

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F400875

ERNEST REYNOLDS,
EMPLOYEE

CLAIMANT

ROBERTSON CONTRACTORS, INC.,
EMPLOYER

RESPONDENT

ZURICH AMERICAN INSURANCE COMPANY,
INSURANCE CARRIER

RESPONDENT

OPINION FILED NOVEMBER 6, 2007

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

Claimant represented by the HONORABLE STEVEN R. MCNEELY,
Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE ERIC NEWKIRK,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and
Adopted.

OPINION AND ORDER

Claimant appeals an opinion and order of the
Administrative Law Judge filed February 6, 2007. In
said order, the Administrative Law Judge made the
following findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation
Commission has jurisdiction over this claim.
2. The stipulations agreed to by the parties
are hereby accepted as fact.
3. A preponderance of the credible evidence
of record reflects that the claimant's healing
period ended on December 30, 2004. The

claimant is entitled to temporary total disability benefits through said date.

4. The claimant has sustained a ten percent (10%) whole body impairment as the result of his January 15, 2004, compensable injury and surgery.

5. The issue of claimant's entitlement to vocational rehabilitation benefits, as well as claimant's entitlement to wage-loss disability has been specifically reserved.

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

In affirming and adopting this opinion, the Full Commission acknowledges the handwritten report found on pages 18 and 19 of Claimant's exhibit A1-A19. Page 18 is written on letterhead from Little Rock Physical Medicine & Rehabilitation Associates, P.A., and page 19 appears to be a continuation of these notes. It is presumed that these are the handwritten notes of Dr. Ward, however neither page is signed or in any manner identified as Dr. Ward's notes and not those of his

nurse or one of his partners. After outlining the claimant's date of injury and course of treatment on the first page, the second page outlines the claimant's diagnosis and sets forth a plan for medical management and indicates a disability of 23% to the body as a whole. This proposed rating is not signed and does not indicate whether it was derived from the The AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, or from an orthopedic or physical medicine guide. Moreover, even assuming that the AMA Guides, 4th Edition was utilized to assess the rating, this handwritten report fails to prove any explanation for the factors used to arrive at this rating. Accordingly, we assess no weight to this rating.

Therefore we affirm and adopt the February 6, 2007 decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

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 sustained a 10% impairment rating as opposed to a 20% impairment rating. The Majority, by affirming and adopting the decision of the Administrative Law Judge as their own, has concluded that range of motion tests and other subjective medical evidence may not be considered in assigning an impairment rating. They have further rejected the DRE Model as an appropriate means to assign an impairment rating. Both of these findings are contrary to the existing case law. In fact, in multiple recent cases, the Court of Appeals has explicitly rejected such an approach. I am confounded by the Majority's blatant disregard of precedent and refusal to follow the direction provided by the Court of Appeals with respect to this issue. As such, I must now respectfully dissent.

The claimant sustained an admittedly compensable injury on January 15, 2004, when he was pinned between a construction basket and a cross brace. As a result of the incident, the claimant sustained a herniation at level C6-7. The MRI report noted the

herniation compressed the existing left nerve root and pushed the spinal cord posteriorly and to the right. On May 27, 2004, the claimant underwent surgery in the form of an anterior discectomy and anterior cervical fusion at level C6-7.

Unfortunately, the claimant received little relief from his symptoms after the surgery. The claimant continued to suffer from neck pain and continued to receive treatment. On August 23, 2004, Dr. Wilson assigned the claimant a 7% impairment rating. On the same date, Dr. Wilson noted the claimant had mild restriction of motion in the cervical spine.

During his followup care, the claimant continued to remain symptomatic and was noted to have numbness in his limbs and pain in his neck and shoulders. Likewise, the claimant continued to present with objective signs of impairment. Specifically, on October 20, 2004, the claimant was noted to have, "muscle spasm in the right shoulder elevator group and tenderness in the posterior aspect of his neck."

Likewise, by 2005, the claimant's diagnostic testing also revealed objective evidence of permanent impairment. Specifically, on May 3, 2005, the claimant's x-rays showed calcification between levels C6

and C7 and "some rertolisthesis of C3 and C4."

Likewise, the claimant was noted to have narrowing of the neuroforamina at C3-C4.

