

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F600083

ELIZABETH A. JOHNSON, EMPLOYEE	CLAIMANT
DILLARD'S DOLLAR, INC., EMPLOYER	RESPONDENT NO. 1
FIDELITY & GUARANTY INS. COMPANY, INSURANCE CARRIER	RESPONDENT NO. 1
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT NO. 2
SECOND INJURY FUND	RESPONDENT NO. 3

OPINION FILED MAY 15, 2009

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

Claimant represented by the HONORABLE GAIL O. MATTHEWS,
Attorney at Law, Little Rock, Arkansas.

Respondent No. 1 represented by the HONORABLE JAMES C.
BAKER, JR., Attorney at Law, Little Rock, Arkansas.

Respondent No. 2 represented by the HONORABLE CHRISTY KING,
Attorney at Law, Little Rock, Arkansas.

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

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The claimant appeals an administrative law judge's
opinion filed September 5, 2008. The administrative law

judge found that the claimant sustained an 11% anatomical impairment and that the claimant failed to prove she was entitled to any wage-loss disability benefits. The administrative law judge found that the claimant failed to prove her seizures and strokes were compensable consequences of the claimant's compensable injury. The administrative law judge found that the claimant failed to prove psychiatric treatment was reasonably necessary in connection with the compensable injury.

After reviewing the entire record *de novo*, the Full Commission reverses the administrative law judge's opinion. The Full Commission finds that the claimant proved she sustained anatomical impairment in the amount of 26% as a result of the compensable injury, and that the claimant proved she sustained wage-loss disability in the amount of 20%. We find that Respondent No. 3, Second Injury Fund, is not liable for the claimant's wage-loss disability. The Full Commission finds that the claimant proved her seizures and strokes were related to the compensable injury. The claimant also proved that psychiatric treatment was reasonably necessary in connection with the compensable injury.

I. HISTORY

Elizabeth Ann Johnson, age 50, testified that she was a high school graduate and had attended college for one semester, studying Shorthand. Ms. Johnson testified that she had worked as an Order Editor for customer service at Orbit Valve Company. The claimant worked for Leisure Arts for about 10 years.

The claimant was assessed with cervical and lumbar strain after a motor vehicle accident in March 2001. An x-ray of the claimant's cervical spine was taken on March 8, 2001, with the following impression: "1. C5-6 spondylosis, mild. 2. No visible acute abnormality is seen."

The claimant began working for the respondent-employer in November 2003. The parties stipulated that the claimant sustained a compensable neck injury on December 31, 2004. The claimant testified, "I worked back in formal wear in the junior department. The long dresses were dragging the floor. I was trying to help lift a huge rack, a metal rack. And the girl's hand slipped and this big metal rack with a glass, about three inches thick on the top for display, all crashed down on my head[.]"

The claimant received emergency medical treatment on January 2, 2005: "The patient is a 46-year-old female who works at Dillard's. On Friday, New Year's eve, she was working when she tried to raise a formal dress rack. The rack slipped and struck her on the top of the head, the right parietal area....MUSCULOSKELETAL: Positive for muscle spasm in her neck bilaterally and radiating down both arms with soreness of the left side and left arm in the triceps region....Cervical spine x-ray shows degenerative changes with loss of disc height between C4 and C5. There is no evidence of subluxation or malalignment in those areas." The claimant was diagnosed with "1. Cervical sprain. 2. Contusion to the scalp."

The claimant testified that she was fired on March 25, 2005. The claimant began treating with Dr. J. Michael Calhoun, a neurosurgeon, on April 27, 2005. An MRI of the claimant's cervical spine was taken on May 4, 2005, with the following impression: "1. Prominent posterior osseous ridging with a moderate left paracentral disc protrusion at C5/6 resulting in moderate to severe central canal stenosis and prominent left anterolateral cord flattening as well as severe left foraminal narrowing. 2. Small left paracentral

disc protrusion at C4/5 causing mild central canal stenosis and mild left anterolateral cord flattening."

Dr. Calhoun reported on May 4, 2005, "Ms. Johnson underwent an MRI today which shows a large left C5-C6 disc herniation. We discussed this today. I think her options are for trying physical therapy again or surgery in the form of a C5-C6 anterior cervical discectomy and fusion." Dr. Calhoun performed a discectomy, foraminotomies, and arthrodesis at C5-6 on June 27, 2005. The pre- and post-operative diagnosis was "Right C5-6 herniated nucleus pulposus."

On June 29, 2005, Dr. Calhoun reported that the claimant's admission diagnosis was "C6-7 herniated nucleus pulposus," and that the secondary diagnosis was "Poorly controlled hypertension." Dr. Calhoun described the claimant's hospital course:

The patient was taken to the operating room on the 27th, where she underwent the above mentioned procedure. She was covered with perioperative steroids. Immediately after surgery, she noticed difficulty with numbness and weakness primarily on her left side. She was continued on IV Decadron and this improved. She had undergone intraoperative x-rays which showed good alignment at C5-6. Also she was found to have significant hypertension with blood pressures over 200 systolic. An Internal Medicine consult was obtained by Dr. Zilk. Her blood pressure

was controlled then with Clonidine and
Altenolol....Her blood pressure was stable and she
was subsequently discharged.

Dr. Calhoun informed Dr. Michelle Ibsen on July 11,
2005, "She underwent a C5-C6 discectomy and fusion on June
27. After surgery she clearly has a myelopathy. Her
surgery was uneventful. She was very hypertensive and
intraoperatively and postoperatively. Potentially she could
have suffered some cerebrovascular compromise of her spinal
cord, but I am uncertain....she has not reached maximal
medical improvement."

A Functional Capacity Evaluation was done on November
2, 2005, with the following conclusions: "Based on the data
collected during Ms. Johnson's evaluation, it is determined
that she did not put forth maximal effort on a consistent
basis. Therefore this evaluation is unreliable due to the
inconsistencies noted within the report. Overall, Ms.
Johnson demonstrates the ability to work at least at the
LIGHT work category over the course of an 8 hour workday."

Dr. Calhoun corresponded with Respondent No. 1's
attorney on May 9, 2006 and stated in part:

When Ms. Johnson underwent surgery for cervical
disc herniation on June 27, 2005, she awoke with
numbness and clumsiness in her hands and was noted
to be unsteady on her feet. It did improve to

some degree, but she still has difficulty with fine motor movements and disc coordination in her hands, as well as, some unsteadiness on her feet and a tendency to fall.

