

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F811104

ALBERT R. WRIGHT,
EMPLOYEE

CLAIMANT

ST. VINCENT DOCTORS HOSPITAL,
EMPLOYER

RESPONDENT

INDEMNITY INSURANCE CO
OF NORTH AMERICA,
INSURANCE CARRIER

RESPONDENT

ORDER FILED APRIL 27, 2011

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

Claimant represented by the HONORABLE GEORGE BAILEY,
Attorney at Law, Little Rock, Arkansas.

Respondent represented by the HONORABLE MICHAEL E. RYBURN,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed in part,
reversed in part.

OPINION AND ORDER

The respondents appeal an administrative law judge's
opinion filed February 12, 2010. The administrative law
judge found that the claimant proved he was entitled to
additional medical treatment. The administrative law judge
found that the claimant had sustained 19% anatomical
impairment and 30% wage-loss disability. After reviewing

the entire record *de novo*, the Full Commission affirms the administrative law judge's finding that the claimant proved he was entitled to additional medical treatment. We reverse the administrative law judge's finding that the claimant proved he sustained permanent anatomical impairment or wage-loss disability as a result of the claimant's compensable injury.

I. HISTORY

Albert R. Wright, age 74, testified that he became employed with St. Vincent in 2007. The claimant testified that he was a therapist and staffing coordinator. The parties stipulated that the claimant sustained a compensable injury on September 25, 2008. The claimant testified that he stepped out of an elevator and "went down approximately 15 inches....my full weight hit on my left foot and my left leg....I swung my body around to bring my balance back, and when I did, then, my right leg and foot jammed down on the floor. It hurt and it hurt severely." An emergency physician record dated September 25, 2008 indicated that the claimant "stumbled exiting elevator," and that the claimant complained of back pain and bilateral hip pain. X-rays of the claimant's lumbosacral spine showed "DJD" and

"spondylosis" with a handwritten notation, "pelvis neg."
The Clinical Impression was "Acute Myofascial Strain
lumbar."

An x-ray of the claimant's pelvis was done on September
25, 2008, with the following findings:

No acute fracture or dislocation. Ring densities
are seen in the right ischium probably from
enchondroma. There are degenerative changes. The
hips are well seated.

OPINION:

No acute fracture.

An x-ray of the claimant's lumbosacral spine was done
on September 25, 2008, with the following findings:

No acute fracture, dislocation, or bone
destruction. There are degenerative changes and
osteopenia.

OPINION -

No acute fracture.

A Return To Work/School Permit dated September 25, 2008
indicated that the claimant could return to work on
September 27, 2008. The claimant testified that he returned
to work at light duty.

The record indicates that Dr. Scott Carle saw the
claimant on October 15, 2008 and diagnosed Lumbar Strain,
Pain in Joint Involving Lower Leg, and Disturbance Of Skin
Sensation. Dr. Carle returned the claimant to work on

October 15, 2008 with restrictions of no lifting over 20 pounds. The claimant was prescribed physical therapy.

An MRI of the claimant's lumbar spine was done on October 22, 2008, with the following findings:

Alignment of the lumbar spine is normal. The vertebral bodies are of normal height. Marrow signal is normal. The conus is unremarkable.

The L1-2 and L2-3 discs demonstrate normal signal without degeneration. No significant disc bulge or herniation is identified at these levels.

At the L3-L4 level there is degenerative disc with some loss of disc space height. There is diffuse disc bulge or protrusion at this level. There is also facet and ligamentous hypertrophy at this level. The combination of these findings does produce spinal stenosis at this level. Foramina are patent.

At the L4-L5 level there is degenerative disc with loss of disc signal and disc space height. There is diffuse disc bulge. There is mild to moderate facet and ligamentous hypertrophy. Foramina are patent.

At the L5-S1 level there is degenerative disc with minimal diffuse disc bulge. No focal disc herniation is noted. Foramina are patent.

