

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F410985

JUDY O'CONNELL	CLAIMANT
WAL-MART ASSOCIATES, INC.	RESPONDENT
CLAIMS MANAGEMENT, INC. INSURANCE CARRIER	RESPONDENT

OPINION FILED JULY 11, 2005

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by MARK FREEMAN, Attorney, Fayetteville, Arkansas.

Respondents represented by TOD BASSETT, Attorney, Fayetteville, Arkansas.

STATEMENT OF THE CASE

A hearing was held on April 12, 2005, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on January 10, 2005. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.

2. On September 23, 2004, the relationship of employee-employer-carrier existed between the parties.

3. The claimant is entitled to a workers' compensation rate of \$239.00 for temporary total disability.

By agreement of the parties the issues to litigate are limited to the following:

1. Compensability of the claimant's left knee injury on September 23, 2004.

2. Related medical.

3. The claimant's entitlement to temporary total disability from September 29, 2004, to January 4, 2005, minus one day (October 5, 2004).

4. The claimant's entitlement to a 2 percent impairment rating to the left knee.

5. Attorney's fee.

In regard to the foregoing issues the claimant contends that she was employed by the respondent on or about September 23, 2004, when she injured her left knee while in the course and scope of her employment. At the time she was generally employed as a stocker earning approximately \$11.80 per hour based on a thirty-two (32) hour work week. She started work at her employment approximately five (5) years ago.

In regard to the foregoing issues the respondents contend that they deny that the claimant sustained an accidental injury to her left knee while in the course and in the scope of her employment on September 23, 2004, or on any other date for that matter. Claimant contends that on September 23, 2004, while squatting and trying to reset a modular, she pulled her left leg around, felt pain in the groin area, which later spread down the entire left leg with the most intense pain settling in the left knee joint. There were no eyewitnesses to the alleged incident. Claimant did not timely report the alleged injury. It was not until approximately two

weeks later on October 7, 2004, that the claimant finally reported the matter. By that time, the claimant had already sought out and received medical treatment for her problems from her own family physician's nurse, Stacy Powell, on two occasions. According to the claimant's medical chart at her family physician's office, the claimant first presented there on September 28, 2004, with a positive history of "leg" pain extending all the way into the groin area. Significantly, the September 28, 2004, medical note of Nurse Stacy Powell indicated that claimant had "denied" any injury. In a subsequent "To Whom It May Concern" letter addressed to the claimant and signed her family doctor, Ronald Bertram, and Nurse Stacy Powell, it was stated that the claimant was previously seen at Northwest Family Care on September 21, 2004, with worsening of her chronic low back pain. The claimant supposedly also related at the time, although not noted in the written record of that date, that she had allegedly fallen at work. Assuming any of that is true, which respondents deny, then the claimant's "fall" would have had to occur on September 21, 2004, as opposed to September 23, 2004, the date that the claimant has maintained she was injured on all along. Respondents question the overall credibility of the claimant as well as the accuracy of the claimant's medical record at Northwest Family Care - Westside.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1. The respondents submitted medical records marked

Respondent's Exhibit No. 1 and the deposition of the claimant marked Respondents' Exhibit No. 2. The parties submitted the first report of injury marked Joint Exhibit No. 1. All these exhibits were admitted without objection.

DISCUSSION

The claimant testified that she began working for the respondent in the year 2000. The claimant testified that on September 23, 2004, she was working as a stocker and due to prior back problems, she has a problem getting down on her knees. The claimant testified that she went down on her right knee and kind of dropped which twisted her left knee and she felt real bad pain. The claimant testified that the pain was so intense it took her breath away and that she had to just sit there for a minute and then the pain went away. The claimant testified that this was right after her break which she takes around 2:00 so that this event probably happened around 2:30. The claimant testified that she did not tell anyone at the store that day that she had hurt her left knee because it had stopped bothering her. The claimant testified that she did not seek medical treatment that day nor did she think she needed any. The claimant testified that she knew that she was suppose to report work injuries but that at the time she did not think she was that bad off. The claimant stated that she was limping a little bit the next day which was Friday but it was not painful. The claimant testified that her knees started bothering her and by Sunday she could hardly walk on it. The claimant testified that she is regularly off Saturday, Sunday and

