IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
May 18, 2015 Session

INGA BROCK v. HEWLETT-PACKARD COMPANY

Appeal from the Circuit Court for Davidson County
No. 13C956 Thomas W. Brothers, Judge

No. M2014-01889-SC-R3-WC – Mailed August 19, 2015
Filed September 23, 2015

The employee sustained a work-related lower back injury, which required surgery. Her treating physician assigned an 8% permanent impairment rating, and referred her to a pain management specialist. The employee's lawyer arranged for an independent medical evaluation with a neurologist, who assigned the employee 23% permanent impairment for her back injury and 2% permanent impairment for the sleep interruption she experienced as a result of ongoing back pain. Because the impairment ratings differed, the employee was seen by a physician in the Tennessee Medical Impairment Rating Registry ("MIR"), as established by statute. The MIR physician, an orthopedic surgeon, assigned the employee a 9% permanent impairment. The depositions of the evaluating physician and the MIR physician were introduced at trial, as well as the medical records of the treating physician, the employee's testimony, and that of several lay witnesses. The trial court refused to allow the employer to call a vocational expert to testify, because the employer had failed to disclose the identity of this witness at an earlier time. At the conclusion of the proof, the trial court found that, regardless of the permanent impairment rating applied, the employee is unable to work and is therefore entitled to permanent and total disability benefits. Alternatively, the trial court found that the employee had introduced clear and convincing evidence to rebut the statutory presumption of accuracy that applies to the MIR physician's impairment rating and adopted the 23% permanent impairment rating of the evaluating physician, even though his assignment of 2% permanent impairment for the employee's sleep interruption was inconsistent with The AMA Guides to Permanent Impairment, 6th Edition ("AMA Guides"). The employer appealed. The appeal was referred to the Special Workers' Compensation Appeals Panel for a hearing and a report of findings of fact and conclusions of law in accordance with Tennessee Supreme Court Rule 51. We

conclude that: (1) the trial court did not err by excluding the employer's vocational expert; (2) the evidence preponderates against the trial court's finding of permanent and total disability; and (3) the trial court erred by concluding that the employee rebutted by clear and convincing evidence the statutory presumption of accuracy that applies to the MIR physician's impairment rating. Accordingly, we reverse and modify the judgment of the trial court, and considering the MIR physician's impairment rating and the lay testimony concerning the employee's limitations, award the employee 45% permanent partial disability benefits.

Tenn. Code Ann. § 50-6-225(a) (2014) Appeal as of Right;
Judgment of the Circuit Court Reversed and Modified

JON KERRY BLACKWOOD, SR. J., delivered the opinion of the Court, in which CORNELIA A. CLARK, J. and PAUL G. SUMMERS, SR. J., joined.

W. Troy Hart, Knoxville, Tennessee, for the appellant, Hewlett-Packard Company.

Stanley A. Davis, Nashville, Tennessee, for the appellee, Inga Brock.

OPINION

Factual and Procedural Background

The parties to this appeal, Inga Brock ("Employee") and Hewlett Packard Company ("Employer"), stipulated that Employee sustained a compensable work-related injury on December 3, 2010, that she reached maximum medical improvement on March 28, 2012, and that her weekly workers' compensation wage rate is $347.17. The parties also stipulated that no disputes exist concerning statutory notice, temporary benefits, or past medical care or payment. The trial court also took judicial notice of the AMA Guides. The dispute at trial, and in this appeal, centers on the extent of Employee's permanent impairment.

Employee, age fifty-four at the trial, is a high school graduate, and she also attended college courses for about a year and a half after high school, although she did not obtain a degree or any certification. After leaving college, Employee worked for a business her family owned, called Maid for a Day, where she progressed from secretary to owner of the business. In her role as secretary, she prepared bids and interacted with clients. After she purchased the business, she became responsible for interviewing, hiring and firing employees, preparing payroll, collecting payments, and making deposits. She next

worked for a family that had been a customer of Maid for a Day. In this job, Employee initially provided child care, and after the children matured and needed less care, she worked for the family as "house manager." In this "house manager" role, she was required to plan events for the family and make arrangements for maintenance and service at the family's home. She also did some house cleaning as well.

In 1998, Employee went to work for Electronic Data Systems ("EDS") as an enrollment clerk, but later moved to the mail room, where she served as a mail room clerk, quality control clerk, and elite clerk. Employee testified that while working at EDS, she took clerical classes, including typing and computer skills courses. Employer later acquired EDS, but Employee's responsibilities after the acquisition remained substantially the same. Employee's duties as enrollment clerk included using a computer to key in information from applications for TennCare. Employee's duties as a mail clerk included opening, sorting, and preparing mail to be scanned. The mail included "HIPAA and UB claims[1] from several doctors' office[s], nursing homes, and things of that nature." As quality control clerk, her job was to "look at the claims, claim by claim," and make sure that each had an IC number on it, which was a number showing the date the claim was received and the type of claim. After her promotion to "elite clerk," her duties included handling UPS and FedEx packages, answering the telephone for the department, supervising other employees, and reporting "to a manager on what the 'daily plan' was going to be." She also planned events for Employer, such as mobile Red Cross, March of Dimes, March for Babies, birthday dinners, and retirement dinners.

Employee had worked for EDS and Employer a total of twelve years, when, on the afternoon of Friday, December 3, 2010, she picked up a "heavy" mail bucket and felt a "popping" sensation in her lower back. Employee's supervisor was unavailable, but she told her fellow employees of the incident when it occurred and finished her work day. Over the weekend, her back pain worsened, so on Monday, December 6, 2010, she went to the emergency room of Nashville General Hospital for treatment. She received pain medication and was referred to her primary care physician for further treatment. She subsequently informed Employer of the injury and elected to see Dr. Chris Glattes, an orthopaedic surgeon, for further treatment, with the first appointment on February 3, 2011. After conservative treatment, including injections, medications, and physical therapy, failed to relieve her symptoms, Dr. Glattes performed back surgery, an L4-5 fusion, on August 23, 2011.

Employee testified that she improved for a time after the surgery, and the record reflects that Dr. Glattes placed her at maximum medical improvement as of March 28, 2012. Dr. Glattes released Employee from his care on August 22, 2012, and referred her to a pain management physician, Dr. Philip Beaulieu.

[1] Employee described UB claims as involving nursing home and Medicaid billing.

Employee remained under Dr. Beaulieu's care at trial and testified that she had not worked for approximately two years.[2] Employee testified that she had applied for jobs at Wendy's, McDonald's and Walmart because she was required to apply for jobs to continue receiving unemployment compensation benefits. She had not applied for any clerical positions or accepted offers made to her to organize events, such as baby and wedding showers, despite offers to do so. Employee stated that her pain from the back injury has worsened after the fusion surgery and stated that she has lower back pain every day. She testified that Dr. Beaulieu has prescribed the pain medications oxycodone, Opana, and Lyrica for her symptoms and that these medications, which she takes regularly, cause her to be groggy and dizzy. Employee stated that she has difficulty moving about her home and getting out of bed because of her pain. She estimated that she leaves her home once or twice per week. Employee stated that her sister and other friends and family do her housework, cooking, and shopping. Employee stated her belief that she is incapable of performing any of her previous jobs or any working at all due to the combined effects of her pain and the effects of the medications she uses to ease it.

During cross-examination, Employee testified that her work for Maid for a Day included answering the telephone, typing, going to work sites, and making bids. As owner, she made personnel decisions and kept financial records. Employee admitted that she is able to answer the phone and converse with the caller, type, write checks and make deposits, calculate withholding tax with the use of a guideline, interview potential employees, make decisions regarding hiring and firing employees, and set appointments and work with vendors. Employee also acknowledged that she is still able to complete some of the event-planning tasks she had performed while working as a house manager and for Employer, so long as she has assistance with the physically intensive components, such as setting up tables and walking venues. Employee agreed that her clerical jobs for EDS and Employer had not required any heavy lifting and had allowed her to stand as needed, and she stated that she was not required to lift more than about ten pounds while working as a house manager. Although Employee described the "mail buckets" she was required to lift while working in the mail room for Employer as moderately heavy lifting, she declined to estimate the weight of these buckets. She acknowledged that her positions with Employer allowed her to stand up and move about as needed. Employee also agreed that she would be able to complete all the tasks necessary to planning a baby shower over the telephone. Employee acknowledged that she had undergone a spinal-cord stimulator implant, which had improved her pain by about fifty percent, and testified that she hoped for more improvement over time.

[2] The record indicates that Employee returned to work for Employer for a period of time in a light-duty capacity, was laid off as part of a company-wide downsizing, and received unemployment benefits. Employer has not argued that Employee made a meaningful return to work for purposes of the statutory caps.