IMPRESSION -

Spinal stenosis at L3-L4 due to a combination of diffuse disc protrusion as well as facet and ligamentous hypertrophy.

Degenerative discs from L3 through S1.

Disc bulges at L4-L5 and L5-S1.

Electrodiagnostic testing was also done on October 22, 2008:

This is a 72-year-old man who twisted his back in late September. He has had a history of polio as a young man. He has had lower extremity cramping and and some intermittent paresthesias....

IMPRESSION:

1. Normal motor nerve conduction velocities and latencies in the tibial nerves bilaterally and in the left peroneal nerve.
2. There is some mild reduction in amplitude of the right peroneal nerve and a prolonged distal latency. However, the conduction is within normal limits.
3. The inability to obtain sensory responses in a patient of this age cannot definitely be interpreted as pathological.
4. There is evidence of chronic denervation with partial reinnervations seen bilaterally in the distributions of the L4, L5, S1, S2 on the left, and L5, S1, S2 on the right.
5. There is evidence of acute denervation seen in the distribution of L5, S1, S2 bilaterally.

COMMENT:

The above findings would suggest some chronic denervation, which may be related to the patient's previous diagnosis of polio. There is, however, acute denervation seen in the muscles innervated by nerve roots L5, S1, S2 bilaterally.

A Physician Activity Status Report dated October 23, 2008 indicated, "Regular Activity - Released from care. Return to regular duty on 10/23/08."

Dr. James W. Bryan examined the claimant and reported on December 18, 2008:

Mr. Wright is a 72-year-old psychiatric social worker who presents with a 3-month history of pain with the acute onset when he stepped off an elevator car which had not reached the level of his floor dropping him an estimated 15 inches onto one of his legs with the immediate onset of pain and shooting burning pains into both lower extremities. Subsequently he developed pain ascending up into the midthoracic and lower cervical spine. He was evaluated at the Concentra Medical Clinic and a workup ensued including MRI scan and neurodiagnostic studies, which are available for my review. He had just 4 visits of physical therapy and felt some slight benefit.

His past history is significant for polio in 1957, a very mild case, but a suspicion of postpolio syndrome in his 40s. He has also had lumbar degenerative disk disease and had a laminectomy performed by Dr. Ron Williams (level not specified) and had recovered completely from this before experiencing some recent discomfort. He is concerned that he may have re-injured a cervical disk with his recent injury.

The neurodiagnostic studies performed by Dr. Elaine Wilson at St. Vincent Medical Center 10/22/2008 did show some acute changes in the L5, S1, and S2 nerve roots bilaterally overlying evidence for chronic neuropathy at these levels consistent with his previous diagnosis of polio. The MRI scan showed spinal stenosis at L3-4 and disk bulging at L4-5 and L5-S1. Plain films of the abdomen performed at the time of the injury were interpreted as normal. No clinical laboratory testing has been done to my knowledge.

The patient states that he has missed minimal work because of his injury. He recounts that only in one other episode during his life has he experienced the excruciating degree of pain he felt at the time of the injury and in the days that followed....

Habits: Pipe smoker for 50 years, low alcohol intake. Nonphysical job. He is not highly physically active outside of his work. He is able to drive and requires no assistance from others with ADLs or work....

IMPRESSION

1. Lumbar sprain, bilateral sacroiliac sprains, and lumbar neuropraxia. Within a reasonable degree of medical certainty the constellation of symptoms is consistent with his report of stepoff-impact injury. Contributing factors to the severity and chronicity of his symptoms include his underlying spinal stenosis. The acuity of the disk bulges cannot be determined.
2. Likely propagation of preexisting but asymptomatic cervical degenerative disk disease.

Dr. Bryan recommended epidural injections and additional physical therapy. Dr. Bryan stated, "4. He is cleared to return to limited duty this date, 12/18/2008. I anticipate a return to his normal duties, without restrictions, in 4 weeks and I am hopeful that his claim can be closed within 2 months with good response to the treatment plan outlined above."

