

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F602233

JOSE AVALOS	CLAIMANT
GEORGE'S INC., SELF INSURED	RESPONDENT
CROCKETT ADJUSTMENT, TPA	RESPONDENT

OPINION FILED NOVEMBER 27, 2006

Hearing before ADMINISTRATIVE LAW JUDGE MICHAEL L. ELLIG in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

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

STATEMENT OF THE CASE

A hearing was held on September 18, 2006, in Springdale, Arkansas. A pre-hearing order was entered in this claim on May 3, 2006. This pre-hearing order set out the stipulations offered by the parties and outlined the issues to be litigated and resolved at the present time. Prior to the commencement of the hearing, the parties announced that they had agreed on the appropriate weekly compensation rates. A copy of this pre-hearing order with those rates noted thereon was made Commission's Exhibit No. 1 to the hearing.

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

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

2. On all relevant dates, including December 28, 2004, the relationship of employee-self insured employer-TPA existed between the parties.

3. The appropriate weekly compensation benefits are \$216.00 for total disability and \$162.00 for permanent partial disability.

4. The claim is controverted in its entirety.

By agreement of the parties, the issues to be litigated and resolved at the present time were limited to the following:

1. whether the claimant sustained compensable injuries to his left knee, left hip, and left foot as the result of a specific incident on or about December 28, 2004.

2. The claimant's entitlement to the payment of medical expenses for these injuries.

In regard to these issues the claimant contends that he was injured on December 20(sic), 2004. while he was working another employee accidentally ran into him with a large chicken transporter injuring his knee, hip, and foot.

In regard to these issues the respondents deny the claimant sustained a compensable injury and controvert this claim in its entirety.

## DISCUSSION

### I. COMPENSABILITY

The initial issue to be addressed is whether the claimant sustained "compensable injuries" to his left knee, left hip, and left foot, as the result of a specific employment related incident on December 28, 2004. The burden of proof rests upon the claimant

to prove all of the elements necessary to establish these alleged “compensable injuries.”

The first elements necessary for a “compensable injury” are contained in Ark. Code Ann. §11-9-102(4)(D). This subdivision requires that the actual existence of the physical injuries alleged to be compensable must be “established” by medical evidence. This subsection further requires that the actual existence of these physical injuries must be supported by “objective findings” as that term is defined by Ark. Code Ann. §11-9-102(16)(A)(i).

The medical evidence presented fails to “establish” the actual existence of any physical injuries involving the claimant’s left hip or left foot. None of the claimant’s various physicians have diagnosed any defect or abnormality involving these portions of the claimant’s body. There is absolutely no mention in the medical evidence of any objective findings or even subjective complaints involving the claimant’s left hip. In his testimony, the claimant makes no mention of any injury or difficulties involving his left hip. There is one mention in the medical records evidence that indicates the claimant complained of his left foot being swollen. This is the initial evaluation by Dr. Baggett, on January 28, 2005. However, in her actual history of the claimant’s difficulties, Dr. Baggett makes no mention of difficulties with the claimant’s left foot. On her physical examination, she noted no abnormalities involving the claimant’s left foot. Most importantly, in her diagnosis, Dr. Baggett diagnosed no injury or condition that involved the claimant’s left foot. Finally, in his testimony, the

claimant denied any injury to or difficulties with, either his left hip or left foot.

After consideration of the evidence presented, it is my opinion that the claimant has failed to “establish” by medical evidence the actual existence of any injury or condition involving either his left hip or his left foot. He has also failed to present credible evidence of any “objective findings” to support the existence of any physical injury or condition involving either his left hip or his left foot. Therefore, in regard to his alleged left hip and left foot injuries, I find that the claimant has failed to satisfy the statutory requirements for a “compensable injury” that are contained in Ark. Code Ann. §11-9-102(4)(D).

The medical evidence presented does “establish” the actual existence of various types of physical injuries or defects involving the claimant’s left knee. Further, the medical evidence shows that the actual existence of some of these physical injuries or conditions are supported by “objective findings.”

In her initial report of January 28, 2005, Dr. Baggett simply diagnosed the claimant’s difficulties as “knee pain, left.” Although she recorded a paucity of objective findings to support this diagnosis, her physical examination did indicate a trace of “effusion” of the knee joint. However, she noted no joint instability or edema. Subjectively, she noted only that the claimant was tender to palpitation over the medial collateral ligament and the poplit (?) fossa and complained of pain only on forced flexion.

As the claimant also complained of swelling of his calf at the time of this visit Dr. Baggett ordered a Doppler study of the claimant's left leg to investigate a possibility of a deep vein thrombosis. This test was subsequently performed on February 2, 2005, and was interpreted as normal.

