

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F602818

DEBORAH K. NORMAN, EMPLOYEE	RESPONDENT
FLASH MARKETS, INC., EMPLOYER	RESPONDENT
COMMERCE & INDUSTRY INS. CO., CARRIER	RESPONDENT

OPINION FILED JANUARY 23, 2008

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on November 8, 2007, at Marion, Crittenden County, Arkansas.

Claimant represented by the HONORABLE MARC I. BARETZ, Attorney at Law, West Memphis, Arkansas.

Respondents represented by the HONORABLE MELISSA WOOD, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-style claim to determine the claimant's entitlement to additional workers' compensation growing out of an acknowledged February 14, 2006, compensable left knee injury. On September 11, 2007, a pre-hearing conference was conducted in this claim, from which a Pre-hearing Order of the same date was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' contentions relative to the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

With respect to the issue of unpaid medical bills, respondents content that the change of

physician order designating Dr. Moffatt as the treating physician was not entered until July 9, 2007, and that any medical bills generated as a result of medical treatment by Dr. Moffatt prior to the entry of the order were unauthorized. Respondents further content that any medical treatment by Dr. Moffatt subsequent to the July 25, 2007, one-time visit of the claimant was not reasonable and necessary care. Alternatively, respondents maintains that in a March 23, 2007, medical report Dr. Moffatt indicated that the claimant had reached MMI, as such if there is a finding that the claimant is entitled to additional temporary total disability benefits the period would not extend beyond that date.

The testimony of Deborah K. Norman, the claimant, and Holly Dawson, coupled with medical reports and other documents comprise the record in this claim.

DISCUSSION

Deborah Norman, the claimant, with a date of birth of May 18, 1962, was employed by respondent-employer on two (2) separate occasions. During her last period of employment, which commenced in 2002, claimant worked as a cashier and was later promoted to manager. Respondent-employer, Flash Markets, Inc., is a convenient store.

As a manager for respondent-employer the claimant was salaried. In describing her job duties, the testimony of the claimant reflects that the same included counting the receipts and making bank deposits. The claimant sustained the injury which serves as the basis for the present claim while making a bank deposit on February 13, 2006. Regarding the afore, claimant explained:

I was walking out, and I tripped off the curb, and fell on both of my knees.

No, sir. I just crawled to my car and cried all the way home.
Yes. I went to the doctor the very next morning. (T. 12-13).

Claimant denies that she experienced physical problems with either of her knees prior to February 2006. The claimant's February 2006 left knee injury was accepted as compensable by respondents. While the compensable injury date is recorded as February 14, 2006, the evidence preponderates that the accident occurred on the afternoon of February 13, 2006, and that the claimant first received medical treatment for the injury on February 14, 2006.

Claimant sought and obtained medical treatment for left knee at Crittenden Memorial Hospital on February 14, 2006. Claimant asserts that at the time she sought medical treatment the left knee was swollen and painful. Claimant maintains that she reported the injury to respondent, however she was not referred to a specific physician by same. As a consequence of the afore, claimant was seen by Dr. Onyia who referred her to Dr. Meredith.

Claimant testified that while under the care and treatment of Dr. Meredith she had x-rays and an MRI performed relative to the left knee, was provided medication and directed to remain off work. Claimant received temporary total disability benefits for approximately four (4) months. Claimant maintains that while surgery was not recommended her left knee remained swollen and painful during her treatment with Dr. Meredith.

The testimony of the claimant reflects that pursuant to directions of respondents she was seen by Dr. Riley Jones, a Memphis orthopedic surgeon, for second opinion. Claimant maintains that her left leg/knee swollen and painful at the time of the visit to Dr. Jones. The claimant was also seen by Dr. Terence Braden, a Jonesboro physician, pursuant to a referral of Dr. Jones or Dr. Meredith.

Claimant maintains that she was placed on Neurontin for RSD by Dr. Braden. Claimant testified that her left knee did not get any better while under the care and treatment of Dr. Jones and Dr. Braden. Claimant acknowledged that there was an occasion where she had a slip in the bathtub:

I had slipped when - - I didn't slip. I stepped out of the bathtub and my knee gave way, and I hit my shin on the toilet. (T. 16).

Claimant disclosed the bathtub incident to Dr. Braden, and maintains that there was no change in his diagnosis of her knee complaint following the incident. The testimony of the claimant reflects that the left knee had given way previously, subsequent to her February 2006 compensable left knee injury. Claimant denies that she fell on the left knee during the bathtub incident.

The claimant testified that when she was released to return to work by Dr. Jones she reported for work and worked for two (2) days. The testimony of the claimant reflects that she last saw Dr. Jones on October 3, 2006, at which time she was released from his care. Claimant maintains that during the two days of work her leg swelled back up, became very painful, and she ended up seeking treatment at the emergency room.

The testimony of the claimant reflects that each of the physicians that she had seen prior to being seen by Dr. Moffatt on October 10, 2006, was pursuant to the direction of respondents. Claimant acknowledged that she selected Dr. Moffatt of her own volition, explaining that she knew something was still wrong with her leg. Claimant heard about Dr. Moffatt through a friend who had surgery. Claimant denies that she did anything to her leg between the October 3, 2006, final visit to Dr. Jones and the October 10, 2006, initial visit to Dr. Moffatt.

The testimony of the claimant reflects that Dr. Moffatt referred her to physical therapy and performed Synvisc injections. Claimant did not receive any relief from her symptoms from the injections. Following additional diagnostic studies Dr. Moffatt performed surgery on the claimant's left knee. Claimant was off work following the surgery. In March 2007, Dr. Moffatt indicated that the claimant was at maximum medical improvement. Claimant explained that she returned to Dr. Moffatt following the March 2007 date because she was continuing to have pain and swelling in the left knee when she was up on it.