Dr. Bryant Turbeville performed epidural steroid injections on January 16, 2009, February 2, 2009, and March 13, 2009. The claimant followed up with Dr. Bryan on March 20, 2009: "He has completed a course of 3 lumbar epidural steroid injections for lumbar radiculitis. His pain cycle broke after the second one. He has not required separate

injections of the sacroiliac joints according to the anesthesia notes. He rates his pain at 2/10 with no pain referring to the legs any longer. He is retiring from work this month and remains on limited duty." Dr. Bryan's impression was "1. Excellent response to lumbar epidural steroid injections. 2. Partial resolution of his sacroiliac sprain symptoms. PLAN: Continue limited duty for 1 month, observe his condition, and return in 1 month in hopes of closing his claim. I anticipate minimal or no permanent partial impairment."

The claimant continued follow-up visits with Dr. Bryan. The claimant's testimony indicated that he began working part-time for the respondent-employer in April 2009. The claimant testified that his last pay period for the respondents ended on June 5, 2009.

Dr. Phillip R. Kravetz examined the claimant on June 11, 2009:

The patient is a 72-year-old gentleman sent here for consultation by his workmen's compensation carrier. The patient has seen Dr. James Bryan, a family practice sports physician. The patient had a work-related injury back on 09/25/2008. The patient had a misstep after coming off an elevator. He had the acute onset of back pain and leg radiculopathy. The leg radiculopathy is left greater than right. He would say it is somewhere around a 50/50 split between the two. The patient

does have a little bit more complicated medical history, having had a history of polio when he was young. He denies having some recent problems; however, he does state that since this incident he has had not just pain, but really his biggest complaint at this time is sort of a fatigue type of weakness in his back and in his legs....

There is an MRI of the lumbosacral spine available for review. MRI was performed at St. Vincent Health System. The study is dated 10/22/2008. There is a separate attached report. The study does show at L3-4 spinal stenosis due to anterior and posterior degenerative changes. L4-5 shows a similar finding. L5-S1 shows some mild bilateral foraminal narrowing due primarily to the spondylolisthesis.

ASSESSMENT:

1. Chronic back pain with leg radiculopathy.
2. Possible post-polio syndrome.
3. Multilevel lumbosacral spinal stenosis.
4. Spondylolisthesis L3 on L4 and L5 on S1.

PLAN: At this time I had a lengthy discussion with the patient. We went over his studies and really went over all the different treatment options in detail. It is impossible to say, of course, what his exact anatomic injury is, although I suspect either all or very close to all the findings we see on imaging studies were there before he ever had his injury. We would say that the injury, therefore, has aggravated his complaints, rather than actually cause particularly a change in the anatomy. To make things more complicated is the history of polio and some of this general fatigue and weakness in his back and legs I would say is probably also related to the polio. Whether or not this was set off by the injury, again, is impossible to say. Ultimately the patient does describe his complaints as having started after the incident and, therefore, it does seem reasonable for treatment. As far as what he has left, I think surgery can be an option; however,

surgery would probably be first and foremost, most successful for radiculopathy, which typically is going to be more pain than just general fatigue-weakness. I think it certainly could help this. The surgery itself is certainly not reliable for back pain. I did go over what surgery would entail and, given the different anatomical factors, there is no question it is a combination of decompression and fusion. His complaints involve multiple nerve root levels, which certainly include L4, L5, and S1 and, therefore, if surgery was done at some point, it would certainly include all three levels anatomically of L3-4, L4-5, L5-S1. At this point, the patient states he clearly has no interest in surgery....My suggestion for him is to go back and see Dr. Bryan to have him do an impairment rating. Technically, one would say that the patient has reached maximum medical improvement, given that there is no additional treatment that he is planning and certainly I would say other than time, hopefully showing some improvement, the patient has reached that point....

Dr. Bryan reported on July 24, 2009:

I am in receipt of the letter from Kathy Prince, Claim Coordinator, dated 07/15/2009 requesting an impairment rating and opinion on the condition of claimant Albert Wright. His diagnosis is lumbar sprain, sacroiliac sprain, spinal stenosis, lumbar degenerative joint disease and lumbar degenerative disk disease. His current condition is that he has subjective weakness in his left leg that was not present before his injury. He has occasional moderate pain in the low back and pain localized to the left sacroiliac notch. His motion remains restricted to less than before the accident. He has gained partial improvement from a course of lumbar epidural steroid injections completed 03/13/2009 and he has had multiple courses of physical therapy....

PLAN:

1. He has reached maximum medical improvement at this time, although consideration could be given for a trial of lumbar facet injections to see if this breaks his pain cycle. Additionally the left sacroiliac joint could be injected. I will have him visit with my associate, Dr. Bryant Turbeville, to discuss these, but since it has been just 4 months since his last lumbar epidural steroid injection, this may need to be delayed.
2. If no further care is provided then an impairment rating, based on the *Guides to the Evaluation of Permanent Impairment*, Fourth Edition, is given. The following considerations were (sic) given: His DRE functional impairment, the objective findings of spondylolisthesis and 3-level degenerative disk disease, with the absence of radicular signs or atrophy. Range of motion assessments were not considered. Using 7% whole person impairment for his spondylolisthesis, 7% sum total of 3-level degenerative disk disease without radiculopathy, and DRE category II (minor impairment) and using the Combined Values Chart on Page 322, I arrived at a whole person impairment of 19%
3. I will await the response from the carrier regarding subsequent care.

A pre-hearing order was filed on September 15, 2009. The claimant contended, among other things, that he was entitled to reasonably necessary medical treatment, anatomical impairment in the amount of 19%, and wage-loss disability in the amount of 75%. The respondents contended, among other things, that the claimant had "no PPD of which the major cause was the injury at work." The parties eventually agreed to litigate the following issues: medical

benefits; permanent physical impairment; wage loss/permanent partial disability; and fees for legal services.

Dr. Jamie D. Howard stated on November 10, 2009:

This letter is being written on behalf of my patient, Albert Wright. He has been my patient for more than 10 years and has not had a significant impairment before September 2008. Mr. Wright has had occasional mild problems with low back pain. Never did it sound like radicular pain or pain from nerve damage. His neurologic exams and straight leg raising test as well as gaits were always normal. The pain always resolved without much more intervention than rest and mild analgesics.

There has never been any objective finding that would support that the polio he [had] in 1957 damaged his back. Especially there is no reason to suspect that his current back pain problem is linked to his past history of polio. His functional status has not been significantly affected if at all by polio. Based on his history, I am aware that he has been an avid exerciser and outdoorsman without any difficulty.

An administrative law judge filed an opinion on February 12, 2010. The administrative law judge found, among other things, that continued medical treatment was reasonably necessary. The administrative law judge found that the claimant sustained permanent anatomical impairment in the amount of 19% and wage-loss disability in the amount of 30%.

The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. §11-9-508(a) (Repl. 2002). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Hamilton v. Gregory Trucking*, 90 Ark. App. 248, 205 S.W.3d 181 (2005).

An administrative law judge found in the present matter, "5. The evidence preponderates that the claimant continues to require medical treatment in connection with [the] September 25, 2008, compensable injury and for which respondent remains liable. Respondent shall pay all reasonable hospital and medical expenses arising out of the compensable injury of September 25, 2008." The Full Commission finds that the claimant proved he was entitled to additional injection treatment as recommended by Dr. Bryan.

The parties stipulated that the claimant sustained a compensable injury on September 25, 2008. The claimant testified that he fell approximately 15 inches after stepping off an elevator. The claimant received emergency treatment on September 25, 2008 and was diagnosed with an acute lumbar myofascial strain.

The claimant received conservative treatment including physical therapy. Pursuant to Dr. Bryan's recommendation, the claimant received three epidural steroid injections from Dr. Turbeville. Dr. Bryan noted on March 20, 2009 that injection treatment had reduced the claimant's complaints of pain. However, the claimant subsequently reported that his condition began worsening, and the assessment of Dr. Kravetz on June 11, 2009 included "1. Chronic back pain with leg radiculopathy." Dr. Kravetz opined that surgery would be "most successful for radiculopathy" but would not be "reliable for back pain." Dr. Kravetz also noted that the claimant was not interested in surgery. Dr. Bryan reported on July 24, 2009 that the claimant's diagnosis was lumbar sprain, sacroiliac sprain, spinal stenosis, lumbar degenerative joint disease and lumbar degenerative disk disease.

Dr. Bryan stated on July 24, 2009 that the claimant had reached maximum medical improvement. The administrative law judge found that the claimant "reached the end of his healing period on July 24, 2009[.]" The claimant does not appeal that finding. Dr. Bryan opined that a trial of lumbar facet injections or a sacroiliac joint injection could benefit the claimant. A claimant may be entitled to ongoing medical treatment after the healing period has ended, if the medical treatment is geared toward management of the claimant's injury. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004), citing *Hydrophonics, Inc. v. Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983). In the present matter, the Full Commission finds that the claimant proved he was entitled to a consideration of additional injection treatment as recommended by Dr. Bryan on July 24, 2009. We find that the claimant proved Dr. Bryan's treatment recommendations stated on July 24, 2009 were reasonably necessary in connection with the compensable injury.

B. Anatomical Impairment

Permanent impairment, which is usually a medical condition, is any permanent functional or anatomical loss

remaining after the healing period has been reached.

Ouachita Marine v. Morrison, 246 Ark. 882, 440 S.W.2d 216 (1969). Act 796 of 1993, as codified at Ark. Code Ann. §11-9-102(4) (F) (ii) (Repl. 2002), provides:

(ii) (a) Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment.

(b) If any compensable injury combines with a preexisting disease or condition or the natural process of aging to cause or prolong disability or a need for treatment, permanent benefits shall be payable for the resultant condition only if the compensable injury is the major cause of the permanent disability or need for treatment.

“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). Preponderance of the evidence means the evidence having greater weight or convincing force. *Smith v. Magnet Cove Barium Corp.*, 212 Ark. 491, 206 S.W.2d 442 (1947).

Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings. Ark. Code Ann. §11-9-102(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[.]

It is the duty of the Commission to translate evidence into findings of fact. *Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994). The Commission has adopted the *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993) to be used in assessing anatomical impairment. See Ark. Code Ann. §11-9-522(g) (Repl. 2002); *Workers' Compensation Laws And Rules*, Rule 099.34.

An administrative law judge found in the present matter, "3. The claimant reached the end of his healing period on July 24, 2009, with a residual anatomical impairment in the amount of 19% to the body as a whole." The Full Commission reverses this finding. We find that the claimant did not prove that he sustained any permanent anatomical impairment as a result of the compensable injury.

The parties stipulated that the claimant sustained a compensable injury on September 25, 2008. The claimant testified that he stepped out of an elevator and fell approximately 15 inches. An x-ray of the claimant's pelvis on September 25, 2008 showed degenerative changes but no acute fracture. The findings from an x-ray of the claimant's lumbosacral spine on September 25, 2008 were "No acute fracture, dislocation, or bone destruction. There are degenerative changes and osteopenia. OPINION - No acute fracture." The claimant was diagnosed with acute lumbar myofascial strain.

