

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E711686

DONALD RAY GROOM, EMPLOYEE	CLAIMANT
NEKOOSA PAPERS, INC., EMPLOYER	RESPONDENT NO. 1
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., BENEFITS ADMINISTRATOR	RESPONDENT NO. 1
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT NO. 2
SECOND INJURY FUND	RESPONDENT NO. 3

OPINION FILED SEPTEMBER 24, 2007

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

Claimant represented by HONORABLE CONRAD ODOM, Attorney at Law, Fayetteville, Arkansas.

Respondent No. 1 represented by HONORABLE MIKE ROBERTS HONORABLE SUSAN M. FOWLER, Attorneys at Law, Little Rock, Arkansas.

Respondent No. 2 represented by HONORABLE JUDY RUDD, Attorney at Law, Little Rock, Arkansas.

Respondent No. 3 represented by HONORABLE DAVID PAKE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed, as modified.

OPINION AND ORDER

This claim is before the Full Commission on remand from the Court of Appeals. In an opinion delivered December 13, 2006, the Court of Appeals affirmed our finding

that the claimant failed to prove permanent total disability. However, the Court reversed and remanded our finding on the determination of anatomical impairment holding that we erred as a matter of law.

The claimant sustained a compensable injury on January 10, 1997. As a result of that injury, the claimant underwent a decompressive laminectomy at L3-4 and L4-5 with a posterior lumbar interbody fusion. This procedure was performed by Dr. Howard Morgan, Jr. on December 10, 1997. Due to complications, the claimant eventually underwent three additional surgical procedures which were performed by Dr. Freddie L. Contreras, a neurosurgeon. A left-sided hemilaminectomy, foraminotomy, and a diskectomy at levels L4-5 and L5-S1 was performed on October 24, 2001. A "re-do" lumbar laminectomy at L5-S1 with removal of a large recurrent disc was performed on January 30, 2002. The claimant's final procedure, which is described more fully below, was performed on June 5, 2002, and involved the placement of pedicle screws. Post-operative diagnostic studies consistently revealed that the claimant's last

surgery was successful in terms of stabilizing the claimant's injured and diseased discs, and in bringing him the relief that he sought. In a discharge report dated June 14, 2005, Dr. Contreras summarized the claimant's surgical history as follows:

Mr. Groom is a 58 year old patient we know well. He had previously undergone two back surgeries, one that Dr. Howard Morgan did in Dallas, with cages and a decompression at 3-4 and 4-5 and then more recently in January ... he underwent a recurrent disk reexploration (sic) at L5-S1 on the left. His work up this time revealed another recurrent disk at L5-S1 on the left and it was thought for his best recovery a big fusion would be what was needed. We had multiple discussions with the patient and he wanted to proceed with the bigger surgery for his best chances of not having back surgery again. He came in with left back pain, left hip and left leg pain, so on 6/5/02, he was taken to surgery and underwent a Brain Lab assisted placement of pedicle screws at L3, L4, L5 and S1 bilaterally with a complete laminectomy at L4, L5 and S1, decompression of the severe lateral recess stenosis at L4-5 and L5-S1 bilaterally and a posterior lumbar interbody fusion at L4-5 as well as a fusion at L5-S1 and then a posterolateral fusion at L3 to S1. Postoperatively he said his legs were

okay. He is moving well. He did have a little right hand numbness and weakness but that improved rapidly. His neuro condition was stable. He had no numbness in his legs and was able to move them with good strength.

On January 20, 2003, the claimant was assessed for permanent physical impairment by Dr. Barry Green. Dr. Green stated that the claimant had reached MMI as of that date, and he assigned the claimant a 20% whole person impairment rating. Dr. Green explained his determination of this rating as follows:

Based on the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, 1993 version, using the DRE Model for diagnostic related estimates (also known as the Injury Model) found on Page 110, Table 72, II, he receives **20% whole person impairment**. He has no motor or sensory deficits; thus, Table 11 and 12 are not used. He has no vascular deficits and no other specific disorders.

In assigning his impairment rating Dr. Green utilized Table 72. Specifically, Dr. Green stated in his report:

He has had 4 back operations. The first one was to place cages at L3 and L4 and, subsequently, in 2001 and 2002, he underwent laminectomies. In June of 2002, he had pedicle screw and fusion. He is much improved, but he is retired now from work. He also has a bone stimulator and wears a back support.

His diagnosis is *herniated nucleus pulposus L3, L4, and L5.*

Respondents introduced the Physical Examination Outline Notes used by Dr. Green to evaluate the claimant. Essentially, Dr. Green took a medical history of the claimant. It is unclear from reviewing Dr. Green's records whether he actually reviewed any of the claimant's medical records, and if so, which ones.

After reviewing Dr. Green's records, and comparing his report to the Guides, it is apparent that Dr. Green did not place the claimant in DRE impairment category II, as stated in his report. Category II is described as "Minor impairment: clinical signs of lumbar injury are present without radiculopathy or loss of motion segment integrity." for which a whole person impairment of only 5% is allowed.

Since Dr. Green assessed the claimant with a 20% impairment, it is more likely that he placed the claimant in Category IV. The description for this category states: "Loss of motion segment integrity: criteria for this condition are described in Section 3.3b, p. 95." Thus, while it is evident that Dr. Green based his impairment rating upon some objective findings, specifically, the four surgical procedures the claimant underwent, Dr. Green's determination to place the claimant in DRE impairment category IV is not explained in the record. Category IV relies upon loss of motion segment integrity as the basis for the 20% impairment rating, yet there are no findings outlined upon which Dr. Green relied to reach a finding of loss of motion segment integrity.

