

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G201671

RICK YOUSEY,
EMPLOYEE CLAIMANT

MULTI-CRAFT CONTRACTORS, INC.,
EMPLOYER RESPONDENT

GALLAGHER BASSETT SERVICES, INC.
INSURANCE CARRIER/TPA RESPONDENT

OPINION FILED MARCH 21, 2016

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

Claimant represented by the HONORABLE JASON M. HATFIELD,
Attorney at Law, Fayetteville, Arkansas.

Respondent represented by the HONORABLE CURTIS L.
NEBBEN, Attorney at Law, Fayetteville, Arkansas.

Decision of Administrative Law Judge: Affirmed in Part;
Reversed in part.

OPINION AND ORDER

The respondent appeals and the claimant cross-appeals a decision of the Administrative Law Judge filed on July 13, 2015. The respondents have appealed the award of benefits for the claimant's facial disfigurement and pain. The claimant has appealed the denial of the benefits for his vision and brain injury. After our *de novo* review of the entire record, the Full

Commission finds that the claimant is entitled to a permanent anatomical impairment rating of 29% for his brain injury and 24% for his left eye injury, both to the body as a whole. The Full Commission finds that the claimant is entitled to benefits in the amount of \$3500.00 for facial disfigurement pursuant to Ark. Code Ann. §11-9-524, but that he is not entitled to benefits based upon a permanent anatomical impairment rating for facial disfigurement in excess of the cap imposed by the statute. The Full Commission finds that the claimant is not entitled to benefits based upon a permanent anatomical impairment rating based upon pain.

The claimant sustained a compensable injury to his head and face on February 24, 2012. In short, the claimant was slammed to the ground, landing face first on the concrete, on February 24, 2012. He was treated at one hospital and transported to UAMS for further treatment. He sustained extreme facial injuries, as well as a torn rotator cuff. He required surgical intervention to correct the broken bones of his face, one surgery to reposition his eye, and shoulder surgery. He was left with diplopia in his left eye, facial disfigurement, and cognitive, mental and emotional

problems. The claimant sought a 29% permanent impairment rating to the body as a whole for his brain injury, a 100% rating for his total loss of vision in his left eye, facial disfigurement compensation and impairment rating, a rating for his uncontrolled facial neuralgic pain, and an attorney's fee.

I. HISTORY

The claimant was brought to the emergency room in Springdale, Arkansas, on February 24, 2012, at four o'clock in the afternoon, after being slammed to the ground from a height of about five feet, by a piece of equipment. He landed on his face and left shoulder and lost consciousness. He underwent CT scans of his head and face which showed many facial fractures. The decision was made to transfer him to UAMS by ambulance.

On February 24, 2012, the date of the accident, a CT of his head showed a small lacunar infarction at genu of the left internal capsule¹ and

¹ The internal capsule is a deep subcortical structure that contains a concentration of white matter projection fibres. These fibres form the corona radiata. Anatomically, this is an important area because of the high concentration of both motor and sensory projection fibres... The internal capsule is made up of five parts [including the] genu... [which] lies medial to the apex of the lentiform nucleus [and] contains corticonuclear fibres (previously called corticobulbar fibres).
Knipe, Dr. Henry and Maingard, Dr. Julian, *Internal Capsule*

pneumocephalus in the anterior cranial fossa, related to the facial fractures. The anterior cranial fossa is the space behind the forehead and eyes², and pneumocephalus is:

Pneumocephalus refers to the presence of intracranial gas, and in the vast majority of cases the gas is air. Rarely a gas forming infection can result in pneumocephalus. The term encompasses air in any of the intracranial compartments, and is most commonly encountered following trauma or surgery.³

On the same date, a facial CT showed "innumerable" facial fractures, bilaterally, including the orbital bones, the sinuses, the mandible, as well as intracranial air, and fluid in the sinuses.

The claimant arrived at UAMS on February 24, 2012 at 11:40 pm. The UAMS discharge report stated that the claimant arrived with multiple facial fractures and pneumocephalus. Discharge with a week of antibiotics and

(2005-2015 Radipaedia.org) Retrieved December 16, 2015 from <http://radiopaedia.org/articles/internal-capsule>

² The anterior cranial fossa constitutes the floor of cranial vault which houses the frontal lobes of the brain. Luijkx, Dr. Tim, and Mudgal, Dr. Prashant, *Anterior cranial fossa* (2005-2015 Radiopaedia.org) Retrieved December 16, 2015 from <http://radiopaedia.org/articles/anterior-cranial-fossa>

³ Rezaee, Dr. Amir, and Weerakkody, Dr. Yuranga, *Radiopaedia.org: Pneumocephalus*, (2005-2015 Radiopaedia.org) <http://radiopaedia.org/articles/pneumocephalus>

follow-up with ENT, ophthalmology and neurosurgery clinics was recommended. However, the claimant was unable to swallow or tolerate anything by mouth, so he was admitted to the hospital for intravenous antibiotics and pain medications. A subsequent examination revealed left hand and foot injuries. He had difficulty swallowing a liquid diet for several days. He underwent surgery on February 29, 2012. He had some physical therapy. He was discharged on March 1, 2012, with instructions to follow-up with the ENT clinic. He was to be on a soft diet. A CT scan was planned for three weeks for his neurosurgery appointment.

On February 29, 2012, the claimant underwent surgery, by Dr. Moody, ENT specialist, with open reduction and internal fixation of right Le Fort II fracture, open reduction and internal fixation of left Le Fort III with multiple approaches, open reduction and internal fixation of left orbital fracture, and closed reduction of nasal fracture. Le Fort fractures are explained as follows:

Le Fort fractures are fractures of the midface, which collectively involve separation of all or a portion of the midface from the skull base. In order to be separated from the skull base the pterygoid plates of the sphenoid bone need to be involved as these

connect the midface to the sphenoid bone dorsally. The Le Fort classification system attempts to distinguish according to the plane of injury.

Classification: The commonly used classification is as follows: ...

Le Fort type 2: pyramidal fracture, with the teeth at the pyramid base, and nasofrontal suture at its apex; fracture arch passes through posterior alveolar ridge, lateral walls of maxillary sinuses, inferior orbital rim and nasal bones

Le Fort type 3: craniofacial disjunction; fracture line passes through nasofrontal suture, maxillo-frontal suture, orbital wall and zygomatic arch

A memory aid is: ... Le Fort II is a floating maxilla; Le Fort 3 is a floating face.

Any combination is possible. For example there may be type 2 on one side and type 3 on the other or there may be type 1 and type 2 on the same side. Also Le Fort fractures can be associated with other facial fractures, neuromuscular injury and dental avulsions.⁴

A second operative report from the same date and physician also noted fracture of the anterior and posterior walls of the frontal sinus and blunt trauma to the left globe (eyeball).

The claimant was seen for his hand on March 5, 2012. He reported difficulty sleeping due to his facial

⁴Luijckx, Dr. Tim, and Gaillard, A.Prof. Frank, *Radiopaedia.org: Le Fort fracture classification*, (2005-2015 Radiopaedia.org)
<http://radiopaedia.org/articles/le-fort-fracture-classification>

trauma. X-rays showed fifth metacarpal neck fracture about seventy degrees angulated. Non-operative treatment was begun, with a cast. He was seen again on March 20, 2012, with improvement. Physical therapy was recommended.

On March 20, 2012, Dr. Lawton observed an inferior orbital blow out fracture of the left eye, with persistent enophthalmos (recession of the eyeball in the orbit)⁵ and downward displacement of the left globe yielding persistent diplopia (double vision). Additional surgery may be necessary. He saw Dr. Moody in the ENT clinic with the same observations of enophthalmos and diplopia.

Beginning in March 2012, the claimant underwent treatment for his left small finger metacarpal neck fracture, which resolved in October 2012, and left foot injury, which resolved in April 2012.

On April 1, 2012, Dr. Magre noted the claimant's insomnia, crying spells, mood swings, and depression.

⁵enophthalmos. (n.d.) *The American Heritage Medical Dictionary*. (2007). Retrieved December 14 2015 from <http://medical-dictionary.thefreedictionary.com/enophthalmos>

On April 13, 2012, Dr. Lawton stated that the claimant could drive and that he should cover his left eye to prevent diplopia.

In April 2012, Dr. Heinzelmann diagnosed a full-thickness tear at the junction of the supraspinatus and infraspinatus tendons and a tear of the proximal infraspinatus tendon, acromioclavicular joint arthrosis, and subacromial/subdeltoid reactive bursitis, for which surgery was performed on April 27, 2012.

On May 1, 2012, the claimant saw Dr. Moody who noted the claimant's history and continued double vision and blurriness on the right. He had decreased sensation of the "V2" cranial nerve on the left. He had left enophthalmos, decreased left ocular height and left lateral canthus inferior displacement. He reported having difficulty ambulating. He was seen on May 24, 2012 with the same observations.

On May 7, 2012, Dr. Magre noted some improvement in the claimant's depression and insomnia. He continued to have anxiety and crying spells.

On June 1, 2012, Dr. Pemberton planned surgery to correct the claimant's enophthalmos with plates. The surgery was performed on June 15, 2012, and corrected

left eye enophthalmos and canthal dystopia. On June 22, 2012, the claimant returned to Dr. Pemberton with sore bone above left eye, a lot of headaches, difficulty opening left eye, and blurry vision in left eye. His diplopia was resolved in primary and reading gaze, but he continued to have diplopia in left gaze.

On June 26, 2012, Dr. Morse, a neurologist, evaluated the claimant, who reported having lost his sense of smell and taste, tinnitis, amnesia for part of the accident, emotional lability, uncontrollable crying spells, emotional "blankness," forgetfulness, and slow speech. Dr. Morse observed left facial deformities and dysarthria due to facial injuries or brain injury. Dr. Morse stated that the "patient had a head injury." He wanted an MRI if possible, a neuropsychological evaluation and access to the ENT and neuro-ophthalmology reports.

