Not designated for publication.

ARKANSAS COURT OF APPEALS

DIVISION IV
No. CA08-44

	Opinion Delivered SEPTEMBER 17, 2008
ERNEST REYNOLDS APPELLANT V. ROBERTSON CONTRACTORS, INC.; ZURICH AMERICAN INSURANCE COMPANY APPELLEES	APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION [NO. F400875] REVERSED and REMANDED

ROBERT J. GLADWIN, Judge

This appeal follows the November 6, 2007 decision of the Workers' Compensation Commission (Commission) affirming and adopting the February 6, 2007 opinion of the Administrative Law Judge (ALJ), finding in part that appellant Ernest Reynolds sustained a ten-percent whole body impairment as a result of a January 15, 2004 compensable injury. On appeal, appellant contends that the Commission erred with respect to its decision regarding his impairment rating. We reverse and remand for additional consideration.

Facts

Appellant sustained an admittedly compensable injury on January 15, 2004, while employed by appellee Robertson Contractors, Inc. Appellant was performing construction on a bridge, working out of a "man basket" that was operated by a truck boom. The truck boom operator apparently hit the lever too hard, causing the man basket to bounce, pinning appellant

between the basket and a steel beam. Appellant was immediately taken to the emergency room where x-rays revealed a fractured rib. Appellant's primary complaint, however, involved his neck and shoulders.

Appellant was initially treated by Dr. Jerry Frankum in Newport, Arkansas, and he continued working for several weeks. His condition grew progressively worse, and appellant was sent back to Dr. Frankum, who referred him to Dr. Jim J. Moore, a neurosurgeon in Little Rock, Arkansas.

Dr. Moore ran various diagnostic studies that revealed a large herniated disc at C6-7, which ultimately required surgery. Dr. Moore consulted Dr. John L. Wilson, an orthopedic surgeon in Little Rock, Arkansas, regarding appellant's condition. Dr. Wilson first examined and evaluated appellant on April 15, 2004. In a report to Dr. Moore on the same date, Dr. Wilson opined that appellant had a large herniated disc at C6-7 and recommended an anterior discectomy and fusion. Appellant underwent the recommended surgery on May 27, 2004. The surgery was performed by Dr. Wilson with the assistance of Dr. Moore. The operative report reflects that the procedure performed was an anterior discectomy and anterior cervical fusion at C6-7.

Appellant continued to see Dr. Wilson for follow-up examinations. Appellees claimed that appellant's healing period ended on August 23, 2004, based upon a report from Dr. Wilson to Dr. Moore on that date that released appellant from active care to return to work. The report indicated that appellant was to return to see Dr. Wilson if appellant continued to have problems while, at the same time, Dr. Wilson estimated appellant's permanent

impairment at seven percent to the body as a whole. Dr. Wilson's report appears to indicate that appellant had not reached maximum-medical improvement on August 23, 2004, because x-rays taken on that date revealed early consolidation of the fusion.

Appellant returned to Dr. Wilson on October 20, 2004, with complaints of neck pain. At that time, he was placed in a cervical collar and prescribed additional medications. Dr. Wilson also prescribed physical therapy, as well as a functional-capacity assessment. Appellant underwent the prescribed physical therapy, as well as a functional-capacity assessment. The assessment report indicated that appellant "put forth inconsistent effort and demonstrate[d] many inconsistencies with inappropriate illness responses" and indicated that appellant's efforts were inconsistent, not indicative of his maximal tolerances, and demonstrated the ability to perform work at least at the medium physical demand classification, as determined through the Department of Labor, for an eight-hour day. On December 30, 2004, appellant was released to return to work with a forty-pound weight restriction based upon the functional-capacity assessment.

Dr. Wilson determined that appellant had reached maximum-medical improvement on December 30, 2004. In his December 30, 2004 report, Dr. Wilson noted that upon examination, appellant walked with his neck stiff and shoulders upward; however, while observing appellant walking out of the building, he noted that appellant's shoulders relaxed to a normal position.

Appellant sought no further treatment until May 3, 2005, when he was examined by Dr. William Blankenship. Dr. Blankenship recommended that appellant return to Dr. Moore,

which he did on May 10, 2005. Dr. Moore diagnosed appellant with post-laminectomy syndrome and recommended Lidoderm patches to treat his permanent condition. Treatment continued, and on September 27, 2005, Dr. Moore indicated that appellant had reached the end of his healing period and assessed that he had a twenty-percent permanent-partial impairment to the body as a whole.

