

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F501700

LINDA PARSONS,
EMPLOYEE

CLAIMANT

ARKANSAS METHODIST HOSPITAL,
EMPLOYER

RESPONDENT

ARKANSAS PROPERTY & CASUALTY
GUARANTY FUND,
INSURANCE CARRIER

RESPONDENT

OPINION FILED SEPTEMBER 17, 2007

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

Claimant represented by the HONORABLE M. SCOTT WILLHITE,
Attorney at Law, Jonesboro, Arkansas.

Respondents represented by the HONORABLE MARK A. PEOPLES,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The Arkansas Court of Appeals has reversed the Full Commission in the above-styled matter and has remanded for further findings of fact. *Parson v. Arkansas Methodist Hospital*, CA06-1223 (June 20, 2007). Pursuant to the remand from the Court of Appeals, and based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove she sustained a compensable injury to

her brain. The Full Commission finds that the claimant did not prove that she sustained any permanent physical impairment as a result of her compensable head injury.

I. HISTORY

The parties stipulated that an employment relationship existed in October 2001, when Linda Lucille Parson, now age 57, "sustained a head injury." Ms. Parson testified, "[T]he best I can remember as I was walking back to my desk with a chart in my hand to do some of my charting, and my feet just like stuck to the floor, both of them, and I stopped and fell forward and caught my forehead and the top of my head on the edge of a desk, like this one here (indicating). Then I fell on down to the floor and landed on my knees and hands."

The claimant received emergency treatment on October 29, 2001, and the event listed on the emergency room record was "Fell Down Stair." According to the record on October 29, 2001, the claimant reported that she had fallen and hit her forehead and then both knees. The history recounted "No LOC ... but later faint feeling." Handwritten notes appeared to indicate that the claimant had hematoma to the left forehead and slight edema and ecchymosis in the left knee. The impression was "soft tissue trauma to head &

knees." The treatment plan included a cold pack to the forehead. The emergency room record did not describe any other bruising to the claimant's face or blackening of the claimant's eyes.

Dr. L. L. Shedd, a family practitioner, examined the claimant on October 30, 2001 and diagnosed the following: "1. Contusion to left orbit. 2. Contusion to left knee. 3. Strain left foot." Dr. Shedd arranged an MRI of the claimant's brain, which was taken on November 12, 2001:

This 51 year old had a near syncope episode and has a contusion to the supra-orbital region on the right. She fell and hit her head on a desk. She has headaches....

The cerebellar tonsils are normally positioned. The 7th and 8th nerve complexes are normal. The ventricles are normal in size. No midline shift is identified and no free intra-axial or extra-axial fluid collection is identified. No abnormal signal is identified in the brain stem or cerebellum. A focal area of increased signal in the occipital lobe on the left is identified and slight increased signal in the paraventricular region of the frontal horns of the lateral ventricles is seen.

Following contrast administration no abnormal signal is identified to suggest neoplasm. The optic chiasm and pituitary infundibulum appear normally positioned.

The corpus callosum is normal.

OPINION: Focal area of small vessel ischemia in the occipital lobe on the left, deep white matter tract probably secondary to hypertension.

(Dorland's *Illustrated Medical Dictionary*, 28th Edition, defines "Ischemia" as "deficiency of blood in a part, usually due to functional constriction or actual obstruction of a blood vessel. "Hypertension" is defined as "high arterial blood pressure." The record does not indicate that either of these conditions was the result of the compensable injury.)

The claimant consulted with a neurological specialist, Dr. Demetrius Spanos, on February 12, 2002:

The patient is a 52-year-old right-handed female with no significant past medical history of headaches other than a rare occasional migraine who was at work at Arkansas Methodist Hospital in Paragould when her "shoes caught" on the floor, causing her to fall forward. As she fell forward she struck the corner of a counter with her left forehead and fell to the ground. Initially she had severe pain for 3 days around the site of the injury and following that she had nearly constant pain of variable intensity in the head. She describes this pain as a throbbing sensation, which is sharp but most often a severe ache....She has undergone an MRI of the brain, which was negative....

The patient was alert/oriented, speech was fluent, memory was intact, fund of knowledge was appropriate, attention span and concentration was normal....

Dr. Spanos' impression was "1. Headache. 2. Limb pain." Dr. Spanos prescribed medication "for the patient's posttraumatic cephalgia."

The claimant followed up with Dr. Spanos on March 19, 2002:

Patient states her headaches "are better" by approximately 75%. Headaches are less intense but as frequent (daily). No new symptoms of diplopia, visual loss, dysarthria, aphasia, focal weakness, numbness, incoordination, loss of consciousness, or seizure like activity. She rarely has severe headache.

Dr. Spanos' impression was "Headache from trauma."

The parties stipulated that the claimant "last worked for respondents in April 2002." The claimant testified that, in April 2002, "I was coming out of McDonald's and helping my mother in the van and I shut the door and I stepped back and I stepped in a pothole and broke my ankle and re-injured my back. And when I went to or called Arkansas Methodist to let them know I had broken my ankle and could not come back for however many weeks the doctor was going to keep me off, they told me I no longer had a job." The claimant agreed at hearing that her employment termination was not the direct result of the October 2001 accident. The claimant testified that she has not worked since April 2002.

The claimant continued to follow up with Dr. Spanos for her headaches.

The record indicates that Dr. Spanos administered and interpreted an EEG study on May 15, 2002:

The patient is a 52 year old female with a history of migraine headaches in the bitemporal area accompanied by memory loss and vision changes related to a head injury that she apparently sustained at work....

INTERPRETATION: Normal awake EEG recording. There is no evidence of epileptiform activity to indicate a seizure. There is no evidence of asymmetry to indicate a focal lesion. There is no generalized slowing to indicate an encephalopathic process.

Dr. Dan Johnson, a neuropsychologist, evaluated the claimant on June 11, 2002:

Linda Parson is a 52-year old, right dominant Caucasian female who was referred for neuropsychological evaluation by Dr. Demetrius Spanos, M.D. to assess the presence/severity of neurocognitive impairment following injury....

Per patient report, on October 29, 2001 Ms. Parson was working as an LPN on the hospital floor when she fell while walking over to the nurse's station. The patient noted that "both her feet stuck at the same spot on the floor," causing her to fall straightforward, head first, striking her forehead on the nurses desk. She noted that her "head snapped straight back." She denied losing consciousness, but noted experiencing some brief alteration of consciousness....

Current neuropsychological test findings indicate that the Ms. Parson is experiencing deficits in some areas of neurocognitive and neurobehavioral functioning while being well within expectations in others. Based on the patient's academic and occupational history, as well as selected subtests that are typically robust to most adult brain

injury, the patient's overall cognitive functioning is generally commensurate with premorbid levels. The patient's performance on memory measure ranged from the Average to Superior range. Overall, the patient did not lose (sic) information over time when asked to recall either visual or auditory information on delayed trials, suggesting information which was acquired was also well retained. Ms. Parson's current memory indices were significantly better than expectations given the patient's current overall functioning and well within normal limits for her age, education, and estimate of premorbid functioning.

Likewise, the patient's processing speed and visual-spatial/constructional abilities were well within normal limits for her age, pre-morbid level of functioning, and current overall level cognitive functioning.

Based on empirically derived measures, there is no objectively supported indications of exaggeration, overendorsement or malingering in the area of cognitive symptomatology....

The patient's most noticeable area of cognitive deficiency was in her attentional abilities. Attention, concentration, and vigilance were assessed through the use of multiple measures. On a three subtest, mediated composite index which measures attention and concentration, as well as ability to hold and manipulate bits of information in immediate working memory, Ms. Parson's performance was in the lower portion of the Low Average range approaching Borderline Impaired.... Ms. Parson's attention abilities are lower the expectations based on her current level of overall cognitive functioning, memory abilities, and most likely represent somewhat of a decline compared to pre-morbid testing.

