BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

WCC NO. F506037

DEBRA HEARD, EMPLOYEE **CLAIMANT**

DEWITT HOSPITAL & NURSING HOME, INC.,
SELF-INSURED EMPLOYER **RESPONDENT**

RISK MANAGEMENT RESOURCES,
THIRD PARTY ADMINISTRATOR **RESPONDENT**

OPINION FILED OCTOBER 2, 2006

Hearing before Administrative Law Judge Barbara W. Webb on June 29, 2006, in Helena, Phillips County, Arkansas.

Claimant represented by Mr. Mike J. Etoch, Jr., Attorney at Law, Little Rock, Arkansas.

Respondents represented by Mr. Guy Alton Wade, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on the above-styled claim on June 29, 2006, before Administrative Law Judge Barbara Webb. A Pre-hearing Order was entered in this case on March 20, 2006. The Pre-hearing Order set forth the stipulations offered by the parties and outlined the issues to be litigated and resolved at this hearing. At the hearing, the parties amended the stipulations to include the impairment rating assigned to the ankle. A copy of the Pre-hearing Order was made Commission's Exhibit No. 1 to the hearing record.

The following stipulations as submitted by the parties in the Pre-hearing Order and as amended on the record are hereby accepted:

1. The employer/employee relationship existed on June 16, 2005.

2. Compensation rate: $152.00 - TTD, based on average weekly wage of $228.00.

3. The claim was initially accepted as compensable and some TTD and medical benefits were paid.

By agreement of the parties, the primary issue to be presented is compensability and if proven, then claimant's entitlement to temporary total disability and medical benefits.

The record consists of a one volume transcript of the June 29, 2006 hearing, consisting of the testimony of Katrina Jones and Debra Heard on behalf of the claimant; the testimony of N. Francis Wisdom and Dana Adams, RN on behalf of the respondent; and all documentary evidence consisting of Claimant's Exhibit No. 1 (medical index and records) and Respondents' Exhibit 1 (medical index and records) and Exhibit 2 (medical index and records of Dr. Webber). I have also blue-backed the post-hearing letter brief submitted by the claimant, which is also incorporated and made a part of the record.

At the hearing, the claimant called Kaniesha Jackson as a witness. The Respondents objected on the basis that Kaniesha Jackson was not disclosed as a potential witness at least 7 days prior to the hearing as required by the Pre-hearing Order. After review of the evidence and arguments of counsel, this Administrative Law Judge determined that the witness had not been disclosed prior to the hearing or during any of the discovery phase of the case. Therefore, based on demonstrated surprise and prejudice, the testimony of Kaniesha Jackson was ruled inadmissible. Claimant made a proffer of the testimony of Kaniesha Jackson outside the presence of this Administrative Law Judge which has been made a part of this record.

FACTUAL BACKGROUND

The claimant offered the testimony of her co-worker, Katrina Jones. Jones testified that she worked with the claimant as a certified nursing assistant. She explained that the job duties entailed taking care of the residents and assisting them with their needs, including lifting the patients in and out of bed. On the particular day in question, Jones testified that she was called by the claimant and Ms. Wisdom to the room of a resident, Ms. Josie Fred. She explained that the resident was heavy and was being helped to the bed from a chair. When Jones arrived at the room, she observed the claimant bent over and Jones was asked to assist Ms. Wisdom in getting Ms. Josie back to bed. She testified that the incident happened around 4:00 and that her shift began at 3:00. She explained that the claimant was told to go ahead and clock out but the claimant waited on Jones to finish her shift since they had driven to work together. Jones drove the claimant home from the nursing home and did not accompany the claimant to the emergency room. She did not witness the incident but observed the claimant bent over and moaning in pain. On cross-examination, she testified that she had known the claimant for two years. She was not aware that the claimant had been treating with a doctor for back pain. She had never heard the claimant complain of back pain before. She was not aware the claimant had injured her back in 1995.

The claimant testified that she had worked at the nursing home off and on for two years. She testified that she did not complain about her back until the incident. She explained that on June 7, 2005, she was moving a resident with Kaneisha Jackson from the

wheelchair to the bed and slipped and slumped over him on the bed. She felt like she strained her back. She reported the incident to Robert, the charge nurse and asked for a Tylenol which was refused. She sought treatment with Dr. Webber the next morning. When she returned to work on the following Monday, she reported the incident to Dana Adams, the Director of Nursing, and was told that she had 48 hours to report the incident (instead of 72 hours). She returned to her regular duties until June 16, 2005. On that date, she testified that she and Fran Wisdom were lifting Ms. Josie Fred from her lift chair to her bed. She described the incident, as follows:

> As I was doing that, I picked Ms. Josie up with my left arm – and I picked her up. And as I was picking her up, I had a strange feeling in my back. It felt like something pulled. And I had to let Ms. Josie go right then, and she was sitting on the edge of the bed. And Ms. Fran called for some help. And that's when Ms. Katrina Jones came in to assist her.

She explained that when Jones came into the room, she was sitting on a stool to relax herself. She testified that she reported the incident to Adams and was told to go to the emergency room. She testified that she went to the emergency room and was treated with a shot and prescription medication. She explained that she could not finish her shift and laid on the sofa waiting for Jones to finish the shift at the request of Dana Adams since they had shared a ride to work. She testified that when she got home, she went to bed and took a pain pill. She sought medical treatment with Dr. Webber the next day. He referred her for an MRI and gave her some pain pills. She was subsequently treated by Dr. Wilson, an orthopedic specialist, and diagnosed with a sprain in her back and released to go back to full duty work. She testified that she tried to return to work but could not handle it. She returned to Dr. Wilson and was referred for physical therapy for a couple of weeks and was taken off work. She continued therapy and filed for a change of physician. She was

granted the change of physician and sought treatment with Dr. Sunder Krishnan. He gave her injections and was informed by the insurance company that they would pay for the injections. She was subsequently told that the insurance company would not pay for the injections. She had a total of four injections and used her own money or insurance to pay for them. She testified that Krishnan had referred her to another doctor. She testified that she had not been able to return to work. On cross-examination, she testified that she had previously injured her back while working for DPS Chemical Company and was treated by Dr. McDaniel and Dr. Engleberg, a neurosurgeon. She had an MRI as part of that treatment and filed a workers' compensation claim. After a full hearing, she was awarded benefits based on the MRI that revealed disk herniations at L4 and L5, with the L5 characterized as a "large, left herniation". She did not return to work after her injury and remained off work for several years. She was subsequently diagnosed with a condition called Stevens Johnson Syndrome and missed 3 to 4 years of work after that diagnosis. She filed for Social Security disability and receives the sum of $517.00 weekly as a result of that condition. She was also diagnosed with lupus and regularly takes medication for her joint swelling. She explained that she worked for the nursing home in 2004 for 4 months when her certificate expired. She testified that she returned to work with the nursing home on April 15, 2005, and got her CNA certificate back in May of 2005. She testified that the incident on the 16th of June occurred after 7:00 p.m. as opposed to 4:00 p.m. as testified by Jones. She testified that Dr. Wilson had returned her to work full duty with no restrictions on 8/18/05. She did not tell Dr. Wilson about an event occurring on June 7 or 8 of 2005. She agreed that she testified at her deposition that she had seen Dr. Webber on June 8, 2006, about her legs bothering her. She agreed that she previously testified in her

deposition that she was not having back problems when she went to see Dr. Webber on June 8, 2005. She testified that she had an MRI on June 20, 2005. She testified that Dr. Webber did not treat her for her previous back injury and had been provided no information of her prior back injury. The June, 2005 MRI showed a large left L/5 disk herniation and disk degeneration, annular tear and stenosing disk bulge observed at L/4. She testified that she had no other events or injuries, but admitted on further examination that she had treated with Dr. Ferguson. In his records, the claimant had reported a history including a motor vehicle accident in which she injured her back in 1993. She admitted she did not disclose the motor vehicle accident in 1993, treatment by Dr. Franklin, the incident on June 7, 2005, or any incident involving the resident named Bennett in discovery responses.

The respondents offered the testimony of Fran Wisdom. She testified that she had worked for the nursing home for a total of 18 years as a certified nursing assistant. She testified that she was scheduled to work as partners with the claimant on a certain hall on several occasions. She worked the same shift as the claimant. She testified that the claimant had complained of back problems and back pain prior to June 16, 2005. She testified that it was not unusual for the claimant to make the complaints of back pain when the two were required to lift or move patients. Wisdom testified that she would have to take a heavier load when Heard complained even though Wisdom was not supposed to be lifting. Wisdom did not recall Heard complaining that her back was hurting on June 16, 2005. She testified that Heard did not tell her that she had hurt her back at work prior to June 16, 2005. She explained that on June 16, 2005, Heard told her that she hurt her back when they were moving Ms. Josie Fred from her bed to her wheelchair. She explained that

she wasn’t shocked because she had heard similar statements before. She testified that they had already moved the patient when she made the statement. She did not call on the intercom and request assistance from Katrina Jones. She testified that other than the statement there was no indication from the claimant that she had injured her back. She did not observe any unusual expression, reaction, movement or any significant behavior by the claimant on the day in question. She did not observe the claimant doubled over in pain. She testified that she did not recall an incident that Katrina Jones had ever been called in to assist her and Heard with a resident, although she explained that it was not unusual to call for assistance if you needed help.

The respondents also called Dana Adams, Director of Nursing. Adams testified that the claimant did not report that she had been hurt at work prior to June 16, 2006. She explained that Heard had complained of back pain on different occasions but did not relate her problems to any specific event at work. On June 16, 2005, Heard reported to her that she and another CNA, Wisdom, were in a room and what had happened and that her back was hurting. She explained that she did not immediately report the incident. She did not observe Heard acting any different from any other day. She did not observe her holding her back or making facial grimaces or any other motion that would indicate that she had hurt her back. She documented the report and made contact by phone with the appropriate person who would direct the claimant for treatment. She testified that Heard went to the emergency room. She did not recall asking Heard to wait on Jones. She testified that Heard returned to the nursing home after June 16, 2005, and worked an 8-hour shift and was unable to come back. She attempted to return again but has not been

able to return to work. She testified that she did not know about an incident on June 7 and did not recall having a conversation with Heard about the deadline to report an incident. She explained that she did not know of any report of an injury involving Heard on June 7, 2005. She explained that if an injury was reported late, she would go ahead and fill out the paperwork, call the appropriate number, and let the employee know that workman's comp would probably not pay for the treatment, because she had done so in the past. She did not recall an incident involving Heard related to an alleged injury while trying to lift a patient named Bennett. The only report she received from the claimant was on June 16, 2005, at which time she had her fill out the paperwork.

The medical records reflect that on July 26, 1995, the claimant sought treatment at the Semmes-Murphey Clinic with Dr. Engleberg after referral by Dr. McDaniel for pain in the low back and right hip. The findings from an MRI performed on the claimant on August 1, 1995 reflect "(1) Large left L5 Disc Herniation. (2) Disc Degeneration, annular tear, and stenosing disc bulge are observed at L4, along with facet hypertrophy and right facet arthropathy". On August 23, 1995, Dr. Engleberg noted inconsistencies in the symptoms reported by the claimant and the test results indicating that "this lady is not able to be dealt with because of her total unreliability". On September 9, 1995, the claimant sought treatment with Dr. Barr. After evaluation, Dr. Barr noted that the claimant should be treated conservatively and encouraged an exercise program. He further noted that "the defect with the disc at L4-5 shown on MRI does not correspond to the patient's symptomatology" and returned the claimant to her regular physicians.

