guide does not adequately address his troubles. It is for these reasons that I believe a 17% partial impairment to the whole is appropriate for Mr. Callahan. (R1X1, p. 82-83).

The January 15, 2008, initial vocational rehabilitation evaluation report of Ms. Heather Taylor reflects that she met with the claimant on January 8, 2008, in Paragould. The January 15, 2008, report reflects, in pertinent part:

. . . Mr. Callahan was pleasant, cooperative and forthcoming with information throughout our interview. Mr. Callahan has not worked since around October or November of 2006 when he attempted to return to light duty for only about one day. He has since retired from Sherwin-Williams effective 1/07. Since that time, Mr. Callahan reported that he has not made any attempts to return to the workforce, and does not think that he would be able to hold down a job. In addition to his workers' compensation injury, Mr. Callahan has numerous other medical problems that could interfere with him successfully returning to the workforce.

MEDICAL INFORMATION

. . . As a result of his back injury, Mr. Callahan had a three-level fusion performed on 4/4/06 by Dr. Gregory Ricca. Mr. Callahan reported that he had physical therapy for a short period to time after his surgery. However, he reported that he still continues to experience pain on a regular basis and was told that this was due to nerve damage. Mr. Callahan has since been released by Dr. Ricca (in 11/06) and was at maximum medical improvement. He has not seen Dr. Ricca since around 11/06.

* * *

Mr. Callahan reported his current physical problems consist of a low-level constant pain in his low back. He said that he is unable to vacuum, as that particular activity causes pain symptoms. He also reported that yard work

such as raking leaves, sweeping or riding his riding lawnmower caused pain symptoms. Hi is no longer able to play with his grandchildren like he used to. . . .

CURRENT SYMPTOMS

_____ As a result of his work-related injury, Mr. Callahan reported that he experiences a low-level constant back pain in his low back area and down his right hip. He said that this pain level is usually of a very low grade, usually a 3 on a scale of 1-10, but can go up to a 7 (10 being very severe pain).

I asked his if there were any particular symptoms that caused an elevation in his pain. He reported that twisting or moving the wrong way, or stooping and even occasionally coughing, can cause an increase in his pain. . . . (R1X2, p. 1-7).

The claimant was provided with lists of jobs in several correspondences from Ms. Taylor commencing February 6, 2008, and concluding April 21, 2008. With the exception of the April 21, 2008, jobs, Claimant followed up on all of the job listing. (CX #2).

_____ After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On June 3, 2005, the relationship of employee-employer existed between the claimant and respondent #1, when the claimant sustained an compensable injury to his back, at which time the claimant earned wages sufficient to entitle his to weekly compensation benefits of \$466.00/\$350.00, total/permanent partial disability.
3. The claimant reached the end of his healing period/maximum medical

improvement relative to the June 3, 2005, compensable back injury on February 4, 2007.

4. Respondent #1 shall pay all reasonable hospital and medical expenses arising out of and in connection with the treatment of the compensable injury of June 3, 2005.

5. The claimant has sustained a permanent physical impairment in the amount of 13% to the body as a whole as a result of the June 3, 2005, compensable injury.

6. Prior to the June 3, 2005, compensable low back injury in the employment of respondent #1, the claimant suffered pre-existing health conditions or impairments, to included macular degeneration, insulin-dependent diabetes, cardiac complaints, and high blood pressure.

7. The claimant's prior disabilities or impairments have combined with the June 3, 2005, compensable low back injury to produce the current disability status.

8. When the claimant's age, education, employment history, permanent restrictions and limitations are considered, the evidence preponderates that the claimant has been rendered permanently and totally disabled within the purview of the Arkansas Workers' Compensation laws, pursuant to Ark. Code Ann. §11-9-519(c).

9. Respondent #2 has controverted liability in this claim, as well as the claimant's entitlement to any wage loss disability benefits to include permanent total disability benefits.

CONCLUSIONS

The compensability of the claimant's June 3, 2005, low back injury is not disputed. The claimant asserts that as a result of the afore injury, he has sustained wage loss disability benefits in excess of the anatomical impairment. Claimant asserts that he sustained an anatomical impairment in the amount of 18% to the body as a whole, as opposed to the 13% accepted and paid by respondent #1. The contentions of the parties are as reflected in their respective pre-

hearing filings, incorporated in Commission Exhibit #1. The present claim is one governed by the provisions of Act 796 of 1993 in that the claimant asserts entitlement to additional workers' compensation as a result of an injury having been sustained subsequent to the effective date of the afore provision.