Monday and that on Monday she called in and reported to the respondent that she would not be in to work, told them what had happened and that she was going to the doctor. The claimant testified that she reported this event to Tamara Bell or Pat Phillips. The claimant testified that she reported to either one of these ladies that when she was working she hurt her leg and it just started getting worse and that she was going to the doctor. The claimant testified that she went to see Stacy Powell, an APN, on Tuesday. The claimant testified that Ms. Powell is with her family physician and that she reported to her what she was doing at work when she hurt her knee. The claimant testified that at the time she was having pain from her left hip all the way down past her knee and that she was not sure where the pain was coming from. The claimant testified that she was off for a week and when she returned to work the following Tuesday, she could hardly walk. The claimant testified that she next was seen by Jayne Moore Pruden, an APN, since Ms. Powell was on vacation. Ms. Moore referred the claimant to Dr. Sites and Dr. Sites set her up for an MRI. The claimant testified that Dr. Sites eventually did surgery on her knee.

The claimant testified that she has also seen Dr. Gary Moffitt and that she reported to him how her injury occurred.

The claimant testified that she understood that work related injuries are to be reported to the management and that Tamara Bell and Pat Phillips are both assistant managers for the respondent. The claimant testified that on the Tuesday morning that she

returned to work after being off work for a week, there was an associates morning meeting and she told everyone in the meeting what had happened and that she also kept in touch with everyone at work. The claimant testified that the surgery which she underwent did help but she did miss work for a period of time. The claimant testified that from September 28, 2004, to January 4, 2005, she was unable to work except for one day when she tried to go back to see if she could work through the pain. The claimant testified that she worked an entire day and was paid for that one day. The claimant testified that currently she uses knee pads when she has to get down on her knees. The claimant testified that her knee still bothers her and she understands that it will never be back to normal. The claimant testified that she is back working for the respondent full time even though she has limited range of motion with her knees in that she cannot sit on her knees and lean back on her feet as she once could.

The claimant testified that in 1992 she was involved in a motor vehicle accident where she shattered three discs in her back. The claimant testified that for this back injury she underwent surgery. The claimant testified that she still has problems with her back and it seems as if every year it gets a little worse. The claimant remembered that she had another motor vehicle accident on December 10, 2003, and again hurt her back but did not injure any other part of her body. The claimant testified that as a result of these back problems she has taken anti-inflammatories. The claimant testified that after her knee injury, she was also

prescribed Oxycotin and Percocet for the discomfort. The claimant testified that she is no longer taking Percocet or Oxycotin and is only taking the anti-inflammatories for her back.

On cross examination, the claimant agreed that as a result of her 1992 automobile accident, she was left with a left foot drop due to some nerve damage in her left leg. The claimant also testified that from her 1992 injury she has been left with a couple of small herniated discs in her low back. The claimant testified that as a result of her second car accident in December 2003 she was seen by several doctors. The claimant testified that she was given prescription medications but did not take any physical therapy following this second motor vehicle accident. The claimant testified that she did miss some work as a result of this incident. The claimant testified that she took an anti-inflammatory called Ultram. The claimant testified that she did not know if it had any pain medication or agent in it, she understood it to be an anti-inflammatory. The claimant agreed that on July 16, 2004, she called requesting a refill of her Ultram. The claimant testified that she would not disagree if the medical records set forth that she was in to see the doctor to get Darvocet on September 21, 2004. The claimant testified that she has taken several different kinds of pain medications for her back over the years because they do not like to keep her on just one for any long length of time. The claimant agreed that she has continuing chronic back pain and was having such back pain two to three days before she had her knee injury. The claimant again explained that because of her prior

back problems she has problems getting up and down off her knees and she always has to kind of drop a little bit to get down. The claimant testified that in the process of her going down on her right knee somehow her left knee twisted causing her injury. The claimant agreed that following her 1992 motor vehicle accident she did have problems with her left leg in that it would go out from under her at times but this had not happened since a couple years after that motor vehicle accident. The claimant testified that on September 23 she did not have drop foot and had not for some time. The claimant agreed that following her December 2003 accident she did experience some numbness and tingling running down into her legs as well as some back spasms. The claimant testified that these symptoms went away approximately four months after her accident. The claimant was asked about the pain she was experiencing after her September 2004 incident and the claimant testified that she started limping a little bit on Friday and then as the weekend progressed she started hurting more and more. The claimant testified that on Friday she did not fill out any paperwork nor did she request to be seen by a company doctor as a result of her injury because she did not realize the extent of her injury. The claimant testified that when she went in to see Stacy Powell on the 28th her complaints primarily were in her hip and groin area. The claimant testified that she got a shot of Cortisone in her butt and it was at this time she gave a history to Stacy Powell of having had an incident at work. The claimant agreed that on this September 28, 2004, doctor's report there is a

notation specifically saying, "Denies specific injury." The claimant testified that she does not know why the medical reports set forth that she denied an injury because she told the nurse that her problem happened at work. The claimant testified that she is not sure who she talked to when she called in on that Monday, September 27, to report that she was going to the doctor for an injury at work. The claimant testified that she was unaware that she was suppose to generate the paperwork for a workers' comp injury, stating further that since she had spoken to an assistant manager about her problem, she assumed that they were taking care of it. The claimant testified that she did return to work on Tuesday, October 5, but was in such pain she called the doctor and made an appointment to be seen. The claimant agreed that at that time she then was taken off work through Friday, October 8, and that she was to see Dr. Sites on Monday the 11th. The claimant testified that it was after Dr. Sites' nurse called and asked if it was a workers' comp claim that she went in to see Tamara about filing a claim. The claimant testified that it was not until the first part of the next week when she was able to see Mr. Kenny King, the store manager, that anyone actually began paperwork on her claim. The claimant testified that her medical bills have been paid under her group policy through the respondents.

Ryan Ardary testified that he has worked for the respondent for several years but prior to working for them he worked at Harps at the same time the claimant worked at Harps. Mr. Ardary testified that in August 2004 he was an assistant manager for the

respondent along with Tamara Bell and Pat Phillips. This witness stated that Kenny King was the store manager. Mr. Ardary testified that part of his duties included taking calls from the different employees reporting that they were not going to be in for work or were going to be late. This witness testified that in September 2004 he recalls getting a call from the claimant reporting that she would not be coming in to work and that she did not know when she would be back to work. Mr. Ardary testified that the claimant did not mention to him that she had hurt herself at work. Mr. Ardary testified that the claimant has never come directly to him and told him that she had a work related injury but he did subsequently learn of her injury from another assistant manager. This witness testified that if an employee calls in and reports that they have had a work related injury, paperwork would be filled out at that time regarding the accident.

On cross examination, Mr. Ardary testified that when he worked with the claimant at Harps some several years earlier, he does not recall her having any left knee problems. This witness testified that the claimant was good at keeping the respondents up to date as to her condition following her injury. Mr. Ardary testified that, to his memory, it was Tamara, one of the other assistant managers, that told him that the claimant had been hurt at work. This witness testified that he has no memory of an associates meeting where the claimant told everyone in the group that she had hurt her knee. Mr. Ardary testified that he had no reason to doubt the claimant's honesty. Mr. Ardary testified that a claimant does not

fill out paperwork for workers' compensation claims for the respondent, that it is all done on the computer. Mr. Ardary explained that it takes two people, one of the managers or assistant managers and the claimant in order to fill out the computerized form. Mr. Ardary was asked, "So an injured employee can't just walk up and enter stuff on the computer?" Mr. Ardary responded, "No, absolutely not." Mr. Ardary testified that he learned from Tamara about the claimant's injury after he had received the telephone call from the claimant reporting that she would not be in.

Tamara Bell testified that she currently was working at the respondent's home office but before that she worked at the store in Fayetteville where the claimant works. Ms. Bell testified that on her last day of work at the Fayetteville store, she remembers it being a Saturday in October 2004 and the claimant came in with her mother. Ms. Bell testified that she and the claimant had a conversation and it came up in the conversation that the claimant probably hurt herself at work at which time Ms. Bell informed her that she needed to fill out a statement. Ms. Bell testified that the claimant told her that the injury happened weeks ago and at that point she, Ms. Bell, suggested that she fill out a statement and both of them would sign it and leave it on Kenny's desk since she, Ms. Bell, was not going to be there the next week. Ms. Bell testified that the normal procedure for filing workers' compensation claims would be to go to a salaried member of management and that, at that time, the associate decides if the

person needs to go to the hospital and if they do someone would accompany them and then paperwork is done. Ms. Bell agreed that all new employees are instructed about reporting injuries when they first go to work.

On cross examination, Ms. Bell testified that she has no memory of being in a meeting with associates where the claimant told everyone in the meeting that she had been hurt. Ms. Bell agreed that the first time she heard or learned that the claimant had been hurt was her last day of work at the Fayetteville store. Ms. Bell testified that the claimant was limping the day that she reported her injury to her. Ms. Bell further remembers that she does not recall the claimant limping before this time.

The medical records set forth that the claimant was seen in the Northwest Family Care Center by Stacy Powell on December 23, 2003, with complaints of low back pain resulting from a motor vehicle accident. After examination, the claimant was assessed with muscle strain and spasm and rest as well as medications were prescribed. The claimant was seen on March 8, 2004, by Stacy Powell, an APN, at which time she was diagnosed with having allergies and chronic back pain for which she was prescribed medications. The claimant was seen by Stacy Powell on September 21, 2004, for complaints of nasal congestion also requesting a refill for pain medication for her chronic back pain. The claimant called in to the clinic on September 27, 2004, stating that she needed stronger pain pills and requested an office visit. The claimant was seen by Stacy Powell on September 28, 2004, for

complaints of leg pain. It is reported that the claimant states that her whole left leg is hurting, denies injury and states that bending her knee increases the pain. The patient had similar past problems. After examination, the claimant was diagnosed with having a muscle strain in the left groin and rest for two to seven days was recommended. Jayne Moore Pruden, an APN saw the claimant on October 6, 2004, for her complaints of leg pain and that she could not bend her knee. Upon examination, it is noted that the claimant has tenderness in her left knee area with no joint instability and no swelling of the thigh or knee noted. The claimant was excused from work on that date to return when released by the orthopedic doctor and a referral was made to Dr. Sites. Dr. Sites writes on October 11, 2004, that the claimant was squatting at work when she had sudden pain in her left lower extremity which she initially thought was hip pain but after a cortisone shot, the pain localized over her left knee. After examination and review of the claimant's x-rays which were normal, the doctor opined that she probably had a torn medial meniscus and/or additional anterior articular pathology of her left knee. Dr. Sites recommended that the claimant use crutches and to undergo an MRI plus he took her off work. The claimant was seen by Dr. Gary Moffitt, on October 14, 2004, at the request of the respondent. Dr. Moffitt notes that the claimant reports that on September the 23rd, she was resetting shelves and was on her right knee and whenever she did this she felt a pop occur in her left knee. Dr. Moffitt notes that the claimant does have swelling and effusion of the knee, and there is

tenderness along the medial tibula plateau anteriorly. Dr. Moffitt also notes she has a positive McMurray's test. Dr. Moffitt opines that the claimant probably has a torn medial meniscus and recommended an MRI of the claimant's knee. Dr. Moffitt again writes on October 21, 2004, that he has rechecked the claimant's right knee noting that she has not had her MRI yet. The doctor notes that the claimant still has tenderness along the medial aspect of her knee and she has a positive McMurray's test. Dr. Moffitt restates his concern that the claimant may have experienced a torn cartilage and recommends that she may continue to work with the same restrictions. On November 3, 2004, Dr. Moffitt again checked the claimant who still had not undergone an MRI noting that she continues to have pain in her left knee. The doctor continued the claimant on the same restrictions and gave her medications for pain. Stacy Powell writes on November 23, 2004, that she has refilled the claimant's OxyContin noting that she continues to have pain in her left knee. Ms. Powell notes that a letter has been written verifying that the patient stated that this was a work related injury and a MRI was scheduled as well as an appointment with Dr. Sites. The claimant underwent an MRI of her left knee on November 29, 2004, which revealed that she had findings consistent with a partial thickness tear or sprain of the medial collateral complex. It is also noted that the claimant had a large joint effusion and small Baker's cyst. Dr. Sites writes on December 2, 2004, that he has reviewed the claimant's MRI which shows a large effusion with no specific meniscal tear but a partial medial