The medical records reflect that the claimant sought treatment with Dr. Webber on various dates from June 12, 2003 until June 17, 2005. Specifically, clinic notes reflect that claimant sought treatment on June 8, 2005, for reoccurring back pain seeking pain medication. However, the clinic notes are illegible and no testimony was offered to explain what was set out in the notes. On June 17, 2005, the clinic notes reflect that claimant returned with complaints of back pain. On June 20, 2005, claimant underwent a second MRI of the lumbar spine. The findings of the MRI reflect that (1) Disc desiccation at L4-5 and L5-S1, (2) Generalized bulging annulus and spondylosis at L4-5, (3) Slight anterior sublaxation at L4 on L5, (4) Left paracentral disc herniation at L5-S1, and (5) Mutilevel facet hypertrophy and neural foraminal narrowing, as described." On June 27, 2005, the claimant was evaluated by Dr. John Wilson, an orthopedic specialist. He noted that the x-rays of her back revealed degenerative changes at 4-5 and 5-1 and that the MRI revealed a left paracentral disc at 5-1. He gave her an injection of Decadron, placed her on a Celestone Tabpack, Celebrex and Robaxin, and placed her in out-patient therapy. In addition, he returned her to full duty work with no restrictions. She returned for treatment with continued complaints of pain in her lower back and new reports of pain in her left buttock on July 20, 2005. Dr. Wilson noted that she had evidence of a "resolving strain and does have degenerative disc disease". She was scheduled for an additional three weeks of therapy. On August 17, 2005, she was released to return to work on August 18, 2005, to full duty work with no restrictions.

The claimant was approved a change of physician and sought an evaluation and treatment with Dr. Krishnan. Dr. Krishnan opined that her symptoms were consistent with

facet mediated syndrome and recommended injections followed by rhizotomies. He noted that the injections would not reverse the existing arthritic change. In February of 2006, she reported overall improvement greater than 60-70% approximately six weeks after the treatments. He indicated that he had never placed the claimant on any job restrictions. She returned to Dr. Krishnan after returning to work complaining of recurrent back pain when standing for a prolonged period of time. She refused surgery and on March 7, 2006, received a lumbar epidural steriod injection with instructions to return in three to four weeks to determine a further care plan. On December 16, 2005, Dr. Krishnan wrote a letter stating that if Heard had seen her family physician complaining of back pain prior to June 16, 2005, he would not be able to state to a reasonable degree of medical certainty that she sustained the injury at work since his conclusions were drawn from the claimant's statements that she had prior history of back pain 10 years ago but she had no symptoms until her "work related injury" on June 16, 2005.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. That the Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. That the employee/employer relationship existed at all relevant times, including June 16, 2005.
3. Claimant has failed to establish by a preponderance of the evidence that she had a compensable injury.

DISCUSSION

The claimant contends that she was injured on June 16, 2005, while performing her duties as a certified nurse assistant for DeWitt Hospital & Nursing Home. She contends she has not worked since the date of the accident, that some TTD benefits were paid, and she has not at this time been rated for permanent disability and has not been released by her doctor. Respondents contend that they initially accepted claimant's claim as compensable, however, upon receipt of medical records regarding prior complaints and injuries and claimant's present complaints, respondents contend that claimant's condition is pre-existing and/or a recurrence of a pre-existing condition and therefore not compensable. Alternatively, respondents contend that claimant is not entitled to the treatment recommended by Dr. Krishnan, the doctor to whom she was granted a change of physician by the Commission on September 29, 2005, since it is unrelated to any additional injury occurring on June 16, 2005.

I. COMPENSABILITY

Ark. Code Ann. § 11-9-102(4)(A) defines "compensable injury": (a)n accidental injury causing internal or external physical harm to the body or accidental injury to prosthetic appliances, including eyeglasses, contact lenses, or hearing aids, arising out of and in the course of employment and which requires medical services or results in disability or death. An injury is "accidental" only if it is caused by a specific incident and is identifiable by time and place of occurrence. A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. § 11-9-102(4)(D). Claimant's burden of proof shall be a preponderance of the evidence. Ark. Code Ann. § 11-9-102(4)(E)(i). If

claimant fails to establish by a preponderance of the evidence any of the requirements for establishing the compensability of the injury alleged, she fails to establish the compensability of the claim, and compensation must be denied.