The claimant underwent a second assessment for permanent physical impairment on March 4, 2003, by Dr. Jim J. Moore. Dr. Moore physically examined the claimant, reviewed some medical records, and examined a folder of only a small portion of the radiographs that have been taken of

the claimant's compensable injury. Dr. Moore's physical examination revealed the following:

He is friendly, cooperative and oriented in all three spheres. He does not appear in any acute distress and his gait appears good. I do not see any obvious evidence of atrophy, atony or fasciculations in any muscle groups. The calf on the right measures 16 1/4" and on the left 16 3/4", 2 1/2" below the fibular head. This patient is right handed. Heel and toe gait is accomplished. Straight leg raising is uncomfortable but not restricted. Stressing the back and sacroiliac is painful to him. He has sensory deprivation in both lower extremities more intense on the left than on the right mostly in the L5 and S1 dermatome levels. There is a nicely healed lumbar laminectomy incision. There is also a healing incision in the area of the left pectoral where the patient has also had some numbness and apparently some sort of subcutaneous mass had been excised recently. The pathology is not known. The patient's range of motion is severely restricted in hyperextension, lateral bending and forward bending. Jugular compression is negative. He does have perception of temperature and vibration. The patella reflexes are perceived at about 1+. The Achilles reflexes are perceived +/- even with reinforcement. Motor power is intact. Dorsiflexion strength of the great toes is intact. Peripheral pulses are

perceived and are good. There is a 1+ pitting edema of the lower extremities.

After examining the claimant, Dr. Moore stated in his March 4, 2003 letter:

This patient then is in a remote post-op status of some rather significant lumbar surgeries the last being done as described above. He has had instrumentation. I notice that Dr. Green has provided him a rating of 20% permanent partial to the body as a whole based upon DRE Table 72, page 110. On the basis of my examination I believe that Table 72, page 110, the DRE of V would be most appropriately submitted in this patient's instance based upon my examination and history today...

A hand written notation with Dr. Moore's signature has 25% out to the side of this paragraph.

When asked in his deposition to list the objective findings made during his examination of the claimant, Dr. Moore stated:

Well, one objective finding is he's got metal in him, and he doesn't have any control over that. The other area that he does not have control is - - range of motion may or may not be under the patient control. As a neurosurgeon,

I have learned, over a number of years of practice, how to overcome that, and, in my judgment the patient's range of motion was significantly restricted.

The patient's reflexes are not great at the Achilles level, and I mentioned this. They were plus/minus even with reinforcement, which means they're - - they've been altered. This is any alteration, and the patient really doesn't have any control over that. Without reinforcement, he might have some control, but reinforcing tends to subtract patient control.

The sensory changes that he exhibits are objective in that they follow a proper dermatome distribution of the L₅ and of the S₁ dermatomes. I mention that his straight leg raising was uncomfortable, but it was not restricted, and, also, I indicated that stressing the back and the sacroiliac is painful to him. This is a - - probably an objective/subjective category. The incision line is not under his control. It's a nicely - - it was a nicely healed laminectomy-type incision. Motor power was intact. Peripheral pulses were intact. There was a one plus pitting edema of the lower extremities, which probably could not be under the patient's control. I think that about covers it.

When asked how much of his impairment rating was based upon the claimant's range of motion, loss of reflexes,

or sensory deprivation, Dr. Moore explained in his deposition that he "did not categorize" or divide the findings into subcategories, or "book it into a box or components." Based upon his examination of the claimant, Dr. Moore explained that he simply "found what appeared to be the more appropriate grouping" to select the claimant's impairment rating.

With regard to loss of motion segment integrity, Dr. Moore testified that he was not sure if any bending x-rays were provided for his review in order to make this determination.

The claimant underwent a third impairment assessment on June 7, 2004, by Dr. Shahim. Dr. Shahim assigned the claimant with a 13% permanent partial physical impairment to the body as a whole. Dr. Shahim explained the basis for this rating as follows:

His impairment rating based on AMA Guide to the Evaluation of Permanent Impairment is 8% for one level lumbar disc with an additional 3% for the three more surgeries and an additional 2% for each additional level. There is 13% impairment of the whole person. I am not

including any peripheral nerve injury in this rating since the EMG studies are not conclusive in radiculopathy or peripheral nerve injury and on my examination I do not see clear radicular changes, although the patient has peripheral numbness and generalized weakness. I am also not including any cervical disc disease. I am not sure if his cervical disc disease is caused by prior work injury.

In reversing our previous finding, the Court of Appeals stated:

With respect to its determination of anatomical impairment, however, the Commission denied relief by employing an analysis that expressly rejected all evidence of physical impairment that was not objective. We hold that, in so doing, the Commission erred as a matter of law. Medical evidence of the injury and impairment must be supported by objective findings, A.C.A. § § 11-9-102(4)(D) and 11-9-704(4)(B) (Repl. 2002), *i.e.* findings that cannot come under the voluntary control of the patient. A.C.A. § 11-9-102(16)(A)(i). (Repl. 2002) There is no question that there were objective finding in the record supporting appellant's claim of back injury and resultant impairment. Nevertheless, the Commission rejected the medical opinions regarding the degree of impairment offered by Dr. Green and Dr. Moore simply because

those opinions were based in part on subjective findings. Quite clearly, the analysis engaged in by the Commission disregarded all non-objective evidence simply because it was subjective. We hold that this was an arbitrary rejection of medical evidence. There is no requirement that medical testimony be based solely or expressly on objective findings, only that the record contain supporting objective findings. *Swift-Eckrich, Inc. v. Brock*, 63 Ark. App. 118, 975 S.W.2d 857 (1998). Although credibility is a matter for the Commission to determine, a determination of credibility based on arbitrary rejection of an entire class of evidence cannot stand....

It is the Commission's duty to determine whether any permanent anatomical impairment resulted from a compensable injury. 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). Furthermore, Ark. Code Ann. § 11-9-704(c) (1) provides that "[a]ny determination of the existence or extent of physical impairment shall be supported by

objective and measurable physical or mental findings.”

Objective findings are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16) (Repl. 2002). Objective findings with regard to physical or anatomical impairment are further defined by A.C.A. § 11-9-101(16) (A) as follows:

(ii) (a) When determining physical or anatomical impairment, neither a physician, any other medical provider, an administrative law judge, the Workers' Compensation Commission, nor the courts may consider complaints of pain.

(b) For the purpose of making physical or anatomical impairment ratings to the spine, straight-leg-raising tests or range-of-motion tests shall not be considered objective findings.