Likewise, on September 27, 2005, Dr. Moore noted,

FILMS: The MRI is compared to the 8-10-05 study. There is changes (sic) at C3/4 and C5/6, the latter being less well demonstrated today the radiologist describes. The patient's wafer is not well visualized.

EXAMINATION: BP: 136/84. P: 76. R:16. The patient comes in with a steady gait. He continues to hold his neck and although he can carry out a range of motion this does appear to be restricted about 50% in all modalities. The patient's reflexes are certainly hyperactive today especially in the uppers, to a lesser extent the lowers. On examination 8-17 I was not impressed necessarily that there was any spasticity. This is not the case today. He does have a possible Hoffmann's click bilaterally. The sensory patters appear intact. He has 1+ spasm of the cervical paraspinous.

RECOMMENDATIONS: This patient it is felt is now at the end of a healing period. He has less than desirable response to the surgery. Therefore, I would categorize him more in the failure rate than in the success rate. I also would feel that a rather significant disability rating is appropriate to consider in this patient's instance because of the

pain because of the spasticity and evidence that would be consistent with neurologic compromise. He also has a restricted range of motion. There is evidence of radiculopathy. This would best be served by Table 73, III/IV, 15%-25% together which would translate to 20% permanent partial to the body as a whole...

The claimant continued to receive treatment in the form of pain management. On October 18, 2003, Dr. Meador indicated that the claimant had signs of nerve root impingement and indicated that the claimant needed trigger point injections to treat his muscle spasms.

Finally, on January 10, 2007, Dr. Ward treated the claimant. Dr. Ward noted the claimant's medical history with respect to the compensable injury and noted the claimant suffered from radiculopathy. He assessed the claimant with a 23% impairment rating to the body as a whole.

The only issue that is on appeal is whether the claimant is entitled to a 10% impairment rating as previously awarded by the Administrative Law Judge, or whether he should be awarded an impairment rating of 20% as assessed by Dr. Moore. After reviewing the record, I find that the claimant should have been awarded the 20% impairment rating.

The claimant sustained an admittedly compensable injury for which he had to undergo fusion surgery. After the surgery, the claimant has been noted to suffer from objective impairment in the form of calcification at levels C5-6, muscle spasms in his cervical spine, retrolisthesis at C3-C4, and narrowing of the neuroforamina at C3-4. Additionally, the claimant was noted to have a loss of range of motion and hyperactive reflexes. Based on these findings, Dr. Moore and Dr. Ward found it appropriate to rate the claimant with a 20 and 23% impairment rating, respectively. They also both relied on the DRE method. These ratings were obviously based, primarily, on the claimant's objective impairment. As the DRE method is the method preferred by the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993), and the claimant has objective findings to support such impairment, I believe that is the appropriate method to rate the claimant.

I also find the Majority's approach in assigning a rating to be flawed. Curiously, the Majority seems to assert that the impairment rating assigned by Dr. Ward, is entitled to little weight. In supporting this argument, the Majority speculates that

Dr. Ward did not use the Guides and argues that it is unknown what criteria he used in giving a rating. This finding is bizarre as it is well known that the Guides are consistently used in workers' compensation cases. Furthermore, the Majority's finding is even more suspect when considering the fact that the rating by Dr. Ward is obviously supported by the DRE approach of the Guides. Additionally, the Majority's rationale for rejecting the opinion of Dr. Moore has been rejected by the Court of Appeals in multiple recent cases. Therefore, I find that the Majority's approach in assigning a rating does not conform with the law on this issue and should be rejected.

The disparity in the ratings of Drs. Ward and Moore, as compared to that of Dr. Wilson (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. Moore, the claimant was in a DRE impairment category

III/IV. 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. Table 73 further provides that to be in a level III, there must be "Radiculopathy: evidence of radiculopathy is present." For level IV, there must be, "Loss of motion segment integrity or multilevel neurologic compromise."

The other method of evaluating spinal injuries is 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 impairment. Those two percentages would then be combined using a combined values table to determine the actual degree of impairment. 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).