It is the exclusive function of the Commission to determine the credibility of the witnesses and the weight to be given their testimony. Johnson v. Riceland Foods, 47 Ark. App. 71, 884 S.W.2d 626 (1994). Furthermore, the Commission is not required to believe the testimony of the claimant or other witnesses, but may accept and translate into findings of fact only those portions of the testimony it deems worthy of belief. Morelock v. Kearney Company, 48 Ark. App. 227, 894 S.W.2d 603 (1995). It is important to note that the claimant's testimony is never considered uncontroverted. Lambert v. Gerber Products Co., 14 Ark. App. 88, 684 S.W.2d 842 (1985); Nix v. Wilson World Hotel, 46 Ark. App. 303, 879 S.W.2d 457 (1994).

In the instant case, there is conflict in the testimony as to the events of June 16, 2005. The claimant testified that she injured her back while assisting Ms. Fred. Ms. Wisdom does not recall the specific incident but testified that it was not unusual for the claimant to complain of back pain when lifting patients. The only witness offered to corroborate the claimant's testimony as to the June 16, 2005 incident was Katrina Jones, a co-worker and friend of the claimant. However, I do not find the testimony of Jones to be credible. She seems to recall the specific events of June 16, 2005, but does not recall the claimant ever complaining of back pain or having any type of back problems. All of the other witnesses, including the claimant, offered testimony concerning the claimant's history of back problems and continued complaints of pain. Further, their testimony is

substantiated by the medical records in the case. I am particularly persuaded by the testimony of Ms. Adams, the Director of Nursing. At the time the claimant reported the injury, she did not observe any of the normal and expected symptoms or behavior of someone who was having the type of back pain reported by the claimant. This testimony is consistent with the testimony of the other certified nursing assistant in the room who did not observe the claimant exhibiting any symptoms or behavior consistent with her complaints. Moreover, I do not find the testimony of the claimant to be credible. It is clear from the record that the claimant did not disclose all of her prior back injuries to the treating physicians or even in the discovery conducted prior to the hearing in the case. At the hearing the claimant contended that she had a similar incident resulting in back pain approximately ten days prior to the date in question, but failed to mention the incident to any of her treating physicians. The medical records reflect that she sought treatment but due to the illegibility of the records, it is not clear whether she sought treatment for back or leg pain and whether it was work-related. Based on my review of the evidence, I find that the claimant failed to prove by a preponderance of the evidence that she suffered a compensable work-related injury in June of 2005.

II. AGGRAVATION/RECURRENCE

Respondents contend the continuation of similar complaints of back pain by the claimant should be considered a continuation and/or recurrence of the claimant's problems from her preexisting conditions.

In Maverick Transp. V. Buzzard, 69 Ark. App. 128, 10 S.W.3d 467 (2000), the Arkansas Court of Appeals discussed the difference between an aggravation and a recurrence as it relates to workers' compensation law. The Court stated:

> An aggravation is a new injury resulting from an independent incident. Farmland Ins. Co. v. DuBois, 54 Ark. App. 141, 923 S.W.2d 883 (1996). A recurrence is not a new injury but merely another period of incapacitation resulting from a previous injury. Atkins Nursing Home v. Gray, 54 Ark. App. 125, 923 S.W.2d 897 (1996). A recurrence exists when the second complication is a natural and probable consequence of a prior injury. Weldon v. Pierce Bros. Constr., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Only where it is found that a second episode has resulted from an independent intervening cause is liability imposed upon the second carrier.

Id. at 130, 10 S.W.3d at 468. An aggravation is a new injury with an independent cause and, therefore, must meet the requirements for a compensable injury. Crudup v. Regal Ware, Inc., 341 Ark. 804, 20 S.W.3d 900 (2000); Ford v. Chemipulp Process, Inc., 63 Ark. App. 260, 977 S.W.2d 5 (1998).

