

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION  
WCC NO. H107730**

<b>GARY W. NORRIS, EMPLOYEE</b>	<b>CLAIMANT</b>
<b>CITY OF NORTH LITTLE ROCK, SELF-INSURED EMPLOYER</b>	<b>RESPONDENT</b>
<b>ARK. MUN. LEAGUE, THIRD-PARTY ADMINISTRATOR</b>	<b>RESPONDENT</b>

**OPINION FILED JANUARY 18, 2023**

Hearing before Administrative Law Judge O. Milton Fine II on October 25, 2022, in Little Rock, Pulaski County, Arkansas.

Claimant represented by Mr. Andy L. Caldwell, Attorney at Law, Little Rock, Arkansas.

Respondents represented by Ms. Carol Lockard Worley, Attorney at Law, Little Rock, Arkansas.

**STATEMENT OF THE CASE**

On October 25, 2022, the above-captioned claim was heard in Little Rock, Arkansas. A prehearing conference took place on September 7, 2022. The Prehearing Order entered on September 8, 2022, pursuant to the conference was admitted without objection as Commission Exhibit 1. At the hearing, the parties confirmed that the stipulations, issues, and respective contentions, as amended, were properly set forth in the order.

**Stipulations**

The parties discussed the stipulations set forth in Commission Exhibit 1.

Following amendments at the hearing, they read:

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1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The employee/self-insured employer/third-party administrator relationship existed at all relevant times, including September 14, 2021, when Claimant sustained compensable injuries to his right upper and left lower extremities. Respondents accepted these injuries as compensable and paid certain benefits in connection therewith.
3. Claimant's average weekly wage entitles him to compensation rates of \$586.00/\$439.00.
4. Claimant was assigned an impairment rating of thirteen percent (13%) to the upper extremity in connection with his stipulated compensable right upper extremity injury. This rating should be assigned to 244 weeks, per Ark. Code Ann. § 11-9-521(a)(1) (Repl. 2012).

### Issues

At the hearing, the parties discussed the issues set forth in Commission Exhibit

1. After amendments at the hearing, the following were litigated:
  1. Whether Claimant is entitled to certain alleged unpaid medical expenses in connection with his stipulated compensable injuries.
  2. Whether, and to what extent, Claimant is entitled to a controverted attorney's fee under Ark. Code Ann. § 11-9-715 (Repl. 2012) in connection with his stipulated impairment rating of thirteen (13%) to the right upper extremity.

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All other issues have been reserved.

Contentions

The respective contentions of the parties, following amendments at the hearing, are as follows:

Claimant:

1. Claimant sustained compensable injuries to his left knee and right arm in the course and scope of his employment when he fell while doing an HVAC inspection on September 14, 2021. He is entitled to the payment of reasonable and necessary medical expenses, out-of-pocket expenses, mileage reimbursement, additional anatomical impairment for his injuries, and an attorney's fee.
2. Claimant continues to be billed by Baptist Health in the amount of \$850.00 for treatment related to his compensable knee injury—specifically, anesthesia rendered in connection with his surgery. Respondents have known about this bill for over a year, but have failed/refused to pay for same. Claimant's credit rating should not be negatively affected by Respondents' action/inaction in this regard.
3. Dr. Mark Tait assigned Claimant an impairment rating of thirteen percent (13%) to the upper extremity for his compensable right upper arm injury. Claimant should have been entitled to 31.72 weeks of permanent partial disability benefits for same under Ark. Code Ann. § 11-9-521(a)(1) (Repl. 2012). But Respondents have paid/are paying Claimant 23.79 weeks in

that they used the elbow-to-wrist reference in the statute (183 weeks – § 11-9-521(a)(2)). Claimant is entitled to the underpayment on the rating (7.93 weeks). After Respondents sent Claimant correspondence that incorrectly used the 183-week standard, Claimant's counsel reached out to Respondents' counsel; and the later agreed with the former that the wrong standard was being used. Therefore, Claimant's counsel is entitled to a controverted attorney's fee on the 7.93 weeks' worth of benefits.

Respondents:

1. Respondents contend that all appropriate benefits have been and are continuing to be paid with regard to this matter. Medical benefits have been afforded to Claimant and bills have been paid. With regard to the unpaid medical bill from Baptist Health, Respondents have been unable to get a properly submitted bill under AWCC R. 099.30. As a result, the bill cannot be sent to the auditing company for payment. Claimant should not have his credit adversely affected by the unpaid bill because Rule 30 prohibits balance billing.
2. Claimant has been assigned permanent impairment ratings by his treating physicians. Both ratings have been accepted and are being paid out. No part of the ratings that Claimant has been assigned has been controverted.

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

After reviewing the record as a whole, including medical reports, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the witnesses and to observe their demeanor, I hereby make the following findings of fact and conclusions of law in accordance with Ark. Code Ann. § 11-9-704 (Repl. 2012):

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The stipulations set forth above are reasonable and are hereby accepted.
3. Issue No. 1, concerning the non-payment by Respondents of a bill for anesthesiology services rendered Claimant in connection with treatment of his stipulated left knee injury, will not be addressed. Instead, it will be considered reserved.
4. Claimant has proven by a preponderance of the evidence that Respondents controverted his entitlement to a thirteen percent (13%) impairment rating under Ark. Code Ann. § 11-9-521(a)(1) (Repl. 2012), as opposed to the lesser-valued rating they accepted under § 11-9-521(a)(2), in connection with his stipulated compensable right upper extremity injury. Thus, his counsel, the Hon. Andy Caldwell, is entitled under Ark. Code Ann. § 11-9-715 (Repl. 2012) to a controverted fee on the additional 7.93 weeks' worth of permanent partial disability benefits to which Claimant is entitled under § 11-9-521(a)(1). At Claimant's stipulated permanent partial

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disability rate of \$439.00 per week, this fee is valued at \$870.32. Claimant and Respondents each owe half of this, or \$435.16, to Mr. Caldwell pursuant to § 11-9-715(a)(2)(B)(i). These monies are to be paid in accordance with this provision.

### **CASE IN CHIEF**

#### **Summary of Evidence**

The witnesses were Claimant and Andrea Sayre.

Along with the Prehearing Order discussed above, the exhibits admitted into evidence in this case were Claimant's Exhibit 1, a compilation of his medical records, consisting of two index pages and 222 numbered pages thereafter; Claimant's Exhibit 2, non-medical documents, consisting of a one index page and eight numbered pages thereafter; Respondents' Exhibit 1, non-medical documents, consisting of a one index page and 24 numbered pages thereafter; and Respondents' Exhibit 2, another compilation of Claimant's medical records, consisting of a one-page index and 36 numbered pages thereafter.

In addition, I have blue-backed<sup>1</sup> to the record the prehearing questionnaire responses filed by Claimant on April 18, August 11, and October 18, 2022, respectively,

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<sup>1</sup>At the hearing, I indicated that without objection, the prehearing questionnaire responses of the parties would "be incorporated by reference" in order to set out the respective contentions of the parties, since those were not included in the September 8, 2022, Prehearing Order. [T. 20] Respondents' counsel spoke up to make sure that all three of Claimant's filings were being incorporated, arguing that they contained information bearing on the issue concerning whether her clients had controverted Claimant's entitlement to a controverted fee on any portion of the impairment rating that

and consisting of three, three, and four numbered pages, respectively; and the

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he had been assigned regarding his stipulated compensable right upper extremity injury. [T. 20-21] In commenting on this, I remarked as follows:

. . . we're going beyond the simple matter of here are the respective contentions of the parties as they have stated them in their pre-hearing questionnaire responses. This is going more to, perhaps, substantive evidence along the lines of whether or not Respondents actually controverted any portion of the 13% rating . . . because it's one thing to simply incorporate them in so I can be able to correctly conceptualize and set out what your respective contentions are. It's another matter altogether if you're wanting them in for some type of substantive evidence on the controversion issue, and that's why I was going to [flesh] this out. We're not even yet to the matter of the exhibits. We're still on just sorting out the contents of the Prehearing Order, believe it or not. So maybe I should even hold my tongue on this and move on, because both of you have agreed—as I understand it, you have agreed to having the prehearing questionnaire responses come in for the purposes of just me being able to restate your contentions. Maybe I should just move on from there and we can talk about the documentary evidence at the appropriate time.

[T. 21, 24] Evidence, once admitted, may be considered by the trier of fact for any legitimate purpose. *See, e.g., Spicer v. State*, 32 Ark. App. 209, 799 S.W.2d 562 (1990)(evidence of defendant's refusal to submit to chemical test admissible as circumstantial evidence showing consciousness of guilt, and also relevant to issue of intoxication). Under Ark. R. Evid. 105:

Whenever evidence which is admissible as to one [1] party or for one [1] purpose but not admissible as to another party or for another purpose is admitted, the court, upon request, shall restrict the evidence as to its proper scope and instruct the jury accordingly.

This proceeding was a bench trial. Moreover, Ark. Code Ann. § 11-9-705(a)(1) (Repl. 2012) provides that the “Commission shall not be bound by technical or statutory rules of evidence . . . but may . . . conduct the hearing, in a manner as will best ascertain the rights of the parties.” Consequently, these prehearing filings, admitted into evidence, may be—and will be—considered not only for the purpose of correctly setting out the respective contentions of the parties, but will also be given due weight in determining whether and to what extent Respondents controverted the upper-extremity impairment

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prehearing questionnaire response filed by Respondents on August 26, 2022, and consisting of three numbered pages.

Adjudication

A. Outstanding Medical Bill

Claimant, who was employed by Respondent City of North Little Rock on September 14, 2021, suffered stipulated compensable injuries on that date. He testified that he was employed there as an HVAC/mechanical inspector, and was hurt in the following episode:

I went to a residence and went up into his—a new residence, no one lived there. I went into the attic and I was lookin' at the heat and air unit, and the electrical was messed up on it, and I was—I'm trying to make it short and sweet—so I was lookin' at the electrical and then it was all messed up and it had failed, so when I turned around, I—there was some debris on the floor and I stepped on it, my feet went backwards and I fell forward and landed on the ductwork, and the two-inch metal strapping caught me in the middle of my arm as I fell.

[T. 31-32]

Not only did Claimant suffer severe lacerations of his right upper extremity as a result of his work-related fall—including a transection of his brachial artery that necessitated surgery that same day—but he hurt his left knee as well. Eventually, on November 5, 2021, he had to undergo an operation on that as well. This consisted of an arthroscopy with meniscectomy. Claimant related that he has been getting a bill for \$850.00 in connection with his knee surgery.

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rating. It was thus unnecessary for their admission to be addressed yet again when the other documentary evidence was being offered into evidence. [T. 27-29]



Andrea Sayre, the workers' compensation adjustor for Respondent Arkansas Municipal League, testified that she has handled the instant claim since its inception.

The following exchange took place during her examination:

Q. Let's talk first about the bill. Can you tell the Judge what your efforts have been to get payment of the bill—the \$850.00 bill that's outstanding in this one?

A. Yes. I've made multiple attempts to get the actual HCFA. I've spoken with multiple people. I've sent letters and I've sent emails requesting the HCFA, and to date have not received it.

Q. Okay. And we have introduced here today your efforts on that, and I think they are at Claimant's Exhibit 2 [sic—actually Respondents' Exhibit 1], starting at page 20. Andrea, can you pay a medical bill without getting a HCFA form?

A. No.

Q. Does Rule 30 require that you have that?

A. Yes.

Q. And what all is involved with obtaining that? Would it just be UAMS, or whoever is sending this bill, to send you the proper statement?

A. That's correct.

Q. Okay. And have you gotten any explanation from them as to why that hasn't been done?

A. No, I have not.

[T. 44-45]

The documentation in Respondents' Exhibit 1, as outlined by Sayre, reflects that Baptist Health has sent Claimant on multiple occasions a bill for \$850.00. This was for

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anesthesiology services in connection with his knee operation. In correspondence to Baptist Health dated January 26, 2022, Sayre wrote:

To Whom It May Concern:

Mr. Norris received the statement included in relation to his workers['] compensation injury. In order for payment to be made, we are requesting the following:

1. A HCFA 1500 claim form or UB claim form
2. Medical records for the outstanding bill

The exhibit does not reflect that the requested items were sent. Instead, Baptist Health simply re-sent the original statement for \$850.00. Email correspondence in the exhibit reflect that Sayre followed up on this matter on September 20 and October 12, 2022.

According to AWCC R. 099.30 Part I, Section (I)(4), "Billing for provider services shall be submitted on the forms approved by the Commission: UB-92 and HFCA-1500 [sic—should be 'HCFA-1500']." Subsection (10) states that carriers may return bills that are not on the proper form so that they can be corrected and resubmitted; but they must take this action within 20 days of receipt of the bill.

Parts II and III of Rule 30 set out the procedure for resolving a billing dispute between a provider and a carrier. The role of an administrative law judge in this matter is to review such matters on appeal, pursuant to Part III, Section (A)(3). That is not the proceeding at hand. Moreover, the general test for standing is whether the person attempting to raise an issue has suffered an "adverse impact." *See, e.g., Pitchford v. City of Earle*, 2019 Ark. App. 251, 576 S.W.3d 103. Since under Part I, Section (I)(6)(b) of Rule 30, the provider cannot instead attempt to collect the bill, or any portion thereof,

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from the claimant who received the service, it does not appear that Claimant has suffered an “adverse impact” by the non-payment of the anesthesiology bill for the purpose of conferring standing to raise this issue. *See also Nelson v. Ark. Rural Practice Med. Practice Loan & Scholarship Bd.*, 2011 Ark. 491, 385 S.W.3d 762 (claimant must have a “personal stake” in outcome of controversy in order to have standing regarding such). For these reasons, Issue No. 1 will not be addressed. Instead, it will be considered reserved.

B. Controversion

In addition, Claimant has argued that his attorney should be entitled to a controverted fee in connection with the permanent partial disability benefits he received for the permanent impairment of his right upper extremity. Boiled down, his position is that counsel’s efforts resulted in Respondents using a different provision of the statute that governs the valuation of his permanent partial disability benefits; that in the process, the amount of benefits that he received increased; and that counsel should collect a statutory fee on the amount of this increase.

Arkansas Code Annotated Section 11-9-715 (Repl. 2012) is the authority in this matter. This provision reads in pertinent part:

(B) Attorney’s fees shall be twenty-five percent (25%) of compensation for indemnity benefits payable to the injured employee or dependents of a deceased employee . . . In all other cases whenever the commission finds that a claim has been controverted, in whole or in part, the commission shall direct that fees for legal services be paid to the attorney for the claimant as follows: One-half (½) by the employer or carrier in addition to compensation awarded; and one-half (½) by the injured employee or dependents of a deceased employee out of compensation payable to them.

(ii) The fees shall be allowed only on the amount of compensation for indemnity benefits controverted and awarded.

*Id.* § 11-9-715(a)(1)(B) & (a)(2)(B)(i)-(ii). One of the purposes of the attorney's fee statute is to put the economic burden of litigation on the party who makes litigation necessary. *Brass v. Weller*, 23 Ark. App. 193, 745 S.W.2d 647 (1998).

The evidence reflects that on January 26, 2022, Dr. Mark Tait assigned Claimant an impairment rating in connection with his stipulated right upper extremity injury, writing:

[T]his is an established patient who has been followed for antecubital fossa wound after arm revascularization work injury on 09/14/2021 . . . [i]n accordance with the American Medical Association [G]uides to the [E]valuation of [P]ermanent [I]mpairment 4<sup>th</sup> [Edition]. Patient has impairment of wrist looking at figure 26/29/35 on pages 3/36, 3/38, and 3/41 of 6% of upper extremity and [o]n page 3/30 to, 3/33, and 3/30 figures 19/21/23 patient has impairment as follows: Index – 4%, long – 3%, right – 2%, small -0%. On page 3/18 and 3/19 [o]n table 1 and 2 this is a 2% loss of hand function. He also has significant decreased grip strength. Therefore has as an 8% loss due to motion and an additional 5% loss secondary to likely permanent grip strength loss. Therefore 13% permanent impairment of the upper extremity is representative of his long-term requirement [sic].

Per DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 730 (30<sup>th</sup> ed. 2003), "cubital fossa" is "the depression in the anterior region of the elbow." Injuries at or above the elbow are governed by § 11-9-521(a)(1), which sets the amount of total loss as being worth 244 weeks' worth of benefits. Injuries between the elbow and the wrist, on the other hand, are entitled only to a maximum of 183 weeks under § 11-9-521(a)(2).

A thirteen percent (13%) rating thus merits 31.72 weeks under the former provision, and only 23.79 weeks under the latter. In a letter to Claimant from Sayre

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dated February 15, 2022, that is in evidence, she informed Claimant that the rating that Tait assigned him “equals 23.79 weeks at your permanent partial compensation rate of \$440.00 for a total dollar figure of \$10,467.60.” This miscalculation, per the evidentiary record, remained unchanged until Claimant’s counsel filed his second prehearing questionnaire response on August 11, 2022. Therein, counsel included the following contention:

Dr. Tait assigned the Claimant a 13% impairment rating to the right upper extremity for the distal biceps injury. The Claimant should have been entitled to 31.72 weeks for same. Respondents paid the Claimant 23.79 weeks in that they used elbow to wrist (183 weeks). Claimant is entitled to the underpayment on the rating and the undersigned is entitled to an attorney’s fee for same.

Thereafter, on September 13, 2022, Respondents’ co-counsel sent Claimant’s attorney a letter and spreadsheet indicating that \$14,080.00<sup>2</sup> had been paid toward his upper and lower extremity ratings, and that \$7,972.80 remained unpaid. Claimant’s lower extremity rating is worth \$8,096.00. That means that Respondents in this correspondence conceded at that point that the upper extremity rating was actually worth \$13,956.80, or 31.72 weeks’ worth of benefits. They repeated this concession at the hearing, agreeing to Stipulation No. 4.

During Sayre’s testimony, she related that the impairment rating was initially applied against the 183-week standard because (in the words of Respondents’ counsel) “[there was] no real indication there was elbow involvement.” [T. 46] However, the

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<sup>2</sup>According to the spreadsheet in evidence, Respondents have been paying permanent partial disability benefits at the rate of \$440.00 per week. This is slightly higher than his stipulated compensation rate, \$439.00. *See infra*.

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analysis above clearly shows otherwise. As to the reason and timing of Respondents' change to the 244-week standard, the following exchange took place when Sayre was on the witness stand:

Q. And at some point and time, why is that you accepted the 244 weeks instead of the 183?

A. I[t] was brought to my attention with communication review that it was calculated at the incorrect rate, and at that point I saw what happened and accepted that is correct; it should be at the 244.

Q. And was that in April of '22?

A. I believe it was—yes, '22.

Q. Okay.

A. I forgot what year it was.

Q. And did you ever send a letter to the Claimant after that?

A. No.

Q. Is there a reason why?

A. I can assume it wasn't sent. It was not scanned in our system. There was really no reason.

[T. 47-48]

Sayre did not explain the source of this "communication" that she reviewed. Furthermore, she could not remember what year this change in position occurred, even though it purportedly happened only approximately six months prior to the hearing. Finally, Sayre offered no explanation why there was no communication to Claimant after this purported change in April 2022. Instead, the evidence bears out that such a communication did take place: by way of the September 13, 2022, letter from

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Respondents' co-counsel, which came slightly more than a month after Claimant's second pre-hearing questionnaire response. In resolving an issue such as the one at bar, the undersigned under Ark. Code Ann. § 11-9-704(c)(4) (Repl. 2012) must "weigh the evidence impartially and without giving the benefit of the doubt to any party." As the party requesting award of the controverted fee, Claimant under Ark. Code Ann. § 11-9-705(a)(3) (Repl. 2012) must prove his entitlement to the relief requested by a preponderance of the evidence. This standard means the evidence having greater weight or convincing force. *Barre v. Hoffman*, 2009 Ark. 373, 326 S.W.3d 415; *Smith v. Magnet Cove Barium Corp.*, 212 Ark. 491, 206 S.W.2d 442 (1947). I cannot credit Sayre's testimony on this point. Instead, the evidence shows that it was the efforts of Claimant's counsel that led to Respondents' decision to apply the impairment rating to the 244-week standard.

Thus, Claimant has proven by a preponderance of the evidence establishes that his counsel is entitled to a controverted fee under § 11-9-715 on  $31.72 - 23.79 = 7.93$  weeks' worth of permanent partial disability benefits to which Claimant is entitled in connection with his stipulated compensable right upper extremity injury. At his stipulated permanent partial disability rate of \$439.00 per week, this fee is valued at \$870.32. Claimant and Respondents each owe half, or \$435.16, under the above-quoted statutory provision; and such should be paid in accordance therewith.

### **CONCLUSION AND AWARD**

Judgment is hereby rendered in accordance with the findings of fact and conclusions of law set forth above.

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**IT IS SO ORDERED.**

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Hon. O. Milton Fine II  
Chief Administrative Law Judge