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 this instance, the Majority has completely rejected the opinion of Dr. Ward, who assessed the claimant with a 23% rating, which is consistent with the DRE Model and the opinion of Dr. Moore. Their reasons for rejecting his opinion are based on sheer speculation that he might not have used the Guides and that it is unknown what criteria he used in giving the rating. As previously indicated, anyone familiar with the Guides could only conclude that the Guides were the basis upon which Dr. Ward assigned a rating. Furthermore, the Court of Appeals has indicated that the Commission may not arbitrarily disregard medical evidence. By failing to properly consider the opinion of Dr. Ward, the Majority has arbitrarily disregarded medical evidence which shows that the preferred method for assigning a rating is pursuant to the DRE method. The Majority has also essentially blatantly disregarded corroborative evidence showing that the method of rating used by Dr. Moore should be preferred over the method used by Dr. Wilson.

Furthermore, the Majority has ignored the language of the Guides itself, which clearly indicates that the Range of Motion Model should only be used if the Injury Model is unavailable. I note that the Guides

indicates that the Range of Motion Model should be used only if the Injury Model is unavailable. The Guides provide,

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 III/IV which includes a finding of loss of motion segment integrity and other objective criteria consistent with radiculopathy.

The claimant was specifically noted to have calcification at level C5-6 which would be evidence of segmental instability. Additionally, the claimant was noted to have narrowing of the neuroforamina at C3-C4, and retrolisthesis at C3-C4. The claimant was also repeatedly noted, upon physical examination, to have muscle spasms. These objective findings clearly place

him in the DRE category III/IV. Furthermore, when considering the fact that the claimant was repeatedly noted to have loss of range of motion and radiculopathy, it is even more apparent that the claimant was appropriately placed in category III/IV.

I must reject the Majority's approach in giving an impairment rating. 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. Wilson has not provided any indication that such would not be an appropriate method in giving a rating. Likewise, the Majority has not cited any case to indicate that the DRE method of assigning an impairment should be disallowed simply because it uses, in part, subjective criteria. In fact, Dr. Wilson 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. Dr. Wilson and the Majority have adopted the Free Range of Motion Model in giving an impairment. However, they have relied only upon the table which provides impairment based upon the degree of injury rather than using Table 75 and then

combining that percentage with the free range of motion model as the Guides provides. Using Table 75 of the Guides, Dr. Wilson determined that the claimant had sustained a 7% impairment. Ironically, the Majority acknowledged the claimant had residual symptoms and awarded the claimant a 10% rating, but still unfortunately failed to combine range of motion and then to compute the actual degree of impairment when using Table 75.

The Majority's argument further rejects the assignments given by Dr. Moore based on the finding that he inappropriately considered subjective criteria such as the claimant's pain, straight leg testing, or range of motion tests in giving an impairment rating. However, pursuant to case law discussed below, that is simply not a valid basis to reject the rating given by Dr. Moore. In fact, as I have previously discussed, even the Guides' own language does not comport with a finding that Table 75 can be used without also accounting for range of motion. I also note that Dr. Ward assessed the claimant with a 23% rating, and there is absolutely no indication that he considered subjective criteria when giving a rating. Furthermore, and as previously discussed, the Majority has provided a

thinly veiled excuse for rejecting the rating assigned by Dr. Ward. Though the Commission has the ability to weigh varying medical opinions and evidence, they cannot simply ignore a medical opinion for speculative reasons as they have done in this instance with Dr. Ward. Likewise, they should not be allowed to simply make up their own approach in interpreting how to read the Guides, when the Guides provides clear instruction to the contrary.

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.

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., CA 06-525 (Ark. App. 2-7-07); See also, Singleton v. City of Pine Bluff, CA 06-398) (Ark. App. 12-6-06); See also, Donald Groom v. Nekoosa Papers, Inc., Et Al., ___ Ark. App., S.W. 3d. (2006); See also, Swift-Eckrich, Inc., v. Brock, 63 Ark. App. 118; 975 S.W. 2d 857 (1998); See also, Avaya v. Bryant, 82 Ark. App. 273; 105 S.W.3d 811 (2003). 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.

That is exactly what has happened in this instance. The claimant had objective findings in the form of calcification, muscle spasms, narrowing of the neuroforamina and retrolisthesis. These objective findings were clearly the primary reason for the claimant's impairment rating. While other subjective criteria was also used in giving a rating, because the claimant already had objective findings establishing impairment, pursuant to the holdings of the Court of Appeals, his subjective complaints and findings are also allowed to be used in assigning an impairment rating. As such, there is simply no valid basis to reject the ratings given by Dr. Moore or Dr. Ward.