Following the Doppler study, the claimant was seen by Dr. Bob Wilson, apparently an associate of Dr. Baggett. Dr. Wilson diagnosed "left knee pain and swelling," as well as "left calf pain and swelling." On his physical examination, Dr. Wilson observed moderate tenderness in the lateral and posterior portions of the knee with mild diffuse swelling of the knee. He also observed diffuse tenderness, tightness, and possible swelling in the left calf. Measurement of the claimant's calves revealed that the left was 1 cm. greater than the right. He also noted that the claimant appeared to walk with a "mild" limp.

Dr. Wilson again saw the claimant on February 5, 2005. At that time, he diagnosed left knee pain and swelling. His physical examination noted that the claimant is tender in the medial and posterior portions of his knee, and also in the posterior portion of his calf. He observed mild edema of the knee, but noted no instability or crepitus. Finally, he noted that x-rays of the claimant's left knee show only mild chronic degenerative changes with nothing that appears recent or "acute."

On February 14, 2005, the claimant was seen by Dr. Christopher Arnold, an orthopaedic surgeon. Dr. Arnold also gave a rather nebulous diagnosis of "left knee pain." On his physical examination,

Dr. Arnold noted that the claimant's knee exhibited no instability, but had a "2 plus effusion." Subjectively, he recorded complaints of pain with extension and flexion of the knee with tenderness in the medial portion of the knee. Dr. Arnold injected the claimant's left knee and recommended an MRI to investigate the possibility of a meniscus tear.

Shortly after the claimant's visit with Dr. Arnold, the respondent sent the claimant for evaluation and/or treatment of his left knee difficulties by Dr. Gary Moffitt, a general practitioner and the respondent's company physician. Dr. Moffitt diagnosed the claimant's difficulties as a "contused" left knee. He noted that x-rays of the claimant's left knee, taken on March 23, 2005, showed degenerative and osteoarthritis changes that had worsened since previous x-rays of the knee in 2001. On his physical examination on March 23, 2005, Dr. Moffitt observed swelling of the left knee, but no instability, laxity, or crepitus.

The MRI of the left knee (initially recommended by Dr. Arnold), was ultimately performed at the request of Dr. Moffitt, on April 1, 2005. This study was interpreted as showing defects in the form of a small Baker's cyst. It also showed questionable signal abnormalities which would be indicative of a possible tear of the posterior horn of the medial meniscus. The examiner went to indicate that these questionable signal abnormalities could be consistent with a "chronic" tear.

After consideration of the evidence presented, it is my opinion that the medical evidence "establishes" the actual

existence of physical defects or damage to the claimant's knee in the form of a contusion, degenerative arthritic changes, and a Baker's cyst. I further find that these physical defects or damage are supported by "objective findings" as that term is defined by Ark. Code Ann. §11-9-102(16)(A)(i).

However, I also find that the greater weight of the credible medical evidence fails to "establish" the actual existence of a physical injury or damage to the claimant's left knee, in the form of a meniscal tear. Although Dr. Arnold stated that he was "concerned" about the possibility of such a defect, such "concern" is not sufficient to actually establish its existence. I would also note that although the MRI study is interpreted as indicating a "possible tear" of the posterior horn of the medial meniscus. This interpretation only noted that the study revealed "questionable" signal abnormalities that could be indicative of such a defect. Such suspicion and questionable abnormalities are not sufficient to establish the actual existence of such a physical injury or defect by "objective findings."

Next, the claimant must prove by the greater weight of the credible evidence that the medically established and objectively documented physical injuries or defects involving his left knee satisfy the definitional requirements for a "compensable injury" that are contained in Ark. Code Ann. §11-9-102(4)(A)(i). These requirements are:

- (1) That the physical injury or damage must arise out of and occur in the course of the employment;

(2) That the physical injury or damage caused by a specific incident;

(3) That the physical injury or damage must be identifiable by time and place of occurrence;

(4) That the physical injury or damage must have caused internal or external physical harm to the claimant's body;

(5) That the physical injury or damage must require medical services or result in disability.

In order to prove the first three of these definitional requirements, the claimant must show by the greater weight of the credible evidence, the presence of a causal relationship between one or more of these medically established and objectively documented physical injuries or defects and the specific employment related incident of December 28, 2004. However, he need not prove the presence of this causal relationship to an absolute or even mathematical certainty. He need only prove such a causal relationship is likely or probable. It is also unnecessary that he show that the employment related incident or accident of December 28, 2004, was the sole or even "major" cause of the physical injury or damage.