Since it has been almost a year since her surgery, I feel that this will persist. It is thought that Mrs. Johnson suffered a "stroke" of the spinal cord during the surgical procedure....

Dr. Calhoun performed a second surgery on the claimant's cervical spine on June 27, 2006:

The patient is a 48-year-old female who, a year ago, underwent C5-6 anterior cervical diskectomy and fusion. Recently she has had worsening problems with her hands not functioning correctly and then difficulty ambulating. She underwent a repeat MRI which showed she has formed a large osteophyte superior to the previous C5-6 diskectomy. There were some ischemic changes within the spinal cord. It was thought that she shoulder (sic) undergone repeat surgery in the form of removal of her instrumentation and repeat corpectomies with repeat fusion....

The pre-operative diagnosis was "1. C5-6 cervical spinal stenosis. 2. Status post C5-6 fusion. 3. Cervical myelopathy."

The claimant received emergency treatment on June 30, 2006: "This is a 48-year-old white female who presented to the emergency department complaining of passing out today. She had spinal fusion surgery last week and has been on some pain medicines. Today she bent over and when she stood up, she got real dizzy, felt hot and passed out. The family

said she had some twitching and jerking of her arms, but no seizure-like activity. They said she was making a snoring noise and was completely unresponsive for a period of about 15 minutes. They turned her on her side and the snoring noise stopped." A physician's diagnostic impression was "1. Syncope. 2. Hypokalemia."

Dr. David Martin noted on June 30, 2006, "Shortly after admission to the floor, the patient had a seizure witnessed by the nursing staff. She was postictal for some time. The seizure lasted about two minutes." Dr. Martin assessed "1. New onset seizure. 2. Hypertension. 3. Recent spinal fusion surgery of the cervical spine."

Dr. Keith Schluterman gave the following impression on June 30, 2006:

Ms. Johnson is a 48-year-old woman, status post recent anterior cervical decompression and hardware placement, who now presents with two likely generalized tonic seizures today. These are without clear recognized precipitant. However, secondary to her recent surgery, I am concerned for a Staphylococcal meningitis. She has also been on Demerol, and this could have lowered her seizure threshold. Also, her husband suspects some marijuana abuse. She does not have evidence of any stroke at this time, and her CT scan did not find evidence of abscess.

Dr. Schluterman's recommendations included a lumbar puncture, medication, and EEG. Dr. Schluterman gave the

following interpretation of an Electroencephalogram Report on June 30, 2006: "This is an essentially normal EEG in the awake and drowsy state. Specifically, there are no definitive epileptiform discharges, electrographic seizures or regions of focal slowing."

The impression from a CT of the claimant's head on June 30, 2006 was "1. Negative noncontrast head CT." An MRI of the claimant's brain was taken on July 5, 2006:

Small to moderate amount of periventricular and subcortical white matter FLAIR and T2 hyperintensities without correlate on other sequences and without enhancement are seen. Within the brain stem, at the level of the pons, there is also a central 1.1 centimeter area of similar abnormal FLAIR signal. No acute infarct, hemorrhage, mass lesion, mass effect, abnormal extraaxial fluid collection, or hydrocephalus is identified. The vascular flow voids appear preserved bilaterally. Visualized portions of the orbits and paranasal sinuses are clear. Mesiotemporal lobes are normal.

IMPRESSION: Nonspecific periventricular and brain stem gliotic foci. Given the history of head trauma, this may be the etiology, although in the appropriate clinical setting, accelerated small vessel occlusive disease, demyelinating disease, osmotic demyelination, infection, migraines, vasoactive pharmaceuticals or sequelae of vasculitis may need to be considered.

Dr. Calhoun informed a claims representative on August 22, 2006, "Ms. Johnson is recovering from her most recent surgery. She should not lift or carry more than ten pounds.

She should do no over the shoulder work and she should not hold her neck in a flexed or extended position for more than two minutes at a time. These are her present restrictions as of this date. These are not related to any other of her problems."

Dr. Calhoun corresponded with a claims representative on January 24, 2007:

I have recently been asked to review the partial permanent impairment of the whole person given Elizabeth Johnson. I was unsure if she had been rated for her first surgery, but I understand that was 10%. I do not think that I rated her correctly on the second surgery. Because she underwent a second operation, this would add 2% partial permanent impairment of the whole person as documented in Table 15.7 in the Guide to Permanent Impairment of the American Medical Association. Also, I neglected to include the fact that she has difficulty with her upper extremities in regard to dexterity. If this is taken into effect that she has difficulty with both of her upper extremities, as well as some balance problems, according to Table 13.7 of the AMA Guidelines, she is awarded a 39% whole person impairment as well. This would bring her most recent impairment to 41%.

Mrs. Johnson also suffers from anxiety and seizures. In reviewing the mental and behavioral disorder impairment tables, and because I am not usually asked to rate an impairment with regards to this, I can find no specific numbers to give this patient.

She also has had some seizures which are secondary, I believe, to her second surgery. According to Table 13.3 in the impairment rating guide, she is awarded another 14% impairment of

the whole person. Thus, her total impairment would be 39+2+14 for a total of 55% impairment of the whole person.

The parties stipulated that the claimant reached maximum medical improvement from her compensable neck injury on January 24, 2007. Respondent No. 1 controverted benefits after February 14, 2007.

The claimant sought emergency treatment on April 3, 2007: "The patient is a 48-year-old white female who presents after having a seizure this morning. A family member reports that she shook and then fell back and hit her head and then bit her tongue....I did find out that the patient has been on narcotics and benzodiazepines chronically for a year and her doctor stopped her 'cold turkey' 5 days ago." The emergency physician's impression was "Seizure activity secondary to medication withdrawal."

A urine drug screen collected April 8, 2007 indicated that the claimant was negative for any drugs of abuse, including THC (marijuana).