In addition to the patient's neurocognitive deficits detailed above, Ms. Parson demonstrated significant emotional/behavioral distress, highlighted by significant depressive

symptomatology and considerable anxiousness and worrying.

Etiologically, based on description of injury, available medical records, and current neuropsychological assessment results, the patient appears to have experienced (sic) an uncomplicated mild head trauma without loss of consciousness, but with confusion-disorientation for several minutes. Research indicates that in the vast majority of these cases, the primary cognitive sequelae are problems with concentration and thinking skills. This is consistent with the patient's current neuropsychological testing. A majority of patients with uncomplicated mild/minor head trauma typically return to baseline functioning typically within a few months. Attentional abilities can be noticeably adversely impacted by elevated levels of emotional distress. Based on available information, Ms. Parson most likely experienced a clinically significant level of depressive/dysthymic and to a lesser extent anxious symptoms prior to her fall; however, these symptoms appear to have been exacerbated significantly by her current general medical condition, loss of work, etc. that has occurred since the fall. The emotional behavioral component is likely complicating/slowing her recovery towards baseline cognitively.

The claimant visited Dr. Spanos on July 11, 2002:

Patient continues to feel her memory is poor; however, I spoke with Dr. Johnson who states the patient scored in the 87th percentile for memory with an IQ of 98. Her depression score was high. The patient says that although she "hears what you're saying" she does not comprehend. Her EEG was normal. She has no new symptoms of diplopia, visual loss, dysarthria, aphasia, focal weakness, numbness, incoordination, loss of consciousness, or seizure like activity. She is now on topamax 200 mg bid with near complete resolution of headaches. Also, the neuropsych evaluation showed significant depression (2 standard deviations

from normal)....

Dr. Spanos' impression was "Post concussion cephalgia."
Dr. Spanos recommended the following: "1. Continue Topamax 200 mg bid for headache prophylaxis. 2. Patient will consider undergoing PET scan in Little Rock for functional testing. 3. No return appointment has been scheduled."

The claimant returned to Dr. Spanos on December 23, 2002:

Since her last visit the patient has had a recurrence of her headaches. She is currently on Topamax 200 mg bid with almost daily headaches. She also complains of "near syncope" with an "aura" proceeding it. There are no new symptoms of diplopia, visual loss, dysarthria, aphasia, focal weakness, numbness, incoordination, loss of consciousness, or seizure like activity.

Dr. Spanos gave the following impression: "Post-concussion cephalgia....My impression is that because the Topamax had done well for her in the past her current change of headache may be psychologically based from her financial stressors."

Dr. Spanos reported on October 14, 2003:

Ms. Linda Parson was initially evaluated by me in February of 2002 with her most recent visit in December of 2002. Since that time the patient has done very well and has had no further headaches. She is currently taking medication and has reached her maximum medical benefit. Her headaches appear to be resolved and she will continue this medication indefinitely. She will only return

to this clinic if future problems arise.

Dr. Spanos examined the claimant on or about October 19, 2003:

Because the patient feels that her memory has declined and this may be a side effect of Topamax I have recommended that we gradually decrease the dose by 100 mg every couple of weeks up to 100 mg bid to see if this improves her symptoms. It is possible that the patient's headaches related to the post-concussion syndrome have resolved and if she seems to tolerate the reduction of Topamax to 100 mg bid I will consider further reducing it to complete discontinuation. She continues to experience occasional sharp pain (headache) every three to four months which lasts for several hours....

I will be seeing her again in six weeks for final recommendations.

Dr. Spanos' impression was as follows: "1. Post-concussion cephalgia. 2. Memory decline."

Dr. Spanos reported on November 24, 2003:

The patient's headaches remain well controlled but her memory has remained unchanged. She is unable to recall the medications at work and to who they are to be given. She denies other symptoms of diplopia, visual loss, dysarthria, aphasia, focal weakness, numbness, incoordination, loss of consciousness, or seizure like activity. She has to make lists of the things she needs to do on a daily basis and this is not her norm....

The patient has reached her maximum level of improvement from a neurologic standpoint. Her headaches have improved with Topamax use although she continues to have several headaches over a year. These will be treated with Stadol. Her memory decline has also reached its maximum

expected improvement given that her accident occurred more than two years ago. Although the patient's cognitive function remains fairly good according to her neuropsychological evaluation it is worse than her premorbid condition.

Dr. Spanos gave the following impression: "1. Post-concussion cephalgia. 2. Memory decline."

Dr. Spanos corresponded with the respondent-carrier on January 5, 2004:

I feel that the patient has reached her maximum medical improvement. I believe her headaches are indeed caused by the injury that occurred at work and although her prognosis is good I suspect that she will need to continue to take medication to prevent headaches. It is possible that in the future her headaches may not be controlled with her current regimen and adjustments will need to be made. I do not feel that the patient will be able to discontinue her medication since she has had fairly steady headaches over the past two years. Finally, the patient has confirmed impairment from her injury as noted in her neuropsychological evaluation which indicates a decline in function from her premorbid condition. I do not feel that this will change with time, again because the injury occurred two years ago and the patient has not had any improvement of significance over the past two months.

On March 24, 2004, the claimant presented to Dr. Spanos for complaints of back pain. The history at that time indicated that the claimant traced her pain to the alleged accident in the McDonald's parking lot in April 2002. Dr. Spanos' impression was "1. Low back pain. 2. Limb pain."

A nerve conduction study of the claimant's left lower extremity was taken on March 30, 2004, with the following conclusion:

1. Absent left lateral femoral cutaneous response consistent with left meralgia paresthetica.
2. No other evidence of entrapment neuropathy or polyneuropathy is seen involving the left sural and superficial peroneal sensory nerves as well as the left tibial, peroneal, and sciatic motor nerves.

Dr. Spanos stated on May 25, 2004, "I do not feel that the patient's headaches are related to migraine but rather to her history of trauma. Her headaches are of variable intensity. According to the guides to the evaluation of permanent impairment the patient suffers from chronic pain predominately of marked intensity with frequent presentation."

Dr. Johnson evaluated the claimant on June 14, 2004:

Since her last evaluation, the patient reports worsening of her memory, attention span, and verbal comprehension. In addition, she describes increases in depression, anxiety, and irritability. Patient has not returned to work since the accident....

The patient was administered a phonemic and semantic fluency task (FAS & Animals) to assess spontaneous word list generation....Ms. Parson was able to produce 21 correct responses with a corresponding percentile rank at the 58th percentile for same-age, declines in short-term memory from 2002. This type of failure to return to baseline after mild concussion with psychogenic

overlay, while not being the norm, is not completely atypical, is often times grouped into the diagnostic category of post-concussive syndrome with poor adjustment. Attentional abilities can be noticeably adversely impacted by elevated levels of emotional distress. As noted in her previous report, Ms. Parson most likely experienced a clinically significant level of depressive/dysthymic and to a lesser extent anxious symptoms prior to her fall; however, these symptoms appear to have been exacerbated significantly by her current general medical condition, as well as psychosocial stressors of occupation, finances, housing, etc. that has occurred since the fall. The emotional - behavioral component of post concussive syndrome is likely complicating recovery.

The parties stipulated to "payment of appropriate medical benefits through June 27, 2004."

Dr. Spanos checked a line beside the following statement on June 27, 2005:

It is my opinion to a reasonable degree of medical certainty based upon the information presented to me, including a history given by the patient, that Linda Parson's work injury in October, 2001, resulted in a head injury which is supported by objective findings, and which resulted in permanent injuries including headaches and memory decline. Furthermore, her work accident was the major cause of her injury and she has sustained permanent impairment of 70 % to the body as a whole as a result of this accident according to the A.M.A. Guidelines, 4th Edition.

Dr. Spanos manually wrote the following in the margin:
"AMA Guidelines 25-50% for moderately severe cognitive decline 20-30% back."

The parties deposed Dr. Spanos on September 28, 2005. The respondents' attorney questioned Dr. Spanos with regard to the June 27, 2005 typed statement regarding anatomical impairment:

Q. You wrote, "AMA Guidelines 25 to 50 percent for moderately severe cognitive decline."

A. Uh-huh.

Q. Okay. Now, how is that cognitive decline measured?

A. By two neuropsychological examinations done by Dr. Johnson in 2002 and 2004....

Q. And do you know how those doctors measure the cognitive decline?

A. Yes, it's a three and a half hour long exam each time. And I'm not - I don't understand exactly how they do it, because I don't perform the tests, obviously. But in great part, there is a validity portion of it to make sure that the patient isn't malingering or, you know, in essence trying to fake the symptoms. And then they measure many of the verbal skills, the memory skills, the intelligent quotient, I.Q., the - I believe for the right/left brain to function, since each side does something different. There's an emotional factor in it too. In part, it's to gauge the validity of the test, because like any kind of lie detector test, if you - the first question they ask you is, "What's your name?" And if you get that wrong, and - then the rest of the test is invalid, obviously. So, it's a very lengthy test, and I will get you the copy....

Q. Do any of those criteria you just mentioned come under the control of the patient?

A. - how do you mean, control?

Q. Well, for instance, if you're measuring - is there a subjective factor; I'll put it that way?

A. That's what the validity part of the test is supposed to exclude. But keep in mind, I don't do this test - I will try to answer your questions within the guidelines you're giving me, or the ones that I can understand, okay?

Q. And it's your understanding that Dr. Johnson found a 25 to 50 percent - I beg your pardon, he found moderately severe cognitive decline?

A. He found mild to moderate in some respects. In the two studies that Ms. Parsons had, some factors improved slightly from the 2/02 to 2/04, but there were others that worsened....

Q. So it - what you're telling me is, based on the dates of these reports, all of the decline occurred after the injury?

A. We - I have no neuropsychological testing before that. The tests are designed also to gauge the patient's ability premorbidly; in other words, before an injury occurred, whatever injury occurred. So how they figure that out I don't know, but there is a way to do it....

Q. Okay. Now, where did that 25 to 50 percent number come from? Is that out of - straight out of the AMA Guidelines?

A. The AMA Guidelines, right....It is the Fourth Edition, yes, sir.

Q. I notice that 25 to 50 percent is a fairly broad range. Is it, in your opinion, closer to 25 or closer to 50 percent?

A. I actually put Ms. Parsons at around 35 percent, because some factors have gotten better, according to Dr. Johnson, and you can divide those out; and certain ones did get worse with time, so I didn't - I erred on the lighter side of the

percentage. So, I put her around 35 percent....

Q. Also on the June 27 report - there's handwritten in there, 20 to 30 percent.

A. Right.

Q. Is that for the back?

A. Yes, but that was related to some - another injury that she had, I believe, at McDonald's, in 4/02. And that was - what I didn't put in was the third issue, which was the headache. And that had been present from the first time. And the headache, unfortunately, has no number. And the guidelines talk about headache and specify certain aspects of headache, but they don't give as strict a guideline as other portions of the guidelines indicate with a number. So, although I wrote down back, I did not include back in the total 70 percent. I gave her approximately 35 percent for her cognitive decline, and 35 percent for her headache, which is again, erring on the lower end of the scale.

Q. And where does the 35 percent come from the headache come from; is that in the guides as well?

A. Yes. Yes, heading 15.9, Headache....Her pain is chronic, which from - which was the main reason that she came in. And the first time I saw her in February of '02, headache was the primary problem....

Q. How do you determine how severe her headaches are; by asking her?

A. - right.

Q. Okay.

A. That part is subjective. And also, I take into account, of course, in her case, four other things at the very least. Two of them are Dr.

Johnson's separate reports, neither of which show of malingering, that she was coming in for gain. Dr. Johnson is very good at what he does. He does, I'm sure, many cases, head injuries and others, for a lot of legal firms. And, I mean, obviously, he can be fooled, but two separate occasions separated by two years, it would be hard for a person, I think, to fool him. The second is, my personal judgment, I mean, I've been doing this for ten years, and I too can be wrong, but I'll add that. And the fourth is, Dr. O'Sullivan's evaluation, which agreed with mine....

The claimant's attorney questioned Dr. Spanos:

Q. And do you feel comfortable in the opinions that you've outlined in the June 27th, 2005 letter that I sent to you and you signed?

A. Yes, not only because I have unbiased evidence behind it, here with the American Guidelines, but also as I said, you had a second opinion from someone that is a neurologist also who was unbiased, and his conclusions were the same as mine, from what I read. Perhaps he wasn't asked about the percent of - the percents that I see of impairment anywhere - at least, I didn't see it in the record. But otherwise, yes, I'm very comfortable with what I said.

Q. And just to restate, I believe what you've already testified to, it's my understanding you assessed a 35 percent rating to the body as a whole for cognitive loss?

A. For cognitive loss.

Q. And a 35 percent rating to the body as a whole for the headaches, based on table 15.9?

A. Yes.

Q. And so, for a total of 70 percent to the body as a whole -

A. Right.

Q. - rating?

A. Approximately, but a number is needed, so we'll say 70 percent.

Q. Okay. And, Doctor, do you feel comfortable in making those opinions to a reasonable degree of medical certainty?

A. Yes, of course....

Q. And, Doctor, just to clarify one more point, do you attribute your 70 percent approximate rating according to the AMA Guidelines Fourth Edition, to Ms. Parson's work injury of 2001?

A. Yes. From the history that I obtained, her headaches clearly became worse following the head injury. Dr. O'Sullivan agreed that this was a post-traumatic headache, and in fact, may be post-concussive, and Dr. Johnson also agreed that her cognitive decline from the injury has deteriorated, and he compared it to her pre-injury states, in their means of testing.

Q. And, Doctor, can you make that opinion to a reasonable degree of medical certainty?

A. Yes, I can make it. But, of course, I can't speak for Dr. Johnson's testing, all right....

Q. And, Doctor, were you familiar with any diagnostic testing performed on Ms. Parsons following the injury, suggesting any sort of objective signs of an injury such as a November 12th, 2001, MRI of the brain?

A. November 12th, 2001; no, I do not have a copy of that.

Q. Let me pass you what I've been provided as an MRI of the brain November 12th, 2001; and if you can review that for me?

A. Yes.

Q. Does that appear to show a finding that - an objective finding of some sort of traumatic injury?

A. No....It means that because the patient has hypertension, high blood pressure, over time, there is - let's call it scarring of the brain. We see it in people that have diabetes, and people that have high blood pressure, and elderly patients, and patients with high cholesterol, and smokers, and this is not a finding of trauma.

Q. If we were to try to identify some objective signs of a closed head injury, are there such things that you can see?

A. Occasionally, yes. A brain wave test, called an EEG, which was later done, but I did not see any abnormalities on that. Of course, it was done a year and a half later, I think, almost. I take these reports as objective, even though I realize that it is a question/answer session, these reports are so lengthy that - and so convoluted in the way that they are done, that I accept them as objective.

Q. And, Doctor, when you refer to, "these" tests, are you referring to the -

A. The neuropsychological tests, I'm sorry.

Q. - that were conducted by Dr. Johnson?

A. Yes, yes.

Q. All right. And is it true, Doctor, that you saw clear evidence that there had been trauma to Ms. Parson's head?

A. No. I saw her - I can't remember the exact date of her injury, but I saw her in February of '02. So - oh, I see that you're saying. There

was a set of pictures, I think that was shown to me some time ago - I don't remember exactly when, of a great deal of facial bruising, and - but I don't recall the date that those pictures were taken. But I do remember pictures of facial bruising around the eyes and around the face....

Q. Were you made aware of a head trauma that Ms. Parsons suffered?

A. Right. That was reported to me on the initial history....

Q. Would you consider that there was no actual injury to the brain or nervous system, if you didn't have an MRI showing an abnormal brain?

A. No. Closed head injuries are often normal. I mean, if you look at the person, they don't even need the bruising around the face to show that. MRI's can be normal, EEG's can be normal, and yet the patient has symptoms from their head injury.

Q. And, Doctor - and understand I'm asking this from a prospective of a workers' comp analysis, but how do you objectively determine that? Is it simply that the testing or other factors, that you would use to make an objective determination?

A. There's some semblance of taking the patient at face value....

A pre-hearing order was filed on November 8, 2005. The claimant contended that she "was working in the course and scope of her employment on or around October 2001, when she suffered an injury as a result of a specific incident. At that time the Claimant fell and hit her head on the nurse's station desk. The Claimant was treated by various physicians, including Dr. Demetrius Spanos, Dr. Dan Johnson,

and/or Dr. Sanders McKee, and it has been determined that the accident resulted in an injury supported by objective findings and the injuries are permanent in nature. The Claimant contends that she is entitled to all appropriate benefits, including medical benefits, TTD benefits, PPD benefits, rehabilitation and/or wage loss, attorney's fees and all other appropriate benefits."

The respondents contended that "the benefits and compensation for which the claimant presently seeks entitlement do not appear related to her October 2001 injury."

An administrative law judge scheduled a hearing "on the issues of **permanent physical impairment, permanent partial disability benefits/wage loss, benefits pursuant to Ark. Code Ann. §11-9-113, and controverted attorney fees**[.]"

A hearing was held on November 18, 2005. The claimant testified that she had loss of memory following the compensable injury, as well as attention-span problems. The claimant testified that she suffered from daily headaches.

The administrative law judge found, in pertinent part:

4. On October 29, 2001, the claimant suffered a compensable physical injury to the brain in addition to her physical injuries to her forehead and both knees within the course and scope of her employment with respondent.

5. The claimant reached the end of her healing period on June 14, 2004.

6. The claimant has suffered a permanent physical impairment in the amount of 35% to the body as a whole as a result of the compensable brain injury growing of October 29, 2001, accident.

7. In addition to her anatomical impairment, when the claimant's age, education, employment history, and other matters reasonably expected to affect her future earning (sic) capacity, are considered, the evidence preponderated that the claimant has suffered a loss of earning (sic) capacity in the amount of 15% over and above her anatomical impairment.

8. The respondents shall pay all reasonable hospital and medical expenses arising out of the injury of October 29, 2001.

The respondents appealed to the Full Commission. The Full Commission reversed the administrative law judge's opinion and found that "the claimant has failed to meet her burden of proof."

The Court of Appeals has remanded to the Full Commission.

II. ADJUDICATION

A. Compensability

Ark. Code Ann. §11-9-102(4) (A) defines "compensable injury":

(i) An accidental injury causing internal or external physical harm to the body ... arising out of and in the course of employment and which requires medical services or results in disability or death. An injury is "accidental" only if it is caused by a

specific incident and is identifiable by time and place of occurrence[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4) (D). "Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16) (A) (i).

The claimant must prove by a preponderance of the evidence that her claim is compensable. Ark. Code Ann. §11-9-102(4) (E) (i); *Stephenson v. Tyson Foods, Inc.*, 70 Ark. App. 265, 19 S.W.3d 36 (2000). Preponderance of the evidence means the evidence having greater weight or convincing force. *Smith v. Magnet Cove Barium Corp.*, 212 Ark. 491, 206 S.W.2d 442 (1947).

In the present matter, the parties stipulated that the claimant "sustained a head injury" in October 2001. The claimant testified that she fell and "caught my forehead and the top of my head on the edge of a desk ... Then I fell on down to the floor and landed on my knees and hands." The claimant received emergency treatment on October 29, 2001. The record at that time showed hematoma to the claimant's left forehead, and slight edema and ecchymosis in the claimant's left knee. Dorland's defines "hematoma" as

follows: "a localized collection of blood, usually clotted, in an organ, space, or tissue, due to a break in the wall of a blood vessel." The emergency room impression was "soft tissue trauma to head & knees." On October 30, 2001, Dr. Shedd's diagnosis included contusion to the claimant's left orbit and contusion to left knee. "Contusion" is defined as "a bruise; an injury of a part without a break in the skin." "Orbit" is of course "the bony cavity that contains the eyeball."

An MRI taken November 12, 2001 showed "Focal area of small vessel ischemia in the occipital lobe on the left, deep white matter tract probably secondary to hypertension." There is no indication that the ischemia and deep white matter tract was the causal result of the claimant's fall on or about October 29, 2001. Dr. Spanos subsequently opined that the MRI of the claimant's brain was negative. Dr. Spanos testified at deposition that the MRI did not show trauma to the claimant's brain. Dr. Spanos also interpreted an EEG study on May 15, 2002 as a "Normal awake EEG recording."

The Court of Appeals has reversed the previous Full Commission finding in the instant matter and has remanded for further findings of fact. The Court states: "The

Commission has failed to address Parson's contention that she suffered a specific-incident closed-head injury. Instead, it has changed Parson's argument to one of *mental* injury or illness. Parson has contended that she suffered a specific-incident closed-head injury." The Court directs the Commission to analyze the case pursuant to *Wentz v. Service Master*, 75 Ark. App. 296, 57 S.W.3d 753 (2001) and *Watson v. Tayco, Inc.*, 79 Ark. App. 250, 86 S.W.3d 18 (2002).

In *Wentz v. Service Master, supra*, the Court reversed and remanded the Commission's determination that the claimant was not entitled to additional benefits. The claimant in *Wentz* had reportedly sustained a concussion as a result of a fall at work. The claimant informed her treating physician that she suffered from headaches and changes in mental status. The Court held in *Wentz* that there were objective medical findings establishing an injury to the claimant's brain, and that the objective findings included the diagnosis of concussion by a treating physician. The Court also relied on a neuropsychological evaluation in holding that *Wentz* had suffered a compensable injury to her brain.

In *Watson v. Tayco, Inc., supra*, the Court of Appeals affirmed the Commission's finding that the claimant did not prove she established a compensable closed-head injury. The claimant in *Watson* was hit in the back of the head by a metal plate. A neuropsychologist subsequently diagnosed "organic brain syndrome, close head injury." The Full Commission affirmed and adopted an administrative law judge's decision that the claimant "failed to establish a compensable closed head injury with medical evidence supported by objective findings." The Court of Appeals in *Watson* held as follows: "Here, the only evidence suggesting that appellant sustained a compensable closed-head injury was found in the results of the neuropsychological testing; there was no other objective evidence establishing a closed-head injury. The results of the neuropsychological testing standing alone is not enough to establish a compensable injury; therefore, we affirm the Commission."

In the present matter, the parties stipulated that the claimant sustained "a head injury." In considering whether or not the claimant also sustained a traumatic compensable injury to her brain, the Full Commission finds the facts of the instant case more analogous to the facts of *Watson, supra*, than to *Wentz*. Although the parties stipulated that

the instant claimant sustained "a head injury" in October 2001, the evidence does not demonstrate that the claimant sustained a compensable physical injury to her brain as a result of the head injury. The claimant was diagnosed as having hematoma to the left forehead and slight edema and ecchymosis in the left knee. A physician's impression on October 29, 2001 was "soft tissue trauma to head & knees." Subsequent diagnostic testing, namely the MRI and the EEG, did not show that the claimant sustained an injury to her brain and these diagnostic studies were in fact negative for any sort of traumatic injuries. Nor can Dr. Shedd's diagnosis of "contusion to left orbit" be interpreted as establishing a compensable injury to the claimant's brain. The Full Commission also does not interpret the findings of Dr. Johnson as medical evidence supported by objective findings establishing a compensable physical injury to the claimant's brain. Dr. Johnson opined on June 11, 2002 that the claimant had sustained "an uncomplicated mild head trauma without loss of consciousness, but with confusion-disorientation for several minutes." Dr. Johnson's evaluation did not indicate that the claimant had sustained a physical injury to her brain. Dr. Johnson stated in June 2004, "The emotional - behaviorial component of post

concussive syndrome is likely complicating recovery." There were no indications in either of Dr. Johnson's reports that his diagnoses were based on objective medical findings establishing an injury to the claimant's brain. The "phonemic and semantic fluency task" administered by Dr. Johnson was not an objective medical finding establishing an injury to the claimant's brain. The administrative law judge's finding that the claimant "suffered a compensable physical injury to the brain" is not supported by any probative evidence of record. The Full Commission reverses that finding.

B. Anatomical Impairment

"Permanent impairment" has been defined as any permanent functional or anatomical loss remaining after the healing period has ended. *Excelsior Hotel v. Squires*, 83 Ark. App. 26, 115 S.W.2d 823 (2003), citing *Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994). Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings. Ark. Code Ann. §11-9-704(c) (1) (B). Ark. Code Ann. §11-9-102(16) provides:

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

(ii) 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; 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.

(B) Medical opinions addressing compensability and permanent impairment must be stated within a reasonable degree of medical certainty[.]

Ark. Code Ann. §11-9-522(g) (1) provides:

(A) The commission, after a public hearing, shall adopt an impairment rating guide to be used in the assessment of anatomical impairment.

(B) The guide shall not include pain as a basis for impairment.

The Commission has therefore adopted the Guides to the Evaluation of Permanent Impairment (4th Ed. 1993) published by the American Medical Association. See, *Workers' Compensation Laws And Rules, Rule 099.34*. The Commission is authorized to decide which portions of the medical evidence to credit and to translate this medical evidence into a finding of permanent impairment using the AMA Guides. See, *Avaya v. Bryant*, 82 Ark. App. 273, 105 S.W.3d 811 (2003), citing *Polk County v. Jones*, 74 Ark. App. 159, 47 S.W.3d 904 (2001). The Commission may assess its own impairment rather than rely solely on its determination of the validity of ratings assigned by physicians. *Id.*

Permanent 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). "Major cause" means "more than fifty percent of the cause," and a finding of major cause shall be established according to the preponderance of the evidence. Ark. Code Ann. §11-9-102(14).

In the present matter, the administrative law judge found that the claimant sustained "a permanent physical impairment in the amount of 35% to the body as a whole as a result of the compensable brain injury growing of October 29, 2001, accident." The Full Commission reverses this finding. We find that the claimant did not prove she sustained any permanent physical impairment as a result of the October 2001 head injury. The Full Commission has determined *supra* that the claimant did not prove she sustained a compensable physical injury to her brain. We recognize that after the claimant reported that she fell, the claimant was diagnosed with hematoma to the left forehead and soft tissue trauma to the head. However, an MRI taken in November 2001 did not demonstrate that the claimant had sustained an injury to her brain as a result of the fall. Dr. Spanos noted in his medical reports and his

deposition testimony that there was no evidence of a traumatic brain injury. Dr. Spanos also recognized that an EEG study performed in May 2002 was normal.

Dr. Johnson examined the claimant on two occasions, June 11, 2002 and June 14, 2004. Neither of Dr. Johnson's reports show that the claimant sustained a permanent impairment as a result of her head injury. Dr. Johnson in June 2002 described "cognitive deficiency" and "mild head trauma," but there is no indication that this description was based on objective medical findings not within the claimant's voluntary control. See, *Watson v. Tayco, Inc.*, *supra*. Dr. Spanos admitted at deposition that he did not know how Dr. Johnson administered his tests or what methodologies Dr. Johnson employed to ensure that his findings were based on objective data. Nor does the record show that the Phonemic and Semantic Fluency Task administered by Dr. Johnson in June 2004 was based on objective medical findings not within the claimant's voluntary control.

On June 27, 2005, Dr. Spanos wrote that the claimant had sustained "25-50%" permanent impairment for "moderately severe cognitive decline." This finding is entitled to minimal weight, in that there is no indication that this

purported cognitive decline was based on objective findings. Dr. Spanos testified that his finding of "cognitive decline" was based on Dr. Johnson's testing, but that he did not "understand exactly" how this testing was administered. The Full Commission notes that Dr. Johnson did not assign a permanent impairment rating. Dr. Spanos testified that he assigned the claimant "approximately 35 percent for her cognitive decline, and 35 percent for her headache, which is again, erring on the lower end of the scale." Dr. Spanos testified that the purported 35% rating for headaches was taken from the Guides, "15.9, Headache." Dr. Spanos' rating in this regard was taken from Chapter 15 of the Guides, which deals exclusively with "Pain." Pain is by definition a subjective criterion and cannot be relied upon to assess a permanent physical impairment. See, Ark. Code Ann. §11-9-102(16) (A) (ii).

Based on our *de novo* review of the entire record, and pursuant to the remand from the Court of Appeals, the Full Commission finds that the claimant did not prove that she sustained a compensable injury to her brain. We also find that the claimant did not prove she sustained any permanent physical impairment as a result of her compensable head injury. Because the claimant did not prove she sustained

any compensable permanent anatomical impairment, the claimant also did not prove she was entitled to any wage-loss disability. See, *Wal-Mart Stores, Inc. v. Connell*, 340 Ark. 475, 10 S.W.3d 727 (2000). The Full Commission reverses the administrative law judge's finding that the claimant sustained a compensable physical injury to her brain. We also reverse the administrative law judge's finding that the claimant proved she was entitled to award of permanent physical impairment and wage-loss disability. This case is denied and dismissed.

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 finding that the claimant did not sustain a compensable brain injury. In my opinion, the Majority has erred by failing to consider any subjective evidence with regard to whether the claimant sustained a

compensable injury and therefore has committed reversible error. I find that the claimant has sustained a compensable injury and that she is entitled to the medical benefits, impairment rating, and wage loss benefits as previously set forth by the Administrative Law Judge.

The claimant in the present case worked as an LPN for the respondent employer. The claimant testified that the accident giving rise to the present claim occurred on October 29, 2001. The claimant described the incident as follows,

Q. And let's talk about what happened on that morning. Tell me specifically what you remember.

Q. (sic) I know I had been moved over to 3 E because they needed a nurse over there. And the best I can remember as I was walking back to the desk with a chart in my hand to do some of my charting, and my feet just like stuck to the floor, both of them, and I stopped and fell forward and caught my forehead and the top of my head on the edge of a desk, like this one here (indicating). Then I fell on down to the floor and landed on my hands and knees.

An emergency room report dated October 29, 2001, indicates the claimant reported falling, hitting

her forehead, and then both knees. The claimant reported that she did not lose consciousness, but did feel faint. The claimant was noted to have hematoma of her forehead, and to have bruising and edema of her knee. She was diagnosed with soft tissue trauma to the head and knee. The claimant began suffering from "spells" where she felt like she was going to fall. On November 8, she was noted to have bruising of her lower eyelids. The claimant was diagnosed with a contusion to the supra orbital area of her brain and referred for an MRI of her brain.