The Commission has the authority and the duty to weigh medical evidence to determine its medical soundness, and we have the authority to accept or reject medical evidence. Mack v. Tyson Foods, Inc., 28 Ark. App. 299, 771 S.W.2d 794 (1989); Wasson v. Losey, 11 Ark. App. 302, 669 S.W.2d 516 (1984); Farmers Insurance Co. v. Buchheit, 21 Ark. App. 7, 727 S.W.2d 391 (1987). Likewise, the Commission

is entitled to examine the basis for a physician's opinion, like that of any other expert, in deciding the weight to which that opinion is entitled. However, as with any evidence, we can not arbitrarily disregard the testimony of any witness. In making determinations regarding the existence and extent of anatomical loss of use, we are not limited solely to medical evidence.

As noted by the Court of Appeals in Swift-Eckrich, Inc. v. Brock, 63 Ark. App. 118, 975 S.W.2d 857 (1998), when the Commission weighs a doctor's opinion, there is no requirement that the opinion or medical testimony "be expressly or solely based on objective findings, only that the record contain supporting objective findings." Thus, in analyzing the medical opinions on anatomical impairment offered in the present claim, we note that all three physicians have rendered an opinion on impairment that contain some supporting objective findings. However, pursuant to A.C.A. § 11-9-102(16)(A)(ii) our analysis cannot end there.

Of these three impairment ratings, it is unknown whether Dr. Moore and Dr. Green took into consideration complaints of pain, straight-leg-raising tests or range-of-motion tests when rendering their opinion. Dr. Moore testified in his deposition that he did not consider range-of-motion testing to be subjective. Nonetheless, A.C.A. § 11-9-102(16)(A)(ii)(b) strictly prohibits the consideration of range-of-motion tests when making a physical or anatomical impairment rating of the spine. Moreover, Dr. Moore testified that he did not compartmentalize or categorize his findings when he determined his impairment rating for the claimant. Thus, it is impossible to determine how much of the 25% anatomical impairment rating assigned by Dr. Moore may be attributable to impermissible range-of-motion testing or complaints of pain. Even when Dr. Moore was asked during his deposition whether the five percent difference between his rating and that of Dr. Green might account for the range-of-motion testing, Dr. Moore only acknowledged that as much as a 10% difference in different physicians' philosophy and findings could account for any

variations. He would not comment on whether the variations in this claim were the result of range-of-motion findings.

The DRE Category V upon which Dr. Moore relied to assess the claimant with a 25% anatomical impairment rating states that this category is appropriate for a finding of "Radiculopathy and loss of motion segment integrity." Loss of motion segment integrity is defined by the Guides as "an antero-posterior motion or slipping of one vertebra over another greater than 3.5 mm for cervical vertebra or greater than 5mm for vertebra in the thoracic or lumbar spine; or a difference in the angular motion of two adjacent motion segments greater than 11° in response to spine flexion and extension." While Dr. Moore may have noted findings of radiculopathy, he made no such findings of loss of motion segment integrity. In fact when asked whether he had any radiographic film evidencing loss of motion segment integrity, Dr. Moore testified that he was not sure whether there were any bending x-rays available for him to review. Accordingly, it is unclear upon what findings Dr. Moore relied to place the claimant within Category V which

requires loss of motion segment integrity. Conceivably, the surgical procedures the claimant has undergone may have left him with loss of motion segment integrity; however, no such finding is made in the medical records.

Likewise, Dr. Green assessed the claimant with a 20% anatomical impairment based upon Table 72 of the DRE. A 20% impairment also calls for a finding of loss of motion segment integrity. Dr. Green did not express a finding in his report that the claimant, indeed, has any loss of motion segment integrity. Furthermore, Dr. Green did not acknowledge reviewing any radiographic films which evidenced loss of motion segment integrity. Accordingly, it is not clear from a review of the medical records just what findings, objective or otherwise upon which Dr. Green relied to assess the claimant with a 20% anatomical impairment rating using Table 72 of the DME.

As Dr. Green's and Dr. Moore's impairment ratings actually require a finding of loss of motion segment integrity which is defined a greater than 5mm antero-posterior motion or slipping of one vetebra over another

greater for the lumbar spine, a findings that is not confirmed in the medical records, we cannot place any weight upon their assessment of impairment. On the other hand, the medical records detail the claimant's surgical history in great detail. Table 75 assigns impairments on the basis of "Specific Spine Disorders;" thus, from reviewing the claimant's medical records a diagnosis based impairment may be determined.

Claimant's first surgical procedure performed by Dr. Howard Morgan on December 10, 1997, consisted of a decompressive laminectomy at L3-4 and L4-5 with a posterior lumbar interbody fusion. The claimant reached MMI from this procedure and did "great" with only occasional soreness in his back in the subsequent years as noted by his physical therapist. Accordingly, at MMI from this first procedure, the claimant's diagnosis based impairment would be classified as Table 75, Category IV, C "a single level spinal fusion with or without decompression without residual signs or symptoms" for a base of 9%. Pursuant to IV, E, an additional 1% is added for the multiple level surgery. The

record reveals that the claimant's first surgery went well, in that after his recovery from this procedure, he continued to work without seeking further treatment for his back for approximately three years. Subsequently, the claimant began experiencing back and leg pain. Suspecting a herniated disc, Dr. Contreras performed an "uncomplicated" decompression at L4-5, and a diskectomy at L5-S1 on October 24, 2001. Because the second surgery involved level L4-5, which was previously operated on, and a new level, L5-S1, an additional 2% is added for the second operation with 1% being added for the additional level (L5-S1). This brings the claimant's total impairment rating to 13%. Thereafter, the claimant underwent two additional surgical procedures involving no new levels. According to E., 2, of Category IV., each of these subsequent surgeries is given an additional 1%. Therefore, utilizing Table 75 of the Guides, the claimant's total anatomical impairment rating is 15%. Thus our interpretation of the Guides is very similiar to that of Dr. Shahim; however, while he began at level A and he only credited the claimant's second surgical procedure with an additional 1%

rating instead of the 2% allowed we began at level C. Therefore, Table 75 offers us the best evidence of the claimant's actual degree of permanent physical impairment without reporting to speculation and conjecture. Therefore, as previously stated, utilizing Table 75 of the AMA Guides, the claimant sustained a 15% permanent partial physical impairment rating to the body as a whole.