Anatomical Impairment

The parties have stipulated that the claimant sustained a compensable low back injury on June 3, 2005, in the employment of respondent #1. In treatment of the compensable injury, the claimant underwent surgery under care of Dr. Gregory Ricca on April 4, 2006, in the form of a posterior lumbar interbody fusions at L3-4 and L4-5. The February 4, 2007, report of Dr. Ricca detailed the specific references in the AMA Guides to the Evaluation of Permanent Physical Impairment, Fourth Edition, of the American Medical Association, to include Table 75 on page 3/113. section IV. Part D. (single level spinal fusion with or without decompression with residual signs or symptoms) for the lumbar spine which yields a rating of 12% impairment of the whole person and Section IV. Part E.1., which adds 1% or a second level. The afore results in a 13% impairment to the body as a whole.

Dr. Ricca assessed the claimant's anatomical impairment at 18% to the whole person. In his explanation of the afore, contained in a February 26, 2007, correspondence, Dr. Ricca offered that the *may* need a Dorsal Column Stimulator Placed, which would generate an additional 1% impairment. Dr. Ricca attributes the additional impairment to the claimant's ongoing symptoms which significantly interfere with the claimant's ability to enjoy life. Dr. Ricca also noted the impact or effect of the afore on the claimant's family.

The Arkansas Workers' Compensation Commission is authorized pursuant to Ark. Code

Ann. §11-9-521 (h) (Repl. 2002) to adopt an impairment rating guide to be used in the assessment of anatomical impairment. In *Polk County v. Jones*, 74 Ark. App. 159, 47 S.W.3d 904 (2001), the Arkansas Court of Appeals stated:

The Workers Compensation Act of 1993 directed the Commission to adopt an impairment rating guide to be used in the assessment of anatomical impairment, and the Commission adopted the AMA Guides. Thus, in all cases where entitlement to permanent impairment is sought by the claimant but controverted by the employer, it is the Commission's duty to determine, using the AMA Guides, whether the claimant met his burden of proof. This being the case, we hold that the Commission can, and indeed, should, consult the AMA Guides when determining the existence and extent of permanent impairment, whether or not the relevant portions of the Guides have been offered into evidence by either party.

Polk County, 74 Ark. App. at 174, 47 S.W.3d at 907. In a recent ruling the Arkansas Court of Appeals stressed that the AMA Guides are "mere guides to aid the Commission in assessing the degree of a claimant's disability as defined and interpreted by the courts". *Singleton v. City of Pine Bluff*, __ Ark. App. __, __ S.W.3d. __ (May 28, 2008).

In the instant claim, the evidence preponderates that the extent of the claimant's anatomical impairment as a result of the June 3, 2005, compensable low back injury is 13% to the body as a whole based on the appropriate AMA Guides. The claimant has failed to sustain this burden of proof by a preponderance of the evidence that he has sustained an anatomical impairment in the amount of 18% to the body as a whole. Respondent #1 has accepted and paid appropriate corresponding indemnity benefits to the claimant in accordance with 13% whole person anatomical impairment.

Wage Loss Disability Benefits

The claimant is a high school graduate with a date of birth of January 30, 1951. The

claimant was employed by respondent #1 for twenty-six years. There is not a disputed regarding the claimant's employment history nor the physical demands of his jobs in the employment of respondent #1. Since sustaining his June 3, 2005, compensable injury the claimant has under fusion surgery in the treatment of same. The claimant is severe limited in the amount of bending, twisting, standing, walking, pushing and pulling that he is physically capable of doing since the compensable injury and surgery.

The credible evidence in the record reflects that the claimant put forth in excess of a valid effort in undergoing the functional capacity evaluation. As a consequence of the afore the FCE reflects that the claimant was capable of performing work in the medium category. The credible evidence reflects that the claimant is physically incapable of performing the job demands of work in the medium category over any significant sustained period of time. Claimant requires medication for pain, suffers shortness of breath with exertion, and must recline periodically during the day in an effort to obtain relief for his low back and right hip/lower extremity pain.

While the claimant attributes his inability to work to residuals of the June 3, 2005, compensable low back injury and resulting surgery, during his vocational rehabilitation evaluation he conceded that his vision, resulting from the macular degeneration, adversely impacted his ability to drive at night. Likewise, claimant conceded the role of his vision in his inability to utilize the keyboard of a computer or in acquiring further computer skills.

The claimant disclosed the condition of his continuing pain complaints and the physical limitations brought on by same during the vocational rehabilitation initial evaluations. The vocational rehabilitation consultant acknowledged that the claimant relayed his physical limitations and complaints of pain as well as the impact of the afore on any employment efforts.