Accordingly, on November 12, 2001, the claimant submitted to a MRI scan of her brain. She was noted to have a contusion to the supra orbital region on the right side and to suffer from headaches. The claimant was noted to have, "Focal area of small vessel ischemia in the occipital lobe on the left, deep white matter tract probably secondary to hypertension."

On February 13, 2002, the claimant was treated by Dr. Spanos. The claimant reported that she had, "no significant past medical history of headaches other than a rare occasional migraine." The claimant reported that

she had sustained an injury after falling, hitting her forehead on a counter, and falling to the floor. She reported that since the incident, she had been suffering from headaches which were accompanied by nausea and vomiting and loss of vision. The claimant also reported that the loss of vision sometimes occurred without the headaches, and reported that she would have near syncopal episodes. The claimant was prescribed Topamax for "posttraumatic cephalgia". The claimant continued with treatment and reported limited resolution of her symptoms. On May 9, 2002, the claimant reported that the pain of her headaches had resolved some 70% in severity of pain, but not in frequency of occurrence. The claimant also expressed concern about continued memory loss and "near syncope" incidents. The claimant's dosage of Topamax was increased and she was referred for an EEG and a neuropsychological evaluation.

The EEG returned as normal and on June 11, 2002, the claimant submitted to a neuropsychological examination. The claimant recounted the fall and again reported she had no loss of consciousness but that she had suffered a brief alteration of consciousness,

including being dazed. The claimant also reported memory problems, difficulty with problem solving, decreased focus, and difficulty in being able to think clearly. The claimant reported increased depression and reported that she was having "spells" and vision problems. She related the symptoms to the fall. The claimant reported that she had suffered from, "occasional headaches" and depression in the past.

Dr. Johnson noted the claimant's overall functioning was within normal limits, but indicated that the claimant did have cognitive deficiencies in the area of attention, and memory. Dr. Johnson noted,

On a three subtest, verbally mediated composite index which measures attention and concentration, as well as the ability to hold and manipulate bits of information in immediate working memory, Ms. Parson's performance was in the lower portion of the Low Average range approaching Borderline Impaired.

Dr. Johnson indicated,

Ms. Parson's attention abilities are lower than the expectations based on her current level of overall cognitive functioning, memory abilities, and most likely represent somewhat of a decline compared to pre-morbid functioning.

Dr. Johnson also noted the claimant, in addition to having neurocognitive defects, appeared to have symptoms related to depression. Dr. Johnson opined,

Etiologically, based on description of injury, available medical reports, and current neuropsychological assessment results, the patient appears to have experiences (sic) an uncomplicated mild head trauma without loss of consciousness, but with confusion disorientation for several minutes. Research indicates that in the vast majority of these cases, the primary cognitive sequelae are problems with concentration and thinking skills. This is consistent with the patient's current neuropsychological testing. A majority of patients with uncomplicated mild/minor head trauma typically return to baseline functioning typically within a few months. Attentional abilities can be noticeably adversely impacted by elevated levels of emotional distress. Based on available information, Ms. Parson most likely experienced a clinically significant level of depressive/dysthmic and to a lesser extent anxious symptoms prior to her fall; however, these symptoms appear to have been exacerbated significantly by her current general medical condition, loss of work, etc. that has occurred since the fall. The emotional behavioral component is likely complicating/slowing her recovery towards baseline cognitively.

Based on these findings, Dr. Johnson recommended neuropsychological intervention to help the claimant with emotional issues. He also indicated the claimant could benefit from medication, including Effexor for depression, and recommended she be reassessed in 6 to 12 months.

On July 11, 2002, the claimant returned to Dr. Spanos. Dr. Spanos noted the claimant had, "near complete resolution of headaches". Dr. Spanos also noted the claimant had scored in the 87% for memory with an IQ of 98, and indicated the claimant's "depression score was high". Dr. Spanos continued the claimant on Topamax and noted the claimant was considering undergoing a PET scan for functional testing. The claimant continued to report headaches and memory loss.

On October 14, 2003, the claimant reported that she had only suffered from three headaches within the last 10 ½ months, but that her memory continued to decline. The claimant was diagnosed with post-concussive headaches and declining memory. Dr. Spanos noted the claimant's memory loss could be a side effect of the Topamax and decreased her dosage. Despite the

claimant's change in dosage, she continued to suffer from memory problems. On November 24, 2003, Dr. Spanos noted,

The patient's headaches remain well controlled but her memory has remained unchanged. She is unable to recall the medications at work and to who they are to be given. She denies other symptoms of diplopia, visual loss, dysarthria, aphasia, focal weakness, numbness, incoordination, loss of consciousness, or seizure like activity. She has to make lists of the things she needs to do on a daily basis and this is not her norm.

The claimant was again diagnosed with post concussive headaches and memory decline. Dr. Spanos placed the claimant at MMI and indicated, "Although the patient's cognitive function remains fairly good according to her neuropsychological evaluation it is worse than her premorbid condition."

On January 5, 2004, Dr. Spanos opined the claimant would likely need medication to control her headaches and indicated that he believed they were caused by the trauma due to the fall. He also indicated the claimant had confirmed impairment as noted by the neuropsychological evaluation. The claimant continued

to receive care from Dr. Spanos for management of her headaches.

On May 25, 2004, Dr. Spanos noted the claimant suffered with headaches which occurred approximately four times per week. Dr. Spanos opined,

I do not feel that the patient's headaches are related to migraine but rather to her history of trauma. Her headaches are of variable intensity. According to the guides to the evaluation of permanent impairment the patient suffers from chronic pain predominantly of marked intensity with frequent presentation.

The claimant submitted to another neuropsychological test on June 14, 2004. The claimant was noted to suffer from worsening of memory, attention span, and verbal comprehension. She also reported an increase in depression. The claimant was noted to have improved in some areas of functioning, but to have stayed the same or to have declined in other areas. Specifically, the claimant's ability to navigate verbally mediated tasks declined, and the claimant's memory proficiency declined.

On June 27, 2005, Dr. Spanos, in response to a questionnaire, indicated the claimant's headaches and memory loss were caused by her work injury and were supported by objective findings of a head injury. He further indicated the claimant's work accident was the major cause of those conditions and rated the claimant with a 70% rating to the body as a whole. To the side, he apparently wrote that the claimant had a 25-50% rating which was related to her cognitive decline and that 20-30% of the rating was for the claimant's back.

The claimant testified that as a result of the fall, she sustained extensive bruising on her face which extended to both of her eyes and down her cheeks. She also said she sustained bruising and swelling to her knee. The claimant said that immediately after falling she felt "woozy and funny", and that her head hurt. The claimant said that she was taken to the emergency room, but she could not recall whether she was transported or walked. She indicated that while she had a vague memory of the accident, she was relying on the records regarding what transpired. The claimant also testified

that she could not remember if she went back to work immediately after being treated.

The claimant testified that prior to falling, she had suffered two heart attacks, had problems with her shoulders, had back problems, elbow problems, and knee problems. However, despite these various injuries, she was able to work without difficulty. She testified that after falling, she began suffering from "spells" in which she felt like she was going to fall. She indicated that the spells would last a matter of seconds or minutes and that she still suffers from them. She attributed the spells to the injury at work and denied having the "spells" before falling. She said that she had spells several times a day immediately after falling, but that she does not suffer from them as frequently now.

The claimant further described that she now suffers from headaches on a daily basis and that she has to take Topamax and Stadol for the headaches. The claimant candidly admitted she suffered from headaches prior to the fall, but said that the headaches after the fall were different and more severe. Likewise, the

claimant testified that she suffers from memory loss and a loss of attention span due to the fall.

