

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F709061

SHEILA K. LAWRENCE EMPLOYEE

CLAIMANT

CENTRAL ARKANSAS NURSING
CENTER, EMPLOYER/
ACE AMERICAN INSURANCE CO.,
CARRIER

RESPONDENTS #1

SECOND INJURY TRUST FUND

RESPONDENT #2

OPINION FILED JULY 11, 2008

A hearing was held before ADMINISTRATIVE LAW JUDGE CHANDRA HICKS, on April 30, 2008, in Little Rock, Pulaski County, Arkansas.

The claimant was represented by The Honorable J. Mark White, Attorney at Law, Bryant, Arkansas.

Respondents #1 were represented by The Honorable Betty Hardy, Attorney at Law, Little Rock, Arkansas.

The Second Injury Trust Fund was represented by the Honorable Judy Rudd, Attorney at Law, Little Rock, Arkansas. The Fund did not participate in the hearing due to the issues being litigated.

STATEMENT OF THE CASE

A hearing was held in the above-styled claim on April 30, 2008, in Little Rock, Arkansas. A Prehearing Order was previously entered in this case on January 3, 2008. This Prehearing Order set forth the stipulations offered by the parties, the issues to be litigated, and their respective contentions.

The following stipulations were submitted by the parties, either in the Prehearing Order or at the start of the hearing,

and are hereby accepted:

STIPULATIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of the within claim.
2. The employee-employer-carrier relationship existed at all relevant times, including August 20, 2007.
3. At the time of the alleged injury, the claimant's average weekly wage was \$330.00, which would yield a weekly temporary total disability rate of \$220.00.

ISSUES

By agreement of the parties, the issues to be presented at the hearing were limited to the following:

1. Compensability of the claimant's left knee condition.
2. Whether the respondents should be estopped from denying liability for the treatment provided to the claimant by St. Anthony's Medical Center on August 20, 2007 (St. Vincent Health System); the treatment provided by Dr. Stephen Carter on August 24, 2007; and the treatment rendered by Dr. Scott Smith on August 29, 2007.
3. Whether the medical care of record is reasonable and necessary treatment. The issue of future medical treatment is reserved.
4. Temporary total disability compensation from August 21, 2007, and continuing through until January 7, 2008.

5. A controverted attorney's fee.

The claimant contends that she sustained a compensable knee injury, which the claimant categorizes as a temporary aggravation of a pre-existing condition. The claimant contends that she is entitled to the medical treatment of record. She further contends that she is entitled to temporary total disability compensation from August 21, 2007, through January 7, 2008. The claimant also contends that she is entitled to an attorney's fee.

Respondents #1 contend that the claimant cannot meet her burden of proof under the elements necessary to show that she had a compensable temporary aggravation of her preexisting condition from an incident that occurred on August the 20th of 2007. Therefore, she would not be entitled to any of the benefits sought.

The documentary evidence submitted in this case consists of the Commission's Prehearing Order of January 3, 2008; the claimant's Prehearing Questionnaire Response; Mr. White's letter to the Commission dated February 27, 2008; and the respondents' (respondents #1) Prehearing Questionnaire Response, as these were all marked as Commission's Exhibit No. 1. The claimant's Non-Medical Packet was marked as Claimant's Exhibit No. 1. (However, pages three(3) and four (4) of Claimant's Exhibit No. 1 were not received into evidence at the time of the hearing, pending a ruling on respondents no. 1's objection to these pages being entered into evidence). Respondent #1's Medical Packet was marked as Joint

Exhibit No. 1., and Dr. Scott Bowen's deposition of February 26, 2008, was marked as Joint Exhibit No. 2.

The following witness testified at the hearing: the claimant.

DISCUSSION

The claimant, age 50(7/07/58), worked for the respondent-employer as a CNA. The claimant admitted that her job required a lot of lifting and physical activity. According to the claimant, a typical shift for her entailed seven-and-half hours. With respect to her asserted injury, the claimant gave the following testimony:

A. We were getting a resident out of bed - - we had dressed her and was getting her out of bed to take her to the dining room. My partner and I, we had done dressed her. We had held her up on the side of the bed, she grabbed under one arm and I grabbed under the other, and then, when we proceeded to put her in the wheelchair, my knee popped.

Q. Did you feel a pop? Did you hear a pop?

A. I heard a pop in my knee.

Q. All right. What did you feel in your knee in, say, the 20 or so minutes after that?

A. It was just - - it was just, really, it was burning and stinging and hurting real bad. I couldn't hardly even walk on it.

She admitted to having next reported the injury to charge nurse, Ms. Johnson. According to the claimant, she and her partner both filled out an accident report. The claimant testified that the nurses who were in charge (Pam and Ms. Johnson) looked at her knee and stated, "Well, your knee is swelling." The claimant

testified that they told her to go to the emergency room, so she did so. She testified that at the emergency room, they put an ACE bandage on it and gave her some pain pills. According to the claimant, she was unable to drive, as a friend came to the nursing home and picked her up and took her to the emergency room and drove her home afterwards.

The claimant testified that she did not go to work the next day because she was in too much pain. She admitted to seeing Dr. Stephen Carter on August 24, 2008 because the procedure is that you go to the emergency room and they send you to a "workman's comp doctor." The claimant could not recall who told her to go see Dr. Carter. She testified that Carter sent her to see Dr. Scott Smith. According to the claimant, the bill from Drs. Carter and Smith have not been paid, nor the bill from the emergency room.

She testified that she did not know these were being denied until after she had gone to see Dr. Scott Smith. The claimant denied having any health insurance during this period of time. According to the claimant, she did not get any more medical treatment until later, as this was from Medicaid.

The claimant admitted to seeing Dr. Scott Bowen. She admitted that she has not seen Dr. Bowen since January 7, 2008. The claimant admitted that Dr. Milligan is her family physician. She essentially testified that when she saw Dr. Milligan on August 17, 2007, she was experiencing jerking symptoms, which were somewhat

similar to the restless leg syndrome. According to the claimant, it was not like a sharp pain, which is what she experienced after the 20th. The claimant agreed that the pain after the 20th was severe because she could hardly walk.

She denied any problems with her knee between August 17, 2007, and August 20, 2007. According to the claimant, she had no problems performing her job duties. The claimant essentially admitted that before the summer of 2007, before she went to see Dr. Milligan in July, she had no problems with her left knee.

The claimant admitted the day before the popping incident, she could probably walk two miles. According to the claimant, a week after the incident, she could not walk two miles because "the pain was too bad." She further testified that she could hardly get in and out of the house, as she had to have a cane and a crutch to move. She denied having required a cane or crutch before August 20, 2007.

On cross-examination, the claimant admitted to a right knee injury while working for Land O' Frost, for which she received some workers' comp benefits. She admitted to other health problems throughout the years. The claimant admitted to having stated during her deposition that she started receiving Social Security Disability in about September or possibly October of 2007. She admitted to drawing Social Security Disability due to other health problems and a surgery that was going to be coming up at some point

in the future. According to the claimant, as of the date of hearing, she was not drawing Social Security Disability.

The claimant admitted that on the day of the incident, when she felt the pop, the patient was already in the wheelchair.

A review of the documentary evidence demonstrates that on September 9, 2007, the claimant filed a Form AR-C, alleging an injury to her knee on August 20, 2007, as a result of lifting a patient.

On August 17, 2007, the claimant was seen by Dr. Joel Milligan due to complaints of severe left knee pain. The claimant reported that it had been bothering her for the last month or so, which was increasing in intensity. She also reported that sometimes it caused swelling behind the knee, in front of the knee and down toward the ankle. The claimant also reported that the pain was keeping her up at night, as it felt like a drawing sensation. She also reported that this was worse when she was twisting at the knee. He noted in pertinent part, that on physical exam, that there was some popliteal tenderness without fullness, and that there was a trace of effusion. Dr. Milligan's assessment was "Left knee severe pain, suspect early internal derangement verse osteoarthritis." He recommended follow-up in the next two weeks, if the claimant was not doing better, as well as the consideration of an MRI verses an orthopedic referral.

The claimant sought medical treatment for her left knee on

August 20, 2007 at the emergency room of St. Vincent Health System due to complaints of "left knee popping and pain." At which point, she was noted to have some peripatellar tenderness with mild swelling, but the knee was noted to be stable. The claimant was treated and discharged home. She was instructed to return to work on August 22, 2007.

On August 24, 2007, the claimant was seen by Dr. Stephen Carter. He notes that the claimant twisted her knee some four days ago at work while lifting a patient. The claimant also reported having heard a pop in the knee. Dr. Carter's assessment was "left knee strain." He referred the claimant to an orthopedist and directed her to refrain from working until seen.