The dissent contends that subsection IV. D should be the starting point for assessing the claimant's impairment rating which provides a 12% rating for "single level fusion with or without decompression with residual signs and symptoms" because the claimant now has documented radiculopathy as noted by Dr. Shahim and because the claimant has pain and rigidity caused by the hardware and fusions in his back. In this regard, the dissent contends that one should start at the end and work backwards; this is not the case. Each impairment is to be considered after a person has reached maximum medical improvement from the procedure. This is not only the method used by Dr. Shahim, but also every other physician with knowledge of the Guides

of whom we are aware that has issued impairments based upon Table 75. As noted above, the claimant reached maximum medical improvement from his first surgical procedure and was not noted to have residual signs or symptoms at the L3-4 and L4-5 levels. Accordingly, the proper starting point in this claim is IV. C. which provides a 9% rating for "single level spinal fusion with or without decompression without residual signs or symptoms." Although the claimant did not have residual signs and symptoms when he reached MMI, the Guides take into account that multiple level operations and multiple operations often leave a patient with residual signs or symptoms as the only category for multiple level or multiple operations states, "...with residual, medically documented pain and rigidity with or without muscle spasm." Thus, the additional percentages that are added for the claimant's second, third and fourth surgeries which resulted in the claimant now having documented radiculopathy as well as rigidity (findings he did not have after the first surgery) take into account these findings pursuant to IV. E.

We further find, for those reasons set forth in our original opinion, that the claimant sustained a 28% wage loss.

Accordingly, we find that pursuant to A.C.A. § 11-9-102 the claimant has sustained a 15% permanent partial physical impairment rating to the body as a whole and a 28% wage loss disability.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority opinion, which finds that the claimant is only entitled to a 15% impairment rating. After a de novo review of the record, I find that the Majority has erred by arbitrarily dismissing all medical opinions that are based, in part, on subjective

criteria. I am particularly disturbed by the findings of this Majority, as this was precisely the reason the Court of Appeals remanded the case. I find that the Majority has simply not provided any rational reason to reject the rating provided for by the DRE portion of the Guides. Furthermore, I find that even if utilizing Table 75, the Majority has still erred in assigning the claimant's impairment rating. Specifically, I find that the Majority has erred by failing to acknowledge that the claimant is entitled to an increased rating based on the fact that he suffers from residual symptoms. Regardless of the date of when these residual symptoms are measured, both the objective and subjective evidence in the record shows the claimant has residual problems related to his injury. Yet, inexplicably, the Majority ignores this evidence and assigns an incorrect rating.

After reviewing the record again, I find that the claimant should be given an impairment rating in the amount of 20%. The claimant suffered an admittedly compensable injury on January 10, 1997. Following that injury, the

respondent paid to the claimant the appropriate temporary total disability benefits and assumed liability for medical treatment he received pursuant to that injury.

The claimant sustained an admittedly compensable injury on January 10, 1997. The claimant would eventually undergo four surgeries to his lower back in an attempt to treat the injuries he sustained in his compensable accident. The first of the claimant's surgeries was performed on December 10, 1997 and consisted of a full laminectomy at L4, partial laminectomies at L3 and L5, and a posterior lumbar interbody fusion with "ray threaded cages at L3-4." The claimant's second surgery occurred on October 24, 2001, and consisted of a "redo" discectomy at L4-5 and a hemilaminectomy at L5-S1. The claimant's third surgery was performed on January 30, 2002. At that time another hemilaminectomy was performed at L5-S1. Finally, the claimant's last surgery was performed on June 5, 2002. It is significant to note that even after the claimant's surgery, he continued to present with objective changes to his spine.

In particular, on August 13, 2002, a CT scan was performed and revealed,

1. POSTOPERATIVE CHANGES FROM POSTERIOR LUMBAR FUSION WITH STABLE POSITION OF THE POSTEROLATERAL RODS, PEDICLE SCREWS, AND METALLIC SPACERS AT L3-4.
2. INTERIM CHANGE IS NOTED AT THE L5-S1 LEVEL WITH EXTRUSION OF THE INTERSPACE BONE GRAFT MATERIAL IN THE RIGHT ANTEROLATERAL EPIDURAL SPACE. THIS APPEARS TO BE EXTRUDED POSTERIORLY 7 TO 8 MM.
3. ADDITIONAL CHANGE OBSERVED WITH DEVELOPMENT OF FULL THICKNESS SCLEROSIS OF THE LEFT SACRAL ALA. THIS MAY REPRESENT STRESS REACTION OR LESS LIKELY STRESS FRACTURE GIVEN PATIENT'S ABSENCE OF SYMPTOMS.

X-rays taken on October 8, 2002, indicated there was no significant change since the time of the August CT scan. A CT scan conducted on January 7, 2003, revealed the claimant's spine appeared to be stabilized with metallic rods and screws, and that the claimant's fracture appeared to have healed significantly. However, the report also indicated, that the claimant's bone fragments at L5-S1 showed no positional change. The claimant reached his

healing period with these injuries on January 20, 2003, but continued to complain of persistent numbness in his hands.

Dr. Barry Green, an orthopedic surgeon in Texarkana, Texas, who the claimant saw at the direction of the respondent, evaluated the claimant for permanent impairment in January 2003. In a report dated January 20th of that year, he opined that the claimant had sustained a 20% whole person impairment based upon the American Medical Association's Guide to the Evaluation of Permanent Impairment, (4th ed. 1993). Dr. Green indicated the claimant had herniated discs from L3-L5 and indicated,

Based on the AMA Guides to the Evaluation of Permanent Impairment Fourth Edition, 1993 version, using the DRE Model for diagnostic related estimates (also known as the Injury Model) found on Page 110, Table 72, II, he receives 20% whole person impairment. He has no motor or sensory deficits; thus Tables 11 and 12 are not used. He has no vascular deficits and no other specific disorders.

