IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT JACKSON
June 27, 2016 Session

MAMIE MARSHALL v. PINNACLE FOOD GROUP

Appeal from the Chancery Court for Madison County
No. 70293 James F. Butler, Chancellor

No. W2015-00382-SC-R3-WC – Mailed September 19, 2016; Filed October 27, 2016

Mamie Marshall ("Employee") developed a gradual shoulder injury as a result of her work for Pinnacle Food Group ("Employer"). She underwent three surgeries and was eventually referred to a pain management specialist. After the third procedure, she was placed in a modified duty job. Two months after her return to work, she retired. Two of her treating physicians assigned 4% impairment to the body as a whole. Employee's evaluating physician examined Employee on three occasions and assigned impairments of 7% to the body as a whole after the second surgery and 11% to the body as a whole after her retirement. A physician chosen from the Medical Impairment Registry ("MIR") assigned 4% impairment to the body as a whole. The trial court found that Employee overcame the presumption of correctness attached to the MIR physician's rating and adopted the evaluating physician's 11% impairment. The trial court also found that Employee did not have a meaningful return to work and awarded 66% permanent partial disability to the body as a whole. Employer has appealed, contending the evidence preponderates against the trial court's findings concerning impairment and meaningful return. The appeal was referred to the Special Workers' Compensation Appeals Panel pursuant to Tennessee Supreme Court Rule 51. We modify the judgment.

Tenn. Code Ann. § 50-6-225(a)(2) (2014) Appeal as of Right; Judgment of the Chancery Court Modified

ROGER A. PAGE, J., delivered the opinion of the Court, in which BRANDON O. GIBSON, J. and WILLIAM ACREE, SR.J., joined.

Michael W. Jones, Fred J. Bissinger, and Michelle D. Reid, Nashville, Tennessee, for the appellant, Pinnacle Food Group.

Ricky L. Boren, Jackson, Tennessee, for the appellee, Mamie Marshall.

OPINION

Factual and Procedural History

Employee began working for Employer's predecessor entity, Quaker Oats Company, in 1975. She worked on the production line for approximately eight years and then transferred to the quality control department. In that job, she pulled samples of products, checked codes on cartons, weighed products, and set up micro-analytical labs. She handled objects weighing up to twenty pounds several times per week. She lifted objects weighing up to forty pounds less frequently. In the summer of 2008, she developed pain in her right shoulder. She eventually made a workers' compensation claim. Employer accepted the claim and referred employee to Dr. Keith Nord, an orthopedic surgeon, to be her authorized physician.

Dr. Nord first examined Employee on February 23, 2009. She had previously been examined by Dr. Timothy Sweo under her private health insurance plan. Dr. Sweo had ordered an MRI of the shoulder, which Dr. Nord reviewed during the initial examination. Dr. Nord testified that the MRI showed a 50% tear of the supraspinatus tendon, mild to moderate subacromial bursitis, and mild infraspinatus tendinopathy. His initial diagnoses were a rotator cuff tear and impingement syndrome of the right shoulder. He prescribed an injection, physical therapy, limited duty, and a pain medication. When Employee returned to him in April, she reported that she was still having significant pain in the shoulder. Dr. Nord's examination was positive for impingement. He then recommended arthroscopic surgery to repair the shoulder.

The surgery took place on May 14, 2009. During surgery, Dr. Nord noted the labrum was intact and observed a 10% tear of the supraspinatus tendon. He debrided or "shaved" the tendon but did not place an anchor. He removed the subacromial bursa and shaved bone in that area as well. When Employee had her first post-operative visit on May 27, Dr. Nord found that she was doing "pretty well." He prescribed that she continue physical therapy and allowed her to return to work on June 4 with no use of her right arm. By June 29, 2009, Employee reported to Dr. Nord that she still had significant pain in her shoulder. Her examination revealed positive impingement signs. Dr. Nord continued physical therapy, a restriction on the use of the right arm, and pain medicine. Over the next few months, Dr. Nord tried various modes of conservative treatment, and

while Employee's strength and range of motion improved, the shoulder continued to be very sore. By November 16, 2009, it was clear that Employee was not improving, and Dr. Nord ordered a repeat MRI.

The MRI revealed a three millimeter by four millimeter rotator cuff tear, mild tendinosis, and acromioclavicular hypertrophy. Dr. Nord recommended a repeat arthroscopy. He performed the procedure on January 14, 2010. During surgery, Dr. Nord found a partial tear of the supraspinatus tendon. He "completed" the tear and used anchors and sutures to repair it. He determined that no additional subacromial decompression was necessary and also observed that Employee's labrum and biceps tendon appeared to be healthy.

Employee's shoulder function and pain level improved for a time after surgery. However, by June 21, 2010, she was reporting deep, aching pain. On August 11, Dr. Nord determined that she had reached maximum medical improvement. He assigned 4% permanent impairment to the body as a whole and released Employee to full duty work. At that time, Employee said that she was doing well, except when she performed overhead work. Employee returned to Dr. Nord with complaints of shoulder pain in October, November, and December of 2010. He continued to provide conservative treatment. Dr. Nord ordered an EMG, the result of which was normal, and another MRI, which showed tendinosis and mild bursitis. Employee saw Dr. Nord again in June, July, and August of 2011. At that time, she reported continuing pain in the shoulder. Dr. Nord administered an injection, which did not alleviate Employee's symptoms. At his last encounter with Employee on August 10, 2011, Dr. Nord determined that her shoulder had a normal range of motion. His final diagnosis was impingement syndrome.

During his deposition, Dr. Nord stated that Employee's three shoulder surgeries put her at risk for chronic pain. He expressed the opinion that the impairments for shoulder conditions set out in the American Medical Association's Guides to the Evaluation of Permanent Impairment, Sixth Edition ("AMA Guides") were too low. He also agreed that if he were still treating Employee, he would add additional impairment for chronic pain.

Employee sought additional medical treatment and was referred to another orthopedic surgeon, Dr. David Sickle. She first saw Dr. Sickle on August 29, 2011. His examination revealed that Employee had pain with movement of her right shoulder and tenderness of the right biceps tendon. He observed that she had a full range of motion, although she had discomfort at the extremes of motion. Dr. Sickle's initial diagnosis was right biceps tendinitis. He injected the shoulder and provided Employee with a set of stretches to perform at home. When Employee returned to Dr. Sickle on September 23,

she reported that she had received some relief from the injection but still had pain in the deltoid area of the shoulder. The results of Employee's physical examination were similar to the results of the August 29 examination. Among other things, Dr. Sickle detected positive impingement signs, which are markers for inflammation in the rotator cuff or bursa.

When Employee returned to Dr. Sickle on November 1, 2011, her complaints and examination were consistent with her previous appointments, and he diagnosed her with rotator cuff tendonitis. Dr. Sickle ordered an MRI. That study showed a recurrent rotator cuff tear or a tear that had not healed, in addition to mild tendinitis and degenerative changes in Employee's labrum. Dr. Sickle recommended physical therapy, a change of anti-inflammatory medications, and work restrictions. On January 10, 2012, Employee was feeling better, and her range of motion had improved. Dr. Sickle gave her an injection to help her pain. On February 7, 2012, Employee reported having pain in her shoulder that increased with activity and prevented her from sleeping. The doctor recommended a third arthroscopic surgery. That procedure took place on February 23, 2012. During the surgery, Dr. Sickle found a recurrent rotator cuff tear. He removed the previous sutures, cleaned the damaged tendon, and reattached it to the bone with two anchors and heavy sutures. He also attempted to stimulate healing by augmenting the repair with her own platelets.

After surgery, Employee was restricted from returning to work, had her arm placed in a sling, and received physical therapy. For the next several months, Employee's symptoms were somewhat improved. Dr. Sickle permitted her to return to work with no use of her right arm on April 3, 2012. He continued to prescribe physical therapy and other conservative treatment, and after her May 15, 2012 visit, he allowed her limited use of her arm at work. By August 14, 2012, Dr. Sickle determined that Employee had reached maximum medical improvement. He assigned permanent restrictions at that time. Those restrictions prohibited reaching outward or upward and lifting in excess of ten pounds. Dr. Sickle assigned 4% permanent impairment to the body as a whole at that time. He later issued an impairment of 3% to the body as a whole. However, his opinion at the time of his deposition was that 4% was the correct impairment. He observed at that time that Employee had a full range of motion and normal strength in her right arm. Employee twice returned to Dr. Sickle after being released from his care. On November 7, 2012, she complained of pain in the deltoid area of the shoulder that started about two weeks earlier. She had full range of motion at that time. Dr. Sickle provided an injection.

Employee's last visit was on January 28, 2013. She reported constant pain in her right arm from shoulder to forearm. Dr. Sickle found that she had full range of motion

of the arm, good strength, and a positive impingement sign. He ordered an EMG, and the result of that study was normal. He prescribed oral steroids and referred Employee to Dr. Davidson Curwen, a pain management specialist. During cross-examination, Dr. Sickle opined that the Sixth Edition of the AMA Guides underestimates the functional effect of multiple surgeries. He agreed that it would be wise for Employee to avoid strenuous work.

Employee had been working in a restricted duty status prior to being released by Dr. Sickle. When she was released by Dr. Sickle, she was placed in a job that included some, but not all, of her previous duties. She testified that she could perform all aspects of that job but that it resulted in pain. On August 28, 2012, she submitted a letter of resignation to Employer. Her retirement was effective September 7, 2012. In her letter, she gave the following reason for her resignation/retirement:

> I have had three shoulder surger[ies] and I continue to be on restriction so I believe it will benefit me to go on out and enjoy my remain[ing] years. [A]fter 37 yrs. & 8 mos. at one location I feel like doing some traveling or whatever I may feel like doing in the future.

However, she testified that she retired because she was "tired of hurting." Since her retirement, she said that she has not traveled. Instead, she sometimes walked at the gym and visited nursing homes. Employee testified that she would have continued working but for her injury.

Dr. Davidson Curwen began treating Employee on March 7, 2013. His examination at that time found normal range of motion, normal strength, no evidence of impingement, and tenderness in the biceps tendon and the trapezius. His impression was that Employee had residual pain from her rotator cuff repair. Over the next nine months, he prescribed a TENS unit, anti-inflammatory patches, injections, pain medications, and an ultrasound evaluation. During his examinations, he found that she had normal ranges of motion and strength in the shoulder. Employee continued to complain of mild to severe pain. On December 19, 2013, Dr. Curwen examined Employee for the last time before his deposition was taken. Employee had normal strength and ability in her right shoulder. However, she reported a focal area of tenderness in the upper triceps muscle. During cross-examination, Dr. Curwen stated that he had not reviewed the records of Dr. Nord. He agreed that pain can be "functionally impairing." In addition, he testified that he believed her complaints of pain to be legitimate.

Employee obtained an independent medical examination from Dr. Apurva Dalal, an orthopedic surgeon. Dr. Dalal testified that he was certified to interpret the Sixth

Edition of the AMA Guides by the American Board of Independent Medical Evaluators. Dr. Dalal examined Employee on three occasions: April 22, 2011; November 19, 2012; and September 18, 2013. Dr. Dalal's April 22, 2011 examination took place after the two surgeries performed by Dr. Nord but before surgery performed by Dr. Sickle. At that time, Dr. Dalal found that Employee had lost a significant amount of motion in the shoulder. He assigned an impairment of 7% to the body as a whole, according to the Sixth Edition of AMA Guides.

Dr. Dalal's November 19, 2012 evaluation occurred after Dr. Sickle's surgery and after Employee had retired. He found that her range of motion had improved. Dr. Dalal testified that Employee had 7% impairment to the right upper extremity. This converted to 4% impairment to the body as a whole, pursuant to the Sixth Edition of the AMA Guides. Dr. Dalal further testified that the Sixth Edition "allows" an additional impairment of 3% to be applied in cases of chronic pain.

Dr. Dalal's September 18, 2013 examination took place approximately one year after Employee's retirement. She was under Dr. Curwen's care at that time. Employee reported that she had pain "all day and all night long." Dr. Dalal found that she had a markedly reduced range of motion in her shoulder. He assigned 8% impairment to the body as a whole for lost range of motion and an additional 3% impairment to the body as a whole for chronic pain, resulting in an overall impairment of 11% to the body as a whole. Dr. Dalal testified that the Guides state that when two methods of assigning impairment are available, the method yielding the higher impairment should be used. During cross-examination, Dr. Dalal testified that he did not know how long Employee had been retired at the time of his examination. He conceded that the AMA Guides provided that impairment for chronic pain was not to be added to impairments derived from other sections of the AMA Guides. However, when asked why he added additional pain impairment, Dr. Dalal stated that it was a matter of interpreting the AMA Guides. He further stated:

> The Guide has written a chapter on pain and then [has] stated that in [the] vast majority of the cases, pain is an inclusion with an injury and the surgery. However, there are circumstances like [Employee] who has had multiple surgeries done, and there is no way to correctly assign a rating on her just from loss of range of motion and think, well, that includes . . . pain and all other problems which you have from that.
>
> That would not be appropriate in my opinion, and to an extent I would say [the] Guide is confusing. It has not clarified the chapter on pain very clearly, and that is the reason they expect physician[s] to make a

> judgment based on their experience of what happens with shoulder surgeries and that's what I have done.

Dr. Dalal also agreed that the AMA Guides require that a "Pain Disability Questionnaire" be used when a separate pain-related impairment is considered. He was unable to locate such a document in his file during the deposition, but he said that he always has patients complete one.

In light of the conflicting impairment ratings, Employer sought a review through the Medical Impairment Registry ("MIR"). Tenn. Code Ann. § 50-6-204(d)(5), (6) (2008). Dr. James Craig, an orthopedic surgeon, was selected to evaluate Employee. Dr. Craig's examination took place on November 19, 2013. Dr. Craig issued a report stating that Employee had 4% impairment to the body as a whole as a result of her injuries and surgeries. Dr. Craig testified that the Sixth Edition permits impairment of a shoulder to be evaluated by either a range-of-motion method or a diagnosis-related method. He testified that based on his measurements, Employee would have received a 5% impairment under the range-of-motion method, if he had used that method. He agreed that the Sixth Edition of the AMA Guides states that when different methods of calculating impairment are available, the method producing the higher impairment is preferred. However, he also stated that the upper extremity impairment section of the Sixth Edition provides at page 461 that the diagnosis-based method "is the method of choice for calculating impairments." Further, the diagnosis-based method includes range-of-motion loss as an adjustment factor.

The trial court issued its findings and conclusions in the form of a letter to counsel. In brief, the court held: (1) The statutory presumption of correctness of Dr. Craig's impairment rating had been rebutted by clear and convincing evidence because Dr. Craig failed to follow the AMA Guides by selecting the rating method that would provide the highest rating; (2) Dr. Dalal's 11% impairment was correct; and (3) Employee had disability of 66% to the body as a whole. Judgment was entered in accordance with the court's findings. Employer has appealed from that judgment, asserting that the trial court erred by finding that the presumption of correctness applicable to Dr. Craig's impairment had been overcome by clear and convincing evidence, by adopting Dr. Dalal's impairment rating, by failing to make specific findings of fact to support its award of more than five times the medical impairment, and by finding that Employee did not have a meaningful return to work.

Analysis

The standard of review of issues of fact in a workers' compensation case is de novo upon the record of the trial court accompanied by a presumption of correctness of the findings, unless the preponderance of evidence is otherwise. Tenn. Code Ann. § 50-6-225(a)(2) (2014). When credibility and weight to be given testimony are involved, considerable deference is given the trial court when the trial judge had the opportunity to observe the witness's demeanor and to hear in-court testimony. *Madden v. Holland Grp. of Tenn., Inc.*, 277 S.W.3d 896, 898 (Tenn. 2009) (citing *Tryon v. Saturn Corp.*, 254 S.W.3d 321, 327 (Tenn. 2008)). "When the issues involve expert medical testimony that is contained in the record by deposition, determination of the weight and credibility of the evidence necessarily must be drawn from the contents of the depositions, and the reviewing court may draw its own conclusions with regard to those issues." *Foreman v. Automatic Sys., Inc.*, 272 S.W.3d 560, 571 (Tenn. 2008) (citing *Orrick v. Bestway Trucking, Inc.*, 184 S.W.3d 211, 216 (Tenn. 2006)). "A trial court's conclusions of law are reviewed de novo upon the record with no presumption of correctness." *Id.* (citations omitted).

Rebuttal of MIR Impairment

Employer's first contention is that the trial court erred by finding that Employee successfully rebutted Dr. Craig's impairment rating by clear and convincing evidence, as required by Tennessee Code Annotated section 50-6-204(d)(5). As we stated in *Beeler v. Lennox Hearth Products, Inc.*:

> Tennessee Code Annotated section 50-6-204(d)(5) does not define "clear and convincing evidence." However, the standard by which this proof is measured was articulated by our Supreme Court in *Hodges v. S.C. Toof & Co.*, 833 S.W.2d 896, 901 n.3 (Tenn. 1992), which held: "Clear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the evidence." . . . [B]y operation of Tennessee Code Annotated section 50-6-204(d), the MIR evaluation is presumed the accurate rating—absent clear and convincing evidence to the contrary. That is, if no evidence has been admitted which raises a "serious or substantial doubt" about the evaluation's correctness, the MIR evaluation is the accurate impairment rating. 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.

Beeler v. Lennox Hearth Products, Inc., No. W2007-02441-SC-WCM-WC, 2009 WL 396121, *4 (Tenn. Workers' Comp. Panel Feb. 18, 2009):

In *Mansell v. Bridgestone Firestone North American Tire, LLC*, 417 S.W.3d 393 (Tenn. 2013), our supreme court described several methods by which an MIR impairment could be overcome by clear and convincing evidence:

> [A] Panel has "observed that the presumption found in section 50-6-204(d)(5) *may be rebutted* by affirmative evidence that an MIR physician 'used an incorrect method or an inappropriate interpretation' of the AMA Guides." Another held that "[p]roof that an MIR physician used an incorrect method or an inappropriate interpretation of the AMA Guides *can be used* to overcome the statutory presumption." . . . In any event, "[w]hen 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*."

417 S.W.3d at 411 (alteration in original) (citations omitted).

The trial court found that Employee had successfully rebutted the presumption of correctness attached to Dr. Craig's rating. It explained this finding as follows:

> The presumption of correctness of Dr. Craig's impairment rating is rebutted by clear and convincing evidence that he failed to follow the AMA Guidelines by selecting the rating method that would provide the highest rating. Further, Dr. Craig, with knowledge that Plaintiff's treating physician, Dr. Sickle, had opined Plaintiff had chronic pain from the shoulder injury, did not consider a rating for chronic pain, which would have also produced a higher rating.

Employer argues that the evidence presented at trial does not support the finding that Dr. Craig erred by using the diagnosis-related impairment method, nor does it support the finding that he erred by failing to assign additional impairment. In reviewing this issue, we must focus our attention upon the evidence offered to rebut Dr. Craig's opinion, including Dr. Craig's own testimony, the testimony of the other doctors—particularly Dr. Dalal—and Employee's testimony. *Mansell*, 417 S.W.3d at 411. We further observe that because all medical witnesses testified by deposition, we are able to independently evaluate the weight and credibility of that testimony. *Foreman*, 272 S.W.3d at 571. Employee's witness, Dr. Dalal, issued his report and gave his final deposition prior to Dr. Craig's examination, report, and deposition. Therefore, his testimony addresses Dr.

Craig's method only indirectly. Dr. Dalal's entire testimony concerning the choice between diagnosis-based and range-of-motion assessment was "Q: And does the AMA Guides advise you to use the rating method that produces the higher rating if there is more than one way to assign it? A: Yes."

Although Dr. Dalal did not cite any specific section or page of the Sixth Edition to support his opinion, it appears from other material in the record that he was referring to Table 2-1, Fundamental Principles of the *Guides*, located at page 20. Item 12 of that table states, "If the Guides provides more than one method to rate a particular impairment or condition, the method producing the higher rating must be used." AMERICAN MEDICAL ASS'N, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 20 (6th ed.) [hereinafter AMA GUIDES]. As set out above, Dr. Craig explained that he based his decision to use the diagnosis-related method based on the language of Chapter 15 of the Sixth Edition, which is applicable to upper extremity impairments. That chapter states, in pertinent part:

> Diagnosis-Based Impairments, is the method of choice for calculating impairment. Range of motion is used principally as a factor in the Adjustment Grid. . . . Some of the DBI grids refer to the range of motion section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a ***stand-alone*** rating when other grids refer you to this section or when no other diagnosis-based sections of this chapter are applicable for impairment rating of a condition.

AMA GUIDES 461 (emphasis in original).

In our view, the cited language appears to provide an appropriate basis for Dr. Craig's decision to rate Employee's impairment according to the diagnosis-based model. Dr. Dalal did not address this section of the Sixth Edition in either of his two evidentiary depositions, nor did he address it in his report of September 18, 2013. Further, we note that Dr. Dalal's range-of-motion measurements taken on September 18, 2013, differ substantially from Dr. Curwen's findings on August 8, 2013, and October 31, 2013, as well as Dr. Craig's findings on November 18, 2013. In light of these factors, we are unable to conclude that Dr. Dalal's testimony raises a serious or substantial doubt about the correctness of Dr. Craig's use of the diagnosis-based model to evaluate Employee's impairment based on the diagnosis model.

As set out above, the trial court also found that Dr. Dalal's testimony established by clear and convincing evidence that Dr. Craig erred by failing to add an additional 3% impairment for chronic pain. Chronic pain is addressed in Chapter 3 of the Sixth

Edition. AMA GUIDES 39. At page 39, that chapter states, "In no circumstances should the [pain-related impairment] developed using this chapter be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 to 17." *Id.* Dr. Dalal explained his decision to use pain-related impairment as an add-on to the rating he assigned pursuant to Chapter 15 of the Sixth Edition as follows:

> Well, what I have stated is the Guide has confused its own chapter. They have said not to use as an add on, but then they wrote the chapter on pain management to give an impairment due to pain. So they recognized there is an issue, but they don't recognize or have not included that the patients could have multiple surgeries on the same body part and that cannot be addressed just by the entity of rating them from the disease.

As we understand this passage, Dr. Dalal conceded that the Sixth Edition does not permit pain-related impairment to be used as an add-on to impairments derived from other chapters. However, he found the section addressing pain-related impairment to be confusing and simply disagreed with the authors' decision to limit the use of such impairments to conditions not addressed in the other chapters of the Sixth Edition. His philosophical disagreement with the explicit instructions set out on page 39 may be sincere. However, it is not clear and convincing evidence that Dr. Craig used either an incorrect method or inappropriate interpretation of the Sixth Edition of the AMA Guides. Having reached this conclusion, we disagree with the trial court's finding that Dr. Dalal's testimony rebutted the presumption of correctness assigned by statute to Dr. Craig's impairment rating. In addition, the testimony of the other witnesses merely established that Employee experienced chronic pain, not that Dr. Craig's methodology was incorrect. Thus, we conclude that the correct impairment is 4% to the body as a whole.

Specific Findings to Support Award

Tennessee Code Annotated section 50-6-241(d)(2)(A) states that in cases where the injured employee does not return to work for the pre-injury employer, the trial court may award permanent partial disability benefits up to six times the medical impairment. However, section 50-6-241(d)(2)(B) provides, "If the 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." Our supreme court has stated that an award of five times the impairment or more requires specific findings "as to [the employee's] 'skills and training,' or as to 'local job opportunities' or 'capacity to work at types of employment available in claimant's disabled condition.'" *Orrick,* 184 S.W.3d at

218 (quoting Tenn. Code Ann. § 50-6-241(c) (West 2006), *repealed by* 2013 Pub. Acts, c. 289, § 89 (corresponds to Tenn. Code Ann. § 50-6-241(d)(2)(A) (2014)).

The trial court based its decision to award six times the medical impairment on Employee's:

> age, education, work experience, her training, job skills, and the job opportunities available to a person with the disabilities she has. This is further justified by her chronic pain diagnosis, ongoing treatment, her three surgeries in the same area, and her doctors all opining she should not do any strenuous activity or lift over ten pounds.

The trial court's recitation of the generic factors listed throughout section 50-6-241 ("age, education, work experience, her training, job skills, and the job opportunities available to a person with the disabilities she has") do not amount to specific findings as to any of those factors. However, the court also gave additional, specific findings to support its decision, including Employee's ongoing medical treatment and the significant medical restrictions imposed on her due to her injury. We conclude that these findings sufficiently support the trial court's decision to satisfy the requirements of section 50-6-241(d)(2)(B). Therefore, we affirm that portion of the judgment.

Meaningful Return to Work

Finally, Employer contends that the trial court erred by finding that Employee did not have a meaningful return to work. It points out that Employer created a job specifically designed to accommodate her medical restrictions. Further, her written letter of resignation did not mention pain or inability to perform her job as a specific reason for her resignation. In *Tryon v. Saturn Corp.*, 254 S.W.3d 321 (Tenn. 2008), our supreme court analyzed numerous prior cases that addressed the meaningful return to work issue. Among other things, the court stated, "These decisions provide that an employee has not had a meaningful return to work if he or she returns to work but later resigns or retires for reasons that are reasonably related to his or her workplace injury." *Id.* at 328-29 (citations omitted). More specifically, the court noted that an employee who attempts to work but leaves because her "workplace injury caused too much pain to permit the employee to continue working" may not have had a meaningful return to work and therefore may be eligible for an award of benefits in excess of the lower cap. *Id.* at 329; *see also Howell v. Nissan N. Am., Inc.*, 346 S.W.3d 467, 473 (Tenn. 2011).

From the time Employee began to see Dr. Nord in February 2009 until she was released by Dr. Sickle in August 2013, Employee was restricted from working by her

physicians from time to time but otherwise continued to work for Employer while under temporary restrictions. After her release, she was placed in a position specifically designed to accommodate her restrictions. She testified that she worked in pain throughout her period of treatment, even while working in the specially-designed position, and that she retired because she was "tired of hurting." The trial court found that Employee "resigned her job because of her chronic pain, which persisted even while working within her restrictions, and her medical providers generally all agreed she should stop working at her factory setting job." It is apparent from this finding that the court accredited Employee's testimony on this subject. *See Howell*, 346 S.W.3d at 472-73. Moreover, the records and testimony of Dr. Nord, Dr. Sickle, and Dr. Curwen support Employee's testimony. All of these doctors frequently found pain and tenderness in the shoulder during routine examinations. Under these circumstances, we are unable to conclude that the evidence preponderates against the trial court's finding.

Conclusion

The trial court's finding that the opinion of the MIR physician's impairment rating was rebutted by clear and convincing evidence is reversed. We find that Employee sustained a medical impairment of 4% to the body as a whole due to her work injury. The judgment is modified to award 24% permanent partial disability to the body as a whole. It is affirmed in all other respects. The case is remanded to the trial court for entry of an order consistent with this opinion. Costs are taxed one-half to Mamie Marshall and one-half to Pinnacle Food Group and its surety, for which execution may issue if necessary.

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ROGER A. PAGE, JUSTICE

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

MAMIE MARSHALL v. PINNACLE FOOD GROUP

Chancery Court for Madison County
No. 70293

No. W2015-00382-SC-R3-WC – Filed October 27, 2016

JUDGMENT ORDER

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 are assessed one-half to Mamie Marshall and one-half to Pinnacle Food Group and its surety, for which execution may issue if necessary.

It is so ORDERED.

PER CURIAM