Jean Ligon, Employee's older sister, testified that Employee had been an "independent," "busy person" and "very active" in her church and community before the December 2010 injury. Since the injury, Ms. Ligon testified that she, and others, perform basic household chores for Employee, such as laundering, cooking, grocery shopping, trash disposal, and vacuuming. Ms. Ligon visits Employee's home once or twice daily for one or two hours per visit. Ms. Ligon stated that Employee's daily medications make her groggy and cause her to sleep much of the time and to go into "a deep sleep," to the point that Employee will not hear the phone, which results in Ms. Ligon driving to Employee's home to check on her. Ms. Ligon also described the physical difficulty Employee has getting out of bed, explaining that Employee must hold onto a person or the headboard and that it takes her "a long time to get out of bed by herself." Ms. Ligon and other friends and family drive Employee to doctor appointments, and Employee does not leave her home very often. Prior to the injury, Employee and Ms. Ligon enjoyed bargain shopping together almost every weekend. Ms. Ligon testified that Employee is in pain every day and that the pain had worsened after her surgery. Ms. Ligon, who had raised Employee from the time their mother died, when Employee was eight years old, testified that Employee has not previously been off work for an extended period of time, although she had been off work previously for a week or two following knee surgery.

Employee's former brother-in-law and Ms. Ligon's ex-husband, Roger Ligon, testified as well, and his testimony was substantially similar to that of Ms. Ligon. He stated that Employee had lived with him and Ms. Ligon from age thirteen until she married and had returned to their home after her divorce. Mr. Ligon explained that he is now Employee's landlord and that she has resided in his rental property for eight or nine years at the time of trial. Mr. Ligon stated that, before her back injury, Employee was "a vibrant person" and had no problems with her back or legs, other than knee problems, for which she was treated surgically. Mr. Ligon stated that Employee volunteered for many activities prior to the injury and was active in her church, particularly the youth ministry, but also various other church activities. Mr. Ligon stated that Employee needed no help with housework, meals, or driving to appointments prior to her injury and was "a clean freak" and "always doing housework." Since the injury, he has driven Employee to many doctor appointments. Concerning the back surgery, Mr. Ligon stated that it had caused Employee's condition to worsen and that he had told Employee "her health went to hell in a handbasket after the surgery." Mr. Ligon explained that he has visited Employee six days a week the two years prior to trial, while working on a construction project a block from her home. During these visits, Mr. Ligon occasionally brings Employee food, and if she is in bed, he waits for her to get up and moving "because she has a hard time getting out of bed." Mr. Ligon confirmed that his ex-wife and other of Employee's friends and family help her with cooking and cleaning, although she does "[e]very now and then" ask him "to mop the floor or something for her." Mr. Ligon stated that, since Employee's back injury, he has installed "handicap bars" in the bathroom for her use when getting into and out of the shower. Mr. Ligon said that Employee had always worked prior to her back injury and had always wanted to work and still talks with him about wanting to go back to

work. Mr. Ligon described Employee's pain medication as "a double-edged sword," explaining that if she takes all the medication, "half the time she's holding onto the walls trying to walk up from the bathroom," but "[i]f she doesn't take the medication, she just barely can move. So I don't know what the answer is." On cross-examination, Mr. Ligon acknowledged that Employee owes him approximately $16,000 in rent at the time of trial. Regarding his expectation of payment, Mr. Ligon stated that if Employee paid it "fine" but if she did not pay him "fine," because "she's family." Mr. Ligon also acknowledged that his ex-wife had paid him rent on Employee's behalf at least one month, but he had told her "not to worry about it until this [the workers' compensation claim] got settled, that — [he would] survive."

Two of Employee's friends, and also her former co-workers, also testified on her behalf at trial. Ms. Sandra Barbee testified that she had observed Employee on a daily basis seven years earlier, while working at Employer, and believed Employee was a good worker. Before the injury, she and Employee would go out to lunch and were often together on their break. Ms. Barbee was present when Employee injured her back, and she testified that Employee had no back problems prior to the injury. Ms. Barbee said that Employee was still hurting after the surgery and has moved slowly and been in pain since the injury. Ms. Barbee testified that Employee had been active in her church prior to the injury and surgery but has not been able to participate in those activities since. On cross-examination, Ms. Barbee testified that Employee was a good employee for Employer and that she could answer co-worker questions and knew the job. Ms. Barbee agreed that Employee is intelligent, has good people skills, and had taken the initiative at Employer to organize birthday parties and bring a cake or cupcakes to the parties.

Ms. Sharon Coure testified that she and Employee remain friends and previously worked together at EDS. Ms. Coure testified that prior to the injury, she and Employee would "do things together," such as church functions and activities, but are unable to "do much of that" since the injury. Ms. Coure had never observed Employee having problems with her back or legs before her injury. Ms. Coure now speaks to Employee on the phone "four or five times" "practically every day" and sees Employee once or twice a week. Ms. Coure has driven Employee to doctor appointments and has assisted Employee with therapy, household chores, and meal preparation, tasks Employee needed no assistance with before her injury. Ms. Coure testified that Employee now has difficulty getting out of bed but must lie down often after taking her prescribed pain medication, as it causes her not to be able to function. Ms. Coure stated that Employee no longer cooks or participates in church activities and is unable to go with Ms. Coure to Walmart or to Franklin, Tennessee, to visit the church at which Ms. Coure's father serves as pastor. On cross-examination, Ms. Coure agreed that Employee is intelligent and articulate.

None of the medical experts testified live at trial. Dr. Glattes' records of Employee's treatment were introduced into evidence by agreement of the parties. Dr. Glattes's records were also summarized in the MIR physician's report. These records reflect that Dr. Glattes diagnosed Employee with degenerative spondylolisthesis with spinal stenosis. Before releasing Employee from his care, Dr. Glattes obtained a Functional Capacity Evaluation ("FCE") to assist him with assessing permanent restrictions. The FCE indicated "[b]ased upon subjective and objective data" that Employee "did not demonstrate a full and consistent effort" during the FCE and that "[s]he may be physically able to do more and [that] the actual levels of work [were] not identified" in the FCE. Dr. Glattes thereafter assigned permanent restrictions as follows: "I have recommended 20-pound weight lift limit in general, 25 push, 25 pull, as far as force is concerned. She can occasionally bend and squat. I would like her to be able to alternate from a sitting to a standing position, or vice versa, for 10 minutes every two hours out of a regular work day." He added, "She cannot do any continuous lifting, bending, stooping, or twisting." Dr. Glattes assigned Employee an 8% impairment based on the AMA Guides. Dr. Glattes released Employee from his care on August 22, 2012, but referred her to a pain management physician.

Less than three months later, on December 3, 2012, Employee obtained an independent medical evaluation from Dr. C.M. Salekin., a neurologist, and he was deposed on February 12, 2014. Dr. Salekin, whose deposition was introduced into evidence at trial, estimated that he spent about two and a half hours performing the IME and that about a half hour of that time was spent reviewing Employee's medical records. Dr. Salekin testified that his physical examination of Employee revealed weakness in her right foot and right extensor muscle and decreased sensation in her L4, L5, and S1 dermatomes. Dr. Salekin also diagnosed Employee with insomnia due to her back and leg pain. He opined that Employee retained a Class III spinal impairment of 23% to the body as a whole and an additional 2% impairment for sleep disturbance, for a combined impairment of 25% to the body as a whole. He recommended that Employee avoid pushing, pulling or lifting weights in excess of twenty pounds and also avoid prolonged sitting or standing. Based on those restrictions, he opined that Employee is not capable of returning to her previous employments. He added that "with the pain that she had after the surgery, and ongoing need for pain medication, and her limitation, I believe that she is not suited for any gainful employment at this point in time." Dr. Beaulieu, Employee's pain management physician, did not testify at trial either live or by deposition, but some of his records were attached to Dr. Salekin's deposition as exhibits. However, Employer objected to the admissibility of Dr. Beaulieu's records as substantive evidence, and the trial court sustained the objection. Nevertheless, in his deposition testimony, Dr. Salekin recited verbatim large portions of Dr. Beaulieu's notes, over the Employer's objection.