The claimant later saw Dr. Jim Moore, a Little Rock neurosurgeon for another evaluation, also at the

direction of the respondent, in March 2003. Dr. Moore indicated he had a variety of medical and diagnostic reports regarding the claimant. He noted the claimant's loss of reflexes, atrophy above the fibular head, and loss of range of motion. Dr. Moore also discussed the claimant's final surgery when assessing the claimant for impairment. He indicated,

I have an operative report for review of the final procedure and this is dated 6-05-02. This is described as showing evidence of recurrent disk, lateral recessed stenosis L5/S1 left, degenerative disk disease L4/5, degenerative disk disease L5/S1. Procedures described as placement of pedicle screw L3/4, L5/S1 bilaterally, complete laminectomy L4, L5, S1 with decompression, decompression of severe lateral recessed stenosis L4/5 and L5/S1 bilaterally, posterior lumbar interbody fusion L4/5 using 11 mm synthes plif spacers, L5/S1 using 11 mm synthes plif spacers, posterior lateral fusion L3 to S1.

In Dr. Moore's report of March 4, 2003, he also opined that the claimant had sustained a permanent impairment. However, Dr. Moore stated that it was his belief

that the claimant's anatomical impairment was 25% to the body as a whole. Dr. Moore opined,

On the basis of my examination I believe that Table 72, page 110, the DRE of V would be most appropriately submitted in this patient's instance based upon my examination and history today. This does not include or incorporate the residual numbness he is experiencing which apparently was positional at the time of the last surgery so far as the numbness of the fingers described above.

Dr. Moore later testified as to the claimant's condition. Dr. Moore indicated the claimant had various objective findings which were the cause of his impairment rating. Dr. Moore noted the claimant had a loss of range of motion, loss of reflexes, and had medical instrumentation in his spine. Dr. Moore acknowledged that he had no knowledge of whether bending x-rays had been performed on the claimant.

Lastly, the respondent also directed the claimant to undergo an evaluation by Dr. Reza Shahim, another Little Rock neurosurgeon, who stated that it was his opinion that

the claimant had a sustained a 13% impairment to the body as a whole. Dr. Shahim opined,

His impairment rating based on AMA Guide to the Evaluation of Permanent Impairment is 8% for a one level lumbar disc with an additional 3% for three more surgeries and for an additional 2% for each additional level. There is 13% impairment of the whole person. I am not including any peripheral nerve injury in this rating since the EMG studies are not conclusive in radiculopathy or peripheral nerve injury and on my examination I do not see clear radicular changes, although the patient has peripheral numbness and generalized weakness. I am also not including any cervical disc disease. I am not sure if his cervical disc disease is caused by prior work injury.

As indicated above, the claimant was evaluated and rated by three different doctors. The claimant saw all of these doctors at the request of the respondent. The first of those doctors was Dr. Barry Green, who is affiliated with the Health South Evaluation Center, and stated that the claimant sustained a 20% impairment to his whole person. The second physician was Dr. Jim Moore, who was of the opinion that the claimant's actual impairment was 25% to the whole

person. Dr. Reza Shahim believed that the claimant's impairment rating was 13%. All doctors purportedly based their opinions on the Guides.

After reviewing the record, I find that the Majority errs in that they continue to dismiss the opinions of Dr. Moore and Dr. Green because they appear to take into account subjective criteria. However, in my opinion, the Court of Appeals has quite clearly indicated in this case and multiple other recent remands, that a doctor's opinion cannot be discounted simply because it is based, in part, on subjective criteria. It is apparent that in the present case the respondents continued to "doctor shop" until Dr. Shahim assigned the claimant with a rating lower than that of the two previous doctors. Perhaps more disturbingly, the Majority fails to even acknowledge all relevant objective criteria in assigning a rating. When reviewing the opinions of the three doctors, I find that it is apparent that Dr. Shahim's rating is incorrect pursuant to even Table 75 of the Guides. Furthermore, it is apparent the Majority has followed the same general approach as the one used by

Dr. Shahim and has erred in regard to the rating they have given the claimant.

Ark. Code Ann. § 11-9-704(c) (B) (Repl. 2002) provides that "[a]ny determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings." Further, permanent disability "benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment." Ark. Code Ann. § 11-9-102(4) (F) (ii) (a) (Supp. 2002). The Commission had adopted the American Medical Association's Guides to the Evaluation of Permanent Impairment, (4th ed. 1993) for use in assessing the extent of permanent anatomical impairment.

The disparity in the ratings of Drs. Green and Moore, as compared to that of Dr. Shahim (which is the approach largely adopted by the Majority), is because of the Guides use of two separate rating systems for spinal injuries. The first method is using a Diagnosis Related Estimate (DRE), in what is referred to as an Injury Model. In using this method, a doctor would examine a particular

patient and, based upon factors set out in the Guides themselves, place the claimant in a particular category of impairment. According to Dr. Green, the claimant was in a DRE impairment category two, however, it is apparent that pursuant to his rating he actually placed the claimant in category four. This finding, according to the Guides, should be based upon a patient's motor abilities, reflexes, muscle atrophy, anal tone, and the need for assistive devices. In this regard, it should be noted that muscle atrophy, reflexes, and motor abilities would all be objective criteria, not to mention the hardware such as metal cages, screws, and pedicles, which had been inserted in the claimant's lumbar spine as part of his fusions. Dr. Moore, likewise, relied upon this section but stated his belief that the claimant would be a better fit in category five which would entitle the claimant to an impairment rating of 25%.

In my opinion, the method used by Drs. Green and Moore is a more accurate evaluation of the claimant's impairment. The claimant had ample objective factors to

justify using this method and I believe that when possible, this section should be used since it can be used in its totality; whereas the range of motion model can only be partially used, giving a skewed picture of a claimant's impairment. After reviewing the Guides, I find that Dr. Green's evaluation of 20% to the body as a whole was correct and the Administrative Law Judge should have been affirmed.

It is the Commission's function to determine witness credibility and the weight to be afforded to any testimony. DeQueen Sand & Gravel v. Cox, 95 Ark. App. 234, S.W.3d (2006). The Commission must weigh the medical evidence and, if such evidence is conflicting, its resolution is a question of fact for the Commission. Allen Canning Co. v. Woodruff, 92 Ark. App. 237, S.W.3d (2005) When the Commission weighs medical evidence and the evidence is conflicting, its resolution is a question of fact for the Commission. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). Moreover, the Commission can reject or accept medical evidence and determine the

probative value to assign to medical testimony. Hamilton v. Gregory Trucking, 90 Ark. App. 248, 205 S.W.3d 181 (2005). However, it is also well settled that the Commission may not arbitrarily disregard medical evidence or the testimony of any witness. Coleman v. Pro. Transportation Inc., CA 06-525 (Ark. App. 2-7-2007).