collateral ligament tear. Dr. Sites notes that surgery was discussed with the claimant and she was scheduled for knee surgery on December 3, 2004. Dr. Sites writes on December the 9th that he has seen the claimant after her knee surgery and that her effusion is much improved. The doctor notes that the synovial biopsy is suspicious of rheumatoid synovium. Medications were at first prescribed and the claimant was referred to Dr. Anne Miller for further testing. On January 20, 2005, the claimant was seen by Dr. Sites who notes that her left knee is swollen again and so the doctor aspirated and injected her knee. Dr. Anne Miller writes on January 25, 2005, that she has seen the claimant with complaints of pain in her left knee as well as her shoulder. Dr. Miller evaluated and examined the claimant. Dr. Miller notes that the claimant possibly has early inflammatory arthritis such as rheumatoid arthritis and that she has had inflammatory synovitis at the knee, pain, as well as limitations at the left shoulder. Dr. Miller further notes that the claimant has a fibromyalgia component and recommended that they check her arthritis panel as well as anti-CCP antibodies, and run other tests. Dr. Miller prescribed medications for the claimant and scheduled a return appointment. Dr. Sites writes on February 14, 2005, that he has seen the claimant noting that her left knee is doing much better. Dr. Sites writes that the claimant has been seeing Dr. Miller and no apparent rheumatoid arthritis was identified, noting further that she may have some fibromyalgia. Dr. Sites writes that as to the claimant's torn meniscus she has reached maximum medical improvement and has

a 2% lower extremity impairment for the partial medial meniscectomy. Dr. Sites notes that he used the AMA Guides Fourth Edition to evaluate this impairment rating and released the claimant to full duty without restrictions.

After a review of this entire record, I find that the claimant has proven by a preponderance of the evidence that she sustained a work related injury to her left knee on September 23, 2004, while working for the respondent. The claimant has testified to a specific incident on a specific day resulting in an injury to her left knee which required medical treatment. There has been objective medical evidence provided which verifies an injury for which medical treatment was needed. Although initially the medical reports set forth that the claimant did not report an injury subsequent notations in a letter from Stacy Powell, an APN, that the claimant did in fact report a fall at work. I do find, however, that the claimant did not appropriately report her injury until she had a discussion with Tamara Bell on October 9, 2004. After this date, the claimant visited with Kenny King, the store manager, and a report of injury was filled out and the claimant was sent to see Dr. Gary Moffitt, the respondents' physician. Therefore, no medical treatment will be paid for by the respondents until October 9, 2004, for this compensable injury. The claimant has also proven by a preponderance of the evidence that she is entitled to temporary total disability from October 9, 2004 until she reached maximum medical improvement on February 14, 2005, when Dr. Sites rated her with a 2% impairment rating to the lower

extremity. The respondents therefore should pay temporary total disability during this period of time to this claimant. The claimant has proven by a preponderance of the evidence that she is entitled to an impairment rating of 2% to the lower extremity as assessed by Dr. Sites in his office note of February 14, 2005.

FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.

2. On , the relationship of employee-employer existed between the parties.

3.

4. The claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her left knee while working for the respondent on September 23, 2004. See Discussion above.

5. The claimant has proven by a preponderance of the evidence that she is entitled to medical treatment for her compensable injury. See Discussion above.

6. The claimant did not appropriate report her compensable injury to the respondent until October 9, 2004. Therefore, no benefits will be paid prior to this date. See Discussion above.

7. The claimant is entitled to temporary total disability for her compensable injury from October 9, 2004 to February 14, 2005, when Dr. Sites notes that she has reached maximum medical improvement for her compensable injury.

8. The claimant is entitled to permanent partial disability for her compensable injury in the amount of 2% to the left lower extremity. See Discussion above.

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

10. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that she sustained a compensable injury while working for the respondent on September 23, 2004.

The respondents shall pay all reasonable and necessary medical treatment for this claimant's compensable injury subsequent to October 9, 2004.

The respondents shall pay temporary total disability to the claimant from October 9, 2004 to February 14, 2005.

The respondents shall pay permanent partial disability to the claimant for her 2% impairment rating to her left lower extremity as assessed by Dr. Sites.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE