

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F104417

NORMAN BATTEN,
EMPLOYEE

CLAIMANT

FERRELL GAS LP,
EMPLOYER

RESPONDENT

FIDELITY & GUARANTY INS. CO.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED DECEMBER 3, 2004

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

Claimant represented by HONORABLE KRISOTFER E. RICHARDSON,
Attorney at Law, Jonesboro, Arkansas.

Respondents represented by HONORABLE MELISSA ROSS, Attorney
at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Affirmed and
adopted.

OPINION AND ORDER

The respondents appeal from a decision of the
Administrative Law Judge filed March 22, 2004. The
Administrative Law Judge entered the following findings of
fact and conclusions of law:

1. The Arkansas Workers' Compensation Commission
has jurisdiction of this claim.
2. On March 17, 2001, the relationship of
employee-employer-carrier existed among the
parties.
3. On March 17, 2001, the claimant earned wages
sufficient to entitle his (sic) to weekly

compensation benefits of \$299.00/\$224.00 for temporary total/permanent partial disability benefits.

4. The claimant has sustained his burden of proof by a preponderance of the evidence that he was engaged in employment service on March 17, 2001, when he sustained an injury to his back arising out of and in the course of his employment. Further, the claimant has sustained his burden of proof by a preponderance of the evidence that the March 17, 2001, compensable injury was reported to appropriate supervisory personnel of respondent-employer prior to the time he received medical treatment for same on April 2, 2001.
5. The claimant was temporarily totally disabled as a result of his March 17, 2001, compensable injury, from the period in November 2001, when respondent-employer ceased to provide work within the limitations of his medical restriction imposed relative to the compensable injury, until October 31, 2002, when he reached maximum medical improvement.
6. Claimant reached the end of his healing period relative to his compensable . . . injury on October 31, 2002, and has sustained a permanent physical impairment as a result of same in the amount of 20% to the body as a whole.
7. The respondents shall pay all reasonable and necessary hospital and medical expenses arising out of the claimant's March 17, 2001, compensable injury. Further, the respondents shall reimburse any other carrier or party for sums expended to and on behalf of the claimant for medical treatment relative to the March 17, 2001, compensable injury.

8. The respondents have controverted this claim in its entirety.

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

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal. All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2002).

Since the claimant's injury occurred prior to July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as it existed prior to the amendments of Act 1281 of 2001. Compare Ark. Code Ann. § 11-9-715 (Repl. 1996) with Ark. Code Ann. § 11-9-715

(Repl. 2002). For prevailing on this appeal before the Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$250.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 1996).

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I respectfully dissent from the majority opinion finding that the claimant is entitled to a 20% permanent partial disability rating to the body as a whole, which was assigned to the claimant by Dr. W. Craig Clark. A carefully conducted de novo review of the record reveals that the claimant is only entitled to a 19% permanent impairment rating according to the AMA Guides to the Evaluation of Permanent Impairment (Fourth Edition).

The claimant underwent lumbar surgery on March 28, 2002, to remove a ruptured disk at L3-L4 (right), and decompression of a lateral recessed stenosis at L4- L5 on the left. Following the surgery, the claimant had excellent release of symptoms on the right side, but he continued to

complain of symptoms on the left. Thereafter, the claimant's pain worsened dramatically and he developed a partial foot drop. An MRI taken in July of 2002, revealed a new disk rupture at L4-L5. As a result of this newly diagnosed rupture, the claimant underwent a partial hemilaminectomy with a posterior microdiskectomy and removal of extensive epidural fibrosis at L4-L5.

On October 31, 2002, Dr. Clark assessed the claimant to be at maximum medical improvement, and he assigned the claimant with a 20% permanent partial impairment rating to the body as a whole. Dr. Clark based this rating on the disc rupture at L3-L4 which was treated surgically, and with the lateral stenosis at L4-L5 left, which was treated with decompression surgery. Additionally, due to the later surgical treatment of the subsequent ruptured disk at L4-L5, Dr. Clark opined that the claimant would be entitled to a 20% combined rating pursuant to Table 75 and the Combined Rating Scales of the AMA Guides to the Evaluation of Permanent Impairment (Fourth Edition). Dr. Clark presented his reasoning for this combined rating as follows:

This is calculated as 10% for the disc rupture at L3-4 with 2% for the additional level at 4-5. He [the

claimant] then had a separate incident with a disc rupture at L4-5 on the left treated surgically. With combination of these values per the Combined Rating Scale he would be entitled to a permanent partial impairment rating of 20% as noted above.

