BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION
CLAIM NO. H405060

LYNN BATTLES, EMPLOYEE	**CLAIMANT**
T & A SANDERS, LLC, EMPLOYER	**RESPONDENT**
STATE FARM FIRE & CASUALTY CO, CARRIER/ SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., TPA	**RESPONDENT**

OPINION FILED 23 JUNE 2026

Heard before Arkansas Workers' Compensation Commission Administrative Law Judge JayO. Howe on 9 April 2026 in Pine Bluff, Arkansas.

The Davis Law Firm, Mr. Gary Davis, appeared for the claimant.

Worley, Wood & Parrish, P.A., Ms. Melissa Wood, appeared for the respondents.

I. STATEMENT OF THE CASE

A Prehearing Order was filed on 3 February 2026 and admitted to the record as Commission's Exhibit № 1.

STIPULATIONS

Following an amendment at the hearing, the parties agreed to the following Stipulations:

1. The Arkansas Workers' Compensation Commission (the Commission) has jurisdiction over this claim.

2. The employer/employee/carrier-TPA relationship existed on 20 May 2024, when the claimant is alleged to have suffered compensable injuries to his back and neck.

3. The claimant's wages at the time relevant to this claim would entitle him to a weekly benefit amount of $125 for both Permanent Partial Disability (PPD) and Temporary Total Disability (TTD).

4. The respondents have controverted this claim in its entirety.

ISSUES TO BE LITIGATED AT HEARING

Following an amendment at the hearing, the parties agreed to litigate the following:

1. Whether the claimant sustained compensable injuries by specific incident to his back and neck.

2. Whether the claimant is entitled to TTD benefits from the date of his claimed injuries to a date yet to be determined.

3. Whether the claimant is entitled to reasonable and necessary medical benefits.

4. Whether the claimant is entitled to an attorney's fee.

All other issues are reserved.

CONTENTIONS

The parties' Contentions were set out in their respective Prehearing Questionnaire Responses and were amended at the hearing to read:

Claimant

The Claimant contends he sustained compensable injuries on 20 May 2024. Claimant contends entitlement to payment of temporary total disability benefits from the date of injury and continuing through a date yet to be determined. Medical expenses have been incurred and are being paid by other insurance. This claim has been entirely controverted for purposes of attorney's fees.

Claimant's attorney respectfully requests that any attorney's fees owed by claimant on controverted benefits paid by award or otherwise be deducted from claimant's benefits and paid directly to claimant's attorney by separate check, and that any Commission Order direct the respondent to make payment of attorney's fees in this manner.

Respondents

The Respondent contends that Claimant did not sustain a compensable injury on 20 May 2024 or at any other time while working for Respondent-Employer. Claimant's issues with his neck and back were preexisting. Respondents had no notice of the alleged injury until the Form C was filed with the Commission on 17 August 2024.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the record as a whole, including the evidence summarized below, and having heard testimony from the claimant, observing his demeanor, I make the following Findings of Fact and Conclusions of Law under Ark. Code Ann. § 11-9-704:

1. The Commission has jurisdiction over this claim.

2. The Stipulations as set forth above are reasonable and are hereby accepted.

3. The claimant has failed to prove by a preponderance of the evidence that he sustained compensable injuries by specific incident to his neck and back.

4. Because the claimant has failed to prove a compensable injury, the other issues listed above are moot and will not be addressed in this Opinion.

III. ADJUDICATION

The stipulated facts as outlined above are reasonable and accepted. It is settled that the Commission, with the benefit of being in the presence of a witness and observing their demeanor, determines a witness' credibility and the appropriate weight to accord their statements. *Wal-Mart Stores, Inc. v. VanWagner*, 337 Ark. 443, 990 S.W.2d 522 (1999). A claimant's testimony is never considered uncontroverted. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S.W.2d 457 (1994). The determination of a witness' credibility and how much weight to accord to that person's testimony are solely up to the Commission. *White v. Gregg Agricultural Ent.*, 72 Ark. App. 309, 37 S.W.3d 649 (2001). The Commission must sort through conflicting evidence and determine the true facts. *Id.* In so doing, the Commission is not required to believe the testimony of the claimant or any other witness but may accept and translate into findings of fact only those portions of the testimony that it deems worthy of belief. *Id.*

SUMMARY OF THE EVIDENCE

The claimant was the only witness at the hearing. The record consists of the hearing transcript, which includes following exhibits: Commission's Exhibit № 1 (the 3 February

2026 Prehearing Order); Claimant's Exhibit № 1 (one index page and 30 pages of medical records); Claimant's Exhibit № 2 (one index page and 36 additional pages of medical records); Respondents' Exhibit № 1 (two index pages and 196 pages of medical records); Respondents' Exhibit № 2 (one index page and 52 pages of non-medical records); and Respondents' Exhibit № 3 (the transcript of Dr. Wayne Bruffett's 25 September 2025 deposition).

Claimant's Testimony

The claimant is seventy-three years old, with a high school education. He began working as a maintenance man for the respondent-employer (Sanders) in 2009. Sanders owns various properties, including a cemetery and an apartment complex. The claimant helped with manual labor of all sorts at those properties.

According to his testimony, the claimant was carrying a ladder down some stairs at the apartment building on 20 May 2024 when he slipped and fell. He said that he felt a sharp pain in his neck and his back and that he reported the fall and injury to Sanders that day. Dr. Jason Smith subsequently treated him. The claimant described his symptoms after the fall as, "My nerves was messed up. I could not move, couldn't walk, could not have walked." [TR at 23.] He said that he had trouble with his hands and that he had sharp pains and weakness down both legs. While he acknowledged a past medical history that included neck and back problems and surgeries, he denied being unable to work before his alleged accident. But he has not returned to work since his fall. He also stated that Sanders continued to pay him after he stopped working due to his alleged injuries and that the reason for doing so was to avoid any potential interruption in his Social Security disability benefits if workers' compensation benefits began to be reported.

On cross-examination, the claimant testified that his disability designation for Social Security benefits dated back to 1982. His lower back was listed as the reason for his

disability. At his deposition for this claim, the claimant denied any prior history of neck or back pain. He acknowledged at the hearing, however, that he had been treating for ongoing back and neck problems for some time. His prior doctor visits had included complaints of pain and weakness in his legs, pain throughout his back, pain and tightness in his arms and hands, neck pain and numbness in his hands, a history of falls, past surgeries, recommendations for additional surgeries, having to use a walker, and a recent recommendation for a powered wheelchair. All of those predated his alleged fall and injuries in this claim. He denied, though, that he was unable to work because of those complaints and/or conditions.

Dr. Wayne Bruffett's Deposition

Dr. Bruffett discussed the claimant's treatment history and past surgeries. Based on his review of the records and imaging, neither the claimant's clinical condition nor his ability to work were changed by the incident fall that was alleged to have occurred on 20 May 2024. His testimony was consistent with his written report. [Resp. Ex. № 3.]

Medical and Documentary Evidence

On 21 February 2022 (more than two years before the fall and injuries alleged in this claim), the claimant presented to Dr. Smith with complaints of back pain and pain with tingling and numbness in both legs. According to the note from that visit:

> This is a 69-year-old male patient who returns after having MRI scan of lumbar spine. This shows multilevel severe spinal stenosis, notably severe at L3-4 severe at L4-5, and severe bilateral foraminal narrowing at L5-S1. He has had ongoing weakness to his legs and unsteadiness on his feet. Physical therapy has not been beneficial.…

An imaging report from that visit included:

> IMPRESSION
> 1. Multilevel degenerative disc disease and facet arthropathy with severe spinal canal stenosis at L3-L4 and L4-L5.
> 2. Severe bilateral foraminal stenosis at L5-S1.

[Resp. Ex. № 1 at 1-5.]

He returned to the clinic on 10 August 2022 complaining of pain and cramping in his legs. The note from that visit references at least one fall and includes, in part, the following:

> This is a 70-year-old male patient who underwent L3-S1 decompression on March 7, 2022. He was doing quite well for about 3 months, then took a fall, and recently took a hard step into a hole. Since that time he has had a new onset lateral thigh pain bilaterally into the calves with cramping. A new MRI scan shows residual significant foraminal stenosis at L4-5 and L5-S1, and mild stenosis at L4-5 centrally. He is feeling a bit better, with less leg pain, but it is still troubling him on a daily basis.

[*Id*. at 8-11.]

On 28 September 2022, the claimant first presented to Arkansas Spine and Pain (ASP) for a new patient consultation. He reported that his pain level was an 8 out of 10 on that day. The records form that visit include, in part, the following:

> ASSESSMENT
> Patient is a very pleasant 70-year-old male referred from Dr. Jason Smith for further evaluation and treatment of chronic pain.
>
> 1. Lumbar radiculopathy, Lumbar facet arthropathy, bilateral SIJ arthropathy- currently has lower back pain and tightness, prior to LESI on 8/25/2022 had pain into legs bilaterally in L5 distribution. Uses a walking cane for ambulation.
> S/P lumbar L3-4, 4-5 decompression with Dr. Smith 3/7/2022, then L5S1 ESI on 8/25/2022, relieved leg pain, until he fell hard, caused return of leg pain. Has continued to have lower back pain post injection. Reports had epidurals in past through Baptist- always helped about a year.
> Reports only had PT for a day and for lower back only, pain was too much to continue.
> LMRI 7/28/2022 from Dr. Smith referring records.
>
> 2. Cervical facet arthropathy/radiculopathy- reports axil pain and tightness, into arms bilaterally to hands, bilateral thumbs numb, left 4th and 5th fingers numb. Reports throbbing sensation in arms.
> He has not had spinal injection in neck in past.
> S/P C4-5 ACDF with Dr. Christian in LR 5/2005.
>
> 3. Multiple joint pain.
>
> 4. Chronic pain syndrome- has not been taking pain medication chronically
> . . .

> ICD: History of lumbar fusion
> ICD: History of fusion of cervical spine
> ICD: DDD (degenerative disc disease), cervical
> ICD: DDD (degenerative disc disease), lumbar
> ICD: Foraminal stenosis of lumbosacral region
> . . .

[Resp. Ex. № 1 at 15-16.] Additional records reflect regular visits to ASP after that initial consultation.

The claimant returned to Dr. Smith's clinic again on 26 June 2023 with concerns of "crippling back pain." The subjective section of the note indicates that *the claimant suffered a fall while working at the Parkview Apartments*, that his pain was at a 9 out of 10, that he was using a cane or walker to assist his mobility (emphasis added). The "duration" of the pain was listed as one year. Notes from that visit also provide, in part, the following:

> ASSESSMENT/PLAN
> The patient is a 71-year-old gentleman who underwent a L3-4, L4-5, L5-S1 decompression early 2022. He did quite well for several months but unfortunately began to develop increasing back pain and radiating leg pain. He has been through physical therapy without benefit at JRMC and has been to pain management with epidural steroid injections and facet rhizotomies. Unfortunately, [he] continues to have significant low back pain and radiating posterior lateral thigh pain bilaterally. He also has been having some neck pain and numbness to the tips of the index and middle fingers as well as thumb [on] both hands…
>
> IMPRESSION
> Lumbar recurrent spinal stenosis and cervical spinal stenosis. *I think it is reasonable for him to have a powered wheelchair*. We will forward this note to his primary care physicians at the AHEC in Pine Bluff so that they can *help him get a powered wheelchair*. In the meantime, we are ordering an MRI scan of the cervical and lumbar spine. He will follow-up with us after this is completed. (emphasis added)

[Resp. Ex. № 1 at 75-77.]

After completing another MRI study, the claimant returned to Dr. Smith on 30 June 2023. The note from that visit includes, in part, the following:

> ASSESSMENT/PLAN
> Mr. Battles returns having had MRI scan of the cervical and lumbar spine. He has ongoing unremitting low back and radiating right buttock posterior

> and lateral thigh pain to the foot. *This is debilitating to him*… (emphasis added)
>
> The patient arises from a chair with difficulty and walks with an antalgic gait to the right. Positive straight leg raise on the right. Diminished sensation L5-S1 right greater than left. Decreased range of motion of the neck. Diminished sensation C6-C7 bilateral hands, slow repetitive fine motor movements of the upper extremities.
>
> AP lateral upright cervical films obtained today show previous fusion C4-5 through C7 with hardware in place C5-6. There is severe stenosis C4-5 with myelomalacia, mild to moderate stenosis at C3-4, and mild stenosis at C7-T1.
>
> IMPRESSION
> Unfortunate 71-year-old gentleman whose had previous L3 to the sacrum decompression and fusion with recurrent progressively worsening right greater than left leg radiculopathy. He also has evidence of cervical spinal stenosis. The low back and leg bother him a lot more than the neck. I recommend consideration of revision decompression L3-4, L4-5, L5-S1, with radical foraminotomies at each of those levels on the right, and spinal fusion L3 to the sacrum. He wants to think about it and will follow-up with us in about 3 weeks.

[Resp. Ex. № 1 at 82-83.]

On 9 August 2023, the claimant presented again to Dr. Smith's clinic. He complained of feeling worse. The visit notes, in part, include:

> ASSESSMENT/PLAN
> Mr. Battles returns with ongoing low back and leg pain, but he is having increasing problems with clumsiness with the use of his hands, numbness to all fingers in both hands, some shakiness into the left arm, and a sense of weakness to bilateral upper extremities. He has had a previous C5-6 ACDF and seems to have autofused C6-7. MRI scans show severe spinal stenosis at C4-5 with mild myelomalacia, at least moderate spinal stenosis at C3-4, both levels with significant bilateral neuroforaminal narrowing, and at C7-T1 severe bilateral neuroforaminal narrowing. He reports that he had significant swallowing difficulties following his original ACDF and continues to have significant difficulties with swallowing. There, consideration of a repeat ACDF is not optimal. His back and leg symptoms continue to be present but are less worrisome than neck.

[*Id.* at 93-94.] Dr. Smith recommended a posterior approach to surgically address the myelopathy and other changes between the C3-4 and T1-2 spinal process. The claimant was agreeable with Dr. Smith's recommendation, but surgery was not scheduled at that time.

The claimant returned to ASP on 15 April 2024 (approximately one month before the fall and injuries alleged in this claim). His assessment from that visit included, among other conditions, the following:

> ICD: Other spondylosis, lumbar region
> ICD: Sacroiliac joint dysfunction
> ICD: Sacroiliitis
> ICD: Lumbar radiculopathy
> ICD: Lumbar spondylosis
> ICD: Lumbar disc herniation
> ICD: History of fusion of cervical spine
> ICD: DDD (degenerative disc disease), cervical
> ICD: DDD (degenerative disc disease), lumbar
> ICD: Foraminal stenosis of lumbosacral region
> . . .

[Resp. Ex. № 1 at 152.]

After the fall and injuries alleged in this claim, the claimant presented to an OrthoArkansas clinic on 21 May 2024 and again saw Dr. Smith. The clinic note indicates that his previous problems included "spinal stenosis in cervical region *with myelopathy-onset: 08/11/2023*," a back surgery on 17 February 2022 and shoulder surgery on 15 February 2018 (emphasis added). The note also includes:

> ASSESSMENT/PLAN
> Mr. Battles returns. He took a hard fall yesterday coming down some stairs. He hit his head but did not lose consciousness. He has thoracolumbar pain. Arm numbness has increased, leg pain and numbness has increased. He had a previous MRI scan of the cervical spine which shows severe spinal cord compression at C4-5, mild stenosis at C3-4. This was done back in June. At this point I am ordering tramadol 50 mg ½-1 p.o. every 8 to 12 hours as needed, off work for 6 weeks, and a new MRI scan of the cervical spine. *His diagnosis is myelopathy* (emphasis added). I told him I do not think that he should be doing a job that involves walking up and down stairs.
> 1. Thoracic back pain
> . . .
> 2. Neck pain
> . . .
> 3. Low back pain
> . . .
> 4. Cervical myelopathy
> . . .

[Cl. Ex. № 1.]

The report from a cervical MRI scan on 18 June 2024 included, in part, the following:

> COMPARISON: 6/30/2023
> . . .
>
> FINDINGS
> Alignment of the craniocervical junction is maintained. Straightening of normal cervical lordosis. Susceptibility from prior C5-C6 anterior cervical discectomy and instrumented fusion with solid osseous ankylosis across the C5-C6 vertebral bodies. Solid osseous ankylosis across the C6-C7 vertebral bodies. Mild retrolisthesis of C2 and C4. No acute cervical fracture.
> Multilevel disc desiccation and disc height loss.
> There is a flattening of the cervical cord [at] the C4-C5 level. Cord signal abnormality at the C6-C7 level, unchanged and compatible with myelomalacia.
> . . .
>
> IMPRESSION
> 1. Multilevel degenerative disc disease of the cervical spine most pronounced at C4-C5 where there is severe canal and bilateral neural foraminal stenosis.
> 2. Prior C5-C6 anterior cervical discectomy and instrumented fusion with solid osseous ankylosis across the C5-C6 and C6-C7 vertebral bodies.
> 3. Unchanged myelomalacia at the C6-C7 level.
> . . .

[*Id*.] The referenced 30 June 2023 reports included, in part, the following:

> PROCEDURE: MR C-Spine
>
> There is a solid intervertebral body fusion from C5 trough C7 with metallic artifact from vertebral body screws and cortical plate at C5-6.
> Marked disc degeneration is seen at C3-4, C4-5, and C6-7. Moderate disc degeneration seen at C2-3.
> A normal alignment is present.
> No fracture is seen.
> There is a mild disc bulge with superimposed moderate broad-based central disc protrusion at C4-5. Mild disc bulges are seen at C3-4, C7-T1, T1-T2, and T2-3.
> Scattered facet arthritis is seen in the upper cervical spine.
> Marked spinal stenosis is seen at C4-5 with moderate spinal stenosis at C3-4.
> Moderate to marked foraminal stenosis is seen bilaterally at C3-4, C4-5, C5-6, and C7-T1. Marked foraminal stenosis is seen on the left at C6-7.
> There is a focal area of abnormal signal in the cord at C6-7 consistent with myelomalacia. Cranial vertebral junction region is normal.

IMPRESSION:
Surgical changes from C5 through C7 described above. Diffuse severe spondylosis. Marked spinal stenosis is seen at C4-5 with moderate spinal stenosis at C3-4.
Moderate to marked foraminal stenosis is seen bilaterally at C3-4, C4-5, C5-6, and C7-T1. Marked foraminal stenosis is seen on the left at C6-7.
There is a focal area of abnormal signal in the cord at C6-7 consistent with myelomalacia.

PROCEDURE: MR L-Spine Without Contrast

Laminectomies are seen at L3-4, L4-5, and L5-S1.
Mild disc degeneration is seen at L3-4 and L4-5.
A normal alignment is present.
The marrow signal is unremarkable and no fracture is seen.
Mild disc bulges are seen at L3-4, L4-5, and L5-S1.
Facet arthritis which is moderate to marked in degree is seen from L3-4 through L5-S1.
Moderate to marked spinal stenosis is seen at L3-4 and L4-5.
Moderate to marked foraminal stenosis is seen bilaterally from L3-4 through L5-S1.

IMPRESSION:
Prior laminectomies at L3-4, L4-5, and L5-S1. Moderate to marked spinal stenosis is seen at L3-4 and L4-5.
Moderate to marked foraminal stenosis is seen bilaterally from L3-4 through L5-S1.

[Resp. Ex. № 1 at 78-79.]

The claimant returned to the clinic on 18 June 2024. The notes from that visit included, in part, the following:

The patient is a 71-years-old gentleman who [has] undergone 2 previous surgeries to his cervical spine at C5-6 and C6-7. Over the last several months he has developed increasing weakness to his arms and his legs after taking off hard fall [sic]. He has had a new MRI scan which shows moderate central canal stenosis with severe cord compression at C4-5, and mild to moderate cord compression at C3-4. He also complains today of some shortness of breath which [he] states has been present for a couple of weeks, chest pain, and what he thinks is acid reflux.
. . .
Impression: cervical myelopathy related to disc herniation at C3-4 and C4-5, and retained hardware at C5-6. He has hardware in place at C5-6 which is a monoplate. I recommended a C3-4 and C4-5 ACDF and hardware removal at C5-6.
. . .

[Cl. Ex. № 1 at 9-10.] The claimant agreed with Dr. Smith's renewed recommendations and underwent the surgery on 12 July 2024. The Operative Note included the following:

> The patient is a 72-year-old gentleman who [has] undergone previous C5-6 and C6-7 fusions. He has developed increasing clumsiness with use of his hands and on his feet and has severe spinal stenosis at C3-4 and C4-5. I have recommended decompressive surgery and removal of previously placed plate at C5-6.

[*Id*. at 13.]

On 30 July 2024, the claimant followed up again with Dr. Smith. The note from that visit includes, in part, the following:

> Mr. Battles returns status post C3-4, C4-5 ACDF done on July 12, 2024. He is feeling well. He has only mild residual numbness to his fingers but is walking much better. X-rays show well-placed hardware C3-4, C4-5 above previous fusion C5-C7 his wound is well-healing with no signs of infection. At this point he will follow-up with us in mid-October and he will wear his cervical collar for 2 months following surgery. At this point I think that he is permanently off work because of the injury sustained to his neck and the surgery at C3-4 and C4-5. I do not think he should return to any form of labor because of that injury and the subsequent surgery.

[*Id*. at 25.]

The claimant returned to see Dr. Smith again a month later. The note from that 28 August 2024 visit provided, in part:

> REVIEWED PROBLEMS
> Spinal stenosis in cervical region with *myelopathy- onset 08/11/2023* (emphasis added)
>
> ASSESSMENT/PLAN
> Mr. Battles returns about 6 weeks out from C3-4, C4-5 ACDF. Generally, he feels much better than he did before surgery with regard to his arms. He does have some pain, but this is better than it was. His biggest issue is he is having increasing and quite severe low back pain and radiating bilateral leg pain. When he sneezes sometimes, he feels that he has a drop to his knees. This is quite debilitating. He has burning dysesthesias down the down the posterior lateral thighs. He [has] undergone a previous L3-4, L4-5, L5-S1 decompression. Exam shows significant tenderness to palpation and percussion at the mid and low lumbar spine he has diminished sensation L4, L5-S1 bilaterally. He has positive straight leg raises bilaterally. X-rays today show nice progression of fusion at C3-C5, X-rays of the low back show spondylosis, mild left hip osteoarthritis. He has full strength bilateral upper

> extremities with exception of right deltoid which is mildly weak. Sensation is intact to light touch. At this point his biggest issue is low back pain and radiating bilateral leg pain. He has been through therapy this year for his low back. I am recommending a new MRI scan of the lumbar spine with gadolinium and a Quickdraw-type lumbrosacral orthosis. He sees a pain specialist down in Whitehall and has an appointment on September 12. [I] asked him to discuss epidural steroid injection to the lumbar spine with her. He will follow-up with me after the MRI scan.

[*Id*. at 30.]

The claimant then presented to Dr. David Bumpass on 14 February 2025 for a "second opinion of chronic neck and low back pain." According to that note:

> … He has a lengthy and complicated spine history. His care to date has primarily been with Dr. Jason Smith and with Arkansas Spine and Pain…
>
> Fell on stairs May 20, 2024; this was at the apartment building where he works. He states there was a mat that was loose. He also reports a prior fall on ice (circa 2021 or 2022) outside the building and showed me a surveillance video that captured his fall. Cervical myelopathy symptoms noted in records dating to August 2023. Known to have severe recurrent lumbar stenosis from July 2023.
>
> Wearing a cervical bone stimulator today. Ambulates with a cane. Reports chronic swallowing difficulty after first ACDF years ago, and this is reflected in Dr. Smith's notes also. Reports right-sided muscular neck pain. Reports bilateral hand numbness that he states did not improve after most recent ACDF. Reports bilateral leg pain R=L that is posterior in distribution down his lower extremities. Reports central low back pain.
>
> Lumbar medial branch blocks as Arkansas Spine & Pain on Nov. 13, 2024; May 10, 2023; March 29, 2023. SI join injections on June 12, 2024; March 27, 2024; December 13, 2023.
> . . .
>
> 2/10/2022 lumbar MRI- severe stenosis at L3-4 and L4-5, prior to surgery
> 7/28/2022 lumbar MRI- moderate residual stenosis at L4-5 s/p decompression
> 6/30/2023 cervical MRI- severe stenosis with cord compression at C3-4 and C4-5
> 6/30/2023 lumbar MRI- moderate stenosis s/p prior laminectomies
> 6/18/24 cervical MRI- no major changes since prior cervical MRI 2023
> I reviewed and interpreted all spinal imaging studies myself.
>
> ASSESSMENT
> Chronic neck and low back pain from degenerative spondylosis. Hx of cervical myelopathy s/p decompression. Hx of lumbar stenosis s/p decompression.
>
> PLAN

> It is difficult to determine how much of patient's current symptoms are perhaps secondary to recurrent lumbar stenosis or from cervical pseudarthrosis. If he were to pursue further treatment he would require a new MRI cervical spine with MARS and new MRI lumbar spine. He would benefit from a cervical CT scan to evaluate his fusion. However, I am not confident the patient would have substantial clinical improvement from further surgery. I am happy to see the patient back for further evaluation and discussion if he wishes.
>
> It Is very difficult to determine, as a second opinion, what percentage of the patient's current symptoms resulted from each fall at work. He has had 3 spine surgeries, 1 prior to the falls and 2 after. Much of his current pain is originating from his degenerative disc disease in his neck and back.
>
> I reviewed the 449 pages of outside medical records provided by Workers' Compensation.

[Cl. Ex. № 2 at 31-34.]

On 19 July 2025, Dr. Wayne Bruffett authored a report in response to a request from the respondents. He noted that the records included recommendations for lumbar spine and cervical spine surgeries that predated the fall and injuries that are alleged in this claim. His report concluded:

> SUMMARY OF OPINIONS
>
> After reviewing extensive medical records in this case as well as x-rays, CT scan, and MRI scans, I state with a reasonable degree of medical certainty the following opinions:
>
> 1. Lynn Battles did not sustain any objective evidence of injury to the cervical spine as a consequence of the accident that occurred on May 20, 2024.
>
> 2. After reviewing the imaging of the lumbar spine before and after the accident that occurred on May 20, 2024, Mr. Battles did not sustain any objective evidence of injury to his lumbar spine.
>
> 3. The MRI scan of the cervical spine which was performed before the accident and the MRI scan of the cervical spine that was performed after the accident are essentially identical.
>
> 4. Mr. Battles had a history of chronic pain both cervical and lumbar and extensive surgery both cervical and lumbar prior to the accident on May 20, 2024.

> 5. Any treatment rendered to the cervical or lumbar spine including the surgery performed to the cervical spine on July 12, 2024, by Dr. Smith was rendered as a consequent of preexisting and degenerative changes and not related to the accident on May 20, 2024.

[Resp. Ex. № 1 at 196.]

DISCUSSION

The claimant has failed to prove by a preponderance of the evidence that he sustained compensable injuries by specific incident to his neck and back. This finding renders the other issues in this litigation moot. Accordingly, those additional issues will not be addressed below.

To prove a compensable injury by specific incident, the claimant must establish four (4) factors by a preponderance of the evidence: (1) that the injuries arose out of and in the course of his employment; (2) that the injuries caused internal or external harm to the body that required medical services or resulted in disability or death; (3) that the injuries are established by medical evidence supported by objective findings, which are those findings which cannot come under the voluntary control of the patient; and (4) that the injuries were caused by a specific incident identifiable by time and place of occurrence. *Mikel v. Engineered Specialty Plastics*, 56 Ark. App. 126, 938 S.W.2d 876 (1997). The employee has the burden of proving by a preponderance of the evidence that he sustained a compensable injury. Ark. Code Ann. § 11-9-102(4)(E)(i). Preponderance of the evidence means the evidence having greater weight or convincing force. *Metropolitan Nat'l Bank v. La Sher Oil Co.*, 81 Ark. App. 269, 101 S.W.3d 252 (2003). If a claimant fails to establish by a preponderance of the evidence *any* of the requirements for establishing a compensable injury, compensation must be denied. *Mikel, supra.*

"Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. § 11-9-102(16)(A)(i). The requirement that a

compensable injury must be established by medical evidence supported by objective findings applies only to the existence and extent of the injury. *Stephens Truck Lines v. Millican*, 58 Ark. App. 275, 950 S.W.2d 472 (1997).

Excerpts from the claimant's medical history are noted above, and they detail his established history of degenerative neck and back conditions, past surgical procedures and degrading outcomes, recent surgical recommendations, and his condition around the 20 May 2024 fall. While the claimant's medical history is complicated, the essence of his claims here is not. He testified that after falling down some stairs on 20 May 2024, he suddenly became injured to the point that he could no longer work. He alleges compensable injuries to his neck and back. He has undergone a cervical spine surgery since his date of injury, and he attributes the need for that surgery to his workplace fall. Dr. Smith took him off work for six weeks beginning on 21 May 2024 and he later ordered the claimant to be "permanently off work because of injury and surgery at C3-4 and C4-5." [Cl. Ex. № 1 at 26.] The claimant relies on those record entries for carrying his burden on compensability in this claim.

But the claimant ignores his substantial history of neck and back problems that predate his alleged fall and injuries in this matter. The cervical surgery that was ultimately performed after his accident was recommended nearly a year before his accident. The 250-some-odd pages of medical records[1] in evidence only go back to a little over two years before the date of injury at issue (20 May 2024) and do not include an untold number of other potentially relevant records relating to the claimant's neck and back complaints, diagnoses,

[1] Dr. Bumpass referenced reviewing 449 pages of medical records for his opinion that was authored after an exam on 14 February 2025. [Cl. Ex. № 2 at 34.] The claimant testified about other past treatment that was not included in the records admitted to evidence. To be clear, while I am acknowledging a potentially relevant history that is much more extensive than that in evidence here, my findings are based only on the record before me.

and treatments that were referenced in the testimony. The claimant's pre-existing problems were not ignored, however, by Drs. Bumpass and Bruffett in their reviews of the case.

Dr. Bumpass was seen by the claimant for a second opinion. He stated that it was "difficult to determine how much of [the] patient's current symptoms are perhaps secondary to recurrent lumbar stenosis or from cervical pseudarthrosis." He went on to say that "It is very difficult to determine, as a second opinion, what percentage of the patient's current symptoms resulted from *each* fall at work. He has had 3 spine surgeries, 1 prior to *the falls* and 2 after.[2] Much of his current pain is originating from his degenerative disc disease in his neck and back" (emphasis added). His opinion plainly states that it is difficult to differentiate between the claimant's ongoing complaints from his degenerative conditions and related treatments and the complaints that might be tied to *either* the fall referenced in the 10 August 2022 clinic note or the 20 May 2024 incident or some other fall that is not included in the record before me. Certainly, he considered *each* of *the falls* (not just 20 May 2024) in attempting to render an opinion on causation. And he ultimately declined to make a causal connection between any workplace fall and the claimant's condition.

Dr. Bruffett was tasked with an independent case review based only on the claimant's medical records and imaging studies. He did not examine the claimant in person. But he offered a clear opinion the claimant's condition not being causally related to the 20 May 2024 workplace fall. Importantly, Dr. Bruffett explained that the pre-accident MRI imaging of the cervical spine was "absolutely identical" to the post-accident MRI imaging of the cervical spine. He succinctly stated, with a reasonable degree of medical certainty, that, "Lynn Battles did not sustain any objective evidence of injury to the cervical spine as a

[2] The medical records include general references to a fall or falls that are not part of this claim. A workplace fall at the same apartment complex is even noted in a 26 June 2023 record. The claimant only attributed his injuries in this claim to a 20 May 2024 fall at the apartment complex.

consequence of the accident that occurred on May 20, 2024… Mr. Battles did not sustain any objective evidence of injury to his lumbar spine… [and that] Any treatment rendered to the cervical or lumbar spine including the surgery performed to the cervical spine on July 12, 2024 by Dr. Smith was rendered as a consequence of preexisting and degenerative changes and not related to the accident on May 20, 2024." [Resp. Ex. № 1 at 196.]

The Commission is authorized to accept or reject a medical opinion and is authorized to determine its medical soundness and probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). While I find all three of the medical opinions refenced above to be credible, I am assigning greater evidentiary value to the opinions offered by Drs. Bumpass and Bruffett. They both addressed the claimant's then-present condition in the totality of his clinical history and neither related the claimant's condition to his claimed fall with injury on 20 May 2024. Dr. Bumpass was reluctant to attempt any assignment of deterioration to the incident; and Dr. Bruffett clearly stated that the imaging was unchanged before and after the incident. The only diagnosis that Dr. Smith appears to clearly assign on the day after the 20 May 2024 fall was myelopathy, which was already noted in his note as onset as of 11 August 2023. His recommendation that the claimant not work in a job that requires climbing stairs is also consistent with his earlier opinion that the claimant required a powered wheelchair for improved mobility.

The claimant has an extensive and significant history of degenerative cervical and lumbar spine conditions, treatments, and surgeries. He required the assistance of a cane or walker at times before his alleged fall; and Dr. Smith had even recommended a powered wheelchair in the preceding year. The claimant's reports of past falls, clumsiness, weakness in his hands, legs and feet, and generally crippling pain are well documented in his records. The imaging studies and clinical assessments relating to those complaints are also well documented as having been established before the claimant's alleged injury in this claim.

The cervical surgery that the claimant ultimately underwent on 13 July 2024 had been recommended back on 9 August 2023, well before the work incident he alleged in this claim.

In short, the claimant produced no objective findings of an injury that support his claim. He has, therefore, failed to prove by a preponderance of the evidence that he sustained compensable injuries by specific incident to his neck and back. Because he has failed to prove a compensable injury, the remaining issues in this claim are moot and are not being addressed in this Opinion.

IV. CONCLUSION

The claimant has failed to prove by a preponderance of the evidence that he suffered a compensable injury to his neck or back. His other claims related thereto are moot. This claim for initial benefits is denied and dismissed.

SO ORDERED.

_____
JAYO. HOWE
ADMINISTRATIVE LAW JUDGE