The claimant underwent a neuropsychological evaluation in July 2012 by Dr. Back. He reported that he remembered the equipment he was delivering started to roll but he did not remember hitting the ground. He had memory problems and headaches behind his left ear and eye. He described himself before the accident as

"hyper," a "go-getter," who walked fast. After the accident he was no longer that person. He was very anxious and fearful in his work environment. He did not operate any equipment or vehicles at work. He drove, but he tried to limit himself to one lane. He reported a recent near-miss accident in which he almost side-swiped a car. He stated that he could not "really" see with his left eye. He would cry, while talking to someone. He had to take medications, which his wife tracked, including one to help him sleep. His wife reported that he was withdrawn, not emotional, inactive, ambition-less, "in a shell," and a worrier, which were all qualities he did not have before the accident. Dr. Back observed that the claimant's gait was very stiff with his shoulders pulled back and awkwardly straight. Dr. Back observed that the claimant's speech was loud and slow.

The claimant took several tests during the evaluation which showed that he was "currently functioning in the borderline range of mental retardation (8th percentile)." For verbal intelligence, the claimant's scores were in the borderline range of mental retardation. For Performance Intelligence, his scores were in the low average range. His scores showed

that his current intellectual functioning corresponded with his reported educational history (eight years, no high school), but not with his vocational history. As a mechanic's helper, he should have an IQ of 95, but his verbal intelligence and performance intelligence scores were significant at the 0.5 level, which is suggestive of a cognitive dysfunction. Dr. Back's diagnoses were dementia due to head injury with adjustment reaction with anxious mood, and closed head injury. He recommended no operation of heavy machinery, cognitive retraining, and behavioral treatment for his anxiety disorder. Dr. Back stated that the claimant's left hand seemed to be impaired, which suggested a right hemisphere dysfunction. In summary, he stated:

Mr. Yousey's test results indicate marked impairment in memory functioning, especially auditory mode. Motor speed, both fine and gross, are noticeably impairment in his dominant hand (left). Visual scanning skills and attention performances are all above average. Anxiety, while riding in a car, is a problem. When he is with his boss, watching him unload equipment, he has flashbacks to the accident.

On July 11, 2012, the claimant saw Dr. Johnson who noted the claimant's overall weakness in his hand and that he was no longer able to play the guitar. He stated that he was not sure what to make of his hand

weakness. He planned physical therapy.

On July 13, 2012, the claimant underwent an MRI which showed:

The brain parenchyma⁶ shows an area of decreased signal intensity on T1 and increased signal intensity on T2 in the left internal capsule. It is unclear if this is an old lacunar infarct⁷ (deep cerebellar strokes), a shear injury,⁸ or "much less likely a perivascular space."⁹ ... The orbits show some asymmetry between the left and the right orbit with the left eye being pushed somewhat posteriorly compared to the right. The paranasal sinuses show a deviated septum and some mucosal thickening without air fluid levels.

⁶ The essential or functional elements of an organ, as distinguished from its stroma or framework. parenchyma. (n.d.) *Dorland's Medical Dictionary for Health Consumers*. (2007). Retrieved December 14 2015 from <http://medical-dictionary.thefreedictionary.com/parenchyma>

⁷ Papamitsakis, Nikolaos, MD, *Medscape: Lucunar Syndrome* (2015) Retrieved December 14, 2015 from <http://emedicine.medscape.com/article/1163029-overview>

⁸ "A blow to the head will impart rotational velocity to the brain and, depending on its magnitude, will produce effects ranging from concussion to profound neurological dysfunction. Resultant shear strains distort and rupture axons, blood vessels and major fibre tracts." Peerless SJ, Rewcastle NB. Shear Injuries of the Brain. *Canadian Medical Association Journal*. 1967;96(10): 577-582. Retrieved December 14, 2015 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1936040/>

⁹ Perivascular spaces are "spaces, often only potential, that surround blood vessels for a short distance as they enter the brain." perivascular space. (n.d.) *Dorland's Medical Dictionary for Health Consumers*. (2007). Retrieved December 14 2015 from <http://medical-dictionary.thefreedictionary.com/perivascular+space>

On July 25, 2012, the claimant saw Dr. Pemberton, who felt that the risks to his central and reading vision far outweighed the benefits of attempting to surgically correct his left-gaze diplopia. He planned a consultation with a strabismologist.

On July 26, 2012, Dr. Magre noted some improvement in his depression.

On July 30, 2012, the claimant saw Dr. Heinzelmann who noted his left shoulder was healing well. Physical therapy was continued.

Dr. Morse saw the claimant on August 1, 2012, noting Dr. Back's assessment of post-traumatic dementia and adjustment reaction with anxious mood. He also noted that Dr. Lawton felt that there was no more to do to improve the claimant's vision. Dr. Morse stated that the claimant had some difficulty with language function. He stated that his MRI was normal. He suggested that the claimant see an ENT about his hearing and language. Dr. Morse's assessment of the claimant's condition was post-traumatic headaches for which he added amitriptyline to his medication regimen, occipital neuralgia for which he performed a nerve block injection, hearing and language function issues for which he recommended an ENT

evaluation, and post-traumatic encephalopathy¹⁰ for which the claimant would continue to see Dr. Back.

The claimant saw Dr. Magre on August 15, 2015, who noted that the claimant's depression was improving with medication.

On August 30, 2012, Dr. Moody, the ENT specialist, noted the claimant's slow speech, in addition to continued left enophthalmos, and his diplopia and blurry vision on the left. He reported difficulty chewing and anosmia (loss of sense of smell) since injury. He had no control over the left side of his lip.

¹⁰ Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by ... increased pressure in the skull, chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state. Depending on the type and severity of encephalopathy, common neurological symptoms are progressive loss of memory and cognitive ability, subtle personality changes, inability to concentrate, lethargy, and progressive loss of consciousness. Other neurological symptoms may include myoclonus (involuntary twitching of a muscle or group of muscles), nystagmus (rapid, involuntary eye movement), tremor, muscle atrophy and weakness, dementia, seizures, and loss of ability to swallow or speak. Blood tests, spinal fluid examination, imaging studies, electroencephalograms, and similar diagnostic studies may be used to differentiate the various causes of encephalopathy. *Encephalopathy Information Page*, (2010 National Institute of Health: National Institute of Neurological Disorders and Stroke), Retrieved December 15, 2015 from <http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm>

On August 31, 2012, Dr. Pemberton evaluated the claimant. The claimant continued to have double vision in left gaze. He saw Dr. Lawton that morning and also reported having seen a strabismus surgeon who planned to put prisms in his glasses. He had double vision, blurriness, tearing, and redness in the left eye (oculus sinister or OS). He also reported depression and sinus issues. Dr. Pemberton felt that any further attempt to improve his diplopia, from a surgical standpoint, would come at risk to his vision. The claimant's vision had improved from baseline.

Dr. Morse saw the claimant again on September 4, 2012, for his post-traumatic encephalopathy and headaches. The occipital block improved his headaches. There were no changes on exam. The diagnoses were post-traumatic encephalopathy and migraines, improving. He was undergoing cognitive retraining with Dr. Back.

On September 11, 2012, the claimant saw Dr. McNeel regarding his ability to chew, to keep dentures stable, and to speak properly. He noted that "nutrition is a serious concern." The claimant was totally edentulous (toothless), prior to his work accident. His current dentures did not fit. Dr. McNeel observed the

following on examination:

moderate to severe atrophy in mandible; severe atrophy in maxilla; coronoid process of the mandible, left side, is fractured and no longer attached; masseter muscle attachment (superior position) has been significantly altered; due to fractured jaws, patient has titanium plates that extend to zygoma; left zygoma is depressed; mandible deviates to the left; left TMJ disc pops open upon opening/closing; left eye droops; infraorbital fractures; LeFort II and III maxilla fractures; premaxilla is flabby; mild to moderate dry mouth, possibly secondary to medications; palate: papillary hyperplasia; patient has deviated septum (left); patient is experiencing paresthesia midface (left).

Dr. McNeel went on:

During the accident, the Coronoid Process (left side) was fractured; consequently there is now loss of attachment to the Temporal Muscle and the Superior Portion of the Masseter Muscle has been significantly altered. Rick has lost the primary muscles used to elevate, retract the jaw as well as necessary force to chop and grind food. In addition, Rick has mild to moderate dry mouth (xerostomia). Dry mouth is more than likely due to the quantity and types of medications patient is required to take.

Dr. McNeel recommended implants to secure and stabilize dentures, to give him strength and stability to eat. He noted that his dry mouth and the damage and instability in his face did not allow the use of conventional dentures. He felt that the claimant would return to normal functioning capacities of speaking and

eating after the surgeries required for the implants and dentures.

On October 3, 2012, the claimant returned to Dr. Morse who noted that the claimant's amitriptyline was not helping. He increased the dosage. Another occipital block was performed. On examination, the claimant was in moderate distress.

On October 10, 2012, Dr. Back wrote a letter to Dr. Morse, stating that the claimant was working on a forty-session long Cognitive Retraining program, using a computer from his office. He had checked in twice for program modification and progress tracking. He had shown some slight improvement, but three months of training was required to obtain notable advancement.

The claimant returned to Dr. Magre on October 16, 2012, with worsening depression, with fatigue and lack of interest. He felt flat on the antidepressant. She planned to wean him off Celexa and to start Wellbutrin.

The claimant saw Dr. Morse on November 14, 2012. The higher dose of amitriptyline worked well, and if he did not take it, his headaches returned. The occipital nerve blocks provided excellent relief.

Dr. Back wrote to Dr. Morse on November 15, 2012, to report that the claimant had completed two sessions since his last check-in on September 26, 2012. He had returned the equipment on October 31, 2012 and discontinued the Cognitive Training program. His progress could not be assessed. He was advised of other non-computer-based home activities. Treatment was discontinued as of October 31, 2012.