Because Dr. Glattes and Dr. Salekin's impairment ratings differed, Dr. James Talmage, an orthopaedic surgeon, occupational medicine specialist and MIR physician, evaluated Employee on June 18, 2013, pursuant to the MIR procedure. Dr. Talmage's report and deposition, taken on April 28, 2014, were introduced into evidence at trial. Dr. Talmage had reviewed all of Dr. Glattes's medical records and had also reviewed the report and film of Employee's February 8, 2011, pre-surgery MRI. Although Dr. Talmage failed to record the precise amount of time he spent with Employee, he testified that he ordinarily sets aside four hours for MIR evaluations. Dr. Talmage explained that a resident physician, whom Dr. Talmage was training, was present at Employee's evaluation. Dr. Talmage had obtained a history from Employee, in which she described having continuous lower back pain that intermittently radiated into her leg; but, on the day of his evaluation, Employee reported that she was not experiencing leg pain. Dr. Talmage described the various physical activities he asked Employee to perform, including walking for 600 feet, and said that none of these activities generated leg pain on that date. Dr. Talmage also described the physical examination he performed, including tests that would confirm or deny the presence of "radiculopathy" as that term is defined by the AMA Guides. Dr. Talmage testified that Employee had "perfectly normal reflexes, perfectly normal strength, and no light touch sensory deficit. No sharp, dull sensory deficit. So she does not have any physical findings of radiculopathy." Dr. Talmage emphasized as well that Dr. Glattes had recorded Employee as having normal sensory exams and no neurologic deficits on all of the multiple occasions he examined her, except for one occasion in February 2011, when Dr. Glattes recorded a slight muscle weakness. Dr. Talmage pointed out that this finding predated Employee's back surgery. Like Dr. Glattes, Dr. Talmage diagnosed Employee with degenerative spondylolisthesis with spinal stenosis. Dr. Talmage assigned Employee a 9% impairment to the body as a whole under the AMA Guides. Dr. Talmage noted that his rating was "almost identical" to the 8% impairment rating Dr. Glattes had assigned. Dr. Talmage testified that Dr. Salekin's findings of neurological weakness in Employee's right leg and decreased sensation in several dermatomes were inconsistent with his own examination findings and with virtually all of Dr. Glattes's examinations, which found normal strength and sensation in the right leg. Given the lack of objective findings to establish radiculopathy as the term is defined in the ABA Guides, Dr. Talmage concluded that the impairment rating Dr. Salekin assigned was inconsistent with the AMA Guides. Dr. Talmage offered no opinion on Employee's ability to perform or not perform any work activities or her ability to return to work.

Prior to the trial, Employee made a motion in limine to exclude the proposed testimony of Michael Galloway, a vocational evaluator. Employer did not disclose Mr. Galloway as a potential witness until three days before trial, although interrogatories requesting, inter alia, the identities and opinions of expert witnesses had been served on Employer over a year earlier. The trial court granted Employee's motion. Employer made an offer of proof that Mr. Galloway would have testified that Employee was not totally disabled.

The trial court issued its findings from the bench. Citing the testimony of Employee and the lay witnesses who testified on her behalf, the trial court found that Employee had established by a preponderance of the evidence that she is permanently and totally disabled, regardless of whether Dr. Talmage's or Dr. Salekin's impairment rating applies. The trial court noted that Employee was on track to receive permanent implantation of a spinal cord stimulator, expressed hope that this device would result in a great deal of benefit, and pointed out that Employer would be free to monitor Employee's condition[3] and return to court and revisit the matter if Employee's restrictions or condition changed. As an alternative finding, the trial court determined that, even though Dr. Salekin's inclusion of a 2% impairment for insomnia was inconsistent with the AMA Guides, Dr. Salekin's testimony concerning the appropriate permanent lumbar impairment amounted to clear and convincing evidence sufficient to rebut the statutory presumption of accuracy that applied to Dr. Talmage's MIR impairment rating. Therefore, the trial court held that Employee retains a permanent impairment of 23% to the body as a whole. Judgment was entered in accordance with these findings, and Employer has appealed.

Analysis

Standard of Review

Appellate review of decisions in workers' compensation cases is governed by Tennessee Code Annotated section 50-6-225(e)(2) (2008 & Supp. 2013), which provides that appellate courts must "[r]eview . . . the trial court's findings of fact . . . de novo upon the record of the trial court, accompanied by a presumption of the correctness of the finding, unless the preponderance of the evidence is otherwise." As the Supreme Court has observed many times, reviewing courts must conduct an in-depth examination of the trial court's factual findings and conclusions. Wilhelm v. Krogers, 235 S.W.3d 122, 126 (Tenn. 2007). When the trial court has seen and heard the witnesses, considerable deference must be afforded the trial court's factual findings. Tryon v. Saturn Corp., 254 S.W.3d 321, 327 (Tenn. 2008). No similar deference need be afforded the trial court's findings based upon documentary evidence such as depositions. Glisson v. Mohon Int'l, Inc./Campbell Ray, 185 S.W.3d 348, 353 (Tenn. 2006). Similarly, reviewing courts afford no presumption of correctness to a trial court's conclusions of law. Seiber v. Reeves Logging, 284 S.W.3d 294, 298 (Tenn. 2009).

[3] See Tenn. Code Ann. § 50-6-207(C) (2014) (applicable to injuries occurring prior to July 1, 2014).

Exclusion of Vocational Evaluator's Testimony

Before determining whether the evidence admitted at trial preponderates against the trial court's finding that Employee is permanently and totally disabled, we will first address Employer's assertion that the trial court erred in excluding the testimony of its vocational evaluator. Employer's vocational expert would have testified that Employee retains vocational skills from her prior work experience and that the permanent restrictions imposed on her by Dr. Glattes do not preclude her from all types of employment that utilize these skills.

Employer concedes that a trial court has wide discretion in the admission or exclusion of evidence. Otis v. Cambridge Mut. Fire Ins. Co., 850 S.W.2d 439, 442 (Tenn. 1992). Employer also acknowledges that it did not disclose the vocational evaluator as a potential witness until shortly before trial. However, it argues that the vocational evaluator was a rebuttal witness, and for that reason, the trial court abused its discretion by excluding his testimony. We disagree. "A rebuttal witness is one called after the sides have presented their proof in their case[-]in[-]chief." Neil P. Cohen et al., Tennessee Law of Evidence § 6.11[10] (6th ed. 2011). Here, Employer intended to call the vocational evaluator as a witness in its case-in-chief. Although Employer attempted to justify its eve-of-trial disclosure of the vocational evaluator on the ground that it had only recently learned that Employee intended to seek permanent *total* disability benefits, we note that extent of disability is at issue in most workers' compensation cases and was clearly the primary issue in dispute in this case. Furthermore, as the trial court concluded, Employer had received notice that Employee intended to seek permanent total disability benefits at the latest by February 2014, at the time of Dr. Salekin's deposition, which was six months prior to trial. Under these circumstances, the trial court did not abuse its discretion by excluding the testimony of Employer's vocational evaluator.

Permanent Total or Permanent Partial Disability

Employer next asserts that the evidence preponderates against the trial court's finding that Employee is permanently and totally disabled. We agree.

In so concluding, we do not disturb the trial court's findings that all of the "live witnesses" who testified on Employees behalf were "credible" and that their testimony established that Employee has sustained "a significant disability" that has "impaired her ability to live a life pain free." But, as the trial court recognized, these findings do not answer the question of whether Employee's permanent disability is total or partial.

An injured employee is permanently and totally disabled when her injury "totally incapacitates the employee from working at an occupation that brings the employee an income." Tenn. Code Ann. § 50-6-207(4)(B) (2014) (applicable to injuries occurring prior to July 1, 2014). The Supreme Court has stated:

> [T]he determination of permanent and total disability is to be based on a variety of factors such that a complete picture of an individual's ability, or inability, to return to gainful employment is presented before the court. Such factors include the employee's skills, training, education, age, job opportunities in the immediate and surrounding communities, and the availability of work suited for an individual with that particular disability. Although such an assessment is often made and presented at trial by a vocational specialist, it is well settled that despite the existence or absence of expert testimony, an employee's own assessment of his or her overall physical condition, including the ability or inability to return to gainful employment, is competent testimony that should be considered.

Vinson v. United Parcel Serv., 92 S.W.3d 380, 386 (Tenn. 2002) (citations and internal quotation marks omitted).

Employee, fifty-four-years-old at trial, is a high-school graduate, who had completed some college courses, as well as clerical and computer courses. Employee has also owned a small business and performed the payroll, management, and supervisory tasks required as owner. All of the lay witnesses testified that Employee has an aptitude for and experience at event planning, and Employee testified that she is capable of organizing a baby shower by telephone and would be able to complete many of the tasks associated with event planning by telephone. Additionally, Employee testified that she is able to type, to conduct business by telephone, to write checks and make deposits, to calculate withholding tax with the use of a guideline, to interview potential employees, to make decisions regarding hiring and firing employees, and to set appointments and work with vendors. The lay witnesses testified, and the trial court found, that Employee is articulate and intelligent. Additionally, by Employee's own testimony, the permanent restrictions Dr. Glattes and Dr. Salekin imposed would not preclude her from working in many of the clerical positions in which she had previously worked, as these positions involved no heavy lifting and allowed her to stand and move about as needed. Although we do not disregard Employee's testimony concerning her belief that she is not capable of working in any of her former jobs, we note that, at the time of trial, she had not applied for any clerical positions and had applied at fast food restaurants and Walmart only during the time she was required to seek employment to continue receiving unemployment benefits. Employee testified that she had refused offers to plan events for others, although she admitted she would have been able to perform all the organizational tasks by telephone. Additionally, we note that Employee failed to offer proof from a vocational expert or present any other proof to show that no jobs are available to her in her current condition in

the Nashville area where she lives. We note that Dr. Glattes's record do not describe Employee as permanently and totally disabled. Additionally, the trial court properly refused to consider Dr. Beaulieu's records as substantive evidence; thus, these records provide no support for the trial court's finding of permanent and total disability.[4] Although Dr. Salekin testified that Employee is unable to work, he spent about two hours with Employee on one occasion, almost two years prior to trial. The restrictions Dr. Salekin imposed do not exceed those imposed by Dr. Glattes, and by her own testimony, these restrictions do not preclude Employee from working at some of the clerical positions she had previously held. We note that Dr. Salekin cited Employee's ongoing pain and the effects of her pain medication as the grounds for his opinion that she cannot work at all, but Dr. Salekin's evaluation occurred before Employee received an implanted spinal cord stimulator. This device, Employee testified, decreased her pain significantly, by about fifty percent. Although we agree with the trial court that Employee has significant permanent impairment, we conclude that the evidence preponderates against the trial court's finding that Employee is totally and permanently disabled.

Applicable Disability Rating

We turn next to consider whether the trial court erred by finding that Employee had presented clear and convincing evidence to overcome the statutory presumption of accuracy that applied to Dr. Talmage's impairment rating. We begin with Tennessee Code Annotated section 50-6-204(d)(5), which states:

> When a dispute as to the degree of medical impairment exists, either party may request an independent medical examiner from the commissioner's registry . . . . The written opinion as to the permanent impairment rating given by the independent medical examiner to this subdivision (d)(5) shall be presumed to be the accurate impairment rating; provided, however, that this presumption may be rebutted by clear and convincing evidence to the contrary.

Tenn. Code Ann. § 50-6-04(d)(5) (2014) (applicable to injuries occurring prior to July 1, 2014). Recently, the Supreme Court comprehensively discussed the foregoing statutory provision as follows:

[4] Although Dr. Salekin recited verbatim portions of Dr. Beaulieu's notes during his deposition testimony, the trial court, contrary to Employer's assertion, properly limited its consideration of this testimony and did not consider it as substantive evidence but as relevant to evaluating the basis of Dr. Salekin's opinion. Holder v. Westgate Resorts Ltd., 356 S.W.3d 373, 379 (Tenn. 2011).

> Although we presume that the trial court's findings of fact are correct, unless the evidence preponderates otherwise, whether the facts establish clear and convincing evidence to overcome the statutory presumption of accuracy of an MIR report is a question of law that we must review de novo with no presumption of correctness.
>
> While a comparison of the differing medical specialties of an MIR physician and other testifying physicians is certainly an appropriate factor to consider in evaluating conflicting expert medical evidence, it is not sufficient alone to rebut the presumption created by section 50-6-204(d)(5). Furthermore, simply because one or more evaluating physicians disagree with a properly founded MIR evaluation does not permit a finding that proof to the contrary has been established. A disagreement between medical expert witnesses as to the proper diagnosis of an employee's condition may not, in and of itself, constitute the clear and convincing evidence needed to overcome the statutory presumption of accuracy afforded an MIR physician's impairment rating.
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> This Court has described clear and convincing evidence as that in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the evidence. In the specific context of the statute at issue, the clear and convincing evidence standard has been interpreted to mean that if no evidence has been admitted which raises a serious and substantial doubt about the evaluation's correctness, the MIR evaluation is the accurate impairment rating. Another Special Workers' Compensation Appeals Panel has also observed that a straightforward interpretation of the clear and convincing evidence standard favors, or even requires, the presentation of affirmative evidence that an MIR physician had used an incorrect method or an inappropriate interpretation of the AMA Guides to overcome the statutory presumption.
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> In any event, when deciding whether or not an employee has rebutted the statutory presumption of correctness enjoyed by an MIR physician's impairment rating, the focus is on the evidence offered to rebut that physician's rating.

Mansell v. Bridgestone Firestone N. American Tire, LLC, 417 S.W.3d 393, 410-11 (Tenn. 2013) (internal quotation marks, citations, and alterations omitted).

In this case, Employee has offered no proof to show that Dr. Talmage misapplied the AMA Guides when assigning her a 9% permanent impairment rating. This record establishes only a simple disagreement between, on the one hand, Dr. Glattes and Dr. Talmage, and on the other hand, Dr. Salekin. Although much has been made of Dr. Talmage's refusal to base his impairment rating on a diagnosis of radiculopathy, Dr. Talmage cogently explained the reasons for his decision. Specifically, Dr. Talmage stated that he was not disputing that Employee's treating physicians had used the term in Employee's treatment records. Dr. Talmage emphasized, however, that the AMA Guides define the term specifically and permit a diagnosis of radiculopaathy only if certain objective neurologic exam findings are repetitively present. Dr. Talmage testified that Employee's medical records, and his own physical examination of her, failed to establish the required objective exam findings. Dr. Talmage testified that, while using "radiculopathy" in a clinical setting to describe radiating leg pain is common and appropriate, the AMA Guides have "a differentiation in terms of severity of impairment between those who just have symptoms in the leg and a normal neurologic exam and those who have an abnormal neuroloic exam."

Not only does the record contain no proof to show that Dr. Talmage misapplied the AMA Guides, Dr. Talmage's diagnosis of Employee and the impairment rating he assigned are entirely consistent with, indeed almost identical to, the diagnosis and impairment rating given by her treating physician. Additionally, the record clearly establishes that Dr. Salekin misapplied the AMA Guides by assigning Employee a 2% impairment for sleep disturbance stemming from back pain. Dr. Salekin's own testimony indicates that he did not view the AMA Guides as particularly authoritative when forming his opinions. He stated, "AMA Guide is a guide. It makes recommendation. And sometimes I have seen AMA Guide is a little deficient and in explaining and recommending the impairment in detail." The trial court appropriately pointed out that Dr. Salekin is a board certified neurologist, but Dr. Salekin's qualifications alone do not amount to clear and convincing evidence sufficient to rebut the statutory presumption of accuracy that applies to Dr. Talmage's impairment rating. Although the trial court appeared to include Dr. Beaulieu's records among the clear and convincing evidence that he viewed as having rebutted the presumption of accuracy, these records were not admitted into evidence and should not have been considered in the calculation as substantive evidence on any issue. Moreover, even if these records were properly considered, as Dr. Talmage explained, simply because the term radiculopathy appeared in Dr. Beaulieu's clinical records does not indicate that Dr. Beaulieu had concluded that the criteria for radiculopathy as used in the AMA Guides were satisfied. Based on our thorough review of the record, we conclude that the trial court erred in finding that the statutory presumption of accuracy applicable to Dr. Talmage's impairment rating was rebutted by clear and convincing evidence. Thus, we conclude that Employee maintains a 9% permanent impairment to the body as a whole, as assessed by Dr. Talmage.

The maximum permanent partial disability benefits an employee may receive "[f]or injuries arising on or after July 1, 2004, but before July 1, 2014, in cases in which the pre-injury employer did not return the injured employee to employment at a wage equal to or greater than the wage the employee was receiving at the time of the injury" is "six (6) times the medical impairment rating." Tenn. Code Ann. § 50-6-241(D)(2)(A) (2014). "If a court awards a permanent partial disability percentage that equals or exceeds five (5) times the medical impairment rating, the court shall include specific findings of fact in the order that detail the reasons for awarding the maximum permanent partial disability." Id. § 50-6-241(2)(B).

In its brief on appeal, Employer asks us to remand to the trial court for a determination of the proper multiplier under Tennessee Code Annotated section 50-6-241. In our judgment, a remand is unnecessary. The trial court found Employee's testimony and that of the lay witnesses to be credible. All of these witnesses testified that Employee has a significant disability, which impairs her ability to function and requires her to obtain assistance with household chores and other activities of daily living. Yet, this same proof establishes that Employee, a high school graduate, and under the age of fifty-five when injured, possesses transferable job skills from her prior vocational background and training and has opportunities for employment using these skills in her local community of Nashville. See Tenn. Code Ann. § 50-6-242(b) (2014) (applicable to injuries occurring prior to July 1, 2014). Based on these factual findings, we conclude that Employee is entitled to an award of 45% permanent partial disability benefits—five times the medical impairment rating.[5]

Conclusion

The judgment of the trial court is reversed and modified as stated herein. Costs are taxed to Inga Brock, for which execution may issue if necessary. This matter is remanded to the trial court for entry of a judgment consistent with this decision and any other proceedings necessitated by, and consistent with, our decision herein.

JON KERRY BLACKWOOD, SENIOR JUDGE

[5] We note that Employer argued in the trial court that Employee's workers' compensation award should not exceed five times the 9% anatomical impairment rating.

IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE

INGA BROCK v. HEWLETT-PACKARD COMPANY

Circuit Court for Davidson County
No. 13C956

No. M2014-01889-SC-R3-WC – Filed September 23, 2015

JUDGMENT

This case is before the Court upon the entire record, including the order of referral to the Special Workers' Compensation Appeals Panel, and the Panel's Memorandum Opinion setting forth its findings of fact and conclusions of law, which are incorporated herein by reference.

Whereupon, it appears to the Court that the Memorandum Opinion of the Panel should be accepted and approved; and

It is, therefore, ordered that the Panel's findings of fact and conclusions of law are adopted and affirmed, and the decision of the Panel is made the judgment of the Court.

Costs will be paid by Inga Brock, and his surety, for which execution may issue if necessary.

PER CURIAM