The evidence presented clearly shows that the claimant was experiencing pre-existing degenerative arthritic changes in his left knee prior to the employment related incident of December 28, 2004. Such degenerative changes had been noted on x-rays of his left knee that were taken in 2001. Although the x-rays of the left knee taken after the incident of December 28, 2004 showed an increase or worsening in these degenerative changes, there is no

evidence showing that this change was in any way the result of the December 28, 2004 accident. This change could reasonably be attributed merely to the natural progression and the period of years of the ongoing arthritic process in the claimant's knee. The documented Baker's cyst in the claimant's left knee is clearly a non traumatic defect and cannot be attributed to the described employment related accident. In fact, the medical evidence even indicates that the possible meniscal tear, if it exists, could also be degenerative in origin. The only medically established physical injury to the claimant's left knee that would reasonably be traumatic in origin would be that of a simple contusion of the left knee.

The specific employment related incident or accident of December 28, 2004, as described by the claimant, would be logically consistent with producing a contusion to the claimant's left knee. The initial symptoms described by the claimant would also be consistent with this type of injury.

However, the claimant's testimony indicating the persistence of significant pain and swelling in his left knee would not be usually expected from a mere contusion. The claimant's testimony concerning the continuation of these symptoms and his subsequent actions are somewhat inconsistent and contradictory. While I recognize that the claimant is not fluent in the English language, his lack of knowledge of English would not adequately explain these numerous variations and inconsistencies.

The claimant testified that at quitting time following the accident on December 28, 2004, his supervisor told him to go to the hospital, which he states is really a medical clinic at the intersection of Highway 412 and 40<sup>th</sup> Street in Springdale. He testified that on that same day or several days thereafter went to this clinic, but that he was not seen at that time and was only given an appointment for some 10 to 15 days later. He testified that he ultimately saw the doctor at this clinic only one time and was referred to an orthopaedic surgeon. He stated that he continued to work for the respondent at his regular job between the date of the accident and the time he was taken off work by the doctor at the medical clinic, a period which he described as being 10 days. He stated that during this period that he continued to work, he was given 2 pills a day by an "interpreter" in the employ of the respondent. It was his testimony that he could stand the pain and do his work because of the pills he was being given. He testified that throughout this period of time, he continued to experience substantial pain in his knee. In his deposition and at the hearing, the claimant initially testified that he had never experienced any prior problems with his left knee (including pain, soreness, weakness, swelling, etc.) Prior to the accident on December 28, 2004. He also denied ever having an x-ray of his left knee.

However, on cross examination, he stated that it was possible that he could have had a minor injury to his left knee when he was working construction and that he could have possibly had a prior x-ray. However, he indicated that this injury was insignificant and

did not keep him from working. On further cross examination, the claimant stated that he remembered seeing a Dr. Green at the Lowell Medical Clinic for a prior on the job injury when he struck his left knee with a hammer.

Finally, on cross examination, the claimant conceded that his supervisor did not send him to the medical clinic at Highway 412 and 40<sup>th</sup>, on December 28, 2004. Instead, he stated that his supervisor merely told him, on that date, to go to the doctor, but did not specify which doctor he should see. He conceded that he was the one who selected the doctor at the clinic at the Intersection of 412 and 40<sup>th</sup> Street in Springdale.

There is no documentary evidence presented to show that the claimant initially sought medical treatment, at any medical facility on December 28, 2004, or shortly thereafter. In fact, the medical evidence shows that the first time the claimant sought any medical services after December 28, 2004, was at the emergency room of Northwest Medical Center in Springdale. This occurred on January 14, 2005. The emergency room record for this visit shows that, at that time, the claimant only had abdominal complaints and underwent extensive testing for these complaints. There was no mention in the emergency room of any complaints involving the claimant's left knee. In fact, the screening physical recorded that the claimant's various extremities appeared normal.

At the hearing, the claimant denied going to the Northwest Medical Center with abdominal complaints on January 14, 2005 or any other date. However, the records of the Northwest Medical Center

show the patient's name, age, and birth date to be the same as the claimant.

The first indication in the medical evidence that the claimant sought any medical treatment for complaints involving his knee was on January 28, 2005. At that time, the claimant was not only complaining of intermittent swelling in his left knee, but also his left calf. Curiously, this is the medical report, which indicates the claimant's chief complaint as his left foot being swollen. However, this would appear to be either a clerical error or an error attributable to faulty translation, as the remainder of the report only notes complaints involving the left knee and calf.

