Cite as 2012 Ark. App. 691

ARKANSAS COURT OF APPEALS

DIVISION II
No. CA12-553

Opinion Delivered December 12, 2012

JEFFREY A. GREENE
APPELLANT

V.

COCKRAM CONCRETE CO. and EMPLOYERS MUTUAL CASUALTY COMPANY
APPELLEES

APPEAL FROM THE ARKANSAS WORKERS' COMPENSATION COMMISSION
[No. G003286]

AFFIRMED

LARRY D. VAUGHT, Chief Judge

Appellant Jeffrey Greene appeals the Arkansas Workers' Compensation Commission's decision awarding a four-percent impairment rating for his compensable right-shoulder injury and denying his request for additional medical treatment for his left-elbow injury. He argues that substantial evidence fails to support these findings. We affirm.

Greene suffered admittedly compensable injuries to his right shoulder and left elbow on January 21, 2010, while working for appellee Cockram Concrete Company,[1] when the scaffolding he was working on collapsed. While he was able to grab on to a concrete form with both hands and hang suspended in the air immediately after the scaffolding's collapse, the weight of the scaffolding, which became tangled up in Greene's safety harness, caused him to fall to the ground.

[1]Cockram Concrete Company's workers' compensation insurance carrier is Employers Mutual Casualty Company, a separate appellee herein.

After the fall, Greene complained of pain in his right shoulder and left elbow, and he received medical treatment from various physicians at the Cooper Clinic in Fort Smith, Arkansas. On March 19, 2010, an MRI of the right shoulder showed several abnormal findings, including a probable tear. A left-elbow MRI taken on the same date showed a probable partial tear of the distal-biceps tendon. On April 6, 2010, Dr. Stephen Heim performed surgery on Greene's right shoulder.[2]

Dr. Heim's postsurgical reports reflect that Greene's right-shoulder complaints improved, but his left elbow continued to cause him pain. A second MRI of the left elbow, performed on June 30, 2010, again showed a probable partial tear of the distal-biceps tendon. An addendum to the MRI report stated that "there may actually be a full thickness tear of the distal[-]biceps tendon." However, Dr. Heim stated in his July 13, 2010 report, "[Greene] is not having any symptoms around the elbow whatsoever, therefore, I am not going to address the elbow." On August 18, 2010, Dr. Heim released Greene to return to work at full duty, stating that the elbow and shoulder had full, smooth range of motion, no pain, and no swelling. Dr. Heim, on September 15, 2010, authored a report that stated, "according to the Guide to Permanent Partial Impairment, 4th Edition, I think [Greene] has a 4% impairment to his right upper extremity due to his right shoulder." Dr. Heim further opined that Greene suffered no disability to his left elbow, concluding that the partial biceps tendon tear had healed.

[2]The surgery on the right shoulder was described as "acromioplasty, resection of the AC joint, repair of the rotator cuff."

Greene continued to have pain with his right shoulder and left elbow. He filed a change-of-physician petition with the Commission, which was granted. On December 20, 2010, Greene was treated by Dr. Wesley Cox, who reviewed the previous MRIs and found that Greene's right-shoulder tear had healed but that there was a distal-biceps-tendon tear in the left elbow. Dr. Cox recommended surgery for the tear, which was controverted by appellees. The appellees sent Greene to Dr. Michael Moore for an independent medical examination on February 15, 2011. Dr. Moore, relying on the prior MRIs of the left elbow and Greene's complaints, also suspected a distal-biceps-tendon rupture. However, before recommending surgery to repair the rupture, Dr. Moore ordered a third MRI. Dr. Moore reviewed the third MRI of Greene's elbow and concluded that it did not reveal any evidence of a distal-biceps-tendon tear. Thus, Dr. Moore opined that surgery on the left elbow to repair the tendon was not indicated.

Greene filed a claim with the Commission for the additional medical treatment, including surgery, recommended by Dr. Cox; additional temporary-total-disability benefits; and benefits related to his permanent impairment rating. After a hearing, the administrative law judge (ALJ) issued an opinion finding that Greene failed to prove that he was entitled to additional medical treatment. The ALJ acknowledged Dr. Cox's opinion that Greene needed surgery on his left elbow, but the ALJ concluded that the February 15, 2011 MRI, coupled with Dr. Moore's opinion that surgery was not indicated, failed to support Dr. Cox's recommendation. The ALJ also found that Greene was not entitled to additional temporary-total-disability benefits. Finally, the ALJ found that Greene was entitled to the four-percent impairment rating for his right shoulder issued by Dr. Heim. Greene appealed these findings

to the Commission, which affirmed and adopted the decision of the ALJ. Greene filed a timely appeal.

When reviewing a decision of the Commission, we view the evidence and all reasonable inferences deducible therefrom in the light most favorable to the findings of the Commission. *Avaya v. Bryant*, 82 Ark. App. 273, 277, 105 S.W.3d 811, 813 (2003). This court must affirm the decision of the Commission if it is supported by substantial evidence. *Avaya*, 82 Ark. App. at 277, 105 S.W.3d at 813. Substantial evidence is that evidence which a reasonable mind might accept as adequate to support a conclusion of the Commission. *Id.*, 105 S.W.3d at 813. The issue on appeal is not whether the appellate court might have reached a different result or whether the evidence would have supported a contrary finding; if reasonable minds could reach the Commission's conclusion, the appellate court must affirm its decision. *Id.*, 105 S.W.3d at 813-14.

On appeal, Greene challenges only two of the Commission's findings. First, he argues that the decision of the Commission awarding him a four-percent impairment rating for his right-shoulder injury is not supported by substantial evidence. Any determination of the existence or extent of physical impairment must be supported by objective and measurable physical findings. Ark. Code Ann. § 11-9-704(c)(1)(B) (Repl. 2012). Pursuant to Ark. Code Ann. § 11-9-522(g)(1)(A) (Repl. 2012), the Commission must adopt an impairment-rating guide to be used in the assessment of anatomical impairment, and the Commission has adopted the American Medical Association Guides to the Evaluation of Permanent Impairment (4th ed. 1993) (AMA Guides), to be used in this assessment. *Avaya*, 82 Ark. App. at 278, 105 S.W.3d at 814 (citing Ark. Workers' Comp. Comm'n R. 34).

In this case, Dr. Heim performed arthroplasty on Greene's right shoulder. Thus, Table 27, "Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints" of the AMA Guides applies. As per the table, a distal clavicle (isolated) arthroplasty has a ten-percent impairment to the right upper extremity. A total-shoulder arthroplasty has a twenty-four-percent impairment to the right upper extremity. These impairments to the right upper extremity convert to body-as-a-whole impairments of six percent and fourteen percent, respectively.[3]

Based on the AMA Guides, Greene argues that the lowest applicable body-as-a-whole impairment rating he can receive for his shoulder injury is six percent. Because Dr. Heim issued, and the Commission awarded, Greene a four-percent rating, he contends that the rating is not supported by substantial evidence. Greene also contends that neither the workers' compensation statutes nor the Commission Rules authorize a physician to deviate from the ratings stated in the AMA Guides.

We hold that substantial evidence supports the Commission's decision to award Greene a four-percent impairment rating. The Commission relied on the opinion of Dr. Heim, who issued the four-percent rating. Dr. Heim was Greene's treating physician and the physician who performed the right-shoulder arthroplasty. Further, in his report Dr. Heim specifically stated that he issued the rating pursuant to the AMA Guides.

True, the AMA Guides show that the applicable range of impairment ratings for this case is six percent to fourteen percent, and Dr. Heim's four-percent rating does not fall

[3]AMA Guides Table 3 is the chart that illustrates the conversion of upper-extremity impairment ratings to body-as-a-whole impairment ratings.

within that range. However, Greene fails to point to any authority that the Commission is required to award the impairment rating recommended by the AMA Guides. We are unable to find such authority. To the extent that Greene argues that Dr. Heim made a mistake in issuing a rating by misapplying the AMA Guides, there is no evidence in the record to support this argument. In fact, there is no evidence (medical or otherwise) in the record disputing or questioning in any way the four-percent rating issued by Dr. Heim.

The Commission is authorized to decide which portions of the medical evidence to credit and to translate this medical evidence into a finding of permanent impairment using the AMA Guides. *Avaya*, 82 Ark. App. at 278, 105 S.W.3d at 814 (citing *Polk Cnty. v. Jones*, 74 Ark. App. 159, 47 S.W.3d 904 (2001)). The Commission may assess its own impairment rating rather than rely solely on its determination of the validity of ratings assigned by physicians. *Id.*, 105 S.W.3d 814 (citing *Polk Cnty.*, 74 Ark. App. at 164, 47 S.W.3d at 907). In this case, the Commission did the reverse. It elected not to assess its own impairment rating. Instead, it relied on the rating assigned by Dr. Heim. We hold that the Commission was not only authorized to make that decision, but also that substantial evidence supports it. Therefore, we affirm on this point.

Greene's second point on appeal is that substantial evidence does not support the Commission's decision that he was not entitled to additional medical treatment for his left elbow. Arkansas Code Annotated section 11-9-508(a) (Repl. 2012) requires an employer to provide an injured employee such medical services "as may be reasonably necessary in connection with the injury received by the employee." The employee has the burden of proving by a preponderance of the evidence that medical treatment is reasonable and

necessary. *Cumble v. Bost Human Dev. Serv., Inc.*, 2012 Ark. App. 389, at 5–6. What constitutes reasonable and necessary medical treatment is a question of fact to be determined by the Commission. *Cumble*, 2012 Ark. App. 389, at 6.

Greene contends that the evidence established that he suffered an admittedly compensable injury to his left elbow; objective medical evidence—two MRIs—revealed a tear of the distal-biceps tendon in the elbow; the injury had not healed; and Dr. Cox recommended surgery to repair the tear. This, however, is not the only evidence in the record on this point. After Dr. Cox's treatment, Greene was seen by Dr. Moore, who recommended a third MRI. Dr. Moore's report reflects that he collaborated with Dr. Bob Lachman and concluded that the MRI did not reveal evidence of a tear in the distal-biceps tendon. Dr. Moore also opined that distal-biceps-tendon surgery would not improve Greene's elbow complaints.

In this case, the Commission gave significant weight to the third and most recent MRI results, along with Dr. Moore's opinions, in finding that additional medical treatment was not reasonable and necessary for Greene's compensable left-elbow injury. The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value. *Id.* When the Commission weighs medical evidence and the evidence is conflicting, its resolution is a question of fact for the Commission. *Medic One, LLC v. Colbert*, 2011 Ark. App. 555, at 7, 386 S.W.3d 58, 61. Therefore, we hold that substantial evidence supports the Commission's finding that Greene failed to prove that he was entitled to additional medical treatment for his left elbow.

Affirmed.
GLADWIN and GLOVER, JJ., agree.
Walker, Shock & Harp, PLLC, by: *Eddie H. Walker, Jr.*, for appellant.
No response.