Dr. Clark's calculation of the claimant's permanent impairment rating, however, does not comport with the AMA Guides for the following reasons. First, Dr. Clark assigned the claimant 10% pursuant, apparently, to Table 75 of the AMA Guides, Category No. II, Line "E," which governs "Surgically treated disk lesion with residual, medically documented pain and rigidity." Dr. Clark then assigned an additional 2% pursuant to the provisions set forth in Category II, Line "G,1" (Multiple operations with or without residual signs or symptoms: 1. Second operation). It is not clear whether Dr. Clark then added an additional 8% or 10% for the second procedure on L4-L5. It can be assumed, however, that because Dr. Clark came up with a total of 20%, he added an additional 8% for the second operation on L4-L5. If Dr. Clark added 8%, which would make the overall total 20%, then according to the Combined Values Chart of the AMA Guides, this translates into a 19% permanent partial impairment rating to the body as a whole. If Dr. Clark

assigned the claimant 10% for the second procedure at L4-L5, then the overall combined total is 22%, which translates into a 21% permanent partial impairment rating to the body as a whole according to the Combined Values Chart. Either way, in spite of Dr. Clark's method of determining the claimant's permanent impairment rating, 20% does not fall within the possible final totals presented in the Combined Values Chart.

The respondent contends that, according to the AMA Guides, the claimant is actually only entitled to an 11% permanent partial impairment rating, per as follows. First, the respondent agrees that the claimant was correctly assigned a 10% rating with regard to the disc rupture at L3-L4, which was treated surgically. However, the respondent contends that there is no rating in Table 75 of 2% for lateral recess stenosis at L4-L5 without surgery. Assuming that Dr. Clark assigned the claimant 8% for "a separate incident with disc rupture at L4-5 on the left treated surgically," the respondent contends that Dr. Clark should have added only 1% for an additional level, as set forth in categories II And IV of Table 75 of the Guides. These numbers combined equal 11%.

Pursuant to Ark. Code Ann. §11-9-704(B), the determination of the existence of physical impairment shall be supported by objective and measurable findings. Moreover, it is the duty of this Commission to determine whether any permanent anatomical impairment resulted from the injury, and, if it is determined that such an impairment did occur, the Commission has a duty to determine the precise degree of anatomical loss of use. Johnson v. General Dynamics, 46 Ark. App. 188, 878 S.W.2d 411 (1994); Crow v. Weyerhaeuser Co., 46 Ark. App. 295, 880 S.W.2d 320 (1994). The AMA Guides provides us with a convenient tool, namely Table 75, by which to make a determination as to a claimant's degree of permanent physical impairment due to specific spine disorders. Table 75, Whole-person Impairment Percents Due to Specific Spine Disorders, is divided into four separate categories of diagnosis-based impairments. These divisions are made in an obvious effort by the AMA to enable us to differentiate between different disorders and their treatment, and assign impairment ratings accordingly. For example, a spinal lumbar fracture, which falls under Category No. 1, is assigned a different rating than lumbar spondylolysis and spondylolisthesis, not operated on, which fall under Category No. III. Moreover, according to Table

75, Category No. II, Line "D," a surgically treated lumbar disc lesion without residual signs or symptoms is assigned an 8% impairment rating to the body as a whole. On March 28, 2002, the claimant underwent removal of a ruptured disc at L3-L4, which reportedly gave him excellent relief. The claimant's March 28th disc surgery obviously falls under Category No. II, Line "D," and should, therefore, be assigned 8%. On the other hand, at the same time that Dr. Clark operated on the claimant's ruptured L3-L4 disc, he also performed decompression of a lateral recessed stenosis at L4- L5 on the left, which did not provide the claimant with sustained relief. Pursuant to Table 75, Category No. IV, Line "B," a single-level decompression with residual signs and symptoms is given a 10% permanent impairment rating to the body as a whole. Therefore, the claimant's first surgery, which involved two distinguishable procedures performed to correct two different disorders at two distinct levels, should be given a combined total of 18%. In July of 2002, the claimant underwent a second surgical procedure at L4-L5, to repair a "newly diagnosed" ruptured disc. Under both Category No. II and Category No. IV, 2% is added for a second operation to correct any of the disorders within those two categories for which surgery has previously been

performed. Thus, the claimant was entitled to a an additional 2% according to the guide. The previous 18% combined with the additional 2% equals 20%, just as Dr. Clark said. However, according to the Combined Values Chart of the AMA Guides, upon which Dr. Craig stated he relied, this 20% translates into a combined overall permanent partial impairment rating of 19% to the body as a whole. Therefore, for all the reasons set forth above, the Administrative Law Judge's award of benefits based upon a 20% permanent partial impairment rating should be modified according to a permanent partial impairment rating of 19% to the body as a whole. Accordingly, I must respectfully dissent from the majority opinion.

KAREN H. McKINNEY, Commissioner