This medical record also noted that the claimant has not yet missed any work, as a result of these complaints. Further, this report indicated that, at this time, the claimant was taken off work until additional testing can be completed. Thus, it would appear that the claimant, in fact continued to work for some 30 days, without seeking medical treatment for knee difficulties, after the accident on December 28, 2004.

Misty Michelle Hankins, the plant nurse, testified that when she arrived at work at approximately 6:00 a.m. on December 28, 2004, she noted an accident report and had the claimant come into her office. At that time, she examined his knee and observed no redness, bruising, or swelling. She further stated that, at that time, the claimant requested no medical attention. She testified that she expressly advised the claimant to come back in her office, if he felt it necessary. It was her testimony that the claimant

never returned to her office during the following weeks with any complaints involving his knee. Finally, she stated that she does not take any medication to anyone in the plant nor does she have anyone take medication to employees on the floor. She stated that the next involvement that she had with the claimant was after he had brought in a note from a doctor, taking him off work, in late January of 2005.

The claimant identified, at the hearing, Gary Clayton, as the supervisor to whom he reported the accident and injury on December 28, 2004. However, the claimant was obviously mistaken. The incident or injury report, dated December 28, 2004, was signed by James Pratt. Mr. Pratt was the night manager, while Mr. Clayton was the day manager.

Mr. Pratt did not testify. However, Mr. Clayton testified that he had no particular knowledge or involvement in this case, until after the claimant brought in the doctor's excuse following the January 28, 2005 doctor's visit.

After consideration of all the evidence presented, I am convinced the claimant was involved in an employment related accident on December 28, 2004. It is my further opinion that the greater weight of the credible evidence shows that this accident caused only a minor contusion of his left knee that resolved shortly thereafter without requiring any medical treatment or producing any disability. Finally, it is my opinion that the greater weight of the credible evidence fails to show that the specific employment related incident or accident on December 28,

2004 was the most likely or probable cause of any difficulties which the claimant may have experienced with his left knee on and after January 28, 2005. The evidence presented shows that these difficulties were more likely the result of the natural progression of the claimant's longstanding degenerative arthritis of the left knee, his non traumatic Baker's cyst, or of the same unknown etiology that was producing the same symptoms of pain and swelling involving the claimant's left calf.

The only direct evidence, which would link the claimant's subsequent left knee difficulties with the employment related accident of December 28, 2004, is the claimant's own testimony that his difficulties and symptoms first began on that date and were continuously present thereafter. This testimony is inconsistent with the claimant's failure to seek medical treatment from either a physician or from the first aid nurse at the respondent for some 30 days following the accident. This testimony is also inconsistent with the claimant's ability to continue to perform his regular employment position for the respondent, which required prolonged walking and standing, without apparent difficulty. Finally, this testimony is inconsistent with the fact that the claimant sought medical treatment at the emergency room for an unrelated condition and made no mention of any difficulties involving his left knee or lower extremity, and (as previously noted) the physical examination section of the hospital records for this visit show this portion of the claimant's body to be within normal limits.

In summary, I find that the claimant has failed to prove by the greater weight of the credible evidence that on December 28, 2004, he sustained a "compensable injury," as that term is defined by the Act, to either his left hip, left knee, or left foot. Therefore, I have no alternative but to deny and dismiss this claim in its entirety.

FINDINGS OF FACT & CONCLUSIONS OF LAW

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

2. On December 28, 2004, the relationship of employee-self insured employer-TPA existed between the parties.

3. On December 28, 2004, the claimant earned wages sufficient to entitle him to weekly compensation benefits of \$216.00 for total disability and \$162.00 for permanent partial disability, should such benefits have been appropriate.

4. The claimant has failed to prove by the greater weight of the credible evidence that on December 28, 2004, he sustained "compensable injuries," as that term is defined by the Act, to either his left knee, left hip, or left foot. Specifically, he has failed to "establish" by medical evidence, which is supported by "objective findings," the actual existence of any physical injury or damage to his left hip or left foot. He has also failed to prove by the greater weight of the credible evidence that he sustained any physical injury to his left knee that required medical services or resulted in any disability. Finally, he has failed to prove that any difficulties, which he may have

experienced with his left knee on and after January 28, 2005, and which may have required medical services and/or resulted in disability, were causally related to the specific employment related incident or accident of December 28, 2004.

The respondents have denied the occurrence of any compensable injuries to the claimant's left knee, left hip, and left foot and have controverted this claim in its entirety.

ORDER

Based upon my foregoing findings and conclusions, I have no alternative but to deny and dismiss this claim in its entirety.

IT IS SO ORDERED.

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MICHAEL L. ELLIG  
ADMINISTRATIVE LAW JUDGE