The claimant saw Dr. Magre with some improvement of his depression on new medication. He reported some vision changes.

Dr. Moody saw the claimant on November 29, 2012. He felt as though the left side of his face was "drawing up."

Dr. Lawton performed a disability rating on November 29, 2012:

His visual acuity was correctable to 20/20 in each eye. Humphrey 30-2 threshold perimetry was full in both eyes. He had double vision looking to his left within 10 degrees of neutral position. The double vision in this location is equivalent to a 100% impairment of ocular motility, total loss of vision in one eye, a 25% impairment of the vision system, and a 24% impairment of the whole person.

Dr. Morse wrote on January 4, 2013, that he was still following the claimant for his post-traumatic

encephalopathy and headaches. He needed an occipital nerve block. He was working but not doing all of his activities. Dr. Morse observed a lot of occipital tenderness and that the claimant was in significant pain.

Between September 2012 and March 2013, the claimant underwent preparation for and implantation of prostheses for dentures. The claimant was referred to Dr. Bolding for a bone graft consultation after the implantation surgery on March 12, 2013. Dr. Bolding planned an iliac bone graft and removal of maxillary plates, which was performed on March 19, 2013. On March 26, 2013, he was released to light work with no heavy lifting, and with no chewing. On April 9, 2013, the claimant reported debilitating pain in his left thigh below the graft site, which prevented him from working.

The claimant returned to Dr. Morse on August 7, 2013, for an occipital block due to increased pain.

The claimant saw Dr. Bolding and Dr. McNeel in August 2013 for preparation for further dental implantation.

The claimant saw Dr. Magre for his worsening depression. He had a depressed mood, diminished interest

or pleasure, excessive worry and fatigue. This was aggravated by traumatic memories. He felt unimportant at work. She prescribed Klonopin and recommended counseling for PTSD, job changes and future surgeries.

On September 26, 2013, the claimant underwent complete maxilla reconstruction and partial mandible reconstruction by Dr. McNeel.

Dr. Back evaluated the claimant on September 30, 2013, and diagnosed post-traumatic stress disorder and single episode, moderate major depression. He planned therapy.

The claimant saw Dr. McNeel on October 10, 2013. He was healing well from surgery. On October 16, 2013, Dr. McNeel stated that the next step was implantation of the newly grafted bone on the maxillary. The surgery was performed on November 20, 2013.

The claimant received another occipital block on January 9, 2014, from Dr. Morse for his post-traumatic headache.

The claimant saw Dr. Magre on August 12, 2014 with worsening depression. Functioning was somewhat difficult. He had anxious and fearful thoughts, depressed mood, diminished interest or pleasure, fatigue

and irritability. He continued to struggle after his work injury. He was crying and irritable at the visit. He was encouraged to exercise and modify his diet for obesity. He was prescribed Cymbalta for his depression and referred to Dr. Back.

Dr. Back saw the claimant on August 25, 2014, for his irritability and emotional lability. He explained that he had trouble with crying for no reason while speaking to someone, getting irritated with people. He was more cautious when driving. His wife stated: "...but his personality has just changed. He's not the same Rick. He does cry out of the blue, and he used to be so easygoing." Dr. Back explained to her that, "based on his neuropsychological results, that his emotional lability and irritability are the consequences of brain injury. Medications may not necessarily control these." Dr. Back observed that the claimant was nervous, with stammering speech, which could be secondary to his head injury. His left eye "squints." He repeated himself. Dr. Back stated that the claimant's irritability and emotional lability were "most likely symptoms commonly associated with head injury." He noted that the claimant seemed to understand that these issues

were a fact of life for him now. The diagnoses were moderate neurocognitive disorder and posttraumatic stress disorder in remission.

Dr. Back performed a disability evaluation on October 2, 2014:

Mr. Yousey was evaluated two years post injury to assess for permanent mental condition.

Mr. Yousey was evaluated in July of 2012 after a closed head injury. He was diagnosed as having dementia due to this head injury. Auditory Delayed Recall performance was at the 0.6 percentile, while visual Delayed Recall was at the 16th percentile. Left hand (dominant) showed slowing. Anxiety was significant when driving or riding in a car.

Mr. Yousey's Auditory Delayed Recall is currently at the 29th percentile. Visual Recall is at the 20th percentile. Sustained concentration is at the 42nd percentile. Anxiety is minimal on the Beck Anxiety Inventory, but Depression is mild to moderate on the Beck Depression Inventory.

His wife was interviewed separately and reported that her husband is much more comfortable driving to work, but that he rarely drives anywhere else. She drives almost everywhere they go. "And he's not the same easy-going Rick. He's changed. Down, negative. Not the positive person he was."

Based upon the above data, using AMA 4th Edition Guidelines for permanent impairment, Mr. Yousey would appear to receive a rating of 14% impairment to the whole person on mental Status Impairments (Table 2 p 142). For Emotional or Behavioral Impairments (Table 3, p. 142) his rating appears to be 18%. Combining these two, using the chart on p. 322, his

total impairment is 29%.

The claimant had another occipital block by Dr. Morse on January 20, 2015.

The claimant underwent a medical examination for a commercial driver's license in 2006, 2008, 2009, 2010 and 2011, which he passed without concern other than hypertension which was controlled with medication. A Performance Appraisal in 2007 showed that the claimant was an excellent employee.

The claimant completed a job review form in February 2012, a week before his accident, which showed a positive attitude, understanding of his work and good communication skills. A wage evaluation showed that the claimant was considered an "excellent employee" with eagerness and ability to take on more responsibility. A plan to increase his computer skills was laid, and he received an increase of one dollar per hour in pay.

In August 2013, the claimant completed another review form, in which he discussed his move to the shop after his accident. He did not feel this was a positive change. He wanted to return to driving, but "due to injury to eye, I don't think that will happen." He noted his appreciation for his job and his employer. He

received an increase of one dollar per hour, based upon his effort to learn a new computer system.

Dr. Lawton testified that there were three components of vision for purposes of the *Guides* evaluation of vision. The claimant did not have issues for the first two components, visual acuity and peripheral vision. To be clear, the claimant had significant visual acuity deficiencies in both eyes, but they were corrected to 20/20 with prescription eyeglasses. The third component is double vision. Dr. Lawton explained:

The system [the *Guides*] recognizes that people with double vision cannot use both eyes together and there's a degree of impairment assigned to how far from the center of vision the double vision kicks in. Generally, it's considered that the central is ten to twenty degrees vision is the essential vision. It's critical for reading and driving and things like that, so that if there's double vision in that area, that's interpreted by the AMA rules as if someone had lost the vision in one eye. They would have to cover that eye in order to function.

In regard to the claimant's double vision, Dr.

Lawton explained:

Any attempts to move and have him look to his left resulted in double vision, even less than ten degrees away from the center of vision. In looking at the misalignment that he had, the main areas of misalignment were... looking to the left and down. Looking to the right he

was okay. If he looked absolutely straight ahead, okay. But as soon as he looked a little bit, tiny bit to the left, the double vision kicked in, or a tiny bit down, the double vision kicked in.

...

It's a minimal of looking to the left and looking down. You didn't have to go very far at all [to trigger double vision].

Dr. Lawton explained that ocular motility is the movement of the eye. The claimant had one hundred percent (100%) impairment of the ocular motility of his left eye.

As defined by the *Guides*, Dr. Lawton testified that double vision within the central ten degree of vision is equivalent to total loss of vision in one eye, a 25% of impairment of the entire visual system, and a 24% impairment of the whole person. Dr. Lawton stated:

He had vertical double vision when he looked down, because the left eye wouldn't move down as well as the right eye would, and he had horizontal double vision looking to his left, because the left eye wouldn't move out as well as the right eye would turn in, so they get out of alignment.

Dr. Lawton stated that the double vision was caused by the misalignment of his eyes. That can be caused by the fractures in his face. He did not have misalignment prior to the accident. He would not have been able to obtain a commercial driver's license with

double vision.

Double vision can be avoided by using only one eye. Using one eye affects depth perception, but Dr. Lawton stated that "people with double vision have no depth perception anyway - have poor depth perception anyway. You're actually better off without the double vision and only seeing with one eye. The brain can develop the ability and use other clues to judge distances. It's just not quite as good as using both eyes together."

Dr. Lawton explained that the misalignment when the left eye looked left or down was observable and measurable. It was measured by observing the "alternate recovery in the eyes when a person is looking at target and you see how much the eye shift when you move from one eye to the other."

The claimant had a surgery which successfully repositioned his sunken left eye, but it did not correct the alignment. The left eye was improved from being sunken by six millimeters to three millimeters. When asked if the remaining three millimeters of depression of the eye explained the misaligned, Dr. Lawton stated:

It's a little more complicated than that because of the nature of fractures around the

eye socket. The bone around the eye socket is very thin. This is intentional. It's a protective mechanism for the eye. It's similar to having a crumple zone in a car, so that when you have an automobile accident, the front end collapses to protect the passenger compartment. In this case the bone will fracture in what's called a blowout. The force will cause the bone to break and then flap downward into the sinus below it.

He stated that the positioning of the eye was changed by the trauma, as well as by some permanent damage to the tissue as a result of the fractures. This led to the impairment rating of 100%.

Dr. Lawton explained that looking all the way over to your ear with your eyeball would be 90 degrees. Looking ten degrees to the left would be looking "barely to your left." When the claimant looked ten degrees to the left, he had double vision, which worsened as he looked further to the left.

Dr. Lawton did not believe, based upon his experience and the measurements he had, that realigning his eyes through muscle surgery would work. The only prescription to correct double vision, prisms on glasses, was tried and failed.

The claimant could not get a commercial driver's license. He could read if he blocked the vision of one eye. He could read with both eyes when the

material was directly aligned in front of his left eye, which would be problematic.

Dr. Morse testified that he saw the claimant on June 26, 2012, for double vision. He had multiple facial fractures which were not completely repaired, and which affected the way his left eye moved. He had lost his sense of smell and taste. He had ringing in his ears. He did not remember part of the accident. He was emotionally labile with uncontrollable crying spells and mild cognitive issues. He was forgetful, with slow speech. He was unable to work.

Dr. Morse discussed the MRI on August 1, 2012:

Essentially it's normal. A few things. I did go back and look at the sequences. They did not do a specific sequence looking for blood, so there's a very sensitive way you can look for brain damage from bleeding. That was not done on this particular scan. It may have been that the technology... at that time didn't allow them to do so. I said there's no evidence of hemorrhage, but again, the most sensitive test for hemorrhage was not performed. It appeared that his left eye was pushed back in his face compared to the right. He had some inflammatory changes in the sinuses and he had something in his left internal capsule. The internal capsule is where all the motor fibers come to one side of your body, so the left internal capsule would control the right side of the body, and he had a spot here and I couldn't tell if it was a cyst that he was born with, a shear injury due to a head injury, shearing where the fibers are separated and leaves a space, or whether

it was an old small infarct.

Dr. Morse stated, based upon the scan alone, there was no way to tell whether the spot observed was a cyst, a shearing injury, or sign of an old stroke.

A CT scan on February 24, 2012, showed a lacunar infarct in the left internal capsule. Dr. Morse stated that an MRI is more sensitive than a CT. The CT showed pneumocephalus in the anterior cranial fossa. Dr. Morse explained:

Pneumocephalus in the anterior cranial fossa, so because of the skull fracture, air was able to go from outside to inside his skull surrounding the brain, so that goes along with a skull fracture. That can happen. There's just about no other way that can happen, which is not unexpected in this case, and it says negative for parenchymal hemorrhage. CT is not great for small hemorrhages. ... [Pneumocephalus] means his skull fracture was pretty bad is all that means.

Raccoon eyes are a sign of skull fracture. Dr. Morse stated that there were no objective findings of brain injury.

Dr. Morse also stated that the images of the claimant's face in the record and the CT scans of the claimant's head and face, which clearly showed skull fracture, swelling, bleeding, contusions and scrapes, as well as pneumocephalus, were "consistent with objective

findings that could cause brain injury.”

The claimant's inability to swallow could have been from swelling or cranial nerve injury. The loss of sense of smell and taste, amnesia, emotional lability, crying spells, forgetfulness and speech issues were consistent with a frontal lobe brain injury. Dr. Morse explained:

Those are typically seen in inferior frontal lobe. The base of your skull, the bottom of your skull right above your eyes is real rough, so when you have a head injury, your brain swirls around and is rubbed up against those rough surfaces and you can have some bruising at the very bottom of your brain there, and the classic symptoms of that are loss of smell and taste, because those fibers go through the cribriform plate, which is a very thin plate at the base of the skull that's often fractured in head injuries. You can get personality changes from that. He had a period of amnesia, which indicated that his head injury was significant. It wasn't just his face. His brain was injured. Emotional lability, again, is a frontal lobe. Uncontrollable crying spells. The cognitive changes could be frontal, could be temporal lobe. Speech slower can be frontal lobe and sometimes that's really hard to see unless you have a really good scan and are looking in a specific way at that part of the brain.

Dr. Morse asked for a neuropsychological evaluation. Dr. Back observed left hand impairment which suggested a right hemisphere dysfunction, which would be consistent with a brain injury.

Dr. Morse could not say with 100% certainty that the claimant had a shear injury.

Dr. Morse explained that post-traumatic encephalopathy is something wrong with his brain. He continued, "He just didn't hit his head. I mean, he had a severe skull fracture. This is the worst thing I've ever seen. I've never seen a fracture like this since 1981, when I started - well, really '77, when I started doing it. He's lucky to be alive."

The claimant could expect to have post-traumatic headaches for the rest of his life. He receives a shot in the scalp for them. "The occipital nerves come up at the back of your head. They supply sensation to the back of your head, and he'd begin the headaches and if you numb them up with some Novacaine, frequently it will knock the headache out." The claimant took Amitriptyline for post-traumatic headaches as well.

Dr. Morse stated that the claimant would have a 15-24% rating for a trigeminal nerve injury. He explained:

So the trigeminal nerve, tri is three. It has three branches, and where they come out right above your eye. The medial aspect, there's a little notch there. If you feel, it comes out there. Right below the eye is a little hole it comes out, and then it comes through your jaw.

So, with the zygoma and zygomaticofacial fractures, I would expect that he has the second division of the trigeminal nerve injured. The inferior frontal orbit, inferior orbital floor, I mean that's just where it kind of comes out. So I would say certainly the second division of the trigeminal nerve would be damaged. I don't really see - there was no mention of a fracture up here in the first division. He has a lot of swelling, but it looks like it's really not near the nerve, which would be about right there, and I don't know that he had a jaw fracture. He had a mandibular fracture, but probably that's okay. It's probably at least the second division. The first and third, probably not.

Dr. Morse stated that the claimant had an injury to the sensory part of the trigeminal nerve, based upon the claimant's facial pain, headaches and facial fractures. He felt the issue was moderate. He also noted that the motor part affected chewing, and opening and closing the mouth. A rating based upon pain is subjective.

Dr. Back testified that the claimant's stiff gait with one shoulder held awkwardly back as a result of a shoulder injury with rotator cuff repair was significant for a potential head injury and neuropsychological deficit. He explained that "to have suffered a blow to the body or a bone or any part of it with enough force to break in indicates - you know gives an indication of the amount of force this person's body

and head has been subjected to."

Dr. Back stated that Dr. Morse's report showed there was an old lacunar infarct versus shear injury in the left internal capsule, which Dr. Back stated was "really not normal." An infarct is a stroke. Shear is "more what relates to a[n] acceleration-deceleration injury which would ... describe the type of injury that he experienced." He stated:

Shearing is what happens when you get any rotation in your head. When you're hit from behind or in front of whatever, shearing is your head jerks and then the whole brain, you know, even if it's just a fourth of an inch, twists quickly and then stops quickly, and so it disrupts - you can get minute shearing and spine separation in the neurons, in the cells. Even if you don't get enough separation for it to show up, it disrupts the chemical and electrical and circuits.

Dr. Back stated that the MRI showed shearing. He also stated that the February 24, 2012 CT scan showed innumerable facial fractures. The force that took to break the bones in his face, nose and eye areas could cause a brain injury, and this the force that causes a brain injury. Dr. Back's opinion was that the accident caused his brain injury. The results of his testing are "consistent with what you would expect from a shearing or an acceleration deceleration injury."

When asked if his opinion was supported by objective evidence, Dr. Back answered:

Well, it's a logical flow. You've got evidence, physical evidence for the force - force of the blow, and then, you know, that's what is required or the basis of enough force to cause shearing spreading out through the whole brain. Of course, it all varies so much according to where the blow is centered, the heaviness of the machine or whether it was a fist or a bullet or whatever. Everything varies in vast and it varies in mass and velocity, so you get lots of - lots of differences, but yes, the evidence from all the fractures shows the power of the force that struck him and that's the power that is consistent with the type of cognitive injury he shows of the testing.

Dr. Back stated that his opinions were based upon his testing and the objective findings in the CT scans, the MRI scan and his clinical examinations.

The claimant's complaints in his first visit with Dr. Back that he had speech and memory problems and headaches behind his left ear and eye were consistent with a head injury. Dr. Back explained:

Well, it indicates - it fits with the x-rays and the MRIs in terms of the injuries and the fractures and the force that it took to fracture those bones which send force - it doesn't stop at the bone. It goes all the way through the brain into the back of the head.

Dr. Back testified that the claimant's loud and slow speech was:

Well, it's also suggestive of a brain dysfunction because again, those shock waves, those shear waves that go all through the brain, there's parts of our brain that are more in charge of speech regulation in terms of speed and modulation, so that indicates to me - that suggests to me - that's not my speciality area, but it's - it's something I do know is associated with a brain dysfunction.

Brain injury is consistent with the impairment ratings, the objective findings, the test results and the clinical examinations. Dr. Back's testing, the MRI scan, the CT scans, the clinical examinations, his subjective complaints are all connected and consistent and they all support the rating.

Dr. Back stated that the responses to the tests that make up the neuropsychological evaluation are all within the control of the claimant. The results showed that the claimant went from having the IQ of a person capable of obtaining a commercial driver's license to that of a twelve year old child. One test, the TPT test, measures a person's ability to sense things through feel, while blindfolded. The claimant's dominant hand, his left, hand had the poorest performance, at just the fifth percentile. His non-dominant hand performed at the thirty-first percentile. Dr. Back said, "That's a big split indicating something

is wrong in terms of his brain and in terms of one side is not working as well as the other." He went on to say:

So anyway, his dominant hand is really poorly performing, but the really interesting thing is when you get down to his conceptualization of what he was working with, he remembered at the 50th percentile and then he put them in the right spot to the 69th percentile. Those are really good scores. As I say, all - all scores in a well functioning brain are going to be within 15 percentile points of each other and he's got a big range from fifth to 69th percentile.

Dr. Back explained that dementia means a brain dysfunction from whatever source, and for the claimant, the source was his head injury. His scores were statistically poorer than men his age with an eighth grade education or his job.

Dr. Back discussed the claimant's cognitive retraining program. It was a computerized program which was explained to him more than once, but that he could just not understand. He was very frustrated by it, and he quit.

Dr. Back testified that the claimant's testing was consistent with a brain injury. His visual and spatial testing was very high, which is consistent with his pre-injury job and skill level, but his verbal and memory testing was very poor. Dr. Back said that his

test results were "consistent with what you see in the acceleration deceleration injury that he - that his head, his brain would have received."

A prehearing order was filed February 17, 2015. The claimant's contentions were:

Claimant sustained a compensable injury while working for respondent on or about February 24, 2012. At that time, claimant was in the course and scope of his employment with respondent when he incurred injuries to his head, face, left eye, left hand, left foot, left rotator cuff, memory loss, jaw injury involving denture, broken nose, and miscellaneous other injuries.

Claimant was issued a 100% impairment of the ocular motility pursuant to Dr. Lawton; which pursuant to Ark. Code Ann. §11-9-521 equated to a total loss of vision in the left eye. Under this same statute, the eye is entitled to 105 weeks of payment at the temporary total disability rate, which calculated to \$61,320.00. The loss of vision in the claimant's left eye is one of the factors that makes him unable to pass a DOT physical and return to his previous occupation of driving a truck.

On October 24, 2014, claimant's treating physician issued a 29% whole body impairment for the claimant's brain injury.

The respondents contentions were:

The claimant is not entitled to a 29% impairment for a brain injury. Included but not limited to this defense is that the claimant did not have measurable and objective findings to support the impairment. The respondents have accepted a 25% impairment to the eye and 4% to the shoulder.

The respondent contends that the claimant is not entitled to a rating for facial neuralgic pain as the findings are not based on objective and measurable findings.

The parties agreed to litigate the claimant's entitlement to a 29% impairment rating to the body as a whole for brain injury, to a 100% impairment rating for total loss of an eye, to facial disfigurement compensation and an impairment rating for facial disfigurement, to a rating of 15-24% to the body as a whole for uncontrolled facial neuralgic pain, and attorney's fees.

A hearing was held on April 20, 2015. The Administrative Law Judge filed an opinion on July 13, 2015. The Administrative Law Judge found that the claimant did not prove his entitlement to an impairment rating for his brain injury or to a 100% impairment to his total vision system. The Administrative Law Judge awarded benefits for facial disfigurement, an impairment rating for uncontrolled facial neuralgic pain, and an attorney's fee.

II. ADJUDICATION

Arkansas Workers' Compensation law provides that when an injured worker's disability condition becomes stable and no further treatment will improve

that condition, the disability is deemed permanent. A worker who sustains an injury to the body as a whole may be entitled to his anatomical loss. Certain injuries to the body are assigned value according the schedule in Ark. Code Ann. §11-9-521, and permanent partial disability benefits are based upon those values. Unscheduled permanent injuries are apportioned to the body as a whole, which has a value of four hundred fifty (450) weeks, and permanent partial disability benefits are paid for the proportionate loss of use of the body as a whole resulting from the injury. Ark. Code Ann. §11-9-522. A permanent anatomical impairment must be supported by objective and measurable physical or mental findings. Ark. Code Ann. §11-9-704(c). "Objective findings" are those that cannot come under the voluntary control of the patient, and specifically exclude pain, straight-leg-raising test, and range-of-motion tests. Ark. Code Ann. §11-9-102(16) (A). The Commission has authority to accept or reject medical opinion and to determine its medical soundness and probative force. *LVL, Inc. v. Ragsdale*, 2011 Ark. App. 144, at 7, 381 S.W.3d 869, 873. It is the Commission's duty to use its experience and expertise in translating the testimony of

medical experts into findings of fact. *Id.*

A. PERMANENT ANATOMICAL IMPAIRMENT
RATING: BRAIN INJURY

The claimant sought a permanent anatomical impairment rating based upon his brain injury. A brain injury is not a scheduled injury. The specific issue here is whether there is objective evidence of a brain injury.

The Court of Appeals has dealt with the question of objective findings in brain injury claims several times. In *Wentz v. Service Master*, 75 Ark. App. 296, 75 Ark. App. 296 (2001), the court determined that the claimant's neurological testing was supported by other objective evidence that indicated that she suffered an injury to her brain. The claimant had slipped and fallen head-first to the concrete floor, which the court stated would surely jar the brain. She had nausea and vomiting. She had light sensitivity. Her doctors diagnosed a closed-head injury as a result of the fall, as well as behavioral and cognitive agitation, reduction in IQ. She reported memory issues, headaches, anxiety, emotional changes. She was diagnosed with a concussion.

However, in *Rippe v. Logging*, 266 S.W.3d 217,

100 Ark. App. 227 (Ark. App., 2007), where the claimant sustained a scalp laceration and elbow injury when a tree fell from a logging truck, striking him and knocking him to the ground, he did not satisfy the objective finding requirement for compensability. He reported many symptoms indicative of a brain injury, as did his friends, but the testimony of a claimant or his friends is not objective under the statute.

Neuropsychological testing also showed a brain injury, but such testing, "standing alone," could not satisfy the objective requirement. 100 Ark. App. at 232-233. A CT scan was normal. The claimant failed to prove all the elements of compensability.

In *Parson v. Arkansas Methodist Hospital*, 287 S.W.3d 646 (Ark. App. 2008), the court of appeals denied compensability of a brain injury and overturned *Wentz*. A nurse had fallen and hit a desk with her head. She had bruising and black eyes. The bruising and black eyes were insufficient to constitute "objective findings" of a brain injury for purposes of compensability or permanent impairment. They only showed a surface injury. The appeals court also rejected neuropsychological test results and held that those tests alone were not medical

evidence supported by objective findings which cannot come under the voluntary control of the patient. The MRI and EMG testing did not show any objective findings. In overruling *Wentz*, it is clear that the court did not find that any of the findings noted in the *Wentz* claim were objective.

Lastly, in *Wayne Smith Trucking, Inc. v. McWilliams*, 2011 Ark. App. 414, 384 S.W.3d 561 (Ark. App., 2011), the court found that the claimant proved objective findings to support an award of permanent disability benefits. The claimant fell and struck his head on a trailer, suffering a laceration from the midline of his forehead to just below his hairline toward his left ear, requiring nineteen stitches and leaving a scar across McWilliams's forehead. He suffered headaches at the site of the laceration. The doctor issuing the impairment rating testified that it was based upon complaints of pain and sensory loss related to laceration left forehead, and that those complaints were related to peripheral nerve injury secondary to laceration involving the first division of the trigeminal nerve. The peripheral nerve injury diagnosis was based upon history and examination. The court stated

that there was unquestionably objective evidence of physical injury – in this case, in the form of the claimant's forehead scar. The court noted that there is no requirement that medical testimony be based solely or expressly on objective findings, only that the medical evidence of the injury and impairment be supported by objective findings. The evidence was sufficient to support the award of benefits based upon the impairment rating.

In the current claim, the claimant had a neuropsychological evaluation which established a brain injury. The evaluation, by itself, is insufficient to support a permanent impairment rating, although it is relevant to the establishment of a rating, when supported by objective findings. The record reveals several objective findings showing a brain injury.

The claimant struck his face, which is obviously the front portion of his head, with sufficient force to break the bones surrounding his eyes, the bones of his nose, mouth and jaw, and internal bones behind his eyes, nose and mouth and at the base of his skull. The severity of the damage to his head is evidence, outside the control of the claimant, of the great force

applied to the claimant's head, skull and brain. This claim can be easily distinguished from the facts in *Wentz, Rippe* and *Parson*, where the claimants' injuries included hitting the concrete from a standing position, being struck in the forehead which caused a laceration, and striking a desk causing bruising and black eyes. Mr. Yousey broke his face, quite literally, to the point that the bones of the left side of his face were detached from the rest of his skull. He had fractures internally, behind his nose, at the base of his skull. This was the worst skull fracture Dr. Morse had seen in almost forty years of practice.

Dr. Back stated that the force that it took to break all the bones that were broken in his face, nose and eye areas could cause a brain injury and is consistent with a force that causes a brain injury. Dr. Back's opinion was that the accident did cause his brain injury. When asked if his opinion was supported by objective evidence, Dr. Back explained that the power or force necessary to fracture his bones is consistent with the cognitive injury demonstrated in his testing. He also stated that his opinions were based upon his testing, and the objective findings in the CT scans, the

MRI scan, and his clinical examinations.

CT scans on the date of injury showed those "innumerable" fractures and pneumocephalus (intracranial air) behind the forehead and eyes. Pneumocephalus is objective evidence of skull fracture, and a skull fracture must involve trauma to the brain.

The claimant's facial and head injuries are sufficient to show the application of force and trauma to the claimant's brain sufficient to cause injury. This is further supported by the claimant's two rotator cuff tears as a result of the accident, for which surgery was required. Dr. Back stated that his injuries were demonstrative of the amount of force to which his head was subjected.

CT scans on the date of injury and a July 2012 MRI also showed evidence of something in the left internal capsule which was either a scar from an old stroke or a shear injury. Dr. Morse stated that a CT scan is not as precise as an MRI. Dr. Morse could not say with one hundred percent (100%) certainty that the MRI showed a shear injury; however, the claimant does not have to show a causal connection with one hundred percent certainty. If the CT and MRI scans showed an old

stroke, then we could expect to have some other evidence of a stroke. There is no medical record to that effect. The claimant was able to successfully function, with a commercial driver's license, handling heavy equipment and learning new skills in his work with the respondents, prior to the accident. He was reported to be an energetic, vigorous man, prior to his accident. Thus, there was no evidence of any limitation which could be related to a stroke. Yet, after having his head slammed to the ground sufficiently to break facial bones and internal bones, the claimant immediately showed signs of head injury, from amnesia to forgetfulness and other issues. The mechanism of injury is clearly consistent with a shear injury, as his brain would necessarily have bounced and spun in his skull as a result of the impact with the ground. There is more than 50% likelihood that the CT and MRI showed evidence of a shear injury and not an old stroke.

In his deposition, Dr. Morse stated that the August 2012 MRI was "essentially normal," but then he went on to state that this kind of MRI could not show brain damage from bleeding, that the left eye was pushed into his head, that he had sinus changes, and that he

had a finding in the left internal capsule. He was unsure whether the finding was a congenital cyst, an old infarct or a shear injury due to a head injury. Shearing is where the fibers in the brain tissue are separated and leave a space. Based upon the MRI alone, he could not determine which was correct. The Full Commission disregards Dr. Morse's statement that the MRI was normal, because he testified that it showed something that was either evidence of an old stroke or a shear injury.

Dr. Back stated that the MRI finding was not "normal" and that it showed shearing. Dr. Back stated that the force that broke the claimant's facial and skull bones traveled through his head from front to back, in an acceleration-deceleration injury, which caused the brain to twist quickly and stop twisting quickly. This caused physical separation at a cellular level and in the brain tissue.

Despite his statement that there were no objective findings of brain injury, Dr. Morse also testified that the photographs in the record of the claimant's face and the CT scans of the claimant's head and face clearly showing skull fracture, swelling,

bleeding, contusions and scrapes, and pneumocephalus, were "consistent with objective findings that could cause brain injury." Dr. Morse went on to state that the claimant's inability to swallow could have been from swelling or cranial nerve injury. Left hand impairment suggested a right hemisphere dysfunction, which would be consistent with a brain injury. This conflict between his two statements is easily explained by his concern with not being able to make statements of one hundred percent (100%) certainty. His testimony shows that there were objective findings that support the existence of a brain injury, even if there is no way to be 100% sure of exactly what happened inside the claimant's brain at the moment of impact.

The Full Commission finds that the claimant has met his burden of proof to present objective findings of injury including the extreme damage to his face and skull evidencing the traumatic forces applied to his brain, pneumocephalus, and shear injury on MRI.

The causal connection among the claimant's objective findings, subjective findings, and his work-related injury is established in many ways.

The claimant presented with subjective

complaints and test results which were consistent with brain injury, including emotional lability; irritability; difficulty swallowing, seeing, speaking, walking, using his dominant hand even after his pinkie finger fracture had healed; cranial nerve deficiencies including loss of his sense of smell and taste, speech and hearing issues, tinnitus; amnesia for part of the accident; uncontrollable crying spells; emotional "blankness;" forgetfulness; post-traumatic dementia, adjustment reaction with anxious mood; worsening depression; language function issues; headaches; occipital neuralgia; and post-traumatic encephalopathy.

The claimant's loss of sense of smell and taste, amnesia, emotional lability, crying spells, personality changes, forgetfulness and speech issues were consistent with a frontal lobe brain injury. Dr. Morse explained that the claimant's injury caused trauma to the area of the brain which controls those functions. He stated, "It wasn't just his face. His brain was injured."

The neuropsychological testing results showed that the claimant went from having the IQ of a person capable of obtaining a commercial driver's license to

that of a twelve year old child. Testing involving his hands showed great inconsistencies, with a much poorer result in his left hand, which is his dominant hand, over his right, which indicated "something is wrong in terms of his brain and in terms of one side is not working as well as the other," according to Dr. Back. He had good scores with his conceptualization of what he was using in those tests, and the difference between his performance and his conceptualization was far greater than normal. In general, his scores were statistically poorer than men his age with an eighth grade education or his job. Dr. Back stated that the claimant's testing was consistent with a brain injury. His visual and spatial testing was very high, which is consistent with his pre-injury job and skill level, but his verbal and memory testing was very poor. Dr. Back said that his test results were "consistent with what you see in the acceleration deceleration injury that he - that his head, his brain would have received."

The claimant qualified for permanent impairment ratings under the *Guides to the Evaluation of Permanent Impairment* (4th Ed. 1993) in the amount of 14% impairment to the whole person under Table 2 on page

142, Mental Status Impairments, and in the amount of 18% under Table 2 on page 142, Emotional or Behavioral Impairments. These combine for a total of 29% to the body as a whole. This rating is supported by the objective evidence of the extreme force applied to the claimant's head and therefore his brain, the presence of pneumocephalus, the presence of evidence of shearing on MRI, as well as the subjective evidence found in the claimant's complaints, the neuropsychological testing, and Dr. Morse and Dr. Back's examinations revealing symptoms consistent with brain injury. The Full Commission finds that the claimant is entitled to a permanent anatomical impairment rating of 29% to the body as a whole for his brain injury.

B. PERMANENT ANATOMICAL IMPAIRMENT
RATING: VISION

The Full Commission notes at the outset that despite the Administrative Law Judge's opinion, the claimant sought benefits for the loss of vision in the left eye, as assessed by Dr. Lawton, not the loss of vision in both eyes. The contentions of the claimant and the respondents are specific to the left eye only. Despite the statement to that effect in the pre-hearing order, which the Administrative Law Judge herself

clarified to show that the loss was quantified by Dr. Lawton, she focused on a request for benefits for total loss of vision in both eyes. This was, of course, error.

The Arkansas Workers' Compensation Act provides that the loss of at least eighty percent (80%) of the vision in one eye is equal to one hundred and five (105) weeks of permanent partial disability benefits, under Ark. Code Ann. §11-9-521(a)(14) and (14)(c)(1). In all cases of permanent loss of vision, the use of corrective lenses may be taken into consideration in evaluating the extent of loss of vision. Ark. Code Ann. §11-9-521(a)(14)(c)(2).

Chapter 8 of the *Guides*, states that, "although not all of the [three] functions [of vision] are equally important, vision is imperfect without coordination of all three." *Guides*, p. 209. Ocular motility, or movement of the eye, is the third component and is discussed in Chapter 8.3 of the *Guides*. If a patient has loss of ocular motility in one eye within twenty to zero degrees, the patient has 100% loss of vision. *Guides*, Figure 3, p. 217. The total loss of vision of one eye is equal to a 25% impairment of the

visual system and to a 24% impairment of the whole body. Dr. Lawton explained that with a loss of ocular motility within twenty to zero degrees, a person would have to cover that eye in order to have functional vision, and therefore that loss causes the total loss of use of that eye. The claimant's misalignment occurred when he looked less than only ten degrees off of the center of his vision. This misalignment when the left eye looked left or down was observable and measurable. This misalignment was caused by the bone fractures and could not have been present prior to the accident. The damage was permanent, and there was no further treatment to improve his condition.

After the accident, the claimant had severe damage to his face. Essentially, his left midface (eyes, nose, mouth, and jaw) were broken off of his skull base. The orbital bones of his face were severely damaged. He had blunt trauma to his left eye. After two surgeries, the claimant continued to have diplopia in his left eye. There was no further treatment available, other than covering his eye to prevent double vision.

Dr. Lawton performed an evaluation for a disability rating, noting that the extent of double

vision in his left eye was the equivalent of the total loss of ocular motility and therefore total loss of vision, pursuant to the *Guides*. His impairment was total to the left eye, or 25% impairment of the vision system, or 24% impairment of the whole person.

The Commission adopted the *Guides*, and the impairment rating is based upon the *Guides*. The visual examination is based upon Dr. Lawton's objective findings. The statute states that a loss of at least 80% of the vision of the eye is equal to a total loss, and the *Guides* state that the loss of ocular motility in one eye within twenty to zero degrees is equal to 100% loss of vision. Therefore, the claimant has a total loss of vision in that eye and is entitled to a 25% rating to the vision system, which is equal to a 24% rating to the whole body. The Full Commission awards a 24% rating to the whole body based upon his 100% loss of vision of the left eye.

The respondents only accepted a 25% impairment to the claimant's left eye, not to the vision system or to the body as a whole.

C. PERMANENT ANATOMICAL IMPAIRMENT
RATING: FACIAL DISFIGUREMENT

The claimant sought and was awarded benefits

under Ark. Code Ann. §11-9-524 which provides:

(a) The Workers' Compensation Commission shall award compensation for serious and permanent facial or head disfigurement in a sum not to exceed three thousand five hundred dollars (\$3500).

(b) No award for disfigurement shall be entered until twelve (12) months after the injury.

In *Fayetteville School District v. Kunzelman*, 92 Ark. App. 160 (2005), the Full Commission affirmed and adopted the Administrative Law Judge's finding that the claimant was entitled to three thousand dollars (\$3000) for facial disfigurement, due to injury to his right eye. The Administrative Law Judge stated that his right eye was watery, red, with a permanently dilated pupil. This was "quite noticeable and does detract from the claimant's appearance. Stating it quite bluntly, it looks weird." 92 Ark. App. at 166.

Certainly, the claimant's facial disfigurement is more extensive than the claimant in *Kunzelman*. The claimant's left eye was sunken and misaligned with the other eye. This is quite noticeable, based upon Dr. Lawton's descriptions and the photographs in evidence. The bone around his left eye was crushed, and his jaw was broken and remained misaligned so severely as to

require the implantation of dentures, because normal dentures could not remain in place. The claimant's broken bones, scars, eye damage and various misalignment support an award of three thousand five hundred dollars (\$3500). The Full Commission affirms the Administrative Law Judge's award.

The respondents argue that the claimant cannot also receive an award for permanent partial disability based upon facial impairment under the *Guides*, because the above section precludes such an award.

The *Guides* explain that the face and its parts serve functions relating eating, drinking, breathing, speech, vision, communication, personal identity, as well as the functions of the skin in protecting internal structures and eyes, regulating temperature, and sensation. *Guides*, p. 229. The impairment criteria is strictly based upon the abnormalities present:

Class 1: Impairment of the Whole Person, 0% to 5%.

A patient belongs in Class 1 when the facial abnormality is limited to a disorder of the cutaneous structures, such as visible scars or abnormal pigmentation. For other criteria, the reader may refer to Chapter 13 on the skin.

Class 2: Impairment of the Whole Person, 5% to 10%.

A patient belongs in class 2 when there is loss of supporting structure of part of the

face, with or without a cutaneous disorder. Depressed cheek, nasal or frontal bones constitute class 2 impairments.

Class 3: Impairment of the Whole Person, 10% to 15%.

A patient belongs in class 3 when there is absence of a normal anatomic part or area of the face. Loss of an eye, which should be evaluated as indicated in Chapter 9, or loss of part of the nose with the resulting cosmetic deformity, constitutes a class 3 impairment. Such impairments may be associated with impairments of other organ systems, for instance the visual system (Chapter 8) or the respiratory system (Chapter 5).

Class 4: Impairment of the Whole Person, 15% to 35%.

A person belongs in class 4 when facial disfigurement is so severe that it precludes social acceptance. Massive distortion of normal facial anatomy constitutes a class 4 impairment. The reader may refer to the chapter on skin impairments (p. 277) and to the chapter on mental and behavioral disorders (p. 291).

The claimant certainly qualifies for a class 2 impairment rating, because he lost significant supporting structure of his face, including the crushed orbital bones, the broken upper and lower jaw, the broken nose, and broken internal bones. The respondents' assertion that there is no evidence of a loss of structural integrity is wholly contradicted by the medical evidence, including for example the instability in the claimant's upper and lower jaws which required

the implantation of dentures.

However, because facial impairment under the *Guides* is based upon the appearance of the face, the rating is based upon the exact same criteria upon which the §11-9-524 award is based. Compensation is defined by the Act as the money allowance payable to the claimant, under Ark. Code Ann. §11-9-102(5), and there is no distinction drawn in §11-9-524 between the possible types of compensation awarded. It simply limits "compensation" to no more than \$3500. Thus, the *Guides* are informative on the question of the appropriate award under §11-9-524, but the amount to be awarded for facial disfigurement is limited to three thousand five hundred (\$3500).

D. PERMANENT ANATOMICAL IMPAIRMENT
RATING: UNCONTROLLED FACIAL
NEURALGIC PAIN

The Act does not allow pain as a basis of impairment, under Ark. Code Ann. §11-9-521(h)(B). Dr. Morse's assessment of an impairment rating for the claimant's trigeminal nerve injury is based upon Table 9 on p. 145 of the *Guides*. The various ratings in that table are distinguished by the level of pain experienced by the claimant. While there is most certainly objective

support for the underlying injury, in the form of the fractures in the location of the second division of the trigeminal nerve, the fact remains that without the claimant's report of pain, there can be no rating. A claimant's report of pain is not allowed for the purposes of assessing a rating.

III. Conclusion

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant has proven his entitlement to a permanent anatomical impairment rating for a traumatic brain injury in the amount of 29% and for his loss of vision in the amount of 24%, both to the body as a whole. The claimant is entitled to benefits under Ark. Code Ann. §11-9-524 in the amount of \$3500 for his facial disfigurement. The claimant is not entitled to benefits based upon a permanent anatomical impairment rating for facial disfigurement in excess of the statutory cap or to a permanent anatomical impairment rating based upon pain. The claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715(a). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to a fee of five hundred

dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b).

IT IS SO ORDERED.

SCOTTY DALE DOUTHIT, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney concurs in part and dissents in part.

CONCURRING AND DISSENTING OPINION

I concur with the majority opinion finding that the claimant is entitled to the maximum amount of benefits (\$3,500) for facial disfigurement pursuant to Ark. Code Ann. §11-9-524. I further concur with the majority opinion finding that the claimant is not allowed an impairment rating for his "uncontrolled facial neuralgic pain" allegedly resultant from damage to the claimant's trigeminal nerve because our statute does not permit impairment ratings to be based on pain. Ark. Code Ann. §11-9-521(h) (B). Regarding all other findings in this claim, I respectfully dissent.

The majority found that the claimant proved objective findings of an injury to his brain due

primarily to the severity of damage he sustained to his head. Therefore, the majority awarded that claimant twenty-nine percent (29%) permanent physical impairment for his brain injury. In so doing, the majority stated, in part: "Mr. Yousey broke his face, quite literally, to the point that the bones of the left side of his skull were detached from the rest of his skull. He had fractures internally, behind his nose, at the base of his skull. This was the worst skull fracture Dr. Morse had seen in almost forty years of practice." The majority further noted in support of its finding that neuropsychologist, Dr. Back, stated that the force that it took to break all the bones that were broken in the claimant's face "could" cause a brain injury. Thus, Dr. Back surmised that the claimant's accident caused an injury to his brain.

In deposition, Dr. Back testified that the power or force necessary to fracture the claimant's facial bones was consistent with the "cognitive injury demonstrated in his [neuropsychological] testing." Moreover, Dr. Back testified that his objective findings of brain injury were supported by CT scans, an MRI scan, and his clinical observations. Indeed, those objective

tests did show evidence of numerous and severe facial fractures. However, to assume that the force and trauma necessary to cause an injury which has been established by objective findings (in this claim, facial fractures), constitutes sufficient objective findings to establish another injury where there are no independent objective findings is not in keeping with our statutory requirement of medical evidence supported by objective findings of an injury. In other words, while there are unquestionably objective findings sufficient to establish that the claimant sustained severe fractures as a result of his injury, he has presented no independent objective medical proof of an injury to his brain, i.e., lesions. For us, then, to jump to a *logical conclusion* that the presence of objective medical evidence confirming severe fracture injuries resultant from traumatic force equates to objective medical evidence of brain injury means we would have to resort to conjecture and speculation, as the majority has done here. It is well-established that 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). Simply put, with no objective findings to support an injury to his brain, the claimant has failed to prove such an injury.

Moreover, neurologist, Dr. Morse, stated in deposition that the claimant sustained a severe skull fracture as a result of his accident which allowed air to enter his brain cavity. However, Dr. Morse could not state within a reasonable degree of medical certainty that this caused an injury to the claimant's brain. Rather, Dr. Morse stated that his review of the claimant's objective diagnostic studies, to include the claimant's MRI and CT scan, showed essentially normal findings, with three *possible* abnormalities noted: 1) a cyst, 2) an infarct (stroke), or 3) an old shear injury. Furthermore, when asked outright if he had any objective evidence of injury to the claimant's brain, Dr. Morse responded, "Not objective." All-in-all, Dr. Morse could not state within a reasonable degree of medical certainty that the claimant had sustained an injury to his brain as a result of his compensable accident. Our workers' compensation law is clear: medical opinions

addressing compensability must be stated within a reasonable degree of medical certainty. Ark. Code Ann. §11-9-102(16)(B). Dr. Morse's opinion of causation fails to meet this statutory requirement

Moreover, the testimony of Dr. Richard Back, Ph.D., whose opinion on which the majority appears to primarily rely, reflects that he conducted a neuropsychological evaluation of the claimant for purposes of determining cognitive impairment, and that it is upon this testing that he generally relies for his opinion. It is well-established that neuropsychological testing, standing alone, cannot satisfy the our statutory requirement for proving compensability. See, *Rippe v. Logging*, 100 Ark. App. 227, 266 S.W.3d 217 (2007).

When asked whether he would dispute Dr. Morse's finding that the claimant's MRI study was normal, Dr. Back was evasive, stating only that "he has it in his report." Furthermore, Dr. Back testified that he administered approximately twelve (12) tests to the claimant during his evaluation, all of which were subjective. In fact, Dr. Back admitted that all of the claimant's responses were "totally within his control."

Dr. Back further admitted that there was a subjective component to scoring of the tests he administered.

While I acknowledge that the courts have found in cases similar to this claim that the injured worker proved a brain injury by neuropsychological testing supported by other objective evidence, I find that this is not the case here. Rather, I find that this claim is most analogous to *Rippe v. Logging*, supra, wherein the court denied compensability of an alleged brain injury after the claimant was struck by a falling tree and knocked to the ground, where there were no objective findings to support Rippe's reported symptoms of brain injury as shown by neuropsychological testing. *Id.*

In the present claim, notwithstanding that the record is replete with objective findings that the claimant sustained severe facial fractures and a fractured skull as a result of his accident and that he displayed subjective signs of cognitive deficits, the record is devoid of objective medical findings to support that the claimant suffered anything other than severe facial fractures and a fractured skull as a result of his injury. This conclusion is supported by the fact that Dr. Morse interpreted the claimant's MRI

study as normal and he could not state within a degree of medical certainty that the claimant had sustained an injury to his brain. Furthermore, Dr. Back's neuropsychological testing, "standing alone," does not satisfy our statutory objective findings requirement. *Rippe v. Logging, supra*. Based on these factors, the claimant has failed to prove that he sustained a brain injury as a result of his compensable injury, and permanent physical impairment for this alleged injury is improperly awarded by the majority.

Turning now to the claimant's scheduled left eye injury, the majority found that it was error for the administrative law judge to focus on a request for benefits for total loss of vision in both eyes since the claimant's alleged injury was to his left eye only. Using both our statute and the *Guides*, the majority found that the claimant sustained one hundred percent (100%) loss of vision of his left eye, which translates to a twenty-five percent (25%) permanent physical impairment rating to his visual system and a twenty-four percent (24%) permanent physical impairment rating to the body as a whole.

In a nutshell, the claimant's ophthalmologist,

Dr. Andrew Lawton, treated the claimant for an anterior blowout fracture of his left eye that resulted in double vision. The claimant underwent surgery to bring his left eye forward, and he was prescribed a prism in a failed attempt by Dr. Lawton to "get his eyes to work together" and correct the claimant's double vision. Diagnostic testing, however, showed that the claimant's peripheral vision was normal in both eyes, and that his nearsightedness was corrected in both eyes with glasses.¹¹ Furthermore, the claimant's left eye was healthy.

In assessing the claimant's degree of permanent physical impairment as a result of his left eye injury, Dr. Lawton explained that there are three measures in the *AMA Guides* for assessing visual impairment: 1) visual acuity in each eye, 2) peripheral vision, and, 3) double vision. Dr. Lawton explained that the "system recognizes that people with double vision cannot use both eyes together and there's a degree of impairment assigned to how far from the center

¹¹ The record shows that the claimant had nearsightedness and an inability to read the big E with his left eye which were unrelated to his accident.

of vision the double vision kicks in." Furthermore, Dr. Lawton stated: "Generally, it's considered that the central is ten to 20 degrees vision is the essential vision. It's critical for reading and driving and things like that, so that if there's double vision in that area, that's interpreted by the AMA rules as if someone had lost the vision in one eye, they would have to cover that eye in order to function." While Dr. Lawton confirmed that the claimant's visual acuity and peripheral vision were both normal, he added that any attempts to have the claimant move and have him look to his left resulted in double vision, "even less than ten degrees away from the center of vision." The claimant also suffered from double vision when looking down.

In summary, Dr. Lawton stated that, as to visual acuity, the claimant had 20/20 vision with corrective lenses, he had no impairment of his peripheral vision, and he suffered one hundred percent (100%) impairment to his left eye due to abnormal ocular motility, or double vision. Therefore, using the steps found at 8.3, *Abnormal Ocular Motility and Binocular Diplopia*, on page 217 of the *Guides*, 4th edition, Dr. Lawton assigned the claimant twenty-five percent (25%)

impairment of his "entire visual system" due to one hundred percent (100%) impairment to his left eye, which translated to twenty-four percent (24%) to the body as a whole. The respondents accepted this twenty-five percent (25%) impairment rating to the claimant's visual system, which I find is correct based upon Dr. Lawton's full explanation of the claimant's visual impairment and how he calculated that impairment in terms of a percentage of loss *should* the *Guides* be utilized to rate the claimant's visual impairment.

However, as the majority has noted, the claimant has sought benefits for the loss of vision in his left eye since the onset of this claim - not loss of vision in both eyes. As the claimant's contentions have always been specific to his left eye only, the majority found that an award of benefits based upon the administrative law judge's focus on a request for benefits for total loss of vision of both eyes was in error. A review of the administrative law judge opinion shows that among the issues to be litigated was whether the claimant was entitled to a one hundred percent (100%) impairment rating for "total loss of vision" pursuant to Ark. Code Ann. §11-9-521, as assessed by Dr.

Lawson. In this regard, the administrative law judge stated, in part, as follows:

There is no question that the claimant has suffered some vision impairment. However, evidence suggests that he has 20/20 vision with corrective lenses. There is also no question that this loss of vision precludes the claimant from passing the DOT physical and returning to his former position with the respondent. However, a review of the AMA Guidelines, 4th Ed., reflects that a 100% impairment of ocular motility is equivalent to total loss of vision in one eye and a 25% impairment to the visual system or the total eyesight of the patient. The AMA Guidelines further set out three steps in determining the impairment of the total visual system. They are the determination of the percentage of loss of central vision of each eye, a determination of the loss of visual field of each eye - separately, and the percentage of ocular motility. The assessment of 100% of ocular motility does not equate to a 100% impairment to the total visual system. This claimant does not have a total loss of vision. He has an impairment to his vision. While there is no question that such an impairment has had a grave impact on the claimant's ability to perform his duties, there simply is no evidence or assessment that would allow the Commission to find the claimant to have a 100% vision impairment or total loss to his visual system. The claimant is not entitled to an assessment of 100% impairment to his vision

system.

The majority correctly points out that, pursuant to our statute which governs benefits for scheduled injuries, specifically Ark. Code Ann. §11-9-521(a)(14) and(c)(1), the loss of at least eighty-percent (80%) of the vision of one eye is equal to one hundred five (105) weeks of permanent partial disability benefits. The majority further correctly notes that in all cases of permanent loss of vision, the use of corrective lenses may be taken into consideration in evaluating the extent of loss of vision. Ark. Code Ann. §11-9-521(c)(2). However, upon describing in detail how the provisions of Chapter 8 of the *Guides* were correctly used by Dr. Lawton to determine the degree of permanent impairment to the claimant's left eye system as a result of his diplopia, the majority stated:

The Commission adopted the *Guides*, and the impairment rating is based upon the *Guides*, The visual examination is based upon Dr. Lawton's objective findings. The statute states that a loss of at least 80% of the vision of the eye is equal to a total loss, and the *Guides* state that the loss of ocular motility in one eye within twenty to zero degrees is equal to 100% loss of vision. Therefore, the claimant has a total loss of vision in that

eye and is entitled to a 25% rating to the vision system, which is equal to a 24% rating to the whole body based upon his 100% loss of vision of the left eye.

A breakdown of the above reveals that the majority's reasoning concerning the claimant's visual impairment is not only flawed, but it is as equally as puzzling as the opinion of the administrative law judge in that both appear to base their determination of benefits on the *Guides* rather than on our statutory provisions governing scheduled injuries. While the *Guides* do exactly what they are intended to do - guide us on issues of impairment - I find that we are constrained to use our statutory provisions over the *Guides* in order to determine benefits in this matter for the following reasons.

The Commission has adopted the *Guides*, and, to the extent that the *Guides* allow the use of subjective criteria for the establishment of an impairment rating, the *Guides* must give way to the statutory definition of objective findings as defined by the General Assembly. The portions of the *Guides* which are based upon subjective criteria cannot supersede the statutory definition established by the General Assembly.

Therefore, to the extent that there is a conflict, the statutory definition as established by the General Assembly takes precedence over any subjective criteria set forth in the *Guides*. See, Ark. Code Ann. §11-9-522 and Commission Rule 34. It is axiomatic that if the those portions of the *Guides* which are based upon subjective criteria cannot supersede the statutory definition established by the General Assembly, and, therefore, to the extent that there is a conflict, the statutory definition as established by the General Assembly takes precedence over any subjective criteria set forth in the *Guides*, our statutory provision for the loss of use of an eye (a scheduled injury) takes precedent over the *Guides* in this matter with regard to benefits for the claimant's scheduled eye injury.

Dr. Lawson correctly calculated the claimant's impairment rating using the *Guides*. According to Dr. Lawton's objective findings of loss of use of the claimant's visual system pursuant to the provisions of Chapter 8, section 3 of the *Guides*, 4th edition, the doctor correctly found that the claimant had sustained 100% impairment to his left eye. As the majority correctly states, our statute specifically states that

compensation for the permanent loss of eighty percent (80%) or more of the vision of an eye shall be the same as for the loss of an eye, which entitles the claimant to one hundred five (105) weeks of benefits - period. While the majority clearly acknowledges this provision in its opinion, it appears to completely ignore its relevance to the outcome of this issue by determining benefits according to the *Guides*. Because our statute very clearly provides that the claimant is entitled to one hundred five (105) weeks of benefits for his scheduled left eye injury, it is error to award him twenty-five percent (25%) permanent physical impairment according to the *Guides* for this injury.

Our statute clearly and decisively accounts for the claimant's impairment pursuant to Ark. Code Ann. §11-9-521(a)(14) and (c)(1), which state that the loss of at least eighty-percent (80%) of the vision of one eye is equal to one hundred five (105) weeks of permanent partial disability benefits. Because it is undisputed that the claimant has suffered an injury to his left eye, which is statutorily defined as a scheduled injury for purposes of permanent impairment benefits, and that Dr. Lawson has opined that the

claimant has sustained one hundred percent (100%) impairment to his left eye as a result of this injury, according to our statute the claimant is entitled to one hundred five (105) weeks of benefits for this impairment.

Furthermore, it is error to award the claimant benefits to the body as a whole due to a scheduled injury. It has been long-established that for a scheduled injury, absent a finding of permanent total disability, the award of benefits is limited to the benefits provided for that scheduled injury. *Rash v. Goodyear Tire & Rubber*, 18 Ark. App. 248, 715 S.W.2d 449 (1986); *see, also, Federal Compress & Warehouse Co. v. Risper*, 55 Ark. App. 300, 935 S.W.2d 279 (1996), (stating that a claimant who sustains a scheduled injury is limited to the applicable allowances set forth in Ark. Code Ann. §11-9-521, and such benefits cannot be increased by considering wage-loss factors absent a finding of total disability).

The majority succinctly stated in its analysis concerning the claimant's facial scarring that our statute supercedes the *Guides* with regard to benefits. The same rule applies here. More specifically,

regarding the statutory limitations as set forth in Ark. Code Ann. §11-9-524, which governs facial disfigurement, the majority stated:

The claimant certainly qualifies for a class 2 impairment rating [pursuant to the *Guides*], because he lost significant supporting structure to his face,....However, because facial impairment under the *Guides* is based upon the appearance of the face, the rating is based upon the exact same criteria upon which §11-9-524 award is based. Compensation is defined by the Act as the money allowance payable to the claimant, under Ark. Code Ann. §11-9-102(5), and there is no distinction drawn in §11-9-524 between the possible types of compensation awarded. It simply limits "compensation" to no more than \$3500. Thus, the *Guides* are informative on the question of the appropriate award under §11-9-524, but the amount to be awarded for facial disfigurement is limited to \$3500.

Despite the majority's correct application of the law to the facts in this claim concerning the claimant's facial disfigurement, the majority attempts to bend this same statutory principle in the case of the claimant's left eye in favor of 1) going outside of the provisions of Ark. Code Ann. §11-9-521 in order to assign the claimant an impairment rating for a scheduled

injury that is clearly governed by 521; 2) using the *Guides* as more than just an informative tool to help determine the extent of the claimant's left eye impairment; making it, instead, the standard by which the amount of money awarded for the claimant's scheduled left eye injury is determined, thus superceding the statutory provisions for such an injury, and; 3) assigning the claimant benefits to the body as a whole, which is clearly contrary to our statutory provisions and the case law interpreting those provisions with regard to benefits awarded above the statutorily set award for a scheduled injury. For these reasons, I find that the majority erred in awarding the claimant twenty-five percent (25%) permanent physical impairment for his scheduled left eye injury, and it went beyond our statutory provisions by utilizing a provision that does not exist in order to assign the claimant an impairment rating to the body as a whole for this injury.

For the foregoing reasons, I respectfully dissent from the majority's opinion regarding the claimant's award of permanent physical impairment for the claimant's scheduled, left-eye injury, in that this award of benefits should be limited to one hundred five

(105) weeks pursuant to Ark. Code Ann. §11-9-521.

KAREN H. MCKINNEY, Commissioner