The claimant underwent initial evaluation with Dr. Scott Smith on August 29, 2007, for a chief complaint of left knee pain.

He reported, in pertinent part, the following:

HISTORY OF PRESENT ILLNESS: Ms. Lawrence is a 49-year-old white female sent for orthopedic evaluation by Dr. Carter. She reports pain in the right knee which began about three weeks ago. At that time she was having pain radiating into her calf. She saw Dr. Carter who made x-rays and the pain seemed to be improving. She says she was lifting a patient on 8/20/07, felt a popping sensation in her knee and had immediate swelling and pain. She has had frequent popping since that time with pain at night, but increased with weight bearing. She has been off work since the 20th of August. She has significant pain when attempting to climb stairs. The pain is located anteriorly, medially, laterally, and posteriorly. She reports swelling in the knee. No other injuries.

EXAMINATION: On exam, left knee is tender along the medial and lateral joint line. McMurray's testing

positive. She guards on McMurray's testing. Range of motion is 0 to 110 degrees with pain on extremes. Increased pain on varus and valgus stress. Straight leg raising negative. Hip non-irritable. Compartments are soft, no effusion.

X-RAYS: A-P and lateral of the left knee taken by Dr. Carter show normal findings.

IMPRESSION: Left knee pain.

TREATMENT: I explained to Ms. Lawrence that my concern would be that she could have a tear of the meniscus cartilage. We will schedule an MRI for further evaluation, hold her out of work in the meantime. She was given a prescription for Ultram 50 mg. dispense 30, one to two po q 6 hours prn pain.

The claimant saw Dr. Milligan again on October 15, 2007 due to persistent left knee pain. He noted that her symptoms started about mid July prior to that. Dr. Milligan also wrote, "No specific injury has been identified." His assessment was "left knee derangement," for which he prescribed medications and recommended that the claimant see an orthopedic.

Dr. Scott Bowen evaluated the claimant on October 16, 2007 for left knee pain. His impression was "patellar chondromalacia, arthritis and synovitis, left knee." He also reported that this was probably related to work since she reported a history of a pop. Dr. Bowen recommended that the claimant undergo a corticosteroid injection to the left knee, a medication regimen, physical therapy, an MRI, and weight loss.

Dr. Bowen reported on November 16, 2007 the following to Dr. Milligan:

SUBJECTIVE: Ms. Lawrence is here today. She has been attending therapy. She is still having pain, particularly over the medial aspect of her left knee with a sensation of it giving way and weakness. In addition at night, she has "jerking" feelings in both knees and legs that might imply restless leg syndrome.

IMPRESSION:

1. Possible meniscus tear, left knee.

PLAN:

1. MRI of left knee.
2. Finish out therapy over the next couple of weeks.
3. We will call her with results of the scan. If it is positive, she may need arthroscopic surgery.
4. At this time, she is not trying to return to work.

The claimant underwent an MRI of the left knee on November 26, 2007, with the following impression:

1. HIGH SIGNAL NOTED IN THE POSTERIOR HORN/ROOT JUNCTION OF THE MEDIAL MENISCUS WHICH LIKELY REPRESENTS HIGH GRADE DEGENERATION/CONTUSION, HOWEVER, COULD ALSO REPRESENT A RESYNOVIALIZED POSTERIOR ROOT TEAR.
2. CARTILAGE LOSS IN THE MEDIAL JOINT COMPARTMENT WITH REACTIVE BONY CHANGES AND FREE EDGE BLUNTING OF THE MEDIAL MENISCUS. GRADE II/III CARTILAGE DEFECT AND FIBRILLATION IS ALSO NOTED IN THE MEDIAL PATELLAR FACET.
3. MINIMAL JOINT EFFUSION IS PRESENT.

On December 4, 2007, the claimant saw Dr. Bowen. His impression was "possible meniscus tear and synovitis of the left knee."

The claimant's attorney wrote the following to Dr. Bowen on December 5, 2007, and he provided the following responses on December 17, 2007.

I represent Sheila Lawrence in her claim for workers' compensation benefits. A signed authorization allowing you to communicate with me regarding her condition is enclosed.

There is a dispute as to whether or not Ms. Lawrence's knee problems are related to her work: by answering two questions below, you can help us resolve this matter promptly.

For purposes of this question, please assume the following history: Ms. Lawrence went to her family doctor, Dr. Joel Milligan, on August 17, 2007, complaining of "severe left knee pain... for the last month or so." Dr. Milligan's treatment note of that visit is attached. Three days later, Ms. Lawrence felt a "pop" in her knee while lifting a patient at work, followed by pain and swelling in her knee. She went to the ER that same day to have her knee evaluated.

1. Assuming the above history is correct, is it probable that the popping incident at work on August 20, 2007, aggravated or exacerbated the pre-existing problems in Ms. Lawrence's knee?

 X Yes No

2. Is your answer to the above question given within a reasonable degree of medical certainty?

 X Yes No

Dr. Bowen reported the following to Dr. Milligan on January 7, 2008, concerning the claimant's care:

 SUBJECTIVE: Ms. Lawrence is here today for follow up. She is having some pain in the anterior aspect of her left knee which is not quite as severe as before. This seems to be over the anterior parapatellar area and patellar tendon as well as along the lateral joint line.

 PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Unchanged since last visit.

EXAMINATION: On examination today, she does have 0 to 125 degrees of motion and is stable.

Previous MRI indicated some signal change in the posterior horn of the meniscus consistent with a possible tear although at this time I don't believe this is consistent with a meniscus tear but rather a patellofemoral chondromalacia syndrome and tendinitis.

IMPRESSION:

1. Patellofemoral chondromalacia and tendinitis, left knee.

PLAN:

1. No surgery.
2. Continue with conservative treatment.
3. I will see her back as needed.

Dr. W. Scott Bowen's testimony was taken on February 26, 2008. He admitted that his speciality is orthopedic surgery. Dr. Bowen gave an overview of his academic training, as he is board certified, and has been in private practice for the past 21 years.

He admitted that the claimant had been referred to him by Dr. Joe Milligan concerning her left knee pain condition. Dr. Bowen testified that the claimant did tell him that on August 25, 2007, (sic) she was working in a nursing home and had done a lift on a resident when she felt a pop in her left knee. According to Dr. Bowen, the claimant reported having gone to the emergency room, and that she had been seen by a physician assigned to her by the workers' comp carrier who felt it was "a strain." Dr. Bowen further testified that the claimant was approximately six or seven weeks out, and had not been back to work since the incident, as she was still having pain and giving away episodes in her knee.

According to Dr. Bowen, the claimant gave a history of some arthritic problems before, but not necessarily any problem with that knee to his knowledge. He testified that when he examined the claimant on October 16, 2007, his physical examination revealed the following:

A. Not a whole lot in the knee. She was a little difficult to examine because she was guarding; that is, resisting any motion, but I did notice that she did have some grinding or crepitus in the patellofemoral joint. She had a trace effusion or water on the knee, and that her motion was somewhat limited from about zero to a hundred degrees of flexion.

Q. What would - - you indicated in her report that she had one plus crepitus. Is there a scale that you use?

A. Yeah. One to four plus, so that would be fairly minor at the time.

Q. Okay. Then the trace effusion or water on the knee, what's the reason for that, or what causes that?

A. A suggestion of inflammation of the knee that produces some water. It's a very small amount though.

Dr. Bowen admitted to having diagnosed the claimant with patellar chondromalacia arthritis and synovitis. He gave the following explanation of these conditions:

Q. At that point in time, it looks like from your report that you had the impression that she had patellar chondromalacia arthritis and - - I can't pronounce that.

A. Synovitis.

Q. - - synovitis.

A. Yes.

Q. Would you explain to the Judge what those conditions are?

A. Well, chondromalacia meaning some wear of the cartilage surface behind the kneecap area that can be a pre-arthritic condition, we see that not infrequently, that can cause some anterior knee pain, popping and catching, difficulty with stooping, squatting, climbing or lifting. That's fairly common. The arthritis would be a suggestion based on the x-ray that there's a little bit of early wear on the medial side of the knee here on the inner side and behind the kneecap, and then the synovitis is suggested from the fluid or the inflammation in her knee. And that means the joint lining of the knee called the synovium is irritated.

Dr. Bowen testified that he was of the opinion that these conditions were probably related to her work with her history, that was reasonable since according to the patient she had not had problems with her knee, to his knowledge, prior to that time. However, he admitted that these conditions would be related to someone who had just general wear and tear on the knee. Dr. Bowen also admitted that weight (claimant's height 5'9" and weight is 300 pounds) would have an effect on the wear and tear of her knee. With respect to her weight and the influence it would have on or cause a condition such as chondromalacia, he testified that it could certainly predispose her to problems earlier in life or exacerbate or accelerate the process once it starts.

According to Dr. Bowen, he recommended some injections, as he thought this was appropriate to reduce the inflammation and hopefully to help her pain and allow her to begin functioning better, along with some physical therapy, and then some oral anti-inflammatory. He also testified he recommended physical therapy to help improve her range of motion, reduce her pain, and gain

strength in her leg. Dr. Bowen agreed that he indicated a possibility for an MRI of the knee, and that he had recommended that it was critical that she lose some weight and understand about walking and so forth.

Dr. Bowen specifically testified that during his visit with the claimant in October of 2007, there were no findings suggestive of a traumatic or acute process that had occurred, other than her history of having the pop as she lifted the patient.

He essentially testified that the MRI did suggest possibly some injury to the meniscus, and that x-ray findings revealed some early arthritic change on the medial compartment and in the patellofemoral compartment. Therefore, Dr. Bowen testified that he suggested to the claimant that he felt like she might have a possible meniscus tear and inflammation of her knee. He testified that the claimant had indicated that she would like to avoid surgery, which he understood, as he felt like she could still improve with some strengthening and time. However, he suggested that if it continued for another month or two that she might warrant arthroscopic surgery.

Dr. Bowen testified:

Q. You indicated the MRI showed blunting at the meniscus.

A. Uh-huh

Q. What causes that and how do you treat that if any?

A. Reviewing the MRI report that was done on 11/26/07, by the radiologist indicated some signal change in the

posterior horn of the medial meniscus which suggests either a high grade degeneration and contusion or bruising or some minor change in that area. It wasn't consistent necessarily with a tear. It also suggested some cartilage loss on the medial compartment in this area which we mentioned and also in the patella area right in here on this side of the patella. So those are consistent with her symptoms and the x-ray findings and the MRI.

Q. Would this be consistent with some type of acute injury or trauma, or is this also related to wear and tear?

A. This appears to be more of a chronic nature.

He admitted that when asked by the claimant's attorney whether or not the incident on August 20, 2007 aggravated or exacerbated the pre-existing problems of the claimant's knee, it was based on her history and report from work that she had done this, had no problems with this before, and all this had started after she lifted this patient, and heard the pop in her knee. Dr. Bowen admitted that there were no objective findings that indicated that the August 20, 2007 incident aggravated or exacerbated a pre-existing condition, as this was based on her history to him.

Dr. Bowen admitted that when he saw the claimant on January 7, 2008, he considered her to be at maximum medical improvement. At which point he suggested conservative treatment of weight loss.

After being given the opportunity to review medical records wherein the claimant had gone to the Morrilton Medical Clinic on August 17, 2007 (three days prior to the incident) due to complaints of knee pain, Dr. Bowen gave the following testimony:

Q. Now that you've had an opportunity to review the August 17th, 2007 report, does that change your opinion regarding the cause of the complaints that Ms. Lawrence had when she came to see you in October and treated until January of 2008?

A. Yes, it would.

Q. Okay. In what way would it change your opinion?

A. Well, it clearly indicates that she had symptoms prior to the injury. Her stated history of no complaints of pain in the knee prior to her pop at the time of her work-related injury is certainly not consistent with the notes from Dr. Milligan on the 17th of August. So, therefore, I believe that my comments about her cause of her pain is not accurate. It was based on her history, and her history was wrong.

Q. So it would be your opinion then, Doctor, that whatever happened on August the 20th of 2007, was not an aggravation or exacerbation of her pre-existing condition?

A. Well, it could have been an aggravation of an existing condition.

Q. Were there any - -

A. But not the initial originating cause.

Q. Okay. Were there any objective findings to support an aggravation of her pre-existing condition?

A. She had had it going on for apparently a month, so to my knowledge, no, other than what she said.

Q. The findings that you had in October of 2007 and continuing until January of 2008, are the same findings that Dr. Milligan had on August the 17th of 2007, is that correct?

A. I think it's consistent, yes.

Q. Okay. Have your opinions here today been stated within a reasonable degree of medical certainty?

A. Yes, they have.

Dr. Bowen essentially admitted that there was no change in the claimant's condition from August 17, 2007, to when he saw her on October 16, 2007.

He testified that an individual can have popping in their knee due to arthritis, a cartilage tear, ligament disruption. He also testified that pain and weakness and swelling can cause the normal structures not to track properly and produce some popping. Dr. Bowen admitted that there was not anything objective from his examination of the claimant's knee or any reports that he reviewed that would indicate what, if anything, caused the popping that the claimant reported as having occurred on August 20, 2007.

With respect to objective findings of a popping having occurred on August 20, 2007, Dr. Bowen testified:

Q. Are there any objective findings to support a popping occurring on August the 20th of 2007?

A. Only that when she presented to me, she still had crepitus in her patella. That's the likely place this occurred, that she had trace effusion, she had tenderness in the area. All that is consistent with a patellar problem where she loaded an abnormal area noted on the scan and caused it to pop and catch.

Q. Okay, and that's basically what her condition was on August 17th, 2007 as well, was it not?

A. That's right.

Q. Now, you indicated that she probably had an aggravation of her pre-existing condition from the incident that she reported on August the 20th of 2007.

A. Correct.

Q. What objective findings are there to show that there

was actually an aggravation of her pre-existing condition even if she did have a popping event on August the 20th of 2007?

A. There are none.

Q. As I understand, she had the effusion before August the 20th, 2007. She had the swelling before as well as the severe left knee pain, is that right?

A. That's right.

ADJUDICATION

A. Evidentiary Objections

At the time of the hearing, the claimant proffered as exhibits into evidence the First Report of Injury or Illness (Form AR-1), and the Form AR-C. Respondents #1 essentially objected to these forms being introduced into evidence on the ground that there is some case law that indicates that these should not be introduced as exhibits since they are actually documents that are contained in the Commission's file. However, the claimant essentially asserted that these forms were not being introduced to establish any particular fact, as they were only introduced just as corroboration of what the claimant's testimony would be. Hence, to show that the claimant had reported the same consistent account of her injury all along. Pursuant to Ark. Code Ann. §11-9-529, I find that respondents #1's objection to the admission of the Form AR-1, should be, and is hereby sustained. Therefore, the Form AR-1 will not be considered in deciding the issues presented in this case, as it has been excluded from admission into evidence in this matter.

With respect to the Form AR-C, I find that pursuant to Ark. Code Ann. §11-9-529, that respondents #1's objection to the admission of the Form AR-C, should be and is hereby overruled. Therefore, the Form AR-C, is hereby admitted into evidence. Specifically, based on my review of this section of the statute, this form should not be excluded from being admitted into evidence under Ark. Code Ann. §11-9-529, as it is filed by the claimant (typically the Form AR-C is considered a claim for benefits) rather than the employer.

B. Compensability

The instant claimant maintains that she sustained a compensable injury to her left knee, which she categorizes as a temporary aggravation of a pre-existing condition, during and in the course of her employment with the respondent-employer on August 20, 2007.

In workers' compensation law, an employer takes the employee as he finds him, and employment circumstances that aggravate a pre-existing injury, are compensable. An aggravation, being a new injury with an independent cause, must meet the definition of a compensable injury in order to establish compensability for the aggravation. Heritage Baptist Temple v Robison, 82 Ark. App. 460, 120 S.W. 3d 150 (2003).

"Compensable injury" means an accidental injury causing physical harm to the body, arising out of and in the course of

employment and which requires medical services or results in disability or death. Ark. Code Ann. § 11-9-102(4)(A)(i). A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. § 11-9-102(4)(D). The claimant must prove by a preponderance of the evidence that she sustained a compensable injury. Ark. Code Ann. §11-9-102(4)(E)(i).

On the basis of the record as a whole, I find that the claimant failed to establish by a preponderance of the evidence that she sustained a temporary aggravation of a pre-existing condition to her left knee, during and in the course of her employment with respondent-employer on August 20, 2007. Specifically, I find that there are no objective findings establishing an aggravation or new injury to the claimant's left knee.

In the instant matter, I believe the claimant's testimony that she experienced a popping while lifting a patient on August 20, 2007, during and in the course of her employment with the employer-respondent. However, even though I find the claimant's testimony believable in this regard, in order for an injury to be compensable, it is necessary for the claimant to offer objective findings to establish the existence and extent of an injury.

Here, the medical records demonstrate that on August 17, 2007, just three days before her work-related incident of August 20,

2007, the claimant complained of severe left knee pain to her family physician, Dr. Milligan, which had lasted for at least the last month or so, as it was increasing in intensity. She also reported that sometimes it caused swelling behind the knee, in front of the knee and down toward the ankle. Dr. Milligan specifically noted that there was a trace of effusion, and that there was some popliteal tenderness with fullness. When the claimant first sought emergency treatment for her work incident of August 20, 2007, she was noted to have mild swelling. While swelling is recognized as an objective finding, it appears that the this same objective finding, swelling/effusion pre-existed the August 20, 2007 incident, as it was already present on her August 17, 2007 visit with Dr. Milligan.

The claimant subsequently underwent an MRI of the left knee on November 26, 2007, which showed some signal change in the posterior horn of the medial meniscus which suggested a high grade degeneration or contusion, along with some cartilage loss on the medial compartment in that area, and also the patella area on the side of the patella. Dr. Bowen opined that such findings appeared to be more chronic in nature. Considering that the claimant's prior symptoms appear to be identical in type and magnitude with those she experienced after the work-related incident, and based on Dr. Bowen's expert opinion, I think that it is more probable than not that these objective findings are degenerative in nature, and

are therefore not consistent with an acute or traumatic injury. In addition to this, the finding of joint effusion which was revealed on the MRI, was clearly present prior to the work incident, as Dr. Milligan noted this finding just three days prior to the incident.

While I recognized that Dr. Bowen initially opined that the claimant had suffered an aggravation of her pre-existing condition as a result of her work-related incident, he admitted that there were no objective findings that a traumatic or acute process had occurred, and that his opinion had been based on an inaccurate history provided to him by the claimant of no prior problems with her knee.

In sum, while the claimant may have experienced a popping during the work-related incident, she has failed to offer objective medical findings establishing an temporary aggravation of a preexisting-condition. Absent objective medical findings establishing any acute or traumatic injury, the claimant cannot meet her burden of proving by a preponderance of the evidence that she suffered a compensable left knee injury. Simply stated, the claimant failed to present any proof of changes related to the alleged August 20, 2007 incident, through new objective findings.

Therefore, her claim must be, and is hereby respectfully dismissed.

C. Estoppel

The claimant essentially asserts that respondents #1 should

be estopped from denying liability for the treatment provided to the claimant by St. Anthony's Medical Center (St. Vincent Health System), on August 20, 2007; the treatment provided by Dr. Stephen Carter on August 24, 2007; and the treatment rendered by Dr. Scott Smith on August 29, 2007. She further asserts that Dr. Carter referred her to Dr. Smith before respondents #1 controverted the claim.

It is well-settled that where an employer has prompted/or caused the claimant to incur medical expenses, the employer is responsible for the cost of treatment rendered to the claimant notwithstanding the fact that the claimant's injury has been found to be noncompensable. See Southern Hospitalities v. Britain, 54 Ark. App. 318, 925 S.W. 2d 81 (1996).

The evidence in the present matter demonstrates that the claimant received treatment from St. Anthony's Medical Center, Dr. Stephen Carter, and Dr. Scott Smith on the aforementioned dates pursuant to directives from the respondent-employer. Therefore, I find that respondents #1 are responsible for all the medical expenses, which resulted from said visits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction of the within claim.
2. The employee-employer-carrier relationship existed on August 20, 2007, and at all other relevant times.
3. At the time of the alleged injury, the claimant's average weekly wage was \$330.00, which would yield a

weekly temporary total disability rate of \$220.00.

4. The Form AR-1 was excluded from admission into evidence, however, the Form AR-C was admitted into evidence.
5. The claim has been controverted its entirety.
6. The claimant failed to prove by preponderance of the credible evidence that she sustained an aggravation/new injury to her left knee, during and in the course of her employment with the respondent-employer.
7. Respondents #1 are liable for the aforementioned medical expenses that the claimant incurred as a result of respondents #1 having directed such treatment, notwithstanding the fact that the claimant's alleged injury has been found not to be compensable.

ORDER

The claimant has failed to prove by a preponderance of the evidence that she suffered a compensable left knee injury while employed by the respondent-employer on August 20, 2007. Specifically, there are no objective medical findings establishing an aggravation and or new injury of the left knee. Therefore, for the reasons discussed herein, this claim must be, and hereby is, respectfully denied and dismissed.

However, respondents #1 are directed to pay for all the medical expenses incurred by the claimant pursuant to directives from her employer set forth herein this Opinion.

IT IS SO ORDERED.

CHANDRA HICKS
Administrative Law Judge

CH/ml