

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F400875

ERNEST REYNOLDS,
EMPLOYEE

CLAIMANT

ROBERTSON CONTRACTORS, INC.,
EMPLOYER

RESPONDENT

ZURICH AMERICAN INSURANCE,
INSURANCE CARRIER

RESPONDENT

OPINION FILED DECEMBER 1, 2008

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.

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

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The Arkansas Court of Appeals has reversed and remanded for additional consideration. *Reynolds v. Robertson Contractors, Inc.*, Ark. App. CA08-44 (Sept. 17, 2008). The Full Commission affirmed and adopted an administrative law judge's finding that the claimant sustained a 10% whole-body impairment as a result of the claimant's compensable injury and surgery. After reviewing the entire record *de novo*, the

Full Commission again finds that the claimant proved he sustained a 10% anatomical impairment rating.

I. HISTORY

Ernest Don Reynolds, age 47, testified that he began working for Robertson Contractors in March 2003. The parties stipulated that the claimant sustained compensable injuries on January 15, 2004. The claimant testified:

Q. What were you doing on January the 15th, 2004?

A. We were hanging cross-braces, which would have to go up in a manlift....And it was two people in a basket, you know, because you've got these big, old angle iron, that you've got to bolt one piece of angle iron up on one side of the bridge and to the other side, then another piece going in the opposite direction to tie them together....

Q. Well, tell the Judge what happened on this accident?

A. Well, we were - had just got done hanging one of the cross-braces, and the other guy, he was talking about his girlfriend breaking up with him and he - well, I assumed that he hit the lever too hard because the basket violently bounced, and when the boom is extended out, if you move that lever too quickly, it makes the basket bounce, and the basket bounced and slammed me against the cross-brace, between the basket and the cross-brace, bounced down and bounced up again and pinned me.

Dr. Jerry M. Frankum saw the claimant on January 19, 2004 and, according to his handwritten notes, apparently diagnosed neck pain and rib fracture.

An MRI of the claimant's cervical spine was taken on February 23, 2004, with the following impression:

1. Left-sided herniated disc at the C6-7 level, which compresses the exiting left nerve root and pushes the spinal cord posteriorly and to the right at this level.
2. Small subligamentous disc bulges are seen at the C4-5 and C5-6 levels causing no significant spinal cord compression.

Dr. John L. Wilson examined the claimant on April 15, 2004 and informed Dr. Jim J. Moore, "It is my opinion that this gentleman has a large disc at C6-7. While he does not have the usual radicular findings in his triceps and ulnar nerve area, he certainly does have the spinal border of the scapula findings and symptoms that you would find with this lesion. This is a large disc and I would recommend doing an anterior discectomy and fusion." Dr. Wilson, assisted by Dr. Moore, performed an "Anterior diskectomy and anterior cervical fusion, C6-7" on May 27, 2004. The pre- and post-operative diagnosis was "Central ruptured cervical disk, C6-7." The claimant testified that surgery provided no relief of his symptoms.

The claimant had follow-up visits with Dr. Wilson after surgery. Dr. Wilson corresponded with Dr. Moore on August 23, 2004:

Exam reveals mild restriction of motion of the cervical spine. His head is tilted slightly forward. His deep tendon reflexes are present and equal in both upper extremities.

X-rays reveal early consolidation of his graft.

This gentleman is released from my care. He may return to his normal activities at work. He is to return to see us if he has continued problems. His permanent impairment is 7% to the body as a whole.

The impression from a CT scan of the cervical spine on October 16, 2004 was "Normal CT scan cervical spine."

Dr. Wilson noted on October 20, 2004, "He was released from our care back on August 23, 2004, and relates he has not been able to return to work since he was released....Examination today reveals a good range of motion of the cervical spine. The deep tendon reflexes are present and equal in both upper extremities. There is muscle spasm in the right shoulder elevator group and tenderness in the posterior aspect of his neck. X-rays of his neck reveal early incorporation of his graft at C6-7....Mr. Reynolds has changed since his release and is temporarily totally disabled at this time."

A Functional Capacity Evaluation was done on December 15, 2004:

Mr. Reynolds underwent functional capacity evaluation this date with unreliable results for

effort. Mr. Reynolds put forth inconsistent effort and demonstrates many inconsistencies with inappropriate illness responses. Mr. Reynolds efforts were inconsistent and do not represent his maximal tolerances.

Mr. Reynolds demonstrated the ability to perform work at least at the MEDIUM Physical Demand Classification as determined through the Department of Labor for an 8-hour day....

Dr. Wilson wrote to Dr. Moore on December 30, 2004:

This gentleman was seen back on 12/30/2004. He is seen back for his Functional Capacity Assessment result. The test is considered to be unreliable which means to me that it is anticipated that he will improve and will be able to do better later on.

This gentleman was released to return to work with a 40-pound restriction as per his Functional Capacity Assessment. He is to return if he has continued problems.

On examination today he walks with his neck stiff and shoulders upward; however, walking out of the building, his shoulders relax to a normal position. He is advised to return as needed....

The claimant testified on cross-examination that "Dr. Wilson lied" about the claimant relaxing his shoulders while walking out of the building.

Dr. Wilson informed an attorney on February 8, 2005, "Mr. Reynolds was released from our care on December 30, 2004, and that is the end of his healing period."

Dr. William F. Blankenship wrote to the respondent-carrier on May 3, 2005:

Mr. Reynolds is seen in the clinic on 5/3/05 for continued complaints of pain in his cervical spine and mid-dorsal spine pain....

Today on examination, he does restrict his motion in all planes. However, he can flex his cervical spine to the point that the chin touches the sternum. He hyperextends the cervical spine within 40 degrees of complete hyperextension. Rotation left and right is 45 degrees. Tilting left and right is 30 degrees. Biceps, triceps and brachioradialis reflexes are normal, active and equal bilaterally. Knee and ankle jerks are normal, active and equal bilaterally. There is no intrinsic weakness or atrophy of either upper extremity. Both arms and forearms measure 10 inches....

X-rays were made today of the cervical spine. On the AP view there is normal alignment. On the lateral view of the cervical spine, there appears to be some anterior longitudinal ligament calcification between C6 and C7. In comparing the neutral lateral with flexion-extension laterals, there is no motion at any level of the cervical spine. There appears to be some retrolisthesis of C3 on C4. This is seen on all views. Left and right obliques reveal some narrowing of the neuroforamina at C3-4; however, no other abnormalities are seen.

Dr. Blankenship's impression was "1. Status postop cervical fusion, C6-7." Dr. Blankenship recommended that the claimant remain off duty and that the claimant see Dr. Moore.

Dr. Jim J. Moore examined the claimant on May 10, 2005 and diagnosed "Post-laminectomy syndrome." Dr. Moore's treatment recommendations included additional diagnostic

testing. The claimant followed up with Dr. Moore on September 27, 2005:

He was not able to carry out the myelogram because of his inability to discontinue the use of anticoagulants. Therefore, he had a cervical MRI with contrast which had been ordered initially....

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

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 Hoffman's click bilaterally. The sensory patterns appear intact. He has some 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. I also feel that this patient is deserving of ongoing care for pain management....

Dr. Annette P. Meador, a chronic pain manager, began treating the claimant on October 18, 2005 and noted, "He has muscle spasms which I believe can conservatively be treated with trigger point injections which I performed with Lidocaine, if he is willing to do stretching exercises and start some type of aerobic exercise program such as walking. Apparently his cardiologist has cleared him to do this, as he had a stent placement this summer. However, he continues to smoke and be inactive."

Dr. Meador noted on November 7, 2005:

Mr. Reynolds returned today, not allowing my nurse to take his vital signs, and stating he was not going to sign anything until he talked to me. He was apparently angry because he thinks he does not need to return to work. He cleared some brush this weekend. He smells like firewood smoke.

He has had six sessions of physical therapy. He was able to duplicate some of his cervical range of motion exercises and his range has improved. He has denied that he is any better, however....

PHYSICAL EXAMINATION

Bones, Joints, & Ext.:	His trapezii were elevated, but this appears to be quite voluntary, because when I asked him to lie supine this apparent "spasm" completely dissipated.
Cervical ROM:	His cervical range of motion is better such that flexion is now full. Rotation to the right and left is 75 degrees....

Dr. Meador's impression was "Cervical myofascial pain. The patient does not show any signs of radiculopathy currently, status post cervical fusion by Dr. Moore....I think his level of pain is out of proportion with his physiologic status....He says he spends most of his day sitting in a chair, but apparently he is capable of clearing some brush, which is not sedentary activity."

Dr. Moore noted on November 30, 2005:

I saw this patient on 9/27/05 at which time I released him and rated him 20 % permanent partial to the body as a whole which would include the 7% he has already been provided....

He comes in with a steady gait. He continues to show contorsions of the head, neck and shoulder. As Dr. Meador noted on at least one examination the patient tended to relax, a tendency to elevation of the left shoulder and trapezius. My examination today reflected that a lot of the cranial, cervical and shoulder posturing would be voluntary and with attention diversion he would assume a very normal and erect position. Again I do not see any evidence of atrophy, atony or fasciculations in any muscle groups. His reflexes are in the high normoactive range but are symmetrical.

RECOMMENDATIONS: I do not have any further recommendations with the exception possibly of the utilization of some cervical halter traction which could be accomplished on an out-patient basis and a home basis. The patient inquired about work. Based upon the FCE a 40 pound weight limit was considered to be appropriate to recommend. The patient is rather adamant that no one will hire him in his "present condition." Further inquiry in this area would suggest that he is

fairly convinced that he is totally and permanently disabled which in my opinion is certainly not the case. He may have some impairment as based upon a rating as provided....

Dr. Moore's diagnosis was "Post cervical laminectomy syndrome."

The parties stipulated that the respondents accepted a change of physician to Dr. Thomas M. Ward on August 22, 2006. The record indicates that the claimant began treating with Dr. Ward, a physical medicine and rehabilitation specialist, on September 14, 2006.

A pre-hearing order was filed on December 20, 2006. The claimant contended, among other things, that his healing period did not end until September 27, 2005 and that he was entitled to temporary total disability benefits through that date. The claimant contended that he was entitled to 90 weeks of permanent impairment benefits based on a 20% anatomical impairment rating. The claimant contended that the respondents had paid only 22 weeks of permanent impairment benefits.

The respondents contended, among other things, that they had paid all indemnity benefits to which the claimant was entitled. The respondents contended that they were entitled to a credit for any possible overpayment in

temporary total disability toward the claimant's permanent anatomical impairment. The respondents contended that they initially accepted and paid a 7% impairment rating assessed by Dr. Wilson on July 4, 2005, but that the respondents had actually paid a total of 46 weeks of permanent partial disability benefits. The respondents controverted permanent impairment benefits beyond the 46 weeks paid. The respondents contended that they had accepted and paid a 10% impairment rating "pursuant to Table 75, Sub-part IV of the Fourth Edition of the AMA Guidelines (actually paying a total of forty-six (46) weeks of permanent partial disability benefits for which it seeks a credit)." The respondents contended that the 20% permanent impairment assessed by Dr. Moore included range of motion and complaints of pain which could not be considered.

The parties agreed to litigate the following issues:

"1. The date claimant's healing period ended. 2. Claimant's entitlement to additional temporary total disability. 3. A determination on the extent of claimant's permanent impairment."

On or about January 10, 2007, on a series of notes written in Dr. Ward's office, it was written that the claimant had "Cervical Dystonia", "Fragments of Dystonia",

"s/p spinal fusion with radiculopathy," and "spinal enthesopathy." The claimant was given a "Disability" rating of "23% to body as a whole."

A hearing was held on January 12, 2007. The claimant testified on cross-examination, "There's not been any improvement. I'm actually worse than I was before the surgery."

An administrative law judge filed an opinion on February 6, 2007. The administrative law judge found, in pertinent part:

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.

The Full Commission affirmed and adopted the administrative law judge's decision in an opinion filed November 6, 2007. The Court of Appeals has reversed and remanded for additional consideration.

II. ADJUDICATION

"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). 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) (Repl. 2002). "Major cause" means more than fifty percent (50%) 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) (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). Ark. Code Ann. §11-9-102(16) (Repl. 2002) 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) (Repl. 2002) 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.*

An administrative law judge found in the present matter, "4. The claimant has sustained a ten percent (10%) whole body impairment as the result of his January 15, 2004, compensable injury and surgery." The Full Commission affirms this finding. We recognize the Court's holding, "there is no requirement that medical testimony be based solely or expressly on objective findings, only that the record contain supporting objective findings." *Coleman v.*

Pro Transp., Inc., 97 Ark. App. 338, ___ S.W.3d ___ (2007), citing *Singleton v. City of Pine Bluff*, 97 Ark. App. 59, ___ S.W.3d ___ (2006). In *Coleman*, the Court held that no substantial evidence outweighed a physician's opinion that the claimant had sustained anatomical impairment in the amount of eleven percent.

In the present matter, the Commission is faced with conflicting medical opinions, i.e., a 7% permanent anatomical rating assessed by Dr. Wilson and a 20% rating assigned by Dr. Moore. Dr. Wilson assigned a 7% rating on August 23, 2004. Dr. Wilson assessed this rating, however, while the claimant remained within a healing period for his compensable injury. Dr. Wilson opined on October 23, 2004 that the claimant remained temporarily totally disabled. Neither party appeals the administrative law judge's finding that the claimant's healing period did not end until December 30, 2004. The Full Commission is therefore unable to attach significant evidentiary weight to Dr. Wilson's assessment of a 7% permanent anatomical impairment rating.

The respondents eventually accepted and paid a 10% permanent anatomical impairment rating. The Full Commission finds that the 10% impairment rating paid by the respondents is squarely in line with the statutorily-mandated Guides for

evaluating permanent impairment. Dr. Wilson performed an anterior diskectomy and anterior cervical fusion, C6-7, on May 27, 2004. The claimant reached the end of his healing period on December 30, 2004. Table 75, p. 3/113 of the Guides, expressly assigns a 10% impairment of the whole person for a single-level spinal fusion such as took place in the instant matter. The Dissenting Opinion in our previous affirming and adopting decision argued that the Commission should consider "range of motion tests and other subjective medical evidence" in assessing the extent of the claimant's permanent anatomical impairment. The Full Commission finds, as did the administrative law judge, that the claimant was not a credible witness or patient with regard to the various range-of-motion tests in the record. Questions concerning the credibility of witnesses and the weight to be given their testimony are within the exclusive province of the Commission. *Patterson v. Ark. Dep't of Health*, 343 Ark. 255, 33 S.W.3d 151 (2000). A Functional Capacity Evaluation on December 15, 2004 showed that the claimant's effort was unreliable with inappropriate illness responses. On December 30, 2004, the date of the end of the claimant's healing period, Dr. Wilson noted, "On examination today he walks with his neck stiff and shoulders upward;

however, walking out of the building, his shoulders relax to a normal position." The record does not support the claimant's assertion at hearing that Dr. Wilson "lied."

Dr. Blankenship's May 3, 2005 report indicated that the claimant was voluntarily restricting his range of motion: "he does restrict his motion in all planes." Dr. Moore saw the claimant on September 27, 2005 and assigned a 20% rating pursuant to Table 73 of the Guides. The Full Commission finds that the 10% anatomical impairment rating accepted by the respondents, in accordance with Table 75 of the Guides, is entitled to more evidentiary weight. The claimant was not a credible witness and the majority of treating physicians eventually noted that the claimant would alter his range-of-motion mechanics when the claimant was not being observed. There is no provision in Table 75 from which the Commission can rely on "ligament calcification" reported by Dr. Blankenship. Nor does Table 75 mention the "dystonia" or "spinal enthesopathy" purportedly observed by Dr. Ward. Nor does the Commission find that the claimant sustained a permanent anatomical impairment based on the various reports of spasm. We again note Dr. Meador's November 7, 2005 report, "His trapezii were elevated, but

this appears to be quite voluntary, because when I asked him to lie supine this apparent 'spasm' completely dissipated."

The issue the Workers' Compensation Commission must resolve is the extent of actual permanent physical damage the claimant sustained to his neck and/or cervical spine as a result of the compensable injury. *Squires, supra*. The claimant was not a credible witness and the various range-of-motion tests were not reliable. The previous Dissenting Opinion's description of "calcification, muscle spasms, narrowing of the neuroforamina and retrolisthesis" are simply not valid evidentiary criteria in the present matter and cannot be relied upon to assess a permanent anatomical impairment rating. Table 73 of the Guides, used by Dr. Moore in computing a 20% rating, mentions "loss of motion segment integrity" and "multi-level neurologic compromise." Neither of these conditions were objectively shown with regard to the instant claimant. The assessment of "23% disability" attributed to Dr. Ward is not entitled to any probative weight in the instant matter.

The current Dissenting Opinion contends that the Commission has erred in relying on Table 75 of the Guides rather than Table 73. Pursuant to language found on p. 3/94 of the Guides, the dissent contends that the Commission

improperly relied on the "Range of Motion" model rather than the "Injury" model. Table 75 is found in the "Range of Motion" model whereas Table 73 is part of the "Injury" model. The Dissenting Opinion does not cite other language found in the instructions on p. 3/94, to wit: "if disagreement exists about the category of the Injury Model in which a patient's impairment belongs, then the Range of Motion Model may be applied to provide evidence on the question....It is emphasized that if an impairment evaluation is to be accepted as valid under the *Guides* criteria, the impairment being evaluated should be a *permanent* one, that is, one that is stable, unlikely to change within the next year, and not amenable to further medical or surgical therapy (refer to definition in *Guides* Chapter I and Glossary)."

In the present matter, the record indicates that Dr. Wilson, the authorized treating surgeon, relied on Table 75 in assessing a 7% permanent anatomical impairment rating. A 7% rating is explicitly found in Section IV of Table 75, whereas no such rating can be found in Table 73. Although the Commission has determined that the 7% rating assessed by Dr. Wilson was premature because it was assigned while the claimant remained within his healing period, Dr. Wilson

never revised this impairment rating even after several follow-up visits with the claimant. Further, there is no evidence in the present matter supporting the impairment descriptions found in Table 73, such as "loss of motion segment integrity or multilevel compromise." There is no evidence in the present matter which supports a finding that the instant claimant is entitled to a permanent rating because of "loss of motion segment integrity or multilevel compromise." The Full Commission finds that Table 75, p. 3/113 of the Guides, is the proper table for assessing the instant claimant's anatomical impairment.

Based on our second *de novo* review of the entire record pursuant to the remand from the Court of Appeals, and in accordance with the relevant provisions of Act 796 of 1993, the Full Commission finds that the claimant proved he sustained permanent anatomical impairment in the amount of 10%. The compensable injury was the major cause of 10% anatomical impairment. Any assertion that the claimant sustained permanent impairment greater than 10% is not based on a proper interpretation of the probative evidence of record or a credible application of Act 796 of 1993. The decision of the administrative law judge is affirmed.

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 sustained only a ten-percent anatomical impairment.

The majority correctly concludes that the seven percent impairment rating given by Dr. Wilson was not appropriate because it was assessed before the claimant's healing period ended. Likewise, Dr. Ward did not provide sufficient documentation to support his twenty three-percent impairment. However, the majority erroneously concludes that the twenty-percent impairment given by Dr. Moore was not in accord with the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993). Thereafter, the majority disregards all of the physicians' opinions and calculates its own impairment of ten-percent. While the Commission is certainly

entitled to make its own assessment of permanent impairment and is not required to select one of the ratings given by the physicians of record, its assessment must be in accord with the medical evidence and the Guides. In this case, the ten-percent impairment assessed by the majority was calculated in a manner contrary to the guidelines. On the other hand, the twenty-percent impairment given by Dr. Moore was consistent with the medical evidence and calculated in compliance with the Guides.

Under legislative authority, the Commission adopted a 1993 publication by the American Medical Association which contains guidelines for the assessment of anatomical impairment. Ark. Code Ann. §11-9-519(g); §11-9-521(h); §11-9-522(g); Commission Rule 34; and AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993). The guidelines for determining impairment for injuries to the spine can be found in Chapter 3, at Section 3.3. Two approaches to the rating of impairment are provided, the "Injury Model" and the "Range of Motion Model" (p.3/94). Only one of these approaches can be used and the Injury Model must be used if the

claimant's condition "is one of those listed in Table 70" (p.3/94). One of the conditions listed in Table 70 is "Previous spine operation with...radiculopathy" (p.3/108). There is no dispute that the claimant had a spine operation and suffers from radiculopathy. Once it has been determined that the claimant's condition is one of those listed in Table 70, then his impairment can be calculated on Table 73 (p.3/110). As can be seen from Table 73, the claimant fits into category III (radiculopathy) or category IV (neurologic compromise), yielding an impairment of from 15% to 25%.

Dr. Moore's assessment of the claimant's impairment complies with the above noted procedure outlined in the Guides, as follows:

I would also 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 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.(emphasis added)

The majority opinion used the Range of Motion Model to arrive at the claimant's impairment (Section 3.3j, specifically Table 75). This was improper, for two reasons. Firstly, the Guides specifically says that:

The Range of Motion Model should be used only if the Injury Model is not applicable, or if more clinical data on the spine are needed to categorize the individual's spine impairment. AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993), p.3/112.

As discussed previously, the Injury Model was applicable to the claimant's case because his condition was specifically listed on Table 70. In addition, all clinical data necessary to categorize the claimant's spine impairment were readily available from the medical evidence of record, i.e., the occurrence of a spine operation, the presence of radiculopathy, and neurologic compromise. Under these circumstances, the use of the

Injury Model was required and the majority erred in using the Range of Motion Model.

And even if the use of the Range of Motion Model was an option under the Guides, which it was not, the majority's decision to use Section 3.3j to assess the claimant's impairment represents an extraordinary contradiction. The majority opinion finds that the claimant's range of motion studies were not reliable and that they could not be used to determine his impairment. Then, the majority rates the claimant's impairment using the Range of Motion Model. Such flawed logic and misuse of the Guides, simply cannot form the basis of a sustainable opinion.

The guide to be used in the assessment of anatomical impairment, adopted by the Commission, is a medical book. It was written by doctors, published by the American Medical Association, and was intended to be used by doctors. While the Court of Appeals has indicated that the Commission may assess its own impairment and is not required to rely on ratings assigned by physicians, a physician's rating should be

given considerable weight if it is in accord with the evidence and the Guides.

Dr. Moore is a well respected neurosurgeon with many years of experience in evaluating and treating spinal injuries. He is well equipped to make a valid assessment of permanent impairment. In this case, he followed the Guides to the letter. The majority ignored his proficiency and made a botched attempt at playing doctor. The approach taken by the majority was not only in violation of the basic instructions outlined in the Guides but was contraindicated by its own findings.

The Guide said to use the Injury Model and not the Range of Motion Model. The majority used the Range of Motion Model. The Range of Motion Model bases impairment on range of motion studies. While the majority said that the claimant's range of motion studies were not reliable and could not be used to assess impairment, the majority, nonetheless, based its impairment on the Range of Motion Model. Under the above mentioned circumstances, any reasonable examiner would question the veracity of the majority opinion.

From a de novo review of the record, I find the twenty-percent impairment rating given by Dr. Moore to be supported by the evidence and the Guides. I further find the ten-percent impairment assessed by the majority to be in conflict with the evidence, the Guides, and the majority's own findings. Therefore, I must respectfully dissent from the majority opinion.

PHILIP A. HOOD, Commissioner