In arguing that the Injury Model or DRE model be used, I note that the Guides themselves, indicate that the Range of Motion Model should be used only if the Injury Model is unavailable. The Guides indicate,

The evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 (p. 108). That model, for instance, would be applicable to a patient with a herniated lumbar disk and evidence of nerve root irritation. If none of the eight categories of the Injury Model is applicable, then the evaluator should use the Range of Motion Model.

In this instance, two out of three physicians believed it was appropriate to use the Injury Model. Indeed, it is also apparent from reviewing the language of the

Injury Model that the claimant was appropriately placed in Category IV which, includes a finding of loss of motion segment integrity and other objective criteria.

Notably, Dr. Moore's report indicated that he had been given various medical records, including the claimant's operative reports from his last surgery. Dr. Moore noted various objective findings, including the claimant's atrophy below the fibular head. Dr. Moore later testified as to several objective findings with the claimant's back, including having a steel rod and pedicles in his back. Furthermore, Dr. Moore also testified the claimant also had a loss of range of motion and reflexes which correlated with his condition. Though Dr. Moore noted that he did not have knowledge of whether bending x-rays were performed, the medical records clearly show the claimant had to have implementation of metal hardware and spacers in his back. After reviewing the records, it is apparent that those actions were taken in part, due to the instability of the claimant's spine.

Likewise, it is apparent that after the final surgery, the claimant continued to have instability of the spine. Specifically, his post-surgery CT scan revealed the claimant had extrusions measuring some 7 to 8 mm in his lumbar spine. As previously discussed, as of the time of the claimant's January 2003 CT scan, the size of those extrusions had not subsided. Dr. Green, in his report for giving an impairment rating, also indicated the claimant suffered from a "HNP" at L3 through L5, indicating that despite the extensive nature of the claimant's surgeries, he still suffered from segmental instability. When considering the reports of these two physicians, the medical records, and the language of the Guides, I find that the reliance on the Injury Model and a rating of 20% should have been awarded. Furthermore, it is apparent that the claimant's segment integrity was objectively documented by radiographic studies and was properly acknowledged by Dr. Moore and by Dr. Green.

In contrast to the opinions of Dr. Green and Dr. Moore, who both used the Injury Model and had minor

discrepancies in the rating the claimant was entitled to, we are presented with the rating given by Dr. Shahim. It is evident that Dr. Shahim was only hired to give the claimant a rating because the respondents were unhappy with the ratings provided by the two previous doctors. It is equally apparent that Dr. Shahim did not give an opinion which is consistent with the Guides. Likewise, the Majority has indicated that while Dr. Shahim's method contained flaws, it was generally correct with regard to whether the claimant would be given a rating for residual symptoms.

When reviewing the opinion of Dr. Shahim, it is apparent that it contains flaws. Likewise, I find that the impairment suggested by the Majority is equally flawed. Dr. Shahim's impairment rating is based upon a partial use of the other method of evaluating spinal injuries referred to in the Guides as a Free Range of Motion Model. This method provides a table which indicates a certain percentage of impairment based upon spinal injuries and then directs the evaluator to perform a number of range of motion tests upon the patient, the results of which are used to compute a

second percentage of impairments. Those two percentages would then be combined using a combined values table to determine the actual degree of impairment. In fact, in the directions for using Table 75, the following is indicated,

***Instructions:**

1. Identify the most significant impairment of the primarily involved region.
2. The diagnosis-based impairment estimates and percents shown above should be combined with range of motion impairment estimates and with whole person impairment estimates involving, sensation, weakness, and conditions of the musculoskeletal, nervous, or other organ systems.
3. List the diagnosis-based, range of motion, and other whole-person impairment estimates on the Spine Impairment Summary Form (Fig. 80, p. 134).

Dr. Shahim relied only upon the table which provides impairments based upon the degree of injury. Using Table 75 of the Guides, he determined that the claimant had sustained a 13% impairment. Unfortunately, the Majority has used a similarly flawed approach.

As previously discussed, the Guides specifically indicate that the Range of Motion model should only be used when a rating cannot be given under the Injury Model. It is significant to note that Dr. Shahim has not provided any indication that such would not be an appropriate method in giving a rating. Furthermore, as previously discussed, subjective factors, such as range of motion are not prohibited in giving an impairment rating so long as other objective findings exist. In fact, Dr. Shahim and the Majority have explicitly disregarded the language in the Guides which specifically instructs one to use Table 75 in conjunction with the range of motion impairment assessments in giving a rating. Finally, in reviewing Table 75 and Dr. Shahim's opinion, it appears that neither he or the Majority have correctly applied Table 75.

The Majority's argument further rejects the assignments given by Dr. Moore and Dr. Green because of the possibility that they might have considered the claimant's pain, straight leg testing, or range of motion tests. However, to make such a conclusion, one has to speculate

regarding whether Dr. Moore and Dr. Green used such criteria. Conjecture and speculation, even if plausible, cannot take the place of proof. Ark. Dept. of Correction v. Glover, 35 Ark. App. 32, 812 s.W.2d 692 (1991); Dena Construction Co. v. Herndon, 264 Ark. 791, 575 S.W.2d 155 (1970); Arkansas Methodist Hospital v. Adams, 43 Ark. App. 1, 858 S.W.2d 125 (1993). More importantly, pursuant to case law discussed below, Dr. Moore and Dr. Green are allowed to consider straight leg testing and range of motion in assigning a rating so long as other objective findings exist.

The Majority argues that "Ark. Code Ann. §11-9-102 (16) (A) (ii) (b) strictly prohibits the consideration of range-of-motion tests when making a physical or anatomical impairment rating of the spine". I strongly disagree with this conclusion. The language of Ark. Code Ann. §11-9-102 (16) provides in pertinent part,

(A) (i) "Objective findings" are those findings which cannot come under the voluntary control of the patient.