The deposition testimony of Dr. Spanos was also included in the record. Dr. Spanos testified that he believed the claimant had sustained an impairment of 35% to the body as a whole due to her cognitive decline. He further indicated that he had given her a 35% rating for her headaches. Dr. Spanos indicated both of those ratings were on "erring on the lower end of the scale". Dr. Spanos noted those ratings were based on the claimant's neuropsychological testing and said that while portions of the test were based on subjective criteria, there were built in validity controls to make sure the tests were accurate. He further noted that Dr. Johnson's report seemed to be consistent with his opinion, and noted that the evaluation performed by Dr. O'Sullivan was also consistent with both his and Dr. Johnson's reports. Dr. Spanos noted the claimant had reported having a history of having an occasional migraine and indicated that such a condition would not detract from his opinion on the claimant's impairment.

Dr. Spanos also indicated that the claimant suffered from bruising and that while the claimant's MRI was normal, often closed head injuries did not result in abnormal tests. In explaining this, he noted that often epileptic children who seize on a weekly basis often do not have abnormal objective testings, despite the fact that they have some abnormality in their brain.

This case is on remand for the Commission to consider the claimant's requests for benefits under a specific incident injury analysis. After a review of the record, I find that the claimant has shown that she sustained a compensable closed head injury, for which she is entitled to ongoing medical treatment, and for which she is entitled to a 35% impairment rating. The major issue in this case is really whether the claimant can show that she has sustained a compensable brain injury and whether the injury was the major cause of any related impairment rating.

The Majority has concluded that the claimant did not sustain a brain injury because diagnostic tests to her brain returned as normal. However, I believe that to find that all other objective evidence has no

validity or weight in determining compensability for a brain injury is seriously flawed. Not only is this rationale in contradiction to the previous cases on this issue, it is also completely at odds with the expert opinion of Dr. Spanos, who testified that serious brain disorders often fail to show up in diagnostic tests. In my opinion, the fact that brain injuries often do not show up in diagnostic tests is precisely the reason that other objective evidence has, in the past, been given great weight in proving a compensable brain injury. Furthermore, because the Majority has refused to consider the other objective evidence in the record, they have held this claimant to an impossibly high burden of proof in showing she sustained a compensable injury.

In the present instance, it is undisputed that the claimant fell at work and hit her head during the process. The claimant was noted to have soft tissue swelling and hematoma at the emergency room. Additionally, the claimant submitted pictures evidencing the severity of her bruising. Likewise, the claimant was noted to have bruising in the supra orbital area on

November 8, 2001. The claimant immediately began presenting with symptoms such as headaches, suffering from "spells", blurred vision, and loss of memory. These complaints were consistent with a brain injury and though objective testing failed to reveal abnormalities, the claimant was repeatedly diagnosed with "post concussive headaches", indicating she sustained a concussion. The claimant's brain condition was well documented throughout the course of her treatment and during her neuropsychological testing. In my opinion, the claimant's presentation with bruising is objective evidence supporting a finding of compensability and impairment. Likewise, the concussion was objective. Finally, the neuropsychological testing itself, is objective in nature, and shows the claimant's memory decline and headaches are due to a brain injury.

There are two relevant cases that are directly on point. They are Wentz and Watson. In Wentz, the claimant worked as a cleaner. She was injured when she fell and hit her head and the right side of her face on a concrete floor. She did not seek immediate medical attention but was later diagnosed with a concussion. A

short time after being injured, the claimant presented to the hospital and reported having headaches and changes in her mental status. She was referred to a neuropsychologist. A neuropsychological evaluation was performed and the claimant was diagnosed with having an organic brain disorder that was secondary to a closed-head injury. The doctor responsible for testing the claimant testified that the results of the neuropsychological evaluation were dependent on the claimant's voluntary responses. However, he also indicated that the claimant was not intelligent enough to manipulate the results of the test and indicated that it was virtually impossible to manipulate the results of such a test. Id.

In Wentz, the Administrative Law Judge found that the claimant sustained compensable injuries to the jaw and face but that she had not sustained a compensable brain injury. The Commission affirmed and adopted the decision as their own. On appeal, the Court of Appeals reversed and remanded the case, finding that the claimant had sustained a compensable brain injury. In making this finding, the Court noted that the

claimant's physical symptoms of nausea, vomiting, and light sensitivity did not present until after she fell. They further noted that the claimant was noted to have cognitive defects after falling and that her intellectual capacity had decreased. They also called attention to the fact that the claimant had been diagnosed with a concussion and specifically noted that during a fall it would be conceivable for a claimant to have jarring of the brain. Id.

In the case of Watson, the claimant was restocking cartons when she was hit on the back of the head by a metal plate that fell. The claimant presented at the emergency room with weakness, nausea, dizziness, blurred vision, and tingling in the upper extremities. The claimant was referred to have neuropsychological testing and was diagnosed with an organic brain injury. The respondents controverted the claim. At the time of the hearing, the claimant testified that she suffered from cognitive problems and suffered loss of balance and headaches. She also said that prior to her injury she had not experienced such symptoms. Id.

In Watson, the Administrative Law Judge found the claimant had not sustained a compensable brain injury. That decision was affirmed by both the Commission and the Court of Appeals. The Court specifically noted that the only objective evidence of a closed head injury was found in the form of the neuropsychological testing. The Court indicated that without other objective evidence to establish a closed-head injury, there was insufficient evidence to show that the claimant sustained a compensable injury. The Court went on to distinguish the holding of Wentz by noting that in Wentz other evidence in the form of medical testimony showed objective evidence of a brain injury and that such was sufficient to show a compensable injury. Id.

In my opinion, the present case is more similar to Wentz than Watson. In fact, the facts of the case are virtually indistinguishable with Wentz. Though the Majority has concluded that this case is more similar to Watson, they have provided no reasonable basis for doing so. Instead, they have simply refused to acknowledge that just as in Wentz, the claimant in

the present case had an objective injury in the form of bruising and a concussion. Each of these would support a finding of a compensable brain injury. Additionally, the claimant had cognitive defects as shown by neuropsychological testing, which is also objective.

Just as in Wentz, the claimant in the present case had no history of memory loss. In both instances, the claimants fell and struck their head. Likewise, in both instances, the claimants had minimal outward objective findings and had no diagnostic brain testing to show abnormalities. Yet, both claimants were diagnosed with concussions and presented with classic neurological deficits, including, headaches, emotional problems, and memory loss. Just as in Wentz, the claimant in the present case also suffered from documented loss of memory by neuropsychological testing. Additionally, the claimant in the present case also suffered from extensive bruising and was diagnosed with a post-concussive condition.

Additionally, I note that in the present case, Dr. Spanos testified that the neuropsychological testing had built in safeguards and that he accepted the results

of the test as being objective. This is exactly like Wentz, in that the claimant had objective findings and then a physician testified that her impairment was shown by objective findings. In fact, there is not a single doctor in the present case who did not note the claimant suffered from a closed head injury or failed to attribute the claimant's loss of memory and headaches to any incident other than the fall at work.

The Majority argues this case is like Watson. However, they are mistaken. As previously discussed, the claimant in the present case had objective symptoms in the form of bruising, a concussion, and neuropsychological testing. In contrast, in Watson, the only findings showing a closed head injury was the neuropsychological exam. The Court indicated that such was not sufficient, by itself, to show compensability. That is substantially different than the instant case. The claimant in the instant case was repeatedly noted to suffer from bruising to her head and face. These are the objective findings which were in addition to the neuropsychological testing. Furthermore, the claimant was diagnosed with post-concussive headaches, indicating

that she had sustained a concussion. Finally, in this case, Dr. Spanos testified the claimant had a brain injury, whereas in Watson, no such opinion was provided. In my opinion, pursuant to the rationale of Watson, the bruising, in conjunction with the neuropsychological testing, would be sufficient in order to satisfy the criteria for compensability. However, when considering that the claimant was also noted to have sustained a concussion in addition to bruising, and Dr. Spanos testified the claimant had a legitimate injury that caused impairment, it is even more apparent that even under the rationale of Watson, the claimant has met her burden of proof.

