NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F511489

STEPHEN COLEBANK,
EMPLOYEE CLAIMANT

T. J. MAXX,
EMPLOYER RESPONDENT

AMERICAN CASUALTY CO. OF READING, PA,
INSURANCE CARRIER RESPONDENT

OPINION FILED OCTOBER 16, 2008

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

Claimant represented by the HONORABLE NEAL L. HART, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE MICHAEL J. DENNIS, Attorney at Law, Pine Bluff, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The claimant appeals an administrative law judge’s opinion filed November 9, 2007. The administrative law judge found that the claimant did not prove he had sustained a permanent anatomical impairment. After reviewing the entire record *de novo*, the Full Commission affirms the administrative law judge’s opinion.

I. HISTORY

The parties stipulated that Stephen Colebank, age 58, sustained a compensable "hip fracture" injury on October 13, 2005. Mr. Colebank testified that he slipped in vinegar oil and fell. Dr. Ethan J. Schock examined the claimant on October 13, 2005:

> Mr. Colebank is an otherwise healthy and active gentleman who fell at work today. He injured his left hip. He is brought to the emergency department at St. Vincent's Hospital where he was noted to have a cortical abnormality of the left greater trochanteric portion of his femur. This was further evaluated with MRI and this confirmed an intertrochanteric femur fracture. It is for this injury that he is admitted....
>
> X-rays and MRI are reviewed. I agree with the radiology report. I feel that he has a left intertrochanteric femur fracture.

Dr. Schock's impression was "Left intertrochanteric femur fracture....He is admitted for this injury and I recommend operative stabilization of this fracture."

Dr. Schock performed an "Intramedullary fixation of left intertrochanteric femur fracture" on October 13, 2005. The pre- and post-operative diagnosis was "Left intertrochanteric femur fracture." The claimant followed up with Dr. Schock following surgery, and Dr. Schock noted on February 17, 2006:

> He is four months out from his left intratrochanteric femur fracture.

> He was noted to be healed on his x-rays on his last visit. He was noted also to be very weak in his hip musculature. He has been working in PT for the past month. He has made noticeable improvement. He still has some weakness of the abductors but this is noticeably improved and I anticipate full recovery in this regard. I do think he will require continued therapy for this and daily exercise at home. Structurally, I think it is safe for him to return to work. I do not see a need for any restrictions at this time. I do believe he has reached maximum medical improvement from this injury. After reviewing his range of motion (full), his strength 5/5, and his lack of degenerative changes or problems with healing on x-ray, I feel that he has no measurable permanent partial impairment. This is based on my review of the physical examination and x-rays as they relate to the guide to permanent partial impairment from the American Medical Association, 4th Edition.

The parties agreed at hearing that the claimant's healing period ended February 17, 2006. The parties stipulated that the respondents "paid all appropriate medical and TTD benefits."

Dr. Harold H. Chakales examined the claimant on September 27, 2006:

> Mr. Steve Colebank is a 56-year-old man who presents with complaints of pain as the result of injuries he sustained at work. He is working at the present time as a store manager for Dollar Tree...
>
> AP pelvis and AP and lateral of the left hip show where he has had nailing for a fracture. This is well healed.

> X-rays of the lumbar spine show lumbar degenerative disc disease at multiple levels. He has facetal arthritis at L4-5, L5-S1, with spurring. Coned down lateral shows definite degenerative disc disease from L3 down to the sacrum....
>
> Physical examination shows a well developed male who walks with an antalgic gait. Examination of the left thigh shows it is 1 cm smaller than the right thigh. The left calf is 2 cm smaller than the right. Range of motion of the right hip is normal. Range of motion of the left hip shows he lacks 5" flexion. He has 5" internal rotation on the left as opposed to 25" on the right. He lacks 10" external rotation of the left hip. Range of motion of the knee is normal. There is good flexion/extension, with no instability. Examination of the lumbar spine shows some point tenderness to palpation in the lower lumbar spine.

Dr. Chakales diagnosed “1. Healed intertrochanteric fracture, left hip, with some restriction of motion. 2. Symptomatic hardware, left hip. 3. Rule out lumbar disc problem....This gentleman is a suitable candidate for an MRI of the lumbar spine to make sure he does not have a disc problem in association with the previous fracture of the hip. The fracture has healed, but he remains symptomatic. We will schedule him for the MRI, as well as an EMG/NCV of his back and both legs.”

Dr. Brent Sprinkle administered an EMG study of both lower extremities of the claimant and gave a

Summary/Interpretation on October 16, 2006: "No electrodiagnostic evidence of a lumbar radiculopathy, focal tibial or peroneal nerve entrapment is seen in the extremity tested today. No electrodiagnostic evidence of a generalized sensory or motor peripheral neuropathy is seen in the extremity or extremities tested today."

Dr. Chakales noted on October 23, 2006, "He had an EMG/NCV study, which was normal. He also had an MRI but I do not have the results. Physical findings are unchanged." And Dr. Chakales noted on October 30, 2006, "He has a couple of bulging discs in his back which could be causing his pain. He is also post op nailing and has symptomatic hardware which is causing some of his hip and back pain. My recommendation would be to consider removal of the hardware from his hip and see how he does, then work up his back if he continues to have problems."

Dr. Chakales wrote to the claimant's attorney on May 10, 2007:

> Mr. Steve Colebank was seen in my office today in follow up. I have enclosed a copy of my recent evaluation on him. I feel his diagnoses remain unchanged.
>
> Mr. Colebank has an anatomical impairment of the left hip of 10% to the body as a whole, and an 5-10% impairment to the body as a whole of the lumbar spine.

The claimant testified that he had not yet undergone the additional surgery recommended by Dr. Chakales.

A pre-hearing order was filed on July 31, 2007. The claimant contended that he was entitled to "payment of permanent partial disability benefits based upon a 10% whole body impairment rating assigned by Dr. Chakales. Claimant's attorney is entitled to payment of a statutory attorney's fee on all controverted benefits. All other potential issues are reserved." The respondents contended that the claimant "has no permanent impairment and that the 10% rating of Dr. Chakales is not compliant with the requirements of Arkansas Workers' Compensation law."

The parties agreed to litigate the issues, "1. Anatomical impairment. 2. Controversion and attorney's fees."

An administrative law judge found, in pertinent part, "6. The claimant has failed to prove by a preponderance of the evidence that he has an anatomical permanent impairment."

The claimant appeals to the Full Commission.

II. ADJUDICATION

The Commission has adopted the Guides to the Evaluation of Permanent Impairment (4th ed. 1993) to be used in assessing anatomical impairment. *See Commission Rule 099.34*; Ark. Code Ann. §11-9-522(g)(Repl. 2002). Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the impairment. Ark. Code Ann. §11-9-102(4)(F)(ii)(a)(Repl. 2002). 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)(Repl. 2002).

In the present matter, the Full Commission finds that the claimant did not prove he sustained a permanent anatomical impairment as a result of the compensable injury. The parties stipulated that the claimant sustained a compensable hip fracture injury on October 13, 2005, for which Dr. Schock performed surgery. Dr. Schock opined on February 17, 2006 and stated, "After reviewing his range of motion (full), his strength 5/5, and his lack of degenerative changes or problems with healing on x-ray, I feel that he has no measurable permanent partial impairment. This is based on my

review of the physical examination and x-rays as they relate to the guide to permanent partial impairment from the American Medical Association, 4th Edition."

Nevertheless, Dr. Chakales assigned the claimant a 10% impairment rating for the left hip on May 10, 2007. Dr. Chakales had examined the claimant on September 27, 2006 and had discussed his "range of motion" findings pertaining to the claimant's left hip. The Commission recognizes that "passive" range of motion tests can constitute objective medical findings in some cases. *Hayes v. Wal-Mart Stores*, 71 Ark. App. 207, 29 S.W.3d 751 (2000). Nevertheless, Dr. Chakales did not indicate whether his purported rating was based on passive or active range of motion. The Guides, at p. 3/77, 3.2e, state, "If it is clear to the evaluator that a restricted range of motion has an organic basis, multiple evaluations are unnecessary. If, however, multiple evaluations exist, inconsistency of a grade between the findings of two observers, or on separate occasions by the same observer, makes the results invalid."

In the present case there is an inconsistency between the range of motion testing performed by Dr. Schock and Dr. Chakales. It is the duty of the

Commission to translate evidence into findings of fact. *Polk County v. Jones*, 74 Ark. App. 159, 47 S.W.3d 904 (2001), citing *Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994). Morever, the Commission has the duty of weighing medical evidence, and, if 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).

The Full Commission in the present matter attaches more evidentiary weight to the opinion of the treating physician, Dr. Schock. Dr. Schock opined that the claimant's range of motion was full (whether said range of motion was active or passive). Dr. Schock opined that he could not assess a permanent anatomical impairment based on the claimant's physical findings and the authorized Guides for evaluating permanent impairment.

Based on *de novo* review of the entire record currently before us, the Full Commission finds that the claimant did not prove he sustained a permanent anatomical impairment as a result of the compensable injury. We therefore affirm the administrative law judge's decision.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. McKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion finding that the claimant is not entitled to benefits for anatomical impairment.

The facts of this case are not in dispute. The claimant sustained an acknowledged compensable injury on October 13, 2005 when he slipped and fell on asphalt because there was oil on his shoes, fracturing his left hip. He was initially seen in the emergency room where he came under the treatment of Dr. Ethan J. Schock, an orthopedic surgeon. Dr. Schock performed surgery for the treatment of the fracture, which included the insertion of a nail, pin, and screw to fix the fracture. Four months after the date of injury, Dr. Schock released the claimant to return work without restriction and with no permanent impairment. At the time of his release, Dr. Schock said that the claimant had full range of motion but that he was “very weak in

his hip musculature". According to the claimant, the only examination conducted by Dr. Schock during his evaluation of permanent impairment was to have the claimant walk across the room and stand on his left leg. The claimant testified that Dr. Schock did not perform range of motion tests.

After his release from Dr. Schock, the claimant testified that he continued to experience pain and weakness and had to walk with a cane. He said that he could not put any weight on his left hip and that he could not squat, climb ladders, or go up and down stairs without holding on to a handrail. He said that when he walks his hip "binds up", is not stable, and he feels like he is going to fall. The claimant testified that had trouble pushing a lawn mower or riding his bicycle.

Because of continuing difficulty with pain, muscle weakness, and loss of range of motion, the claimant sought additional medical treatment with another orthopedic surgeon, Dr. Harold Chakales. During his initial examination, Dr. Chakales found muscle atrophy in the amount of 1 centimeter in the thigh and 2 centimeters in the calf. Range of motion tests showed losses in the left hip of 5 degrees in flexion, 5 degrees in internal rotation, and 10 degrees of external

rotation. Dr. Chakales acknowledged the presence of muscle weakness and noted that the claimant was afflicted with an antalgic gait. Dr. Chakales also indicated that the hardware, which had been used to fix the fracture at the time of surgery, was symptomatic. In a later report, he recommended that the hardware be removed. Based on these findings, Dr. Chakales rated the claimant’s impairment for the left hip at 10% to the body as a whole.

The claimant continued under the treatment of Dr. Chakales as of the date of the hearing in this case and was, at that time, contemplating additional surgery to have the hardware removed.

There are two statutory provisions which control the result in this case. Ark. Code Ann. §11-704(c)(1)(B), provides:

> (B) Any determination of the existence of extent of physical impairment shall be supported by objective and measurable physical or mental findings.

Ark. Code Ann. §11-9-102(16)(A)(i), provides:

> (16)(A)(i) “Objective findings” are those findings which cannot come under the voluntary control of the patient.

Despite overwhelming evidence to the contrary, the majority determined that the claimant was not entitled to benefits for anatomical impairment. The majority bases this decision on several erroneous assertions. Firstly, the majority concludes that Dr. Schock and Dr. Chakales both tested the claimant's range of motion and that there is a conflict of opinion as to the results of those tests and that the opinion of Dr. Schock should be afforded greater evidentiary weight than that of Dr. Chakales. The credible medical evidence of record demonstrates that the claimant's hip injury has resulted in muscle weakness in the hip, muscle atrophy in his thigh and calf, loss of range of motion in the hip joint, and an antalgic gait. While Dr. Schock did acknowledge the presence of muscle weakness, there is no evidence to suggest that he ever assessed the degree of muscle weakness, measured his thigh or calf to determine the existence and extent of muscle atrophy, or took into account the claimant's gait derangement. Most importantly, there is no evidence that Dr. Schock actually tested the claimant's range of motion. The claimant testified that Dr. Schock did not perform range of motion tests on his hip and Dr.

Schock's final report does not say that range of motions tests were performed only that he had reviewed the claimant's range of motion. In short, the presence of multiple abnormalities coupled with Dr. Shock's failure to evaluate and record them, makes it impossible to reasonably conclude that his 0% impairment was supported by the medical evidence.

Quite to the contrary, Dr. Chakales gave the claimant a through examination and tested and recorded, in specific degrees, the claimant's range of motion. In addition, Dr. Chakales observed and recorded the presence of weakness, atrophy, antalgic gait and acknowledged the fact that the hardware which had been placed at the time of surgery was causing the claimant a great deal of difficulty. Under these circumstances, it was inappropriate to ignore the opinion of Dr. Chakales.

Secondly, the majority acknowledges that passive range of motion tests are to be considered objective findings but fails to acknowledge that the range of motion tests performed by Dr. Chakales were shown to have been passive range of motion tests. The uncontradicted evidence of record established that Dr. Chakales used passive range of motion testing to determine the claimant's impairment. In Hayes v. Wal-

mart Stores, 71 Ark. App. 207, 29 S.W.3d 751 (2000), the Arkansas Court of appeals said that active range of motion tests are those which measure the range of motion of a joint when the patient moves the affected limb. These tests are subjective because the results are under the voluntary control of the patient. Ark. Code Ann.§11-9-102(16)(A)(i). Passive range of motion tests involve measurement of range of motion when the examiner moves the limb. These tests produce objective findings because the examiner controls the results. Because passive range of motion tests are objective findings they can be used, alone, to assess permanent impairment without the necessity of additional objective findings to support them. In Hayes, the claimant proved that the range of motion tests conducted by his physician were passive, through the following testimony:

> At the time of the May 18, 1998, check-up Dr. Meredith performed some tests to determine range of motion to my left shoulder. These tests did not have anything to do with my spine. Dr. Meredith did not instruct me to move my arm. . . What the doctor did with the nurse present is he put his hand under my elbow towards the forearm and guided my hand upward

> with my arm extended and lifted it with my elbow up and then put it back down and he raised it to the level that he had it raised and went forward and he kept going forward until he stopped and then he did the same thing going to the back. . . .I did not control my arm when he was doing the test. He had my arm in his hand. At all times during the test Dr. Meredith was manipulating my arm and shoulder and I was not in control of it. . . .When the doctor was performing the test I did not have voluntary control of my arm. The doctor did not ask me to move my arm during the test and I could not have moved it forward to the extent that he moved it.

The claimant in this case, provided similar testimony establishing that the range of motion tests conducted by Dr. Chakales were passive. In this regard, the claimant testified that it was Dr. Chakales who moved his leg during testing, as follows:

> Q We have a physical examination section on Page 12 of the joint exhibit, and it looks like he did some range-of-motion testing and some other things. Tell us what he did.

A Doctor Chakales had me remove my pants and walk across the room to watch and see how my hips interlocked and worked. Then he had me try to walk on my tiptoes, which I physically could not do. Then he laid me on his examining table and took my right leg and moved it around to check the motion in it.

Q Did he move it himself?

A He moved it. Then he took my left leg and did the same thing with it to check the range of motion, moving it up towards my chest and backwards and trying to move it side to side. He also did a measurement of my muscles on both my legs.

Q Fair enough.

* * * *

Q When you saw Doctor Chakales on May 10, 2007, did he do any of the same tests that you told us he did on the first visit?

A Yes. He did them all again.

Q The same tests that he did on September 27 of '06?

A He did the range of motion and had me walk across the room. I mean,

> he did all of the testing that he did prior to.
>
> Q Did he do it the same way that you described it to us earlier?
>
> A Yes, he did.

And even if the range of motion tests performed by Dr. Chakales were not proved to be passive, the majority fails to acknowledge that active range of motion tests may also be used to assess permanent impairment. In Department of Parks & Tourism v. Helms, 60 Ark. App. 110, 959 S.W.2d 749 (1998), the Arkansas Court of Appeals said that active range of motion tests are "subjective" findings. The Court said that if these are the only findings which are present to support an impairment rating, then there can be no award of benefits for anatomical impairment. However, in Singleton v. City of Pine Bluff, 97 Ark. App. 59, 244 S.W.3d 709 (2006), the Arkansas Court of Appeals said that if other objective findings exist to support the existence of impairment then the subjective active range of motion tests can be used to determine impairment. Singleton involved a police officer who had suffered a work related gunshot to his ankle. As a result, the claimant was left with bullet fragments in his ankle

which affected the range of motion in his ankle joint. The claimant's treating physician assessed an 8% impairment based on his antalgic gait. The Commission concluded that the claimant could not be awarded any benefits for permanent impairment because the findings upon which the impairment was based were subjective findings. Citing Swift-Eckrich, Inc. v. Brock, 63 Ark. App. 118, 975 S.W.2d 857 (1998), the Court reversed the Commission decision holding that there is no requirement that medical evidence of impairment be based solely or expressly on objective findings. According to Singleton, impairment ratings can be based, in part, on non-objective criteria as long as the impairment is "supported" by objective findings. The Court considered the observed bullet fragments to be sufficient objective evidence to support a permanent impairment rating which was arrived at by considering the subjective findings of antalgic gait and loss of mobility.

Like the observed bullet fragments in Singleton, there are other objective findings to support impairment in this case. The claimant has a crack in his femur and a metal nail, pin, and screw in his leg and hip. In addition, there is measurable atrophy in the muscles of his left leg. These are objective

findings, as none of these findings come under the voluntary control of the claimant. Since there are other objective findings to support impairment, the subjective findings of active range of motion can be used to assess the claimant's impairment.

And finally, the majority erred in concluding that the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993) do not provide for an impairment under the facts of this case. Under legislative authority, the Commission has adopted the Guides to be used in the assessment of anatomical impairment. Ark. Code Ann.§11-9-519(g); §11-9-521(h); §11-9-522(g); and Commission Rule 34. As noted earlier, the claimant has been afflicted with muscle weakness, muscle atrophy, loss of range of motion, and an altered gait. Table 64 of the Guides provides for an impairment rating to be assessed for a femoral neck fracture which has healed and is in good position (p. 3/85). There is no dispute that this is the claimant's condition. According to the Guides, the degree of impairment for this condition is to be evaluated according to examination findings. Figures 52, 53, and 54 of the Guides explain how examination findings of flexion, abduction, and rotation of the hip joint are to be

obtained (p. 3/90-91). Once the degrees of flexion, abduction, and rotation have been calculated, the extent of impairment for loss of hip motion can be determined from Table 40 (p. 3/78). In this particular case, additional percentages of impairment can be obtained from Table 36 (gait derangement, p. 3/76), Table 37 (leg muscle atrophy, p. 3/77), and Table 39 (lower extremity muscle weakness, p. 3/77). Therefore, the majority committed an egregious error when concluding that the Guides did not provide for an impairment rating under the facts of this case.

And finally, the majority incorrectly concludes that the Guides would invalidate the range of motion studies in this case. In so concluding, the following passage from the Guides is quoted:

> If it is clear to the evaluator that a restricted range of motion has an organic basis, multiple evaluations are unnecessary. If, however, multiple evaluations exist, inconsistency of a grade between the findings of two observers, or on separate occasions by the same observer, makes the results invalid.

It is quite obvious, from the above quotation, that inconsistent range of motion tests are invalid only under circumstances where there is no organic basis for the restricted range of motion. As discussed in detail earlier, the claimant in this case has multiple findings of an organic basis for his restricted range of motion and the quoted passage would, therefore, have no effect on the validity of his results.

And even if the claimant's impairment can not be evaluated under the "Range of Motion" section of the Guides (p. 3/77, 3.2e), it could be assessed using the sections covering "Gait Derangement" (p. 3/75, 3.2b), "Muscle Atrophy" (p. 3/76, 3.2c), or "Manual Muscle Testing" (p. 3/76, 3.2d). In light of the numerous methods of assessing the claimant's impairment under the Guides, it was error to conclude that the Guides do not provide for an impairment in this case.

When the Arkansas Court of Appeals remanded to the Commission the previously discussed case of Singleton v. City of Pine Bluff, supra., for a determination of impairment, the Commission refused to make an award for impairment benefits saying that the Guides did not provide for the rating of impairment in that case. The case was appealed to the Court of

Appeals for the second time and remanded to the Commission for the second time. In Singleton v. City of Pine Bluff, __Ark. App.__, __S.W.3d__ (2008), the Court said:

> The mandate in our prior decision reversed for the reasons set out in our opinion, *i.e.,* that the Commission had erroneously and arbitrarily ignored all medical proof that did not constitute an "objective finding" in arriving at its decision. We remanded for the Commission to make new findings of fact consistent with the law as expressed in our opinion. Instead of making additional findings of fact as directed, the Commission ignored our mandate and denied relief on the same theory of law that we held to be erroneous in our prior opinion, justifying this refusal to comply with our mandate on the legal theory that compensability was decided by the *Guides* it had adopted, rather than by the provisions of the Arkansas Workers' Compensation Act as interpreted by this court. Although it "recognized" in its opinion that we had expressly held that objective medical evidence was not necessary to prove

> each and every element of compensability, the Commission stated that it had adopted the Fourth Edition of the *Guides to the Evaluation of Permanent Impairment* as an impairment rating guide, stated that it had done so pursuant to authority vested in it by the legislature, and denied benefits on the ground that "[t]here is not a single table or figure in [the *Guides*] which allows the Commission to assign a permanent anatomical impairment to the instant claimant's left ankle in accordance with the relevant standards of Act 796 of 1993."
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> * * * * *
>
> The *Guides* are just that: mere guides to aid the Commission in assessing the degree of a claimant's disability as defined by statute and interpreted by the courts. If those *Guides* do not contain an express method of rating an injury that is compensable pursuant to Arkansas law, the Commission must adopt a reasonable method of doing so.

Like the claimant in Singleton, the claimant in this case has undeniable impairment but the majority

has denied benefits concluding that the Guides do not provide for a method of rating that impairment. Apparently, the majority does not agree with the Court's holding in Singleton and has, again, chosen to ignore its directives. Like it or not, Singleton is the law and it should have been followed by this Commission. If we had done so, the claimant would have been awarded benefits for anatomical impairment in this case.

For the reasons stated above, I must respectfully dissent from the majority opinion.

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PHILIP A. HOOD, Commissioner