Claimant testified that while she has not worked since the two (2) days that she returned to respondents following the release by Dr. Jones, she has been able to work since her left knee surgery and recovery period. Claimant's testimony reflects that her symptoms of swelling and pain in the left knee were consistent from her February 13, 2006, injury until the arthroscopic surgery by Dr. Moffatt. Claimant noted that the symptoms were exacerbated by walking or standing for prolonged periods of time. Claimant maintains that her symptoms were alleviated following the surgery. Claimant walks with a limp explaining that she has now arthritis in the knee. Claimant maintains that her present symptoms are not as painful as before the surgery.

Claimant has health insurance through her employment with respondent. The testimony of the claimant reflects that she submitted her bills relative to her treatment under the care of Dr. Moffatt to her health insurance carrier who agreed to pay them. Claimant added that the day following the surgery by Dr. Moffatt the health insurance carrier declined to pay the bills.

The testimony of the claimant reflects that she contacted respondents when she went to see Dr. Moffatt:

I did go in and talk to them. I told them that I was going to

file it on my own insurance because I knew something was still wrong with my leg. (T. 24).

Claimant asserts that she spoke with both Holly Dawson and Kevin Waller at Flash Market.

Claimant testified that she was not offered additional benefits by respondents.

During cross-examination claimant testified that she had been a store manager for respondent for several of years and as such was responsible for other employees. Claimant's testimony reflects that as a manager she was familiar with the process of filing a workers' compensation as well as the paperwork. Claimant filled out her own paperwork relative to her February 13, 2004, injury.

In selecting Dr. Moffatt to provide medical treatment relative to her injury and whether respondents would be pay for further treatment, the testimony of the claimant reflects:

I didn't know for sure. I filed it under my insurance. Because they had already, workman's comp told me they had already closed my case. (T. 26).

Claimant's testimony reflects that she has not made any effort to go back to respondents or elsewhere since her March 2007 release by Dr. Moffatt.

The claimant testified that when she reported to respondents for work following the release by Dr. Jones in October 2006, she was sent to different store and performed the duties of doing the counts and running the cash register. Claimant noted that the afore entailed more physical work than her regular job as a store manager. Claimant explained:

Well, in order to count like the stuff on the shelves and everything I would have to squat down. And that was almost impossible with my knee hurting like that. And to count and everything I would have to climb ladders, climb up in the cooler to count everything on the top shelves. So it was physical. (T. 27).

Claimant concedes that at the time her treating physician had not imposed any medical/physical restrictions on her employment activities.

In addition to seeing Dr. Moffatt on her own, claimant acknowledged that she attempted to schedule an appointment at Campbell Clinic for treatment of her left knee injury. Claimant attempted to file the afore appointment on her health insurance. Claimant explained that she was aware that respondents would not pay for the treatment and she “knew something was still wrong” with her leg. (T. 32). Claimant testified that she did not want surgery, but she wanted her knee fixed.

Claimant also insists that she accurately and consistently reported her symptoms relative to her left knee injury:

Yes, sir. And I even showed my knee to Kevin Waller at Flash Market. And he could see, they could see the swelling themselves. (T. 33).

Claimant noted that prior to the surgery she had difficulty bending her knee; that she could not squat down completely; and that when she walked on it the knee would swell even worse.

The testimony of the claimant reflects that approximately six (6) weeks following her surgery by Dr. Moffatt she felt that she was physically able to go back to work. Dr. Moffatt released the claimant to return to work following the February 2007 surgery effective March 23, 2007. Claimant added:

But the arthritis was still messing, you know, still there and everything. And it was causing me a little problem, but. (T. 36).

Claimant denies that she had ever been diagnosed with arthritis in her knee prior to the February 13, 2006, injury. Claimant testified that Dr. Moffatt diagnosed the arthritis in her left knee. The

testimony of the claimant reflects that her medical treatment under the care of Dr. Moffatt since the March 23, 2007, visit has consisted of injections. Claimant testified that her last visit to Dr. Moffatt was October 2007.

Claimant maintains that at the time she last received temporary total disability benefits she was not physically capable of working due to residuals of her compensable left knee injury. Claimant's testimony reflects that respondents did not have light duty work and that none was offered to her. Claimant acknowledged that she did not request light duty from respondents, offering:

No, ma'am. I couldn't perform my job duties at Flash Market. You know, I couldn't squat down and count candy on the bottom shelf, or climb ladder, and stuff like that. But There is no light duty in my job description. (T. 40).

The testimony of the claimant reflects that she completed the workers' compensation claim form in the presence of Ms. Holly Dawson. Claimant maintains that until she consulted with her attorney she was not familiar with the process of changing treating physician. The evidence in the record does not reflect the presence of a Form AR-N.

Ms. Holly Dawson, Payroll and Human Resources for Flash Market's Corporate Office, has been employed by same since January 2003. In describing her job duties, Ms. Dawson testified:

I do payroll for all of our stores. I do accounts payable for all of our stores, 401K, medical insurance, taxes, pay bills. That's pretty much. (T. 42).

With respect to workers' compensation matters, the testimony of Ms. Dawson reflects:

Just providing the information to the stores for the employees to each manager of the store as far as, you know, who the work comp

is each year, forms to file work comp, things like that. We don't, Our stores are responsible for reporting their own claims, though. (T. 42).

Respondent operates approximately 70 stores.

Ms. Dawson's testimony reflects that she was familiar with the claimant as a manager of the West Memphis store, and as such was in the corporate office frequently. The claimant became a store manager in April 2003. Regarding the posting of workers' compensation notices in each store Ms. Dawson testified:

Yes. They're suppose to post it. Yes. But they're responsible for doing that too. They're provided with the information, and they're responsible for the posting of it. (T. 43).

Ms. Dawson testified that the claimant made an effort to return to work following her release by the various physicians relative to the February 13, 2006, compensable left injury. Ms. Dawson's testimony reflects, regarding the afore:

Yes, ma'am. She came back on Monday, June, I believe the 19th, worked, the manager had sent an email. She worked until 2:00 that day. On Tuesday she worked 2:00 to 10:00. And on Wednesday she worked 2:00 to 10:00. (T. 43).

Ms. Dawson was not aware of any other periods that the claimant worked, and noted that the claimant's employment with respondents was terminated as of October 1, 2006. Ms. Dawson explained the basis for the termination:

I had talked to work comp, and they had released, the doctor had released her in September. And they, since the doctor released her, then that's when she was supposed to come back. And since she didn't come back, - -
- - that was considered not showing up for work. (T. 43-44).

Ms. Dawson asserts that in addition to terminating the claimant's employment with respondents on or about October 1, 2006, her health insurance was also terminated. Ms. Dawson offered:

Correct. Along with, supposedly with her insurance. I don't know why they paid the claim like they did. Because they were noted to cancel as of October the 1st since she didn't return to work. Because at that point we had paid her premium, her entire premium.

Right. Well, through the end of September. (T. 45).

Ms. Dawson noted that had the claimant reported back to work for respondent at the time of October 2006, doctor's release she is uncertain what employment position she would have been place in, whether as a manager or an assistant manager. Ms. Dawson testified that the claimant's pay would not have changed, even if she had been placed in a cashier position.

Ms. Dawson acknowledged that she was aware that the claimant was going to see Dr. Moffatt. Further, Ms. Dawson concedes that the claimant informed her that she had not received any relief from her symptoms relative to the left leg compensable injury as a result of the treatment that had been rendered by the treating physicians prior to Dr. Moffatt. Ms Dawson testified that she was uncertain if she was aware of the claimant's plans to see Dr. Moffatt prior to the visit, however the claimant did come in with doctor's excuse from Dr. Moffatt.

The medical in the record reflects that the claimant was seen at the emergency room of Crittenden Memorial Hospital on February 14, 2006, for complaints of knee pain growing out of a fall on February 13, 2006. The clinical impression of the claimant's complaints, as reflected in the emergency room records, is that of internal derangement of the knees. (CX. #1, p. 1-6). After undergoing x-rays of both knees, claimant was released with a diagnosis of internal derangement of the knees, provided an off-work slip; and directed to make an appointment with Dr. Onyia for follow-up care. (CX. #1, p. 11).

The claimant was seen by Dr. Wilfred Onyia, relative to her February 13, 2006, left knee

injury, on February 16, 2006, March 2, 2006, and March 9, 2006. During a March 9, 2006, visit to Mid-South Internal Medicine, the claimant was released to light duty by Dr. Onyia. (CX. #1, p. 12). While a March 24, 2006, Medical Treatment Report of Dr. Onyia relative to the claimant reflects an expected MMI date of June 2006, the report also noted a light duty release with no lifting or pulling, a diagnosis of a knee injury with mild ligament tear, and a referral for an MRI of the knee. (CX. #1, p. 13).

On April 5, 2006, the claimant was seen by Dr. Samuel G. Meredith, a West Memphis orthopedic physician, relative to the February 13, 2006, left knee injury. The April 5, 2006, report of Dr. Meredith relative to the claimant's visit reflects, in pertinent part:

This 43 year old female presents today with an acute knee injury and residual pain and dysfunction following an acute injury to the knee. Associated signs and symptoms include swelling and discoloration entire extremity, oversensitivity. The mechanism of injury was: a direct blow, anterior knee. Pt denies remote or previous trauma to the area and no other conditions previously treated. Trauma to the area occurred as a result of a fall or injury outside the home and a specific, documented work injury. Severity of condition: acute and incapacitating initially, now improving, becoming constant whenever active, enough to cause the patient to give up some regular activities and enough to prevent return to work since the incident. Quality of pain is described by the patient as constant whenever active, limiting full movement, localized, mechanical, movement related, sensitive and sharp. Onset was 02/14/2007.

* * *

Left knee ROM shows decreased flexion, decreased extension. Knee demonstrated normal allignment, mechanics, stability, and synovium. But there is obvious skin mottling, coolness, and generalized edema entire extremity. McMurray's test is negative for pain in the knee. Anterior drawer test - normal. Lachman's test - normal. Posterior drawer test - normal. Pivot shift negative. no varus/valgus instability. No anteroposterior laxity. probably grossly intact. Extensor mechanism intact above and below patella.

* * *

Impression: Knee contusion. patellofemoral injury. Probably to internal derangement. Probably no disruption of extensor machism. RSD. (CX. #1, p. 14-15).

The April 5, 2006, report of Dr. Meredith concluded by noting that the claimant was referred to Pain Management and that her work restriction included “seated only” until the pain evaluation. (CX #1, p. 15-19).

On May 23, 2006, the claimant was evaluated by Dr. Robert Riley Jones, a Memphis orthopedic surgeon, at the request of respondents #1. The report of Dr. Jones relative to the claimant’s May 23, 2006, visit reflects, in pertinent part:

. . . . She was walking out of a bank, she tripped on a curb and fell hitting directly on both knees. She was seen in the ER. X-rays were taken, negative for fractures and then she was seen by her local medical doctor who did an MRI. That MRI was read as a very small acute non full thickness tear involving the anterior inferior portion of the posterolateral band of the anterior cruciate ligament. There is some osteoarthritic chondromalacie thinning of the lateral and medial femoral articular surfaces. This MRI was done on 2/28/06. This is the left knee. She states the right knee is not bothering her like the left knee. She tried to return to light duty, continued to have pain and then it was transferred over to WC and she say Dr. Sam Meredith. We have Dr. Meredith’s notes. Dr. Meredith that she had a knee contusion, patellofemoral injury and possibly an RSD. They asked for a second opinion and she comes in today for evaluation. She is wearing a brace and she says she still has pain. It is a burning sensation around the knee.

On examination, first, she has fair skin and she has mottled type of skin in both legs. There is no difference in either leg. She has equal quadriceps measurements at 10 cm above the superior pole of the patella. There is no temperature difference between the two legs. She will let me examine the knee. There is no medial or lateral instability. Negative anterior drawer sign. She has full extension. She will flex up to 130 degrees. There is no effusion at this time. There are no palpable defects. (CX. #1, p. 22).

As a part of the evaluation Dr. Jones arranged for the claimant to have a three phase bone scan,

which was accomplished May 26, 2006. Claimant was seen in follow-up by Dr. Jones on May 30, 2006. The office note relative to the afore visit reflects, in pertinent part:

. . . . There is nothing here that would look like an RSD. She comes in today and I have re-evaluated. She has full unrestricted ROM today. There is no effusion, no swelling, no real tenderness to palpation. I think most of this is just contusion. I don't doubt that she may have had a little bone contusion, but there is nothing else there. She is walking today without a brace and without support and I think the best thing she can do is return to her regular duty. She may have a little ache and pain and I told her to see me in a couple of weeks. She is much improved today. (CX. #1, p. 25).

On June 12, 2006, the claimant was again seen by Dr. Meredith. At the time of the afore visit Dr. Meredith had access to the results of the diagnostic study performed at the request of Dr. Jones. The June 12, 2006, office note reflects, in pertinent part:

. . . . Complaints are mild - moderate, nonspecific anterior pain and late PM swelling. Exam - stable knee without effusion or swelling. Reviewed bone scan - very subtle if any increase in knee, symmetrical. I injected her knee and we discussed OA, if this be the case. I agree with no disability status. **RTS** next wee. She is at **MMI** and has no measurable impairment. (CX. #1, p. 28).

The evidence in the record reflects that the claimant was seen at the emergency room of Crittenden Memorial Hospital on June 22, 2006, chief complaints of pain and swelling in her left knee. The physical examination by the attending emergency room physician disclosed tenderness and swelling in the claimant's left knee. (CX. #1, p. 31-32). At the time of her discharge from the emergency room claimant was provided an instruction sheet directing that she schedule an appointment at Campbell Clinic "ASAP" for her chronic knee pain. (CX. #1, p. 35).

The claimant was not seen at Campbell Clinic pursuant to the June 22, 2006, emergency room discharge but rather received a June 29, 2006, correspondence from the Rebecca Poston, a

nurse case manger with CompCHOICE, directing her to attend a July 10, 2006, scheduled appointment with Dr. Samuel Meredith. (CX. #1, p. 36). The July 10, 2006, office note of Dr. Meredith relative to his evaluation/examination of the claimant reflects, in pertinent part:

Objective: Reviewed previous notes and studies. Knee: the entire extremity appears dystrophic with diffuse edema, mottled discoloration, and objective cool temperature as compared to the opposite extremity. Left knee ROM shows decreased flexion. Right knee ROM within normal limits. Knee demonstrates: diffused tenderness and swelling/synovitis.

* * *

Assessment: DJD mild. Direct blow injury with residual pain. Amplified pain, pain/dysfunction syndrome versus mild RSD. No additional special concerns.

Plan, counselling: Plan is unchanged from last visit, in my opinion this lady has mild but definite indications of possible sympathetic mediated pain, and I still think she needs evaluation by pain management person for RSV even though her bone scan was not classic. She will certainly not benefit from any further definitive orthopedic management. (CX. #1, p. 37-38).

On July 25, 2006, the claimant was Terence P. Braden, III, D.O., pursuant to a referral of the nurse case manager Rebecca Poston with CompCHOICE. Ms. Poston's address is reflected as Oklahoma City, Oklahoma. Dr. Braden's July 25, 2006, office note reflects that while the claimant was referred to Campbell Clinic following an emergency room visit, the facility declined to see her because her complaint was the product of a workers' compensation injury and claim. The July 25, 2006, office note further reflects:

She reports that she has chronic pain in the left knee. It is present all the time. Nothing seems to give her any relief. The knee swells each day at the end of the day and she said it will increase in size during the day until it reaches its maximum size at night and when she lays down at night the swelling seems to go down. If she rests any and does not get up and walk

on her knee the swelling is not as bad. She reports that the entire knee has a burning pain and it aches around the knee itself. She said sometime she feels pain that goes up her thigh and down her leg. Nothing makes it better. It is made worse by any bending, walking, stooping, or activity. She reports that she has not been able to return back to her work in Flash Market because there are no alternate duty jobs. She also reports that her position is no longer available at her place of employment since she has already been replaced as manager in that facility.

* * *

Assessment:

1. Chronic left knee pain.
2. Questionable diagnosis of complex regional pain syndrome. (CX. #1, pl 42-43).

In addition to listing specific recommendations regarding the claimant's left knee complaints and a 4 week follow-up visit, Dr. Braden noted that he could not refute nor confirm a diagnosis of complex regional pain syndrom in the left knee. Claimant was released by Dr. Braden to an alternate duty setting with the seated position and the ability to sit or stand intermittently. (CX. #1, p. 43-44). Claimant also underwent physical therapy relative to the left knee between July 25, 2006, and August 7, 2006.

The claimant was again seen by Dr. Braden on August 9, 2006. The afore office note reflects, in pertinent part:

I can find no evidence of marked swelling in the knee. No evidence of effusion. She complains of tenderness when palpated anywhere around the knee, anteriorly or posteriorly.

I then called down to William, supervising therapist, where she is receiving therapy at 901-529-4045.

I asked William if he had ever seen any significant swelling around her knee, he reports he has never seen any swelling around Ms. Norman's knee and that she gives a poor effort during her therapy and intervention.

* * *

. . . I am uncertain though that we are truly treating now Complex Regional Pain Syndrome in the left knee and that there may be psychosocial issues that are causing her ongoing symptomatology that is unrelated to the diagnosis of a Complex Regional Pain Syndrome. (CX. #1, p. 52).

During an August 14, 2006, visit, Dr. Braden informed the claimant that he anticipated releasing her to full duty without restriction at the time of next visit in two (2) weeks. (CX. #1, p. 56).

The claimant was seen in follow-up by Dr. Braden on September 1, 2006. The office note relative to the September 1, 2006, visit reflects, in pertinent part:

Ms. Norman continues to have complaints of pain in her left knee area. She said it continues to swell on and off. Now she reports that as she was getting out of the bathtub and she slipped and fell and struck her knee and she points to below the knee itself over the tibial tubercle. There is no evidence of trauma, redness, erythema.

Her gait is still an antalgic gait.

There is no effusion about the knee that I can ascertain.

The medication adjustments I have give have not really given her marked or distinct improvement in her symptoms although she did call and ask for refills on her medications on 8/28/2006. (CX. #1, p. 62).

On September 1, 2006, claimant was released from active medical care and to full duty by Dr. Braden as having reached maximum medical improvement. (CX. #1, p. 61). Dr. Braden also opined that the claimant had a 0 % impairment relative to her left knee complaint.

Claimant was again seen by Dr. Robert Riley Jones pursuant to the directions of nurse case manager Poston on September 19, 2006. The September 19, 2006, report of Dr. Jones reflects, in pertinent part:

Patient returns today, after a long absence. She apparently saw a

physician, Dr. Braden who did PT. He returned her to work, but she has had swelling. She states it swells mainly when she is up on it, so she tries to stay off of it as much as possible.

PE: On examination, she has mottled skin, just as she did before on both legs. Her quad measurements are equal at 10cm above the superior pole of the patella. She has what appears to be a mild effusion. There is no medial or lateral instability. Negative anterior drawer sign. Negative posterior drawer sing.

PLAN: While in the office we attempted to aspirate the knee in the area of the suprapatellar pouch, but we could not get any fluid. We injected with Celestone and Marcaine. (CX. #1, p. 66).

A September 25, 2006, MRI scan of the claimant's left knee, pursuant to the directions of Dr. Jones, yield a normal study. (CX. #1, p. 70). Claimant was seen in follow-up by Dr. Jones on October 3, 2006. The office note relative to the afore visit reflects, in pertinent part:

The patient returns today with her MRI, which I personally reviewed, and it appears to be a normal study. She flexes to 125 degrees. She has no effusion. In fact, the area that she describes as being swollen, is the same as on the other area and it's a lateral and over the suprapatellar, but it's more muscular and not joint wise. She has no instability. At this point quad measurements measured 10 cm above the superior pole of the patella are equal. I don't find anything objective on this lady from an orthopaedic standpoint to do anything with. (CX. #1, p. 71).

The October 3, 2006, office note reflects that the claimant was released from the care of Dr. Jones as having reached maximum medical improvement with a no permanent partial impairment.

On October 10, 2006, the claimant was evaluated by Dr. W. Lee Moffatt. In his progress note of the same date, after reciting the history of the claimant's left knee injury and medical treatment received in connection with same, the October 10, 2006, Dr. Moffatt reported:

She complains that she is unable to bend, stoop, squat, stair climb, turn over in bed at night or do any heavy lifting due to left knee pain

anteriorly. The pain has not responded to any means of treatment to this point. She has been put through physical therapy, but has not had bracing performed. Her physical therapy was limited to a two week time frame.

* * *

PHYSICAL EXAMINATION:

* * *

Extremities: She walks with an antalgic limp on the left lower extremity due to left knee pain. She has increased left knee pain with toe walk and to a lesser degree with heel walk. She has pain on stepping up onto a single step with the left lower extremity. She has a full range of motion at the left knee with crepitus as the patellofemoral joint. She has no effusion present. She has no soft tissue swelling or soft tissue masses noted. She is tender along the medial and particularly at the lateral retropatellar facet. She has positive patella compression test on exam. The knee is stable in all planes. She has negative McMurray's and negative Apley for any meniscus pathology.

* * *

IMPRESSION:

1. Chronically painful left knee reportedly secondary to on-the-job injury.
2. Chondromalacia patella without significant x-ray or MRI changes left knee.

PLAN: I have placed her in an EPX Dynamic patella control brace. She is to wear this 20 out of 24 hours for the next two weeks. She will be in this for at least two months. She is to return to the office in two weeks for follow-up on this. She is to continue with the Celebrex 200 mg daily. (CX #1, p. 73-74).

Claimant was seen in follow-up by Dr. Moffatt on October 24, 2006. The progress note relative to the afore visit reflects, in pertinent part:

She states that she has had an MRI in the past that showed a "torn structure." What she had was an MRI on 02/28/06 at Crittenden Memorial Hospital that showed a very small acute non-full thickness tear involving the anterior inferior portion of the posterior lateral bend of the anterior

cruciate ligament. It did show that there was osteoarthritic chondromalacia and thinning of the lateral and medial femoral articular cartilage, which is consistent with the area of her pain. This was not seen on the second MRI of 09/26/06. (CX. #1, p. 75).

Dr. Moffatt continued the claimant with the brace and added physical therapy three (3) times a week at Crittenden Memorial Hospital. A November 7, 2006, progress note of Dr. Moffatt relative to the claimant noted improvement with less knee pain and swelling. The progress note also cited the beneficial results with the use of a TENS unit by the claimant. (CX. #1, p. 76).

The medical records reflects that between December 6, 2006, and December 20, 2006, claimant underwent three (3) Synvisc injections under the care of Dr. Moffatt. (CX. #1, p. 77-79). The January 24, 2007, progress note of Dr. Moffatt reflects that the claimant was continuing to have left knee pain at the patellofemoral joint as well as continued swelling with effusion of the left knee. The January 24, 2007, progress note further reflects:

PLAN: At this point I am going to obtain lab work to work up thyroid function, CBC and tests for SLE and rheumatoid arthritis. If these are positive then she will be treated appropriately. If they are negative, then there is little more to offer her other than a diagnostic arthroscopy, which she understands may be difficult to justify in face of negative MRI, but it may be the last diagnostic step taken and if there is nothing found at that point then there will be nothing more to offer. She is have blood work performed later this week and return in a week for follow-up. (CX. #1, p. 81).

The medical reflects that at the time of the claimant's follow-up visit with Dr. Moffatt on February 20, 2007, the negative blood work results had been received. The February 20, 2007, Progress Note of Dr. Moffatt further reflects, regarding the claimant:

PHYSICAL EXAMINATION: once again she shows tenderness at the retropatellar surface particularly at the medial facet at the left knee. She has tenderness along the medial joint line with a questionable positive McMurray's and Apley test for medial compartment pathology of the

meniscus. Today she shows an effusion of the left knee.

PLAN: This is an on the job injury to her left knee that she sustained at this point almost a year ago while working at Flash Market and she had treatment by Dr. Riley Jones with MRI of the left knee on 09/25/06 that was a normal study. However she is still unable to bend, stoop, squat or climb stairs or turn over n bed at night without pain. And heavy lifting causes knee pain anteriorly and medially. She is no longer responding to any forms of treatment. She is not responding to physical therapy, TENS unit, bracing, Cortisone injections or Synvisc injections. At this time I believe that she should considers diagnostic arthroscopy. I have discussed this with her in the past and now she does agree that she should undergo further diagnostic study with arthroscopic evaluation of the knee. She wishes to proceed with this as soon as possible. Arrangements are going to be made for this within this week. She is to return to the office one week after her surgery.

The necessity for surgery, alternative therapies, materials and prognosis of each usual surgical risk and the fact that no guarantees can be made has been explained to the patient in full. She states that she understands completely and gives her fully informed consent for surgery of the LEFT knee. (CX. #1, p. 82).

The claimant underwent the arthroscopic procedure at Surgery Center at Saint Francis on February 21, 2007, under the directions of Dr. Moffatt. The postoperative diagnoses included a tear of the anterior horn medial meniscus of the left knee. The procedures performed by Dr. Moffatt during the February 21,2007, procedure included arthroscopy of the left knee, partial medial meniscectomy of the anterior horn and mid body of the medial meniscus of the left knee, and chondroplasty of the medial facet of the retropatellar surface of the left knee. (CX. #1, p. 83).

The February 21, 2007, operative note of Dr. Moffatt reflects, in pertinent part regarding the claimant:

. . . . The arthroscope was introduced into the knee. Immediate findings showed a normal lateral compartment, but there was an immediate appearance of an anterior horizontal tear of the medial meniscus extending from the anterior horn to the mid body. The anterior cruciate ligament appeared to be intact. There was a small area of grade

2 chondromalacia at the medial femoral condyle at lateral wall where the torn portion of the meniscus was in contact and abrading that area. The retropatellar surface was intact, except for extensive grade 2 and mild grade 3 changes of chondromalacia on the medial facet of the retropatellar surface. At this time, using the aggressive meniscal shaver and the VAPR radiofrequency unit, a partial medial meniscectomy was performed of the portion torn at the anterior horn and extending into the mid body. This was contoured down smoothly with the use of the VAPR radiofrequency unit. The retropatellar chondromalacia underwent chondroplasty with a whisker shaver with satisfactory results. . . . (CX. #1, p. 84).

The claimant was initially seen in follow-up by Dr. Moffatt on February 28, 2007, during which time she remained under active medical treatment relative to her left knee injury. (CX. #1, p. 87).

On March 23, 2007, claimant was again seen by Dr. Moffatt. After noting the claimant's progress and following a physical examination, the March 23,2007, Progress Note concludes:

PLAN: At this time she is able to return to full functional activities. She is able to return to full employment. She has reached maximum medical benefits at this point. She is to return to the office in a month if she has any problems. (CX. #1, p. 88).

Claimant was again seen by Dr. Moffatt on April 20, 2007, at which time the Progress Note of the visit reflects that had reached maximum medical benefits and was discharged to return to the office only as needed. (CX. #1, p. 89).

The claimant returned to Dr. Moffatt on July 25, 2007, and provided a history of increasing pain over the lateral aspect of the left knee at the supracondylar region over a two (2) month period. Further the July 25, 2007, Progress Note reflects that the claimant relayed that the Celebrex was no longer helping. As a consequence of the afore the claimant's medication was changed from Celebrex to Relafen and the claimant was directed to use her Dynamic petallar control brace. (CX. #1, p. 90). At the time of the claimant's return visit of August 29, 2007, the

Progress Note of Dr. Moffatt reflects that there had been no improvement in her complaints as a result of the prior recommendations. (CX. #1, p. 91).

The final medical report reflects in the record is a September 12, 2007, Progress Note relative to a visit by the claimant to Dr. Moffatt. After reciting a history of the treatment measures rendered relative to the claimant's left knee complaint, the September 12, 2007, Progress Note concludes:

PLAN: At this point she has once again failed on Celestone and Carbocaine injection, but it would be to her benefit to try one more series of Synvisc or OrthoVisc injections, one injection a week for three weeks, to see if she shows any response to this. If no further response to this, then there is very little else to be offered to her from an orthopedic standpoint. Arrangements are going to be made to discuss this with her Workers Compensation insurance carrier and a copy of this note will be sent to her insurance carrier. (CX. #1, p. 92).

As noted above, the record does not reflect the presence of a Form AR-N, which reflects that the claimant was advised of her rights and duties with respect to a change of treating physician in accordance with Ark. Code Ann. §11-9-514 (c)(1). On July 9, 2007, a Change of Physician Order was entered by the Medical Cost Containment Department of the Commission changing the claimant's treating physician from Dr. Robert Riley Jones to Dr. W. L. Moffatt, III. (RX. #1, p. 25-26). The claimant's initial visit to Dr. Moffatt following the entry of the Change of Physician Order was July 25, 2007. (RX. #1, p. 24).

After a thorough consideration of all of the evidence in this record, to include the testimony of the witnesses, review of the medical reports and other documentary evidence, application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On February 13, 2006, the relationship of employee-employer-carrier existed among the parties when the claimant sustained a compensable left knee injury.
3. The claimant earned an average weekly wage of \$515.00, which generates compensation benefit rates of \$344.00/\$258.00, for temporary total/permanent partial disability.
4. The claimant was temporarily totally disabled for the period beginning February 14, 2006, and continuing through March 23, 2007.
5. Respondents failed to provide the claimant with a Form AR-N, Employee's Notice of Injury, pursuant to Ark. Code Ann. §11-9-514 (c)(1), following her February 13, 2006, compensable injury. Medical treatment rendered to the claimant by and pursuant to the directions of Dr. W.L. Moffatt between October 10, 2006, and July 25, 2007, was reasonably necessary in connection with the February 13, 2006, compensable left knee injury.
6. Medical treatment rendered to the claimant by and at the directions of Dr. W.L. Moffatt on and after July 25, 2007, was reasonably necessary in connection with the claimant's February 13, 2006, compensable injury.
7. The respondents shall pay all reasonable necessary and related hospital and medical expenses arising out of the claimant's compensable injury of February 13, 2006.
8. The respondents have controverted the payment of temporary total disability benefits subsequent to June 19, 2006, and the payment of medical benefits subsequent to October 10, 2006.

CONCLUSIONS

The claimant sustained an injury to her left knee within the course and scope of her

employment with respondents on February 13, 2006. The injury was accepted as compensable by respondent, who paid both medical and indemnity benefits in the claim. Claimant asserts that as a result of the February 13, 2006, left knee injury she is entitled to additional medical and indemnity benefits. Respondents contend that they have paid all appropriate workers' compensation benefits to which the claimant is entitled as a result of the compensable injury.

The present claim is one governed by the provisions of Act 796 of 1993, in that the claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

The claimant worked as a manager of one of the respondents' store, and had done so since April 2003. It is undisputed that she suffered a fall while performing employment services on February 13, 2006, and injured her knees in the process. The injury was reported to appropriate personnel of respondent. Claimant initially sought and obtained medical treatment relative to her February 13, 2006, accident on February 14, 2006, at the emergency room of Crittenden Memorial Hospital. The course of the claimant's medical treatment is detailed in the medical reports contained in the record.

There is no evidence in the record to reflect that the claimant experienced complaints, restrictions, or physical limitation relative to her knees prior to the February 13, 2006, accidental work-related fall. Subsequent to the accident claimant experienced pain, and swelling in the left knee which required medical treatment and restricted her physical activities. Save for the February 14, 2006, Crittenden Memorial Hospital emergency room visit, the claimant's medical treatment was had pursuant to the directions of respondents through October 3, 2006.

Compensability

As reflected in the stipulations respondents acknowledged that the claimant sustained a compensable injury to her left knee in her February 2006, accidental fall. The evidence reflects that the claimant suffered the afore fall on February 13, 2006. The evidence preponderates that the claimant presented consistent symptoms and complaints relative to her left knee subsequent to the February 13, 2006, accidental fall. The medical evidence in the record is devoid of any prior complaints of pain, swelling, stiffness or physical restrictions relative to the claimant left knee before the February 13, 2006, accident.

While the claimant provided credible testimony regarding her complaints and symptoms attributable to the February 13, 2006, accidental injury to her left knee, to include instances of it giving way, contrary to the assertions of respondents there is no evidence of an independent intervening event having occurred to sever their liability to provide workers' compensation benefits. Respondents point to a September 2006, incident which is recorded in the September 19, 2006, Employment Report authored by Dr. Robert Riley Jones, in of their argument of an intervening event.

The testimony of the claimant reflects that she did not injury her knee in the fall at home. Further, the claimant noted that the left knee was subject to giving way during the pertinent period as a result of the compensable February 13,2006, compensable injury. There is no evidence in the record to reflect that the claimant's activities at the time of the at home bathroom incident was contrary to the directions of her treating physician or negligent. The determination of the existence of an independent intervening cause is a question of fact. *Oak Grove Lumber Co. v. Highfill*, 62 Ark. App. 42, 968 S.W.2d 637 (1998). Nevertheless, the evidence preponderates that the claimant's need for medical treatment subsequent to September 1. 2006,

was the product of the February 13, 2006, compensable left injury. The claimant did not sustain an independent intervening event in September 2006.

Medical benefits

Ark. Code Ann. §11-9-508 mandates that employers provide such medical services as may be reasonably necessary in connection with the compensable injury sustained by the employee. *Air Compressor Equipment v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000); *GEO Specialty Chemical v. Clingan*, 69 Ark. App. 369, 13 S.W.3d 218 (2000). In the instant claim, respondents acknowledged that the claimant sustained a compensable injury to her left knee during the February 13, 2006, accident. Respondents paid for the cost of the claimant's medical treatment in connection with the February 13, 2006, compensable left knee injury through October 3, 2006. Further, the evidence discloses that the claimant's medical treatment was had primarily at the directions of physicians designated by respondents through October 3, 2006.

The claimant has sustained her burden of proof by a preponderance of the evidence that she continued to require medial treatment in connection with her compensable February 13, 2006, left knee injury subsequent to October 3, 2006. The medical reports reflects that the claimant's treating physician suspected the presence of meniscal tear as the source of her complaints and symptoms. The afore was ultimately borne out during the claimant's treatment under the care of Dr. W.L. Moffatt. The claimant dose not have to support a continuing need for medical treatment with objective medical findings. *Chamber Door Industries, Inc. v. Graham*, 59 Ark. App. 224, 956 S.W.2d 196 (1997); *Hambelton v. Guy King & Sons, Workers' Compensation Commission E904812* (Feb. 22, 2001).

The claimant selected and initiated medical treatment under the care of Dr. W. L. Moffatt

relative to her February 13, 2006, compensable left knee injury on October 10, 2006. Dr. Moffatt served as the claimant's treating physician relative to the February 13, 2006, compensable left knee injury through July 25, 2007, and thereafter. The credible evidence reflects that the claimant informed supervisory personnel of respondents that she would be seeking further medical treatment once she was discharged from the care of Dr. Robert Riley Jones on October 3, 2006.

Respondents did not offer the claimant access to either of her prior treating physician subsequent to the October 3, 2006, release by Dr. Jones. On February 21, 2007, the claimant underwent surgery at the direction and under the care of Dr. Moffatt in connection with the February 13, 2006, compensable left knee injury. The claimant received a good results from the surgery and offered that by March 23, 2007, she was physically capable of resuming work. Dr. Moffatt authored a report reflecting that the claimant was released to return to work as of the March 23, 2007, visit. The evidence preponderates that the claimant benefitted from the medical treatment rendered by Dr. Moffatt in that the same was reasonably necessary in connection with her February 13, 2006, compensable injury.

The claimant incurred substantial medical bills in connection with her medical treatment under the care of Dr. Moffatt from October 10, 2006, through July 25, 2007. Respondents assertions that the afore medical treatment was not authorized is not persuasive. As noted above, the evidence preponderates that the medical treatment received by the claimant under the care and at the directions of Dr. Moffatt was reasonably necessary in connection with the claimant's February 13, 2006, compensable injury. There is no evidence in the record to reflect that the claimant was furnished a Form AR-N in accordance with Ark. Code Ann. §11-9-514 (c)(1)

following her February 13, 2006, compensable left knee injury. The change of physician rules were not applicable in the instant claim during the time period that the claimant receive medical treatment under the care of Dr. Moffatt from October 10, 2006, through July 9, 2007. The claimant has sustained her burden of proof by a preponderance of the evidence that the medical treatment received by her under the care of and at the direction of Dr. Moffatt from October 10, 2006 through July 9, 2007, was reasonably necessary in connection with the February 13, 2006, compensable left knee injury, and respondents are liable for the payment of same. Respondents have controverted the afore incurred unpaid medical bills.

The credible evidence reflects that once the claimant secured the services of an attorney she petitioned for a change of treating physician pursuant to Ark. Code Ann. §11-9-514 (a)(3)(A)(ii). On July 9, 2007, a Change of Physician Order was entered by the Medical Cost Containment Department of the Workers' compensation Commission, pursuant to the afore statutory provision, and a July 25, 2007, appointment scheduled with Dr. W.L. Moffatt on behalf of the claimant. Respondents paid for the scheduled July 25, 2007, visit of the claimant to Dr. Moffatt, however have refused to pay for any visit thereafter.

The evidence in the record reflects that the claimant has been seen by Dr. Moffatt on at least two (2) occasions since the scheduled July 25, 2007, visit. Further, the medical records reflects that Dr. Moffatt has recommended a course of medical treatment to address the claimant's complaint associated with the left knee injury. The evidence preponderates that the medical treatment rendered to the claimant by Dr. Moffatt subsequent to July 25, 2007, is reasonably necessary in connection with the claimant's February 13, 2006, compensable left knee injury. Respondents have controverted the claimant's entitlement to continued medical treatment

under the care of Dr. Moffatt subsequent to July 25, 2007.

Temporary Total Disability Benefits

An employee who has suffered a scheduled injury is to receive temporary total disability benefits during the healing period or until the employee returns to work. Ark. Code Ann. §11-9-521(a); *Wheeler Construction Co. v. Armstrong*, 73 Ark. App. 146, 41 S.W.3d 822 (2001).

Whether an employee's healing period has ended is a question of fact.

In the instant claim, the evidence preponderates that the claimant has continued to receive active medical treatment in connection with her February 13, 2006, compensable left knee injury since the February 14, 2006, Crittenden Memorial Hospital emergency room visit. The credible evidence reflects that the claimant remained symptomatic subsequent to the October 3, 2006, release by Dr. Jones. Further, when initially released to return to work in June 2006, claimant reported for work and attempted to discharge assigned duties until her symptoms relative to the left knee injury rendered her incapable of continuing to do so.

The claimant has remained under active medical treatment in connection with the February 13, 2006, compensable left knee injury. At the time respondents terminate the claimant's employment in October 2006, they were aware that the claimant was continuing to seek medical treatment relative to the compensable left knee injury. Further the credible evidence in the record reflects that at the time of the October 3, 2006, release by Dr. Jones claimant continued to symptomatic relative to her left knee injury. The claimant went on to obtain medical treatment under the care of Dr. Moffatt and ultimately underwent surgery on February 21, 2007, in connection with the February 13, 2006, compensable left knee injury. The claimant was released to return to work on March 23, 2007. Claimant concurs that at the time of

the March 23, 2007, release she felt physical capable of return to gainful employment. The evidence preponderates that the claimant remained within her healing period and unable to work as a result of her compensable scheduled injury from February 14, 2007 through March 23, 2007, and correspondingly entitled to temporary total disability benefits. Respondents have controverted the claimant's entitlement to temporary total disability benefits subsequent to June 2006.

AWARD

Respondents are herein ordered and directed to pay to the claimant temporary total disability benefits at the weekly compensation benefit rate of \$344.00, for the period commencing February 14, 2006, and continuing through March 23, 2007, as a result of the February 13, 2006, compensable left knee injury. Said sums accrued shall be paid in lump without discount. Respondents may claim credit for sums heretofore paid toward the afore obligation.

Respondents are further ordered and directed to pay all reasonably necessary and related hospital, medical, nursing and other apparatus expenses growing out of and in connection with the claimant's compensable February 13, 2006, left knee injury, to include medical related milage.

Maximum attorney fees are herein awarded to the claimant's attorney on the controverted indemnity benefits herein awarded pursuant to Ark. Code Ann. §11-9-715.

This award shall bear interest at the legal rate pursuant to Ark. Code Ann. §11-9-809, until paid.

Matters not addressed herein are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, ADMINISTRATIVE LAW JUDGE