Appellant then sought treatment from Dr. Annette Meador on October 18, 2005, and she indicated that there was "no reason why [appellant] will not be able to return to work actually in the next six to eight weeks . . . [a]ctually, he may return to work in two days, with light duty, not lifting more than 20 pounds. . . ." Dr. Meador also indicated that appellant's recovery would depend largely on his motivation, which she questioned.

Dr. Moore saw appellant on November 30, 2005. At that time, he noted that his "examination today reflected that a lot of the cranial, cervical and shoulder posturing would be voluntary and with attention diversion [appellant] would assume a very normal and erect position."

Dr. Thomas Ward appears to be the final treating physician prior to these proceedings. In a handwritten report that appears to have been faxed on January 10, 2007, Dr. Ward indicated that appellant's disability rating was equal to twenty-three percent to the body as a whole. This report fails to mention the American Medical Association Guidelines, and it seems to be based solely upon appellant's statements to Dr. Ward regarding the injuries. The Commission specifically addressed this report and the resulting rating, and gave no weight to it, in part because it was not signed and could not be directly attributable to Dr. Ward, rather

than a nurse or one of his partners. Additionally, the report provides no explanation of the factors utilized in arriving at the impairment rating.

A hearing was conducted January 12, 2007, before the ALJ to determine whether appellant was entitled to additional workers' compensation benefits. Appellant was the only witness to testify at the hearing, and he argued that (1) his healing period did not end until September 27, 2005; (2) appellees should be responsible for temporary total disability benefits through that date at the rate of $453.00 per week; (3) thereafter, he was entitled to ninety weeks of permanent-impairment benefits based upon an impairment rating of twenty percent to the body as a whole; and (4) appellees had only paid twenty-two weeks of permanent-impairment benefits. Appellant specifically reserved the issue of vocational-rehabilitation benefits and/or wage-loss disability. Appellant requested a controverted attorney's fee on any additional benefits awarded.

Appellees responded that (1) they had paid all related medical and indemnity benefits to which appellant was entitled; (2) appellant's healing period ended on August 23, 2004, rather than the September 27, 2005 date maintained by appellant; and (3) they initially accepted and paid a seven-percent impairment assessed by Dr. John Wilson on August 23, 2004, but actually paid a total of forty-six weeks of permanent-partial-disability benefit, pointing out that respondents had accepted and paid a full ten-percent-impairment rating pursuant to Table 75, Sub-part IV of the Fourth Edition of the AMA Guidelines. Appellees specifically maintained that the twenty-percent permanent impairment assessed by Dr. Jim J. Moore was based, at least in part, on straight-leg range of motion tests and complaints of pain,

which cannot be considered. Appellees also asserted that they had accepted and paid the proper impairment rating. Appellees further claimed a credit for any temporary-total-disability benefits that it may have overpaid beyond the actual healing period.

After a review of the record as a whole, including medical reports, documents and other matters properly before him, and having had an opportunity to hear the testimony of appellant and to observe his demeanor, the ALJ found that appellant's healing period ended on December 30, 2004, and that he was entitled to temporary-total-disability benefits through said date. The ALJ also found that appellant had sustained a ten-percent whole-body impairment as the result of his January 15, 2004, compensable injury and surgery.

The ALJ specifically stated that he did not find the appellant to be a particularly credible witness. He determined that appellant's testimony that he was unable to work was a mere conclusion that was not supported by the record as a whole. Although he recognized that appellant did have restrictions, he found that they were permanent in nature and went to the issue of wage-loss disability, which had been reserved. Appellant appealed to the Commission on February 28, 2007, and on November 6, 2007, the Commission affirmed and adopted the ALJ's opinion. Appellant filed a timely notice of appeal on November 30, 2007. This appeal followed.

Standard of Review

Typically, on appeal to this court, we review only the decision of the Commission, not that of the ALJ. *Daniels v. Affiliated Foods S.W.*, 70 Ark. App. 319, 17 S.W.3d 817 (2000). In this case, the Commission affirmed and adopted the ALJ's opinion as its own, which it is

permitted to do under Arkansas law. *See Death & Permanent Total Disability Trust Fund v. Branum*, 82 Ark. App. 338, 107 S.W.3d 876 (2003). Moreover, in so doing, the Commission makes the ALJ's findings and conclusions the findings and conclusions of the Commission. *See Branum, supra.* Therefore, for purposes of our review, we consider both the ALJ's order and the Commission's majority order.

In appeals involving claims for workers' compensation, this court views the evidence and all reasonable inferences deducible therefrom in the light most favorable to the Commission's decision and affirms the decision if it is supported by substantial evidence. *See Kimbell v. Ass'n of Rehab Indus. & Bus. Companion Prop. & Cas.*, 366 Ark. 297, 235 S.W.3d 499 (2006). Substantial evidence is evidence that a reasonable mind might accept as adequate to support a conclusion. *Id.* The issue is not whether the appellate court might have reached a different result from the Commission; if reasonable minds could reach the result found by the Commission, the appellate court must affirm the decision. *Id.* We will not reverse the Commission's decision unless we are convinced that fair-minded persons with the same facts before them could not have reached the conclusions arrived at by the Commission. *Dorris v. Townsends of Ark., Inc.*, 93 Ark. App. 208, 218 S.W.3d 351 (2005).

Questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. *Patterson v. Ark. Dep't of Health*, 343 Ark. 255, 33 S.W.3d 151 (2000). When there are contradictions in the evidence, it is within the Commission's province to reconcile conflicting evidence and to determine the true facts. *Id.* The Commission is not required to believe the testimony of the claimant or any

other witness, but may accept and translate into findings of fact only those portions of the testimony that it deems worthy of belief. *Id.*

The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has the force and effect of a jury verdict. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). Thus, we are foreclosed from determining the credibility and weight to be accorded to each witness's testimony. *Arbaugh v. AG Processing, Inc.*, 360 Ark. 491, 202 S.W.3d 519 (2005). As our law currently stands, the Commission hears workers' compensation claims de novo on the basis before the ALJ pursuant to Arkansas Code Annotated section 11-9-704(c)(2), and this court has stated that we defer to the Commission's authority to disregard the testimony of any witness, even a claimant, as not credible. *See Bray v. Int'l Wire Group*, 95 Ark. App. 206, 235 S.W.3d 548 (2006). However, in *Kimbell*, *supra*, our supreme court held that while the Commission may be insulated to a certain degree, it is not so insulated to render appellate review meaningless. Likewise, the Commission may not arbitrarily disregard evidence in support of a claim. *Id.*

Discussion

Appellant's primary argument is that this court should review the Commission's decision in light of *Coleman v. Pro Transportation, Inc.*, 97 Ark. App. 338, 249 S.W.3d 149 (2007). Specifically, appellant relies on the statement in *Coleman v. Pro Transportation, Inc.*, *supra*, that once an impairment rating is established by objective medical findings, the Commission may consider both objective and subjective findings in establishing the amount

of the impairment rating. Appellant contends that the ALJ's opinion, affirmed and adopted by the Commission, did not consider the guidance this court provided in that case.

Appellant quotes the dissenting opinion from the Commission, at length, and specifically relevant is the section that reads:

> Accordingly, I read Ark. Code Ann. § 11-9-102 to stand for the proposition that straight leg testing and range of motion are not, in themselves objective findings. However, if other objective findings exist, then they can be considered in giving an impairment rating.
>
> That is exactly what has happened in this instance. The appellant had objective findings in the form of calcification, muscle spasms, narrowing of the neuroforamina and retrolisthesis. These objective findings were clearly the primary reason for the appellant's impairment rating. While other subjective criteria was also used in giving a rating, because the appellant already had objective findings establishing impairment, pursuant to the holdings of the Court of Appeals, his subjective complaints and findings are also allowed to be used in assigning an impairment rating. As such, there is simply no valid basis to reject the ratings given by Dr. Moore or Dr. Ward.

The dissent then quotes Dr. Moore's rating report, which states:

> I would also feel that a rather significant disability rating is appropriate to consider in this patient's instance because of the pain because of the spasticity and evidence that would be consistent with neurologic compromise. He also has restricted range of motion. There is evidence of radiculapathy. This would best be served by table 73, III/IV, 15%-25% together which would translate to 20% permanent partial to the body as a whole.

Appellant reminds the court that, while the Commission is empowered with the authority to weigh medical evidence and to examine the basis of an expert's opinion in deciding what weight to give it, it may not arbitrarily disregard the testimony of any witness. *See Crow v. Weyerhauser Co.*, 46 Ark. App. 295, 880 S.W.2d 320 (1994). Although he fails to explain how he feels Dr. Moore's testimony was disregarded, we agree that there is merit to that argument.

Appellees direct our attention to the ALJ's opinion and his recitation of the language of Arkansas Code Annotated section 11-9-704(c)(1)(B), which provides that "[a]ny determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings," and to Arkansas Code Annotated section 11-9-102(16)(A)(i), which defines objective findings as "those findings which cannot come under the voluntary control of the patient." The very next subsection specifically states that complaints of pain may *not* be considered by a physician or ALJ when determining physical or anatomical impairment. *See* Ark. Code Ann. § 11-9-102(16)(A)(ii)(a). The same is true of straight-leg raising test or range-of-motion tests with regard to making physical or anatomical impairment ratings to the spine. *See* Ark. Code Ann. § 11-9-102(16)(A)(ii)(b); *Dep't of Parks & Tourism v. Helms*, 60 Ark. App. 110, 959 S.W.2d 749 (1998) (stating that the legislature had eliminated range-of-motion tests as a basis for ratings to the spine, by definition).

Appellees argue that it is appellant's burden to present proof that range-of-motion tests do not come under his voluntary control because there is authority to suggest that they are based almost entirely on a patient's cooperation and effort. *See Helms*, *supra*. Appellees maintain that appellant has cited no authority whereby such tests have been utilized for assessing a permanent-anatomical-impairment rating for an individual's spine. Furthermore, appellees contend that appellant has failed to present evidence that active range-of-motion tests were even used by Dr. Moore. From the paragraph quoted by appellant in his brief, it is impossible to discern whether active or passive tests were utilized; accordingly, appellees assert that Dr. Moore's September 27, 2005 report is both inaccurate and unreliable.

Appellees maintain that appellant's impairment rating assessed by Dr. Moore was based on range-of-motion tests and complaints of pain, neither of which can be considered, and further, that the rating is even more unreliable taking into account the ALJ's findings regarding appellant's lack of credibility. Another reason appellees claim Dr. Moore's rating is inaccurate is because Table 75 of the AMA Guides, rather than Table 73 relied upon by Dr. Moore, is the appropriate guide in this case.

This court held in *Stephens Truck Lines v. Millican*, 58 Ark. App. 275, 950 S.W.2d 472 (1997), that although it is irrefutably true that the legislature has required medical evidence supported by objective findings to establish a compensable injury, it does not follow that such evidence is required to establish each and every element of compensability. Subsequently, in *Singleton v. City of Pine Bluff*, 97 Ark. App. 59, 244 S.W.3d 709 (2006), the court further addressed this issue with respect to the requirements of Arkansas Code Annotated section 11-9-102(4)(D), stating that all that is required is that the medical evidence of the injury and impairment be supported by objective findings, i.e., findings that cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16)(A)(i). The court reversed and remanded the Commission's decision because, although the requirement of support by objective findings had been satisfied, the Commission rejected the medical opinion offered by a physician that the claimant's injury resulted in eight-percent anatomical impairment simply because it was based in part upon non-objective evidence. *Singleton*, *supra*. The *Singleton* opinion cites *Swift-Eckrich, Inc. v. Brock*, 63 Ark. App. 118, 975 S.W.2d 857 (1998), for the

proposition that there is no requirement that medical testimony be based solely or expressly on objective findings, only that the record contain supporting objective findings.

There is evidence before us that appellant had specific objective findings in the form of calcification, muscle spasms, narrowing of the neuroforamina, and retrolisthesis. While no one is arguing that Arkansas Code Annotated section 11-9-102 supports straight-leg testing and range of motion as objective findings, we hold that under *Stephens* and *Singleton*, if other objective findings exist, then that type of subjective evidence can be considered in determining an impairment rating.

While we do not take issue with the cited language from *Coleman*, *supra*, we do hold that appellant's reliance on that case is misplaced because the court in *Coleman* was not faced with dueling doctors' opinions, which is the case here. Appellees correctly quote the language in the opinion that states specifically that the court "would not overturn the Commission's ruling [regarding appellant's impairment rating] if this were simply a case of dueling doctors' opinions." *Id.* at 350, 249 S.W.3d at 158. To compare and contrast, the court in *Coleman* had to contend with a doctor's hand-written note assigning the injured employee's impairment rating. Additionally, the doctors in that case argued about the application of the proper AMA Guidelines table. In the current case, the ALJ, and later the Commission through affirmation, compared Tables 73 and 75 when analyzing the case and determined that Table 75, rather than Table 73 relied upon by Dr. Moore, was the appropriate table for this claim. Also unlike *Coleman*, appellant's credibility was severely questioned, not only by the ALJ, but also by his own treating physicians. Although the specific language cited in *Coleman* is consistent with

Stephens and *Singleton*, the facts and issues at play in *Coleman* are simply not significantly similar to those in the current case.

We reiterate that while it is the province of the Commission to weigh conflicting medical evidence, the Commission may not arbitrarily disregard medical evidence or the testimony of any witness. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004); *Hill v. Baptist Med. Ctr.*, 74 Ark. App. 250, 48 S.W.3d 544 (2001). Because the opinions of the Commission and the ALJ do not fully address all the relevant medical information, we reverse and remand this case for additional consideration of all the relevant medical findings of the various physicians in this case. We make no comment on the impact of this evidence; we merely require findings upon which we can perform meaningful review.

Reversed and remanded.

ROBBINS and BIRD, JJ., agree.