Furthermore, as has recently been noted by the Arkansas Court of Appeals in multiple cases, a compensable injury only need be supported by objective findings. As such, the claimant only need to show minimal objective findings in order to show that she sustained a compensable injury. In Singleton v. City of Pine Bluff, CA06-398 (Ark. App. 12-6-2006), the Court noted,

Although it is irrefutably true that the legislature has required medical

evidence supported by objective findings to establish a compensable injury, it does not follow that such evidence is required to establish each and every element of compensability. Stephens Truck Lines v. Millican, 58 Ark. App. 275, 950 S.W.2d 472 (1997). All that is required is that the medical evidence of the injury and impairment be supported by objective findings, Ark. Code Ann. §§ 11-9-102 (4) (D) and 11-9-704(b) (4) (B) (Repl. 2002), i.e., findings that cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102 (16) (A) (i).

In sum, I find that the claimant's closed head injury is supported by objective findings as evidenced by the bruising of the claimant's head, the diagnosis of post-concussive headaches, the claimant's subjective complaints of neurological problems, and the results of the neuropsychological tests. Dr. Spanos provided convincing testimony that was based on objective findings that the claimant sustained an injury and impairment due to her fall at work.

I further find that the claimant is entitled to related medical treatment for her brain injury. Arkansas law provides that the employer shall promptly provide for an injured employee such medical treatment

as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. Wal-Mart Stores, Inc. v. Brown, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In this instance, the claimant, while suffering from pre-existing migraines, has sustained a sharp increase in the frequency and severity of her headaches since falling. The claimant's treating physician, Dr. Spanos has opined the claimant will likely need to continue receiving medication for those headaches. Though the respondents now controvert the claimant's entitlement to benefits, the parties agree they paid for all treatment until June 2004, including the claimant's treatment for these headaches. Furthermore, and as previously discussed, every doctor has attributed the claimant's headaches to the fall at work, thus indicating her need for ongoing medical care

is reasonable and necessary in treating her compensable injury.

I further find that the claimant has shown she is entitled to a 35% impairment rating in relation to her cognitive deficits. This impairment rating is supported by objective findings in the form of the neuropsychological test showing impairment. Furthermore, the injury was the major cause of the claimant's impairment.

Permanent 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(F)(ii)(a). If any compensable injury combines with a preexisting disease or condition or the natural process of aging to cause or prolong disability or a need for treatment, permanent benefits shall be payable for the resultant condition only if the compensable injury is the major cause of the permanent disability or need for treatment. Ark. Code Ann. § 11-9-102(F)(ii)(b). "Major cause" means more than fifty percent (50%) of the cause. Ark. Code Ann. § 11-9-102(14)(A).

In order to assess anatomical impairment, the Commission has adopted the Guides to the Evaluation of Permanent Impairment (4th ed. 1993). See, Ark. Code Ann. § 11-9-522(g); Commission Rule 099.34. Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical findings. Ark. Code Ann. § 11-9-704(c)(1)(B).

Dr. Spanos, the claimant's treating physician, assessed the claimant with a 35% impairment rating for her headaches, pursuant to the Guides. He further assessed her with an additional 35% impairment rating for her cognitive deficits pursuant to the Guides. The Administrative Law Judge awarded the claimant a 35% impairment rating, but it appears that rating was given with regard to the claimant's deficit in memory loss rather than for her headaches.

After reviewing the record, I find that the rating of 35% should have been upheld. The respondents essentially argue that the claimant did not sustain an impairment because her loss of cognitive function was related to her depression rather than due to her closed head injury. They further assert that the claimant's

impairment rating was based on having a headache. Finally, the Majority argues that the opinion of Dr. Spanos should be rejected because he did not conduct the neuropsychological test and may have taken subjective criteria into consideration when giving an impairment rating.

I first address the Majority's dismissal of Dr. Spanos' opinion. In my opinion the Majority errs in asserting that the opinion of Dr. Spanos should be rejected. Though Dr. Spanos did not conduct the neuropsychological test himself, there is simply no reason to refuse his opinion. I find that to be particularly true since the claimant was subjected to repeated testing which showed she had a decline in her memory. Additionally, Dr. Spanos testified that there were built in safeguards in the test to make sure that the results were valid. As previously discussed, the Court has in the past, considered such a test to be objective in nature. Furthermore, I simply cannot support any decision finding that subjective criteria must be discounted. As discussed previously, the Court of Appeals has specifically indicated that once

objective findings exist, subjective criteria may be considered. Thus, the Majority's opinion on this issue is simply not in accordance with the law.

With respect to the claimant's request to benefits related to her loss of cognitive function and headaches, I have extensively discussed the causal connection between the claimant's injury and memory loss. I have also discussed the fact that the claimant only need objective findings in support of showing a compensable injury or impairment rating.

It is important to note in this case that every physician believes the claimant's headaches and memory loss are directly related to the compensable injury. Additionally, every physician has related the claimant's conditions, and more specifically, her memory loss, to the fall at work. As has been frequently noted by the courts, while the Commission is free to weigh the medical evidence, it cannot arbitrarily disregard medical evidence. See, Patchell v. Wal-Mart Stores, 86 Ark. App. 230, 184 S.W.3d 31 (2004).

Dr. Spanos has opined the claimant's injury was the major cause for her condition. Additionally,

while Dr. Johnson noted the claimant did suffer from depression and opined that might cause her to recover more slowly, that is a separate issue from the claimant's declined memory and increase in headaches. Furthermore, while Dr. Johnson indicated that the claimant's depression would cause her to have a delay in healing neurologically, the claimant was placed at MMI on November 24, 2003, and yet she still suffered from neurological defects. Finally, I note that even if there is a psychological component to the claimant's memory loss, it is apparent that the major cause of the claimant's memory loss and her headaches are due to her head injury and are not benefits limited by Ark. Code Ann. §11-9-113, as suggested by the respondents.

The respondents also argue the claimant did not provide accurate history as to the frequency of her prior headaches. I reject such an argument. First, I note that the Administrative Law Judge did not award the claimant an impairment for her migraines. I also note that while the claimant admittedly suffered from prior migraines, there is simply no convincing evidence that they occurred as frequently as they did after falling.

Furthermore, and more importantly, the only plausible explanation for the claimant's memory loss is her fall. As previously discussed, the claimant presented with various objective findings which clearly indicate the claimant sustained a brain injury which caused memory loss.

In sum, I find that the Majority is holding the claimant to an impossible burden of proof. The unrefuted evidence is that the claimant fell at work, struck her head, and has suffered memory loss due to a brain injury. The objective nature of the claimant's injury is well documented and there is not a single physician in the record that has expressed an opinion that the claimant did not sustain a brain injury. Though the claimant is required to show an objective injury, she is not required to show that every aspect of her condition can be objectively proven. Furthermore, in an instance such as this, where the expert medical testimony reveals that brain injuries are often not shown by diagnostic testing, to require such proof, and ignore all the other objective evidence in the record, is to essentially find that brain injuries are simply

not compensable as a matter of law. Such a finding is not in accordance with the purpose of the Workers' Compensation acts or the law on this issue.

Accordingly, I must respectfully dissent.

PHILIP A. HOOD, Commissioner