(ii) (a) When determining physical or anatomical impairment, neither a physician, any other medical provider, an administrative law judge, the Workers' Compensation Commission, nor the courts may consider complaints of pain.

(b) For the purpose of making physical or anatomical impairment ratings to the spine, straight-leg-raising tests or range of motion tests shall not be considered objective findings.

The Majority has essentially interpreted this language to mean that straight-leg-raising tests and range of motion tests may not be considered when giving an impairment rating. Yet, that interpretation is directly in contrast with the explicit statutory language and interpretation by the Courts. The statute indicates that straight leg and range of motion testing are not objective findings-not that they cannot be considered once objective findings of an impairment rating already exist. Furthermore, as has been noted time and again by the courts, an impairment rating must only be supported by objective findings. See, Coleman v. Pro Transportation, Inc., supra;

See also, Singleton v. City of Pine Bluff, CA 06-398) (Ark. App. 12-6-06); See also, Swift-Eckrich, Inc., v. Brock, 63 Ark. App. 118; 975 S.W.2d 857 (1998). Accordingly, I read Ark. Code Ann §11-9-102 to stand for the proposition that straight leg testing and range of motion are not, in themselves objective findings. However, if other objective findings exist, then they can be considered in giving an impairment rating.

In my opinion, while the DRE method of rating is the correct one, even if one does not agree with that conclusion, then a more appropriate method of applying Table 75 would result in an 18% impairment rating. The claimant should have been rated under Table 75, Category 4, Section D, which refers to, "Single level spinal fusion with or without decompression with residual signs or symptoms." In my opinion, the medical records clearly show the claimant had residual signs and symptoms which existed immediately after her first surgery and which have worsened throughout the course of her treatment. In fact, even Dr. Shahim notes the abnormalities of the claimant's nerve test, which is

consistent with the claimant's residual pain and rigidity. As such, the appropriate impairment value from this section is 12%, not the 8% assessed by Dr. Shahim, or 9% as assessed by the Majority. Under Table 7 Category 4, Section E, the claimant would also be entitled to a one percent increase for multiple levels operated on. After all the surgeries, the injuries to the claimant covered three levels (L3-L4, L4-L5, and L5-S1), therefore an additional 2% should be added to the 12%, which would provide a 14% impairment. The Table goes on to provide that for a second surgery, an additional 2% should be added and an additional 1% for each additional surgery beyond that. Since the claimant underwent a total of four surgeries, an additional 2% should be added to that total which would yield 18%.

Likewise, the impairment rating adopted by the Majority is flawed. Specifically, it appears the Majority has failed to initially assess the claimant with a 12% rating rather than an 9% rating. Additionally, the claimant would be given an additional 1% for the additional level that was operated on during the initial surgery.

As previously discussed, the claimant's initial rating, without considering the additional level, would be 12%; not 9%. As such, after the claimant's first surgery, his rating would be 13% rather than the 10% awarded by the Majority. The claimant's second surgery would entitle the claimant to another 2% for being an "additional surgery". However, notably, during the claimant's second surgery, he was operated on at a new level (S1). This would provide him an additional 1% for that level, as it had previously not been operated on, thus bringing his rating at that time to 16%. Then, the claimant had two additional surgeries for which he would be entitled to 1% each. This makes the claimant's total impairment 18% if relying on Table 75.

According to Dr. Shahim, the claimant's herniated disc would entitle him to an impairment rating of 8% to the body as a whole. In arriving at that number, Dr. Shahim was apparently relying upon Part 2, Section D of Table 75 which relates to a "surgically treated disc lesion without residual signs or symptoms; including disc injections." (Emphasis added). However, that clearly is not the correct

part to use in regard to the claimant as he had a fusion and since he does have residual symptoms, specifically, rigidity caused by the hardware and fusions in his back, and a 7 to 8 MM extrusion in his lumbar spine. Furthermore, he has radiculopathy which has been measured by NCV tests.

Therefore, the correct part of the Table which should have been used was Part 4. Though it is apparent the Majority has correctly used the portion of Table 75 designed for a fusion surgery rather than a discectomy, it appears they have shared Dr. Shahim's flawed conclusion that the claimant did not have residual symptoms. As previously discussed every physician other than Dr. Shahim, has indicated the claimant suffered from residual symptoms, and ironically, even Dr. Shahim recognized the claimant had abnormal nerve testing.

In particular, I note the Majority asserts that the claimant is not entitled to an increase in his impairment rating because he is somehow asserting that he currently has residual symptoms but did not have such symptoms after his initial surgery. In supporting this

argument, the Majority finds that the claimant had allegedly reached MMI after his first surgery and that he had no residual symptoms after his initial surgery.

Unfortunately, the Majority is simply wrong with regard to the facts of this case and wrong in their assertion as to how to apply the Guides. The simple fact of the matter is that the claimant has had residual problems from the time of the first surgery until the present date. These symptoms were present after each surgery and at the time the claimant exited his healing period in 2003. Accordingly, it simply does not matter when one calculates the residual nature of the claimant's problems. What is apparent is that the Majority has ignored the true facts of this case in finding the claimant had no residual symptoms.

In their opinion, the Majority has indicated that the portion of Subsection E of Table 75 which allows for an additional percentage for subsequent surgeries is designed only to compensate a claimant for the residual symptoms due to the additional surgeries and multiple level operations. The language of the Guides simply does not comport with such

an interpretation. Rather the simple language of Subsection E seems to indicate that a claimant would be entitled to a 12% rating based on a condition causing them to suffer from, "Multiple levels, operated on, with residual medically documented pain and rigidity with or without muscle spasm." They would then be entitled to an additional 1% or 2% for a second or subsequent surgery or for multiple level operations with residual pain. While I agree that the claimant's rating would be assessed according to when their healing period ended, to determine that they cannot be assessed under Subsection D rather than Subsection A after they have re-entered their healing period would be to, in effect, deny them compensation for their residual symptoms.

Certainly, in my opinion, the reason for the additional 1% per level, 2% for the second surgery, and the additional 1% for each subsequent surgery is designed to compensate both for residual symptoms and for the additional physical impairment of their body due to the additional levels that had not been previously operated on or due to the additional impairment of the body caused by the second

surgery. In fact, the Guides even instructs one to, "Identify the most significant impairment of the primarily involved region," when calculating a rating. As such, it is evident that one would consider the condition at the time the rating is given and then assess the person as of that time; not the time that they first had surgery.

I am also baffled by the Majority's argument because even under their own rationale, the additional 1% given for the additional level that was performed on during the first surgery, would, according to their interpretation of Subsection E, require the claimant to have medically documented residual symptoms. In fact, the language of Subsection E indicates, "Multiple levels, operated on, with residual, medically documented pain and rigidity with or without muscle spasm. (Emphasis added.) As the Majority admits the claimant would be entitled to a 1% additional rating pursuant to Subsection E due to the first surgery, an additional 2% due to the second surgery, and an additional 1% for each surgery thereafter, even under their own interpretation, the claimant had residual symptoms

throughout his treatment. Accordingly, I find that it is clear that he should have been given a 12% rating pursuant to Subsection D.

I am also particularly disturbed by the Majority's approach in this case because it is evident that the claimant did not exit his healing period until January of 2003. Accordingly, even if one agrees with the Majority's interpretation regarding Subsection E, I find that they have still erred in their calculation as the claimant did not reach the end of his healing period after the first surgery.

To find the claimant reached MMI after his first surgery is simply not supported by the record and the Majority provides absolutely no evidence to support such a conclusion. In fact, when reviewing the evidence it becomes apparent that there is absolutely no medical evidence that the claimant reached MMI after his surgery in 1997.

The parties stipulated prior to the hearing that the claimant's healing period ended on January 20, 2003. In the past, it has been well accepted that stipulations are binding on both parties. Furthermore, the claimant's

testimony and the medical records clearly show that the claimant continued receiving treatment after the initial surgery and that he had residual problems.

This is shown by the CT scan performed within a week of his surgery and which revealed that the claimant had spinal defects at the L4/5 and L5/S1 levels. The claimant testified that he continued to have pain and that he had numbness as he had before the first surgery. These complaints were documented in a multitude of medical records from the period immediately after his initial surgery. It is also important to note the claimant was not given an impairment rating until after his fourth surgery, which seems to indicate that he had not reached MMI until that period of time. In sum, as the medical records are completely silent as to any time period prior to that in which the claimant would have been at MMI or as to what his impairment rating was prior to 2003, I simply cannot agree with the Majority's assertion that the claimant reached MMI after his initial surgery.

Furthermore, even if the claimant did reach MMI after his first surgery, it is of no consequence, as the overwhelming weight of the evidence shows the claimant had residual symptoms after his first surgery. There are a plethora of medical documents showing that after the claimant's first surgery, he remained symptomatic due to back pain. Additionally, the claimant's ongoing injury is supported by the objective evidence which shows that he suffered from nerve defects due to the first surgery. In fact, the evidence shows that his condition was so severe that he eventually had to undergo three additional surgeries.

The claimant's residual symptoms after the initial surgery are evidenced by the fact that the claimant received physical therapy in 1998 and reported that he was suffering from leg pain and numbness. The claimant apparently continued to receive treatment for chronic back pain, including left leg numbness. In fact as early as December 15, 1997, some five days after surgery, the claimant's diagnostic studies showed residual abnormalities.

In particular, I note that a CT scan showed bulging discs at L4-5 and a disc protrusion that deviated the S1 nerve root at L5-S1. Not surprisingly, when a nerve conduction velocity study performed on May 31, 2001, indicated that the claimant, did, in fact, have abnormal results, "DUE TO ABSENCE OF THE SURAL SENSORY RESPONSES BILATERALLY AS WELL AS DIMINUTION OF THE LEFT PERONEAL NERVE PROXIMAL AND DISTAL MOTOR RESPONSES AMPLITUDES." Notably, each of these findings occurred before the claimant's second surgery, which would indicate that the claimant had residual symptoms. In fact, the claimant's residual symptoms were so severe that when he had additional surgery in 2001 the physicians had to perform a "redo" of his first surgery. Certainly, if the claimant had no residual symptoms then the need for this additional surgery would not have existed.

The claimant's testimony also corroborates the existence of residual symptoms after the first surgery. The claimant testified that around six months after his initial surgery he returned to work. However, he said that even immediately after the first surgery, the surgeon knew there

were residual problems. The claimant indicated that, "They had done a CT on me two days after they did the surgery in Dallas, and there was still problems between the L4 and 5 and 5 and S1 right after the surgery has been done." The claimant said that his employer told him he would be sent back to the physician for his problems. The claimant further testified that he received physical therapy throughout at least 1998 and that he had continued numbness in his leg which caused his need for the second surgery.

Notably, the claimant's testimony on this issue is virtually identical to the medical records in evidence. Clearly, when considering the claimant's testimony and the medical evidence in the record, the overwhelming weight of the evidence shows that regardless of whether the claimant's residual symptoms are considered at the time after his first surgery or at the end of his treatment, he had residual symptoms for which he is entitled to an increased rating.

In sum, I find that the claimant should be given the impairment rating as awarded by Dr. Green. Additionally, it is apparent that the claimant sustained substantial

injury for which he required four surgeries and for which his treating physicians believed he was entitled to either a 20% or 25% impairment rating. The Guides specifically indicate that the methods used by Dr. Green and Dr. Moore are to be preferred over that of the method used by Dr. Shahim. Additionally, the medical records support these ratings with objective findings, including instability; whereas, Dr. Shahim, has obviously committed error even in applying the rating which is more in favor of the respondents. Unfortunately, the Majority has generally adopted the approach of Dr. Shahim and used Table 75 despite the fact that both they and Dr. Shahim fail to provide a reason not to use the method of rating preferred by the Guides. Rather the Majority has, yet again, erroneously concluded that subjective criteria may not be considered in giving an impairment rating; despite the fact that there were other, objective findings present. Likewise, even if Table 75 is used, the Majority simply has not given the claimant the appropriate rating in that they fail to

acknowledge the claimant is entitled to an additional rating for residual symptoms, including rigidity.

_____For the aforementioned reasons, I must respectfully dissent.

PHILIP A. HOOD, Commissioner