An MRI of the claimant's lumbar spine was performed on October 22, 2008. The impression was spinal stenosis at L3-L4, degenerative discs from L3 through S1, and disc bulges at L4-L5 and L5-S1. Dr. Bryan began treating the claimant on December 18, 2008. Dr. Bryan reviewed the lumbar MRI and noted, "The acuity of the disk bulges cannot be determined." Dr. Bryan reported on March 20, 2009, "I anticipate minimal or no permanent partial impairment." The assessment of Dr. Kravetz on June 11, 2009 was chronic back pain, possible post-polio syndrome, multilevel spinal stenosis, and lumbar spondylolisthesis. Dr. Kravetz did not opine that the

findings of stenosis and spondylolisthesis were a result of the September 25, 2008 accidental injury. Dr. Kravetz in fact stated, "It is impossible to say, of course, what his exact anatomic injury is, although I suspect either all or close to all the findings we see on imaging studies were there before he ever had his injury. We would say that the injury, therefore, has aggravated his complaints, rather than actually cause particularly a change in the anatomy."

Dr. Bryan assigned the claimant a 19% whole-person impairment on July 24, 2009, based on Dr. Bryan's interpretation of the Combined Values Chart of the *Guides* at p. 322. The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). In the present matter, the preponderance of the evidence does not support Dr. Bryan's finding that the claimant sustained a 19% whole-person impairment. The Full Commission attaches more significant evidentiary weight to the findings of Dr. Kravetz, who opined that there had not been a change in the claimant's anatomy as a result of the compensable injury. We reiterate the opinion of Dr. Kravetz, i.e., "I suspect either all or

very close to all the findings we see on imaging studies were there before he ever had his injury. We would say that the injury, therefore, has aggravated his complaints, rather than actually cause a change in the anatomy."

The Full Commission finds that the instant claimant did not prove by a preponderance of the evidence that the September 25, 2008 compensable injury was the major cause of any percentage or degree of permanent physical impairment. The claimant did not prove that he sustained any percentage or degree of permanent physical impairment which was supported by objective and measurable physical findings. The preponderance of the evidence does not demonstrate that the claimant sustained any permanent structural or physical damage to his back or lumbar spine as a result of the September 25, 2008 compensable injury. The electrodiagnostic testing carried out on October 22, 2008 was not probative evidence demonstrating any percentage or degree of permanent physical impairment as a result of the compensable injury. The November 10, 2009 letter of Dr. Howard was not probative evidence demonstrating any percentage or degree of permanent physical impairment as a result of the compensable injury.

Based on our *de novo* review of the entire record currently before us, the Full Commission finds that the claimant proved he was entitled to additional medical treatment as outlined in Dr. Bryan's July 24, 2009 report. The claimant did not prove by a preponderance of the evidence that the September 25, 2008 compensable injury was the major cause of any percentage or degree of permanent physical impairment. We therefore affirm the administrative law judge in part and reverse in part. Because the claimant did not prove that he sustained any percentage or degree of permanent physical impairment as a result of the compensable injury, the claimant also did not prove he was entitled to any percentage of wage-loss disability. See *Wal-Mart Stores, Inc. v. Connell*, 340 Ark. 475, 10 S.W.3d 882 (2000). The claimant does not contend that he is entitled to permanent total disability benefits. See *Rutherford v. Mid-Delta Cmty. Servs., Inc.*, 102 Ark. App. 317, 285 S.W.3d 248 (2008).

For prevailing on the issue of additional medical treatment, the claimant's attorney is entitled to a 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

KAREN H. McKINNEY, Commissioner

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

CONCURRING AND DISSENTING OPINION

After my de novo review of the entire record, I concur with the majority opinion that the claimant proved his entitlement to additional medical treatment; however, I must respectfully dissent from the majority opinion's finding that the claimant failed to prove that he sustained permanent anatomical impairment or wage-loss disability as a result of his compensable injury.

Ark. Code Ann. Sec. 11-9-102(4)(F)(ii)(a) provides that permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment. "Major cause" is defined as more than fifty percent (50%) of the cause, and a finding of major cause shall be established according to a preponderance of the evidence. Ark. Code Ann Sec. 1-9-102(14)(A); see Pollard v. Meridian Aggregates, 88 Ark. App.