Dr. Reginald J. Rutherford performed an Independent Medical Examination on June 18, 2007 and stated in part:

[I]t is not possible from the supplied medical documentation to formulate an opinion pertaining to the etiology of Ms. Johnson's seizures. Imaging comprising both CT and MRI studies of the

brain do not demonstrate any evidence for traumatic brain injury. It is possible that her seizures represent toxic effect from medication for the first two seizures and medication withdrawal for the third seizure. This should be further addressed via ambulatory EEG with Dr. Victor Biton. If normal I would attribute these seizures to medication effect. If epileptiform activity is disclosed then remote effect of head trauma would be the most reasonable explanation and clearly would warrant ongoing use of anticonvulsant medication. This would not be required if the ultimate conclusion is adverse medication effect which would not pose a risk for future seizures....

The parties deposed Dr. Calhoun on June 21, 2007. Dr. Calhoun testified regarding the surgery he performed in June 2005 and the additional surgery in June 2006. Dr. Calhoun testified that, prior to the second surgery, an MRI showed that the claimant had developed a bony spur which severely compromised her spinal cord. As a result of the bony spur, Dr. Calhoun opined that the claimant's spinal cord had developed a "white spot," which meant that part of the claimant's spinal cord was not receiving proper blood flow. This condition was causing the symptoms of numbness and weakness in the claimant's extremities. Respondent No. 1's attorney questioned Dr. Calhoun:

Q. Is there any objective medical evidence upon which you can relate her upper extremity numbness and dysfunction to a spinal stroke, as opposed to the bone spur?

A. Well, I mean, it's got to be one of the two things. I don't know. I mean, I think that clearly after her first surgery, there wasn't a bone spur there. She clearly had some malfunction of her spinal cord then, so I mean, my thoughts are that at least part of her symptoms have to be coming from some kind of compromise of the spinal cord, blood flow or whatever during the first - during or after the first surgery. At least part of her symptoms have to be attributable to that.

Q. That part that is attributable, were those - was that a permanent condition, or is that a condition that can reverse.

A. Well, I mean, hers persisted, so I would have to say it was permanent.

Dr. Calhoun corresponded with the claimant's attorney on June 27, 2007: "I reviewed my rating impairments for Elizabeth Johnson. This was in a letter dated January 24, 2007. I actually had put the wrong table down. The accurate table is Table 13.17 of the AMA guidelines. This is the criteria for a rating impairment of 2 upper extremities....Thus, the entire 39% that I mentioned is due to the upper extremity difficulties."

Dr. Gary T. Souheaver evaluated the claimant and provided a Neuropsychology Report on July 25, 2007:

Elizabeth Johnson is a 49 year-old WF referred for evaluation of possible TBI residuals after she was hit on the posterior skull from a falling heavy dress rack. She denied, and medical records also noted, no loss of consciousness. However, she

said she was dazed and confused for the remainder of the day. She has had two cervical spine (C5/6) surgeries. She said that during the first such surgery in June 2005 she had a "stroke" with left side weakness. However, records indicated left arm weakness and pain in 1997. There apparently was a compression on the cord from that first surgery and one year later, June 2006, she underwent a 2nd cervical spine surgery. Subsequently, she reported two seizures (unknown etiology) and was placed on Dilantin, but became toxic and it was stopped. However, she reported another (last) seizure with loss of awareness, on April 3, 2007. Brain imaging via MRI and EEG studies have been normal.

She underwent a three-day Video-EEG monitoring with Dr. Victor Biton, and the results of that evaluation was normal, with no indication of epilepsy on EEG even though there were 5 episodes of subjective seizures reported by the patient. Also of note was an incidence of hallucinations of unexplained reason at the time of the first surgery. Past medical history does not include a previous TBI or any episodes of LOC. She has been treated for chronic depression with Paxil, dating back to her early 20s. She had a cyst removed from her right wrist in 1990, hysterectomy (1997), hepatitis B in 1979, high blood pressure, and Gastric Reflux.

Current complaints include: chronic pain of neck, arms, and back; tingling and numbness of each hand, headaches, balance difficulty, including falls since the 2005 neck surgery. Left-arm weakness, short-term memory loss, disorganized thinking/poor concentration, emotional lability, and dizziness. She no longer drives "due to seizures."...

Personality testing via the MMPI-2 yielded an abnormal profile. Specifically, the profile was strongly suggestive of psychological and emotional factors that are significantly influencing daily

activities of living. The profile included chronic, and significant, depression, anxiety, somatic fixations, obsessive-compulsive traits, restlessness, and emotional lability. Diagnostically, the profile was not consistent with exaggeration of psychiatric symptoms; nor was the profile indicative of a conversion disorder. However, the profile is very common for patients with stress-induced medical complaints, including cognitive and physical complaints that are misattributed to organic functions rather than underlying chronic emotional distress.

In summary, the results of this extensive neuropsychological evaluation were abnormal. The pattern of scores was not specific to a traumatic brain injury residual. In fact, the pattern was from a probable negative response bias by the patient, which resulted in an artificial lowering of most IQ, Memory and neuropsychological tests. Such poor test results would be expected for persons who are institutionalized, or who have been declared in need of 24-hour supervision such as nursing home placement. Clinically, and by history, such a description or classification would not be appropriate in this case. Given the history, it is extremely unlikely that the current test results are related at all to such a minor head injury as was described in the records of this case. I strongly suspect this patient's symptoms are related to underlying personality and/or emotional factors, which interact with chronic pain and medications to produce the cluster of complaints and issues reported by Mrs. Johnson.

IMPRESSION:

1. Abnormal neuropsychological test results - not consistent with effects of a closed head injury noted in this case on 12/31/2004.
2. Neurocognitive symptoms are most probably related to orthopedic, medication, personality and/or emotional factors.

3. Abnormal MMPI-2 profile - consistent with a Somatization Disorder, with underlying chronic Depression and Anxiety exacerbating, or manifested as, medical and cognitive symptoms.

Dr. Rutherford provided the respondents with an Independent Medical Examination Addendum on September 21, 2007:

I have received and reviewed the ambulatory EEG performed by Dr. Victor Biton and the independent psychological examination performed by Dr. Souhever. Ambulatory EEG is negative for a seizure disorder. In this setting I would attribute Ms. Johnson's seizures to adverse medication effect. She does not need to be on an anticonvulsant. Psychological testing as performed by Dr. Souhever is consistent with somatization disorder which correlates with her FCE pertaining to non-valid profile. There is no evidence for traumatic brain injury.

Ms. Johnson has suffered injury to her cervical spinal cord as outlined in my IME. Fortunately her clinical examination is devoid of objective neurological abnormality and thus while imaging is abnormal clinically Ms. Johnson is not. An impairment rating in this setting is limited to that applicable to one level cervical spinal surgery with second revision surgery. This yields an impairment of 11% representing 9% for the initial surgery and 2% for second surgery drawn from Table 75, page 113 of the AMA 4th Edition "Guides to the Evaluation of Permanent Impairment."

Dr. Bradley C. Diner performed an independent psychiatric evaluation of the claimant on December 11, 2007 and stated in part:

This is now 49-year-old white female, status post occupational injury in which she suffered what is thought to be a cervical disc herniation as a result of a large clothing rack falling on her head. Though past records would indicate she indeed had some degenerative disc disease at C5-C6, current agreement is that the disc herniation was directly the result of the occupational accident. She required a second surgery for successful structural correction. There is some suggestion that her surgery was complicated by a vascular accident. Despite complaints of memory and functional deficit, neurologic and neuropsychologic evaluations are unremarkable for any residual brain injury.

Ms. Johnson is certainly depressed with neurovegetative symptoms and even some suicidal thoughts. There is no question that her chronic pain syndrome is at least partially explained by psychogenic factors. She has always experienced a significant degree of overlap between pain, anxiety, and depressive symptoms. Her current complaints far outweigh any objective physiologic data. This is consistent with depressive overlay.

I do not believe that Ms. Johnson is malingering, but rather, I think she experiences a significant amount of pain and distress. However, it is my belief that much of these complaints are the result of her psychiatric condition. I am also of the belief that some of her anergia, as well as cognitive complaints are the result of her pain medications, and in the past, her alcohol intake has likely contributed to the same. It is certainly possible that her intake was at least partially responsible for her seizures, not often a complication of abrupt withdrawal or intermittent intoxication.

As is noted above, Ms. Johnson has suffered depression for at least the last 16 years, and probably longer. She was marginally controlled with paroxetine and various anxiolytics, however,

I doubt she was ever substantially symptom-free. Nonetheless, she was capable of working and maintaining her day-to-day functions. She currently complains of impairment in carrying out her daily living activities and depends on her mother and husband for support. She has little meaningful social contactor enjoyment.

Her previous GAF (global assessment of functioning) was probably 72. Given her current GAF of 50, it is my belief that the current impairment as a result of her depression, would be approximately 22% (that is, the difference between 72 and 50). It should be also noted that this is a dynamic figure which reflects her best functioning. It is my sincere belief that continued aggressive psychiatric management would raise her GAF. However, I doubt she will ever rise higher than a level of 70 to 75, based on her underlying chronic dysthymia and personality factors.

Alternatively, I would place her impairment as outlined by the AMA Guidelines as Class 3 (Moderate Impairment) indicating that her depression is compatible with "some, but not all" useful functioning. Her baseline was close to Class 2, suggesting that there has been some worsening of her condition secondary to her injury. With continued depression treatment, she may eventually recover back to Class 2.

A pre-hearing order was filed on April 7, 2008. The claimant contended: "1) She is entitled to a 55% whole body anatomical impairment due to her stipulated compensable injury. 2) She is now permanently and totally disabled due to her compensable injury or, in the alternative, entitled to wage-loss disability benefits. 3) Claimant contends that

her stroke and seizures she has had (starting on June 29 or 30, 2006) are related to her compensable injury and resulting surgeries. 4) Claimant contends Respondent No. 1 has controverted all permanent benefits over a 10% whole body impairment. 5) Claimant is entitled to psychiatric treatment."

Respondent No. 1 contended: "1) The claimant is not permanently and totally disabled. 2) Respondents have accepted a 12% impairment rating. 3) Respondents controvert Dr. Calhoun's assessment of 55% impairment to the whole person attributable to this accident. 4) They should be given credit for all permanent disability benefits paid. 5) That claimant's stroke and seizures are not related to the 12/31/04 compensable injury. 6) Respondents controvert any psychiatric treatment. 7) Respondents contend Second Injury Fund liability."

Respondent No. 3, Second Injury Fund, contended: "1) Respondent No. 1 has failed to meet their burden of proving Second Injury Fund liability."

An administrative law judge filed an opinion on September 5, 2008. The administrative law judge found that the claimant sustained an 11% anatomical impairment but that

the claimant was not entitled to any wage-loss disability benefits. The administrative law judge found that the claimant did not prove her strokes and seizures were compensable consequences of the claimant's compensable injury. The administrative law judge found that the claimant did not prove psychiatric treatment was reasonably necessary. The administrative law judge therefore denied the claim. The claimant appeals to the Full Commission.

II. ADJUDICATION

A. 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 findings. Ark. Code Ann. §11-9-704(c) (A) (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[.]

The Commission has adopted the Guides to the Evaluation of Permanent Impairment (4th Ed. 1993), published by the American Medical Association, to be used in assessing anatomical impairment. See *Workers' Compensation Laws And Rules, Rule 099.34*; Ark. Code Ann. §11-9-522(g) (Repl. 2002). 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).

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 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, an administrative law judge found that the claimant sustained 11% anatomical impairment as a result of the compensable injury. The Full Commission finds that the claimant proved she sustained anatomical impairment in the amount of 26%. The parties stipulated that the claimant sustained a compensable injury to her neck on December 31, 2004. Dr. Calhoun subsequently operated on the claimant's cervical spine on two occasions. The parties stipulated that the claimant reached maximum medical improvement on January 24, 2007. Dr. Calhoun reported on that date that he had assessed a 10% impairment for the first surgery and an additional 2% anatomical impairment after the second surgery. Respondent No. 1 indicated at the pre-hearing conference that it accepted a 12% impairment rating.

Dr. Calhoun also reported on January 24, 2007 that he assigned the claimant an additional 39% anatomical impairment for her upper extremity condition and balance problems. Following his deposition testimony, Dr. Calhoun noted on June 27, 2007, "The accurate table is Table 13.17

of the AMA guidelines. This is the criteria for a rating impairment of two upper extremities....Thus, the entire 39% that I mentioned is due to the upper extremity difficulties." Dr. Calhoun was apparently referring to Table 13-17, Criteria for Rating Impairments of Two Upper Extremities, found in the Fifth Edition of the Guides. The Commission is not authorized to rely on the Fifth Edition of the Guides. See *Workers' Compensation Laws And Rules, Rule 099.34*; Ark. Code Ann. §11-9-522(g), cited *supra*. The Full Commission recognizes that the authorized Fourth Edition of the Guides, Table 15, page 4/148, Criteria for Two Impaired Upper Extremities, provides for up to a 39% whole-person impairment for the following impairment description: "Patient can use both upper extremities for self-care, can grasp and hold objects with difficulty, but has no digital dexterity." Yet the evidence in the present matter does not demonstrate that the claimant sustained any permanent impairment to either upper extremity as a result of her compensable neck injury and surgeries. The Full Commission, cannot, based on the record before us in the instant matter, find that the claimant sustained a 39% whole-person impairment as assessed by Dr. Calhoun.

Dr. Calhoun reported on January 24, 2007, "She also has had some seizures which are secondary, I believe, to her second surgery. According to Table 13.3 in the impairment rating guide, she is awarded another 14% impairment of the whole person." Dr. Calhoun was apparently referring to Table 13.3 in the unauthorized Fifth Edition of the Guides. The authorized Fourth Edition of the Guides contains Table 5, page 4/143, Impairments Related to Epilepsy, Seizures, and Convulsive Disorders. Table 5 assigns up to a 14% impairment for the following impairment description: "Paroxysmal disorder with predictable characteristics and unpredictable occurrence that does not limit usual activities but is a risk to the patient or limits performance of daily activities."

The instant claimant contended that she began suffering from strokes and seizures on June 29, 2006. The claimant received emergency medical treatment for a seizure on June 30, 2006, and hospital personnel witnessed another seizure by the claimant the same day. Dr. Schluterman opined on June 30, 2006 that the claimant had suffered from two likely seizures. Dr. Calhoun opined on January 24, 2007 that the claimant's seizures were causally related to the claimant's

second surgery. An emergency physician opined on April 3, 2007 that the claimant's seizure activity was secondary to medication withdrawal. Dr. Rutherford independently concluded on September 21, 2007 that the claimant's seizures were attributed to adverse medication effect.

The Full Commission finds that the claimant sustained a 12% anatomical impairment accepted by the respondents in relation to the compensable surgeries and an additional 14% impairment as a result of the claimant's documented seizure disorder. We find that the claimant's seizure disorder was causally related to the claimant's compensable injury, surgery, and medication related to the compensable injury and surgery. The claimant proved that she sustained a 26% anatomical impairment as a result of her compensable injury, surgeries performed by Dr. Calhoun, and causally-related seizure disorder. The claimant proved that the December 31, 2004 compensable injury was the major cause of her 26% anatomical impairment.

B. Wage-Loss

Ark. Code Ann. §11-9-522(b) provides:

(1) In considering claims for permanent partial disability benefits in excess of the employee's percentage of permanent physical impairment, the Workers' Compensation Commission may take into

account, in addition to the percentage of permanent physical impairment, such factors as the employee's age, education, work experience, and other matters reasonably expected to affect his or her future earning capacity.

In the present matter, an administrative law judge found that the claimant failed to prove that she was entitled to wage-loss disability benefits. The claimant contends on appeal that she is entitled to permanent total disability or some percentage of wage-loss disability. The Full Commission finds that the claimant proved she sustained wage-loss disability in the amount of 20%. The claimant is now age 50 with only a high school education. The claimant's work history consists primarily of clerical duties and unskilled labor. The claimant began working for the respondents in November 2003 and sustained a compensable injury in December 2004. The Full Commission has determined that the claimant sustained a 26% anatomical impairment rating as a result of her compensable injury, surgery, and seizure disorder. Although the 26% whole-body rating may represent some limit to her future prospects for employment, the claimant did not prove she was permanently and totally disabled. The claimant did not put forth maximal effort in a November 2005 Functional Capacity Evaluation, and it was

concluded that the claimant could perform light work duties for eight hours daily. The Full Commission recognizes that the Functional Capacity Evaluation was done prior to the claimant's second operation on June 27, 2006. Dr. Calhoun opined on August 22, 2006 that the claimant was able to perform light work even before the claimant reached maximum medical improvement. There is no probative evidence of record or credible indication that the instant claimant is permanently and totally disabled. The Full Commission finds that the compensable injury was the major cause of the claimant's 20% wage-loss disability.

C. Second Injury Fund

Liability of the Second Injury Fund comes into question only after three hurdles have been overcome. First, the employee must have suffered a compensable injury at her present place of employment. Second, prior to that injury the employee must have had a permanent partial disability or impairment. Third, the disability or impairment must have combined with the recent compensable injury to produce the current disability status. *Mid-State Constr. Co. v. Second Injury Fund*, 295 Ark. 1, 746 S.W.2d 539 (1988).

The record in the present matter does not demonstrate that the Second Injury Fund should be liable for the claimant's 20% wage-loss disability. The first hurdle for Second Injury Fund liability was admittedly overcome, in that the claimant suffered a compensable injury at her present place of employment. However, the evidence in the present matter does not show that the claimant had a permanent partial disability or impairment prior to the compensable injury. An MRI in March 2001, prior to the compensable injury in 2004, showed mild spondylosis in the claimant's cervical spine. This condition did not arise to a prior disability or impairment. Nor did any of the pre-injury conditions described by Dr. Souheaver in July 2007, including left arm weakness, high blood pressure, or chronic depression, constitute a prior disability or impairment. Even if the claimant did have a prior permanent partial disability or impairment, the record does not show that this disability or impairment combined with the recent compensable injury to produce the claimant's current disability status. The Second Injury Fund is not liable for wage-loss disability benefits in the present matter.

D. Medical Treatment

Finally, Ark. Code Ann. §11-9-508(a) (Repl. 2002) 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. The claimant must prove by a preponderance of the evidence that she 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 the present matter, the claimant does not contend that she sustained a mental injury or illness pursuant to Ark. Code Ann. §11-9-113. The claimant instead contends that psychiatric treatment is reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a). The Full Commission finds that the claimant proved psychiatric treatment was reasonably necessary. Dr. Diner, a psychiatrist, independently opined on December 11, 2007 that the claimant's condition was the result of her pain medication. The Full Commission finds that psychiatric treatment for claimant is reasonably necessary in connection

with the claimant's wide and varied symptoms following her compensable injury.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant proved by a preponderance of the evidence that she sustained anatomical impairment in the amount of 26% and additional wage-loss disability in the amount of 20%. The claimant proved that her compensable injury was the major cause of both her anatomical impairment and wage-loss disability. The record does not demonstrate that Respondent No. 3, Second Injury Fund, should be liable for the claimant's wage-loss disability. Based on the reports of Dr. Calhoun and Dr. Rutherford, the claimant proved that her strokes and seizures were causally related to and were a compensable consequence of the compensable injury and surgery by Dr. Calhoun. The claimant proved that the medical treatment of record, including psychiatric treatment, was reasonably necessary in connection with the compensable injury. The Full Commission therefore reverses the administrative law judge's decision. The claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715(Repl. 2002). For prevailing in part on appeal to

the Full Commission, the claimant's attorney is entitled to an additional fee of five hundred dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b) (Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney concurs, in part and dissents, in part.

CONCURRING AND DISSENTING OPINION

I must respectfully concur, in part and dissent, in part, from the majority opinion. Specifically, I concur in the majority's finding that the claimant was not permanently and totally disabled, the finding that the Second Injury Fund is not liable for any wage loss disability benefits in addition to the claimant's permanent anatomical impairment and the finding that the claimant did not sustained a 39% whole-person impairment assessed by Dr. Calhoun. However, I must respectfully dissent from the majority's finding that the claimant was entitled to a permanent anatomical impairment rating of 12% for her compensable neck injury, the finding that the claimant was

entitled to a permanent anatomical impairment rating of 14% for her seizure disorder, the finding that the claimant had a stroke and seizure disorder as a result of her compensable injury, the finding that psychiatric treatment was reasonable and necessary medical treatment and the finding that the claimant is entitled to a 20% loss in wage earning capacity in addition to her permanent anatomical impairment. In my opinion, the claimant has failed to meet her burden of proof.

With respect to the permanent anatomical impairment rating for the claimant's admittedly compensable neck injury, I find that the appropriate rating is 11%. The claimant underwent an independent medical evaluation by Dr. Reginald Rutherford and in his report dated September 21, 2007, he stated:

Ms. Johnson has suffered injury to her cervical spinal cord as outlined in my IME. Fortunately her clinical examination is devoid of objective neurological abnormality and thus while imaging is abnormal clinically Ms. Johnson is not. An impairment rating in this setting is limited to that applicable to one level cervical spinal surgery with second revision surgery. This yields an impairment of 11% representing 9% for the initial surgery and 2% for the second surgery drawn from

Table 75, page 113 of the AMA 4th
Edition "Guides to the Evaluation of
Permanent Impairment."

Dr. Calhoun assessed the claimant with a 12% permanent anatomical impairment rating and the majority has awarded this amount presumably because the respondent's accepted this rating at the pre-hearing conference. It is of note that the respondent's should be given a credit for the additional 1% it paid to the claimant. Dr. Calhoun's rating was based upon the 5th Edition of the Guides. The Commission is only authorized to use the 4th Edition of the Guides. Therefore, I agree with the assessment of Dr. Rutherford and find that the appropriate permanent anatomical impairment rating should be assessed by using Table 75, page 113 of the Guides. Accordingly, I must dissent from the award of a 12% award of permanent anatomical impairment for the claimant's compensable neck injury.

The majority also found that the claimant's stroke and/or seizures were a compensable consequence of her compensable injury. I cannot agree with this finding. In my opinion, the medical evidence does not support such a finding. A compensable injury must be established by medical

evidence supported by objective findings, and medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. See, Smith-Blair, Inc. v. Jones, 77 Ark. App. 273, 72 S.W.3d 560 (2002).

Speculation and conjecture cannot substitute for credible evidence. Id. Therefore, in order to prove a compensable injury, a claimant must prove, among other things, a causal relationship between his employment and the injury. McMillan v. U.S. Motors 59 Ark. App. 85, 953 S.W.2d 907 (1997).

Objective medical evidence is necessary to establish the existence and extent of an injury, but not essential to establish the causal relationship between the injury and a work-related accident. Horticare Landscape Mgt. V. McDonald, 80 Ark. App. 45, 89 S.W.3d 375 (2002); Wal-Mart Stores, Inc. v. VanWagner, 337 Ark. 443, 990 S.W.2d 522 (1999); Wal-Mart Stores v. Leach, 74 Ark. App. 231, 48 S.W.3d 540 (2001).

Moreover, objective medical evidence is not essential to establish the causal relationship between the injury where objective medical evidence established the injury's existence, and a preponderance of other non-medical evidence establishes a causal relation to a work-related incident. See, Wal-Mart Stores, Inc. v. VanWagner, supra; Wal-Mart v.

Leach, supra. In Liaromatis v. Baxter Co. Regional Hosp., 95 Ark. App. 296, 236 S.W.3d. 524 (2006), the Court disagreed with the claimant's argument that the medical evidence must merely establish the existence of the injury. The question, stated the Court, is not whether there are new objective findings, but whether there is a new compensable injury. Id. It is the injury for which appellant seeks benefits that must be proved with objective medical findings. Id.

Objective findings are defined at Ark. Code Ann. § 11-9-102(16) (A) (i) as those findings which cannot come under the voluntary control of the patient. When the Commission determines physical or anatomical impairment, complaints of pain, straight-leg raising tests, or active range of motion tests shall not be considered objective findings. Ark. Code Ann. §11-9-102(16) (A) (ii) (a)&(b). The onset of pain does not satisfy our statutory criteria for benefits. Test results that are based upon the patient's description of the sensations produced by various stimuli are clearly under the voluntary control of the patient and therefore, by statutory definition, do not constitute objective findings. Duke v. Regis Hair Stylists, 55 Ark. 327, 935 S.W.2d 600 (1996). Further, medical opinions addressing compensability and

permanent impairment must be stated within a reasonable degree of medical certainty. Objective medical evidence is not essential to establish the causal relationship between the injury and a work-related accident where objective medical evidence establishes the extent and existence of the injury, and a preponderance of other non-medical evidence establishes a causal relation to a work-related incident. McDonald, supra.

While the possibility of the occurrence of a spinal stroke is mentioned in various medical records, there is no evidence that the claimant actually experienced a spinal stroke. Dr. Calhoun testified that the claimant "could have" experienced a spinal stroke, but indicated that no diagnostic tests were performed after the claimant's first surgery to confirm that it indeed occurred. Dr. Calhoun declined to give a medical opinion that a spinal stroke had actually occurred. When questioned about the cause of the spinal stroke and if the claimant did experience one, Dr. Calhoun stated that "[t]here is no objective way I can really explain it" and that he could only rely on "conjecture" to give possible causes. In my opinion, the medical evidence in this case does not contain

any objective findings that the claimant experienced a spinal stroke, and even if she did, the medical evidence does not adequately link it to her surgery. Dr. Calhoun was only able to "conjecture" as to the cause of the spinal stroke. Conjecture and speculation, even if plausible, cannot take the place of proof. Ark. Dept. of Correction v. Glover, 35 Ark. App. 32, 812 S.W.2d 692 (1991); Dena Constr. Co., et al v. Herndon, 264 Ark. 791, 575 S.W.2d 155 (1979); Arkansas Methodist Hosp. v. Adams, 43 Ark. App. 1, 858 S.W.2d 125 (1993). Therefore, I find that the claimant's spinal stroke was not related to her compensable injury.

I also find that the claimant's seizures cannot be adequately linked to the claimant's surgeries. Although Dr. Calhoun initially stated that the seizures were related to the claimant's second surgery, he then backed off from this opinion and stated that he was not in a position to state whether or not the seizure were related to the surgery.

The record lacks objective evidence of seizure activity. The EEG test the claimant underwent at Conway Regional Medical Center was essentially normal, with "no definitive epileptiform discharges, electrographic seizures

or regions of focal slowing." The 24-hour ambulatory EEG video monitoring did not reveal any epileptiform activity or ictal events. Dr. Biton noted that the EEG recordings were essentially within normal limits. Dr. Souheaver gave the opinion that the claimant had not suffered a traumatic brain injury or developed trauma-related seizures.

The evidence does demonstrate that the claimant simultaneously used marijuana, alcohol and a number of other prescription drugs. The claimant's husband told Dr. Schluterman that the claimant smoked marijuana daily. The claimant admitted to Dr. Diner on December 5, 2007, that she drank "at least three to four beers a day for the last two years, but none in the past six months." It is highly likely that the seizures are linked to the claimant's use of marijuana and alcohol with prescription drugs rather than her compensable injury. Accordingly, I must dissent from the majority's finding that the claimant's seizure disorder is a compensable consequence of her compensable injury.

The majority awarded the claimant a 14% permanent anatomical impairment rating for the seizure disorder based upon Table 5, page 4/142 of the Guides. Table 5 assigns up to 14% impairment for the following impairment description:

"Paroxysmal disorder with predictable characteristics and unpredictable occurrence that does not limit usual activities but is a *risk* to the patient or limits performance of daily activities." Dr. Calhoun used 5th Edition of the Guides to assess the claimant with a 14% permanent anatomical impairment rating with regard to seizures. In comparing the 4th Edition Table 5 and the 5th Edition Table 13-3, Class 1 is identical except the 5th Edition contains an "or" section which is not applicable for our purposes. In all other respects, the description is the same. Therefore, it is my opinion that we may go to the 5th Edition to review the examples contained in that section to determine how Dr. Calhoun assessed the 14%. The examples set forth in the 5th Edition with regard to assessing a 0-14% impairment rating are nothing like the facts that we have presently before us. Therefore, I can only assume that Dr. Calhoun used an arbitrary determination to assess the 14%. As stated previously, the claimant does not have a documented seizure disorder. Although the medical evidence indicates that the claimant did likely have two seizures, this does not mean the claimant has a seizure disorder. All of the claimant's EEG's were within normal limits.

Therefore, I cannot agree with the majority's award of a 14% permanent anatomical impairment rating for a seizure disorder.

I also must dissent from the majority's finding that the claimant has proven by a preponderance of the evidence that psychiatric treatment is reasonable and necessary medical treatment. In my opinion, the claimant has failed to meet her burden of proof. The evidence in the record indicates that the claimant did not suffer from a traumatic brain injury which would have caused her psychiatric problems. The claimant has previously been treated for depression and had been treated for it since she was in her 20's. Dr. Souheaver diagnosed the claimant with having a somatization disorder, which means her depression and anxiety were causing her medical complaints and pain, with underlying chronic depression and anxiety. Dr. Souheaver's diagnosis was based solely upon the claimant's verbal statement. The claimant, in my opinion, is not a credible witness. Her testimony is replete with inconsistencies. The claimant told Dr. Calhoun that she had a pre-existing psychiatric problem with depression and paranoia, but when asked whether she had paranoia-type

symptoms in the past, the claimant testified, "No, sir, only after my first surgery." When Dr. Diner conducted his psychiatric independent medical evaluation, the claimant denied the use of any illicit drugs. She also denied drug use to other medical providers. For instance, she died using drugs during her consultation with Dr. Schluterman on June 30, 2006. However, the claimant's husband informed Dr. Schluterman privately that the claimant smoked marijuana on a daily basis. At the hearing the claimant testified that she used marijuana before and after her surgery. However, in her deposition, the claimant stated that she had not used marijuana since her 20's. When I consider the inconsistencies in the claimant's testimony, medical records and deposition, I find that the claimant is not a credible witness and is therefore not entitled to psychiatric treatment. It is well settled that questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. White v. Gregg Agriculture Ent., 72 Ark. App. 309, 37 S.W.3d 649 (2001); Johnson v. Riceland Foods, 47 Ark. App. 71, 884 S.W.2d 626 (1994); Scarborough v. Cherokee Enterprises, 306 Ark. 641, 816 S.W.2d 876 (1991); Ark. Coal

Co. v. Steele, 237 Ark. 727, 375 S.W.2d 673 (1964); Potlatch Forests, Inc. v. Smith, 237 Ark. 468, 374 S.W.2d 166 (1964).

The constitutionality of the Commission's authority and duty to conduct a de novo review of the record, including issues of credibility, has been established by the court. See, Stiger v. State Line Tire Serv., 72 Ark. App. 250, 35 S.W.3d 335 (2000). Accordingly, when there are contradictions in the evidence, it is constitutionally within the Commission's exclusive province to reconcile the conflicting evidence and to determine the true facts. Stiger, supra; see also, White, supra.

Ark. Code Ann. §11-9-704(b) (6) (A), vests with the Commission the duty to "review the evidence" and if deemed advisable to "hear the parties, their representatives, and witnesses." By allowing the Commission this latitude, Ark. Code Ann. §11-9-704(b) (6) (A) (Repl. 2002), adequately protects a claimant's due-process rights. Stiger, supra. The statute further requires the Commission to determine, "on the basis of the record as a whole, whether the party having the burden of proof on the issue has established it by preponderance of the evidence." A.C.A. § 11-9-704(c) (2). However, neither the Workers' Compensation Act nor Arkansas

case law contains a requirement that the Commission personally hear the testimony of any witness. Moreover, the Commission is not required to believe the testimony of the claimant or other witnesses, but may accept and translate into findings of fact only those portions of the testimony it deems worthy of belief. Morelock v. Kearney Company, 48 Ark. App. 227, 894 S.W.2d 603 (1995).

When the Commission reviews a cold record, demeanor is merely one factor to be considered in determining credibility. Stiger, supra. Numerous other factors must be considered, including the plausibility of the witness's testimony, the consistency of the witness's testimony with the other evidence and testimony, the interest of the witness in the outcome of the case, and the witness's bias, prejudice, or motives. Id. More specifically, in Stiger, supra, the Court of Appeals stated:

When the Commission reviews a cold record, demeanor is merely one factor to be considered in credibility determinations. Numerous other factors must be included in the Commission's analysis of a case and reaching its decision, including the plausibility of the witness's testimony, the consistency of the witness's testimony, the interest of the witness in the outcome of the case, and the witness's bias, prejudice,

or motives. The flexibility permitted the Commission adequately protects the claimant's right to due process.

Uncorroborated testimony of an interested party is always considered to be controverted. However, the rule also applies to a non-party witness whose testimony might be biased. Burnett v. Philadelphia Life Insurance Co., 81 Ark. App. 300, 101 S.W.3d 843 (2003). It is not arbitrary to choose not to credit such testimony. Id. Furthermore, a witness's close familial relationship to a party has been held to demonstrate a sufficient possibility of bias so as to treat the witness's testimony as disputed. See, Sykes v. Carmack, 211 Ark. 828, 202 S.W.2d 761 (1947). Moreover, the testimony of an interested party is taken as disputed as a matter of law whether offered on his own behalf or on the behalf of another interested party. Knoles v. Salazar, 298 Ark. 281, 766 S.W.2d 613 (1989).

Finally, there is nothing in the statutes that precludes the Commission from accepting or rejecting any finding made by the Administrative Law Judge, including findings pertaining to the credibility of witnesses. Stiger, supra. The findings of the Administrative Law Judge on issue

of credibility are not binding on the Commission. Roberts v. Leo-Levi Hospital, 8 Ark. App. 184, 649 S.W.2d 402 (1983); Linthicum v. Mar-Bax Shirt Co., 23 Ark. App. 26, 741 S.W.2d 275 (1987).

I also dissent from the majority's award of 20% loss in wage earning capacity in addition to the claimant's permanent anatomical impairment. The Commission is charged with the duty of determining disability based upon a consideration of medical evidence and other matters affecting wage loss such as the claimant's age, education, and work experience. Eckhart v. Willis Shaw Express, Inc., 62 Ark. App. 224, 970 S.W.2d 316 (1998). "Other factors" includes the claimant's credibility, motivation, and willingness to cooperate with medical providers. Simply put, when considering all factors, I find that the claimant has failed to prove by a preponderance of the evidence that she is entitled to any wage loss disability benefits over and above her 11% permanent anatomical impairment. The evidence demonstrates that the claimant lack's credibility and she was also unwilling to cooperate with her physical therapy. On September 23, 2005, Dr. Calhoun stated as follows:

Ms. Johnson's appointment was scheduled for 11 o'clock today. She did not keep her appointment. I talked with her nurse case manager. I am not sure what to do. She did not go to therapy for a month and was finally threatened with cutting off her benefits and then she did go. She has been noncompliant with almost every treatment. We will see if she calls and reschedules. If she does not, then one would have to consider saying that she is maximal medically improved.

The Functional Capacity Evaluation in which the claimant gave an unreliable effort must also be taken into consideration when determining the claimant's wage loss. As stated above, the claimant's failure to adequately give truthful statements regarding her alcohol and drug use to her medical providers are also a factor to consider when considering wage loss because doctors cannot properly care for their patients if they are not given true social and medical histories. It is clear Dr. Calhoun was trying to get the claimant off of numerous medications in order to help the claimant recover; however, Dr. Calhoun states in his report from September 24, 2007,

She asked if there was anything that I would give her as far as Xanax or pain medicine. She and I have been through this exhaustively in the past. I have made it quite clear that I would not.

She then said that she was planning to kill herself.

In my opinion, those type of threats to her medical providers is just an example of the claimant's attention seeking statements to achieve whatever end she wants.

The claimant's work history shows that she primarily worked in light duty capacities which is the recommendation that was given in the Functional Capacity Evaluation. The claimant argues that the Functional Capacity Evaluation should not be given any weight because it was done before the second surgery. However, I find that the claimant gave an unreliable effort on the first Functional Capacity Evaluation and her testimony and other evidence lead me to believe that she would not give her best effort or be truthful on any future Functional Capacity Evaluations. When the claimant was asked what problems affect her ability to work, she responds with the following statements, "I have no short-term memory at all.... I fall all the time.... I can't hold things. My hands and feet are numb.... I'm very emotional right now." All the claimant's restrictions or inabilities to work are based upon her subjective feelings. In order to find that the claimant is

entitled to wage loss disability benefits in addition to her permanent anatomical impairment rating would require one to find that the claimant's statements regarding her inability to work were believable and credible. As stated previously, I do not find the claimant to be credible. I find that the credible evidence shows that the claimant cannot be believed when it comes to her true condition. Therefore, after taking into account all factors and considering wage loss, I find that claimant has failed to prove by a preponderance of the evidence that she is entitled to any wage loss disability benefits. Therefore, for all the reasons set forth herein, I must concur in part and dissent in part from the majority's opinion.

KAREN H. MCKINNEY, COMMISSIONER