The test to determine whether a subsequent episode is a recurrence or an aggravation is whether the subsequent episode was a natural and probable result of the first injury or if it was precipitated by an independent intervening cause. Bearden Lumber Co. v. Bond, 7 Ark. App. 65, 644 S.W.2d 321 (1983). If there is a causal connection between the primary and the subsequent disability, there is no independent intervening cause unless the subsequent disability is triggered by activity on the part of the claimant which is unreasonable under the circumstances. Guidry v. J & R Eads Const. Co., 11 Ark. App. 219, 669 S.W.2d 483 (1984), Georgia-Pacific Corp. v. Carter, 62 Ark. App. 162, 969 S.W.2d 677 (1998), Davis v. Old Dominion Freight Line, Inc. 341 Ark. 751, 20 S.W.3d 326 (2000).

The determination of the credibility of the witnesses and the weight to be given their testimony are matters exclusively within the province of the Commission. Cooper v. Hiland Dairy, 69 Ark. App. 200, 11 S.W.3d 5 (2000).

The claimant relies primarily on the fact that she had allegedly recovered from her prior back problems and had been able to perform her job with the nursing home for several years before the alleged work-related incident. However, the medical records reflect that the claimant continued treatment of her back problems. In addition, the evidence established that claimant had only returned to her certified nursing assistant (CNA) job with the nursing home for four months in 2004 when her certificate expired. She did not return to a job with the nursing home until April of 2005 and returned to her duties as a CNA in May of 2005. Her alleged new injury to her back occurred either on June 7, 2005, and June 16, 2005, within a month of her re-employment. In the instant case, it is clear that claimant suffered from degenerative disc disease and that her complaints of back pain preceded the alleged incident.

Based on my review of the entire record, I find that the preponderance of the evidence demonstrates that claimant’s condition was a recurrence of the pre-existing condition and not the result of a specific incident injury or intervening cause.

III. OBJECTIVE FINDINGS

Respondent contends that there are no “objective findings” as required in order to support compensability of a February 10, 2005 injury. The claimant bears the burden of proving a compensable injury by a preponderance of the evidence. Smith v. City of Fort Smith, 84 Ark. App. 430, 143 S.W.3d 593 (2004). In addition to proving her injury by a

preponderance of the evidence, the claimant must establish the existence of the injury by medical evidence and supported by "objective findings." See Ark. Code Ann. § 11-9-102(4)(D). Objective findings are those that cannot come under the voluntary control of the patient. See Ark. Code Ann. § 11-9-102(16)(A)(i). The claimant must also prove that there is a causal connection between the work-related accident and the injury. Stevenson v. Tyson Foods, Inc., 70 Ark. App. 265, 19 S.W.3d 36 (2000). With respect to this proof, the claimant must show that the "major cause" of the injury is the workplace. When making this determination, the claimant does not receive the benefit of the doubt. Ark. Code Ann. § 11-9-704(c)(4)(Supp. 1995); Glencorp Polymer Products v. Landers, 36 Ark. App. 190, 820 S.W.2d 475 (1991). A claim for workers' compensation benefits must be based on proof. Speculation and conjecture, even if plausible, cannot take the place of proof. Arkansas Department of Correction v. Glover, 35 Ark. App. 32, 812 S.W.2d 692 (1991).

In the present case, the claimant has not presented any objective medical findings supporting a change of or the existence of a compensable injury as a result of any work performed by the claimant. There is no evidence offered to show that the MRI taken in June of 2005 revealed any significant new injuries or varied from the previous MRI taken ten years earlier with the exception of degenerative and arthritic problems which were noted. The lack of objective findings is further demonstrated by Dr. Krishnan in his letter of December 16, 2005, indicating that if the claimant had seen her family physician complaining of back pain prior to June 16, 2005 (as testified by the claimant at the hearing), he would not be able to state to a reasonable degree of medical certainty that she sustained the injury at work since his conclusions were drawn from the claimant's own

statements that she had prior history of back pain 10 years ago but that she had no symptoms until her "work related injury" on June 16, 2005. Therefore, I find that the claimant does not establish a compensable injury by medical evidence supported by objective findings.

ORDER

For the reasons discussed herein, this claim must be, and hereby is, respectfully denied.

IT IS SO ORDERED.

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HONORABLE BARBARA WEBB
Administrative Law Judge