1, 193 S.W.3d 738 (2004). Further, Ark. Code Ann. §11-9-102(4)(F)(ii)(b) provides that if any compensable injury combines with a preexisting disease or condition or the natural process of aging to cause or prolong disability or a need for treatment, permanent benefits shall be payable for the resultant condition only if the compensable injury is the major cause of the permanent disability or need for treatment.

In Needham v. Harvest Foods, 64 Ark. App. 141, 987 S.W.2d 141 (1998), a claimant was not entitled to benefits based upon an impairment rating solely for a condition that predated her aggravation, where she did not suffer any impairment for the compensable aggravation of the pre-existing condition. In Wal Mart Stores Inc. v. Westbrook, 77 Ark. App. 167, 72 S.W.3d 889 (2002), the claimant was entitled to benefits for 3% of the 30% overall impairment rating, where exacting testimony proved that the 3% was attributed to the compensable injury at issue. Therefore, there was no question that the Wal Mart claimant's last compensable injury was the major cause of the 3% of his impairment rating.

In Pollard v. Meridian Aggregates, supra, the claimant sustained a compensable back injury in 2000, for which his employer accepted liability. The claimant had a pre-existing back condition, which had required two previous surgeries. The Commission found that the work-related injury caused the claimant's pre-existing stenosis, which had been asymptomatic prior to the work injury of 2000, to become symptomatic and requiring surgery. Notwithstanding this finding, the Commission denied the claimant's claim for benefits for permanent physical impairment, because the 2000 compensable injury was not the major cause of his impairment, relying on Needham v. Harvest Foods, 64 Ark. App. 141, 987 S.W.2d 141 (1998). Rather, the Commission found that the claimant's work injury had only aggravated a pre-existing condition, and had not caused the stenosis which had eventually led to surgery and permanent anatomical impairment. Relying on Wal Mart Stores Inc. v. Westbrook, supra, the Court of Appeals reversed the Commission and remanded the claim for a determination of benefits. The doctor in Pollard who gave the impairment rating stated that his "preexisting disease accounted for 80% of his disease process," but the court noted that this opinion did not

resolve whether or not the compensable injury was the major cause of an impairment. The court found significant the facts that the claimant's back disease did not require surgery, or any other medical treatment, prior to the compensable aggravation. Id., 88 Ark. App. at 7.

The claimant suffered a compensable injury to his back on September 25, 2008. Prior to that date, the claimant was active in his employment and his private life. The record shows that while the claimant did have preexisting conditions in his spine, he was not having symptoms prior to the injury similar to the symptoms he had afterwards. The claimant's activities were not limited prior to the injury, and he did not require the medical treatment or narcotic and other medications prior to the injury that he required afterwards. He did not have an impairment rating at all before the compensable injury.

The fact that Dr. Kravetz felt that the claimant's condition pre-existed his work-related injury does not show that the compensable injury was not the major cause of the disability or impairment. Prior to September 25, 2008, the claimant had no impairment or disability as a result of his pre-existing conditions. After the compensable injury, the

claimant did have impairment and disability. Therefore, the inescapable conclusion is that the compensable injury was the major cause of the claimant's 19% permanent anatomical impairment rating to the body as a whole, just as it was in the Pollard, supra, case.

I would award the claimant the 19% permanent anatomical impairment rating, and 75% wage-loss benefits above that rating due to the claimant's limitations caused by the injury, including his pain, need for medications, injections and further treatment, restrictions of no lifting or bending, inability to sit or stand for long, as well as his age.

For the foregoing reasons, I must concur with the majority's award of additional medical treatment, but I must respectfully dissent from the majority opinion's denial of an impairment rating and wage-loss benefits.

PHILIP A. HOOD, Commissioner