The Majority also concludes that pain and other subjective complaints may not be considered in giving an impairment rating. It is important to note that Dr. Moore indicated, "I also feel that a rather significant disability rating is appropriate to consider in this instance because of the pain because of the spasticity and evidence that would be consistent with neurologic compromise. He also has a restricted range

of motion. There is evidence of radiculopathy." While the Majority would use this language to indicate that Dr. Moore was giving the claimant a rating based on pain, the aforementioned language simply is not consistent with that finding. Rather it is apparent that Dr. Moore believed the claimant had pain and other symptoms which were consistent with neurological compromise and radiculopathy. Thus, because of the claimant's objective problems and his resulting neurological compromise and radiculopathy; not his pain, he would be entitled to a high impairment rating.

Furthermore, even if one finds that Dr. Moore's rating was based on pain, (a finding I do not agree with), since the Commission has the ability and duty to assess its own rating pursuant to the Guides, and because even without the consideration of pain, a rating of 20% is entirely appropriate pursuant to the DRE method, there is no reason to reduce the claimant's impairment rating.

Additionally, even if one disagrees with Dr. Moore's rating, that does not excuse the Majority's blatant failure to appropriately consider the impairment rating awarded by Dr. Ward. As Dr. Ward specifically noted the claimant's medical history, including his

surgery, and his resultant condition, it is apparent that he was well equipped to assign a rating. In Dr. Ward's report there is absolutely no indication that his impairment rating was in any way related to the level of the claimant's pain, and given the language of the DRE Table 73, it is apparent that his method was appropriate. Yet, the Majority summarily dismisses his opinion. This is, in my opinion, tantamount to arbitrarily disregarding a medical opinion, which is impermissible and cannot be accepted.

Notably, the Majority's approach with respect to whether an impairment rating can be rejected simply because pain was used as one consideration in an impairment rating has also been expressly rejected by the Court of Appeals. I find the case of Swift-Eckrich, Inc. v. Brock, 63 Ark. App. 118; 975 S.W.2d 857, (1998) to be instructive. In Brock, the claimant sustained a compensable injury when she was knocked unconscious. CT scans revealed that the claimant had cerebral edema and interhemispheric hemorrhage. Neurological testing indicated the claimant had defects in verbal memory, higher level balance, and that she had loss of smell and taste due to cranial nerve damage. The Court of Appeals found that the claimant was entitled to a 5% permanent

impairment rating. In making that determination, the Court noted that while the claimant had control over her complaints of pain and headaches, the CAT scan showed results that were indicative of an objective finding. Accordingly, they affirmed a finding which awarded the claimant benefits in the form of an impairment rating.

When the language of Brock is considered in conjunction with the other cases cited which indicate an impairment rating only need be supported by an objective finding, it is evident that the argument proposed by the Majority is simply not in accordance with the law. Notably, in Brock, the same statutes were in effect as well, which would seem to indicate that the Court does not agree with the statutory construction proposed by the Majority.

Likewise, in this instance, the claimant clearly has suffered from objective findings that show impairment. Due to his compensable injury, the claimant has calcification, retrolisthesis, narrowing of the neuroforamina, and muscle spasms. These are each findings that were observed by diagnostic tests or upon physical examination, thus qualifying them as objective. Additionally, just as in Brock, the claimant suffers

from subjective findings of pain. Likewise, just as in Brock, because the claimant has already shown he has objective findings that show permanent impairment, simply because he was noted to have pain, that does not mean his impairment rating was invalid. Likewise, the claimant suffers from loss of range of motion and radiculopathy. The Majority has not indicated that these subjective complaints are not legitimate or that they do not result in impairment. Rather, they have simply found that because they are subjective, they may not be considered. However, as previously discussed, this approach is also flawed pursuant to the rationale of Singleton, Coleman, and Groom.

In short, it seems to me that the Majority is simply refusing to acknowledge that subjective criteria may be considered in assessing a permanent impairment. This is disturbing as the Court has repeatedly indicated that such an approach is simply not a correct interpretation of the applicable statutes. It is also unfortunate that because of the Majority's refusal to follow the prior holdings of the Court of Appeals, there will undoubtedly be needless delay and clogging of the courts in both this case and in others. There is no

excuse for this arbitrary refusal to follow precedent,
particularly when the law on this issue is quite clear.

For the aforementioned reasons, I must
respectfully dissent.

PHILIP A. HOOD, Commissioner