Nevertheless, the evidence disclosed that the claimant put forth valid and cooperative efforts in following through on the jobs identified and provided by Ms. Taylor.

Ark. Code Ann. §11-9-519 (e)(1) defines “permanent total disability” to mean inability, because of compensable injury or occupation disease, to earn any meaningful wages in the same or other employment. While the claimant has held management positions in his employment history, the same has always entailed manual labor as well in the discharge of his duties. Clearly, while the claimant’s employment with respondent #1 covered a period of twenty-six (26) years he was unable to return to the employment of same following his compensable injury and surgery based on the permanent physical limitations and restrictions generated as result of the compensable injury. When the claimant’s age, education, permanent restriction and physical limitations, along with his work experience and other matters reasonable expected to affect his future earning capacity, the evidence preponderates that the claimant has been rendered permanently and totally disabled.

Second Injury Fund Liability

The purpose of the Second Injury Fund is to insure that an employer employing a handicapped worker will not, in the event such a worker suffers an injury on the job, be held liable for greater disability or impairment that actually occurred while the workers was in the employer’s employment. *Douglas Tobacco Products Co. v. Gerrald*, 68 Ark. App. 304, 8 S.W.3d 39 (1999). Pursuant to the ruling in *Mid-State Construction Co. v. Second Injury Fund*, 295 Ark. 1, 746 S.W.2d 539 (1988), the test to determine Second Injury Fund liability is as follows:

First, the employee must have suffered a compensable injury at his

present place of employment. Second, prior to that injury the employee must have had a permanent partial disability or impairment. Third, the disability or impairment must have combined with the recent compensable injury to produce the current disability status.

Id. at 5, 746 S.W.2d at 541.

In the instant claim, it is undisputed that the claimant sustained a compensable injury to his low back in the employment of respondent #1 on June 3, 2005. Further, the evidence preponderates that the June 3, 2005, compensable injury resulted in 13% permanent physical anatomical impairment to the whole person. Finally, the evidence preponderates that prior to the June 3, 2005, compensable low back injury the claimant suffered from pre-existing health conditions to include macular degeneration, cardiac heart disease which resulted in cardiac catheterization procedure and ultimately the placement of stents, as well as insulin dependent diabetes and surgical procedures on both feet for neuromas removal.

A pre-existing impairment or disability can be either work related or non-work related. *Second Injury Fund Trust Fund v. POM*, 316 Ark. 796, 875 S.W.2d 832 (1994). Further, an impairment does not necessarily mean that a claimant has suffered wage loss. *Second Injury Trust Fund v. White Consolidated*, 317 Ark. 26, 875 S.W.2d 834 (1994).

While the claimant attributes his inability to work to the residuals of the June 3, 2005, compensable injury, a clear examination of the record preponderates that the claimant's current disability status is the product of a combination of the June 3, 2005, compensable injury with the pre-existing impairments or disabilities. The evidence clearly reflects that the claimant pre-existing macular degeneration, cardiac heart disease, neuromas, insulin dependant diabetes have combined with to June 3, 2005, compensable low back injury to render the claimant present

disability status. The claimant is unable to drive at night in unfamiliar areas or to follow through in obtaining additional keyboard skills on the computer due to his vision difficulties. The medical record recite the claimant's vision at 20/200 in numerous instances. While the claimant's chest pain was successfully addressed by the placement of the stents in the 2004, surgical procedure, the medical records reflects that the claimant continued to experience shortness of breath and exhaustion with exertion. The claimant is limited in the amount of walking and standing due to neuromas for which he has undergone surgical procedures on both feet.

The evidence preponderates that the claimant's pre-existing disability or impairment combined with his last injury to cause a greater degree of disability. Respondent #2, the Second Injury Fund, is liable for the payment of permanent total disability benefits to the claimant. Respondent #2 has controverted the claimant's entitlement to wage loss benefits in excess of the anatomical impairment, to include permanent total disability benefits.

AWARD

Respondent #2, the Second Injury Fund, is herein ordered and directed to pay to the claimant permanent total disability benefits at the weekly compensation benefits rate of \$466.00, as a result of the claimant having been rendered permanently and totally disabled as a result of the combination of the June 3, 2005, compensable injury with his pre-existing impairments or disabilities. Said sum accrued shall be paid in lump without discount.

Maximum attorney fees are herein awarded to the claimant's attorney on the controverted indemnity benefits herein awarded pursuant to Ark. Code Ann. §11-9-715.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809,

until paid.

Matters not addressed herein, to include further medical benefits, are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE