

**BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION**

**WCC NO. F702426**

**CHRISTOPHER J. TATE, EMPLOYEE**

**CLAIMANT**

**UNIMIN CORPORATION, EMPLOYER**

**RESPONDENT**

**ACE AMERICAN INSURANCE COMPANY,  
C/O ESIS, CARRIER/TPA**

**RESPONDENT**

**OPINION FILED FEBRUARY 11, 2008**

Hearing before Administrative Law Judge O. Milton Fine II on November 13, 2007, in Little Rock, Pulaski County, Arkansas.

Claimant represented by Mr. R. Theodor Stricker, Attorney at Law, Jonesboro, Arkansas.

Respondents represented by Mr. James C. Baker, Jr., Attorney at Law, Little Rock, Arkansas.

**STATEMENT OF THE CASE**

On November 13, 2007, the above-captioned claim was heard in Little Rock, Arkansas. A pre-hearing conference took place on June 11, 2007. A prehearing order entered that same day pursuant to the conference was admitted without objection as Commission Exhibit 1. At the hearing, the parties confirmed that the stipulations, issues, and respective contentions, as amended, were properly set forth in the order.

**Stipulations**

At the hearing, the parties discussed the stipulations set forth in Commission Exhibit 1. The parties reached additional stipulations concerning the status of Dr. Earl Peeples and Claimant's average weekly wage. The four stipulations, which I find to be reasonable, are as follows:

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The employee/employer/carrier relationship existed between the parties on June 9, 2006, at which time Claimant sustained a compensable injury to his right hip.
3. Dr. Earl Peeples did not treat Claimant.
4. Claimant's average weekly wage was \$577.92.

### Issues

At the hearing, the parties discussed the issues set forth in Commission Exhibit 1. Claimant reserved issues concerning his entitlement to permanent disability benefits. Respondents added issues concerning compensability and entitlement to an offset. The following issues were thus litigated:

1. Whether Claimant sustained a compensable injury.
2. Whether Claimant's hip infection and ultimate replacement was an independent intervening cause or a compensable consequence of his original injury.
3. Whether Claimant is entitled to additional medical treatment.
4. Whether Claimant is entitled to temporary total disability benefits for any period of time.
5. Whether Respondents are entitled to an offset for short-term disability benefits Claimant allegedly received.
6. Whether Claimant is entitled to attorney's fees.

Contentions

Claimant removed his contention concerning permanent partial disability benefits. Respondent amended his contentions to include one concerning compensability. The contentions of the parties are thus as follows:

Claimant:

1. Claimant contends that is entitled to temporary total disability benefits from his last date of work, June 10, 2006, to a date yet to be determined.
2. Claimant contends he suffered a compensable injury to his right hip on June 9, 2006 and is entitled to continued medical treatment, including but not limited to, all surgeries and complications arising from his compensable injury.
3. Claimant contends that he is entitled to attorney's fees.

Respondents:

1. Respondents contend that Claimant is unable to meet his burden of proving that he sustained a compensable right hip injury on June 10, 2006 for want of medical evidence establishing evidence of a right hip injury.
2. Respondents contend that Claimant sustained an independent intervening cause in the form of a hip infection caused by a left arm infection that was detected on July 3, 2006.
3. Respondents contend they are not responsible for treatment of benefits after July 3, 2006.

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

After reviewing the record as a whole, including medical reports, deposition transcripts, documents, and other matters properly before the Commission, and having had an opportunity to hear the testimony of the hearing witnesses and to observe their demeanor, I hereby make the following findings of fact and conclusions of law in accordance with Ark. Code Ann. § 11-9-704 (Repl. 2002):

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.
2. The stipulations set forth above are reasonable and are hereby accepted.
3. Even though the parties stipulated to compensability as set forth above, I find that Claimant has nonetheless proven by a preponderance of the evidence that he sustained a compensable injury to his right hip on June 10, 2006.
4. Claimant has proven by a preponderance of the evidence that his right hip infection and ultimate replacement was a compensable consequence of his original compensable hip injury.
5. Claimant has proven by a preponderance of the evidence that he is entitled to reasonable and necessary medical treatment of his right hip, including all such treatment rendered to date and future annual checkups on the hip.
6. Claimant has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from June 11, 2006 to June 20, 2006, and from July 3, 2006 to March 19, 2007, at the stipulated maximum rate of \$488.00 per week.

7. Respondents have proven by a preponderance of the evidence that they are entitled under Ark. Code Ann. § 11-9-411 to a dollar-for-dollar offset for short-term disability benefits Claimant received.
8. Claimant's attorney is entitled to a controverted attorney's fee on all indemnity benefits awarded to Claimant, pursuant to Ark. Code Ann. § 11-9-715.

### **CASE IN CHIEF**

#### Summary of Evidence

The witnesses at the hearing were Claimant and Steven Mark Bell, the plant superintendent for Respondent Unimin. In addition to the prehearing order discussed above, also admitted into evidence in this case were Joint Exhibit 1, a compilation of his medical records, consisting of a two-page cover letter, a four-page index, a four page affidavit, and 117 individually numbered pages thereafter; Joint Exhibit 2, the 39-page transcript of the deposition of Dr. James E. Zini taken September 7, 2007; Joint Exhibit 3, the 44-page transcript of the deposition of Dr. Jeff Angel taken September 12, 2007; Joint Exhibit 4, the 42-page transcript of the deposition of Dr. Thomas Hunt Cummins taken October 26, 2007; and Joint Exhibit 5, 17 individually numbered photographs depicting people ascending a Bobcat loader. In addition, Respondents' prehearing questionnaire filed April 18, 2007 and letter from Respondents' counsel dated September 11, 2007 regarding an amendment to their questionnaire will be blue-backed to the record.

#### Testimony-Hearing

Christopher Tate. Claimant testified that he served in the military from December 10, 2002 until August 15, 2005, when he was released because his father passed away

and he was needed to help take care of the family farm. He went to work for Respondent Unimin in May 2006 as a dryer operator. His job was to run the dryer, take sand samples, and keep the facility clean. His shift was from 7:00 p.m. to 7:00 a.m.

Claimant stated that he incurred an on-the-job injury on June 9, 2006 while getting on a Bobcat loader: "I turned around on the bucket and caught my toe and popped my hip out of place . . . I turned back to it and put it back in and went on doing what I was doing." He testified that he reported the injury to Bobby Cannon, the senior person present, but continued to work and completed his shift on Saturday morning.

He returned to work Saturday night, but was only able to complete half his shift. After sitting for awhile, Claimant was unable to stand up. A coworker helped him go to Jerry Frazier, who had just shown up for work that morning. Frazier took him to the emergency room. There, Claimant received a muscle relaxer and pain pills and was sent home. However, he did not feel better and he reported as much when he returned to work on Monday. Claimant was then taken to the Dr. Zini, who gave him some more pain medication. Later, Dr. Zini prescribed anti-inflammatories and had Claimant undergo an MRI on June 15 or 16, 2006. The test showed that he had fluid on the joint.

Thereafter, Claimant was referred to Dr. Jeff Angel on July 3, 2006. He determined that the joint fluid was infected. Angel operated that day and flushed the hip. After receiving antibiotics for three days, Claimant underwent a second surgery to flush out the joint. After receiving another round of antibiotics in the hospital for one week, Claimant continued to receive treatment at home for another six weeks. He was referred to Dr. Evans in August 2006, who determined that he needed a hip replacement. Claimant

underwent the procedure on January 19, 2007. He stated that Dr. Evans released him from further treatment, but that he is supposed to have annual checkups on the hip.

He returned to work in the first week of May 2007 driving a dump truck for \$10.00 per hour for another employer. Claimant averaged 50 or 60 hours a week at that job, which lasted nearly five months. However, after that job “fizzled out” in August 2007, he went to work for Columbia Flooring, where he earns \$10.50 per hour and worked 40 hours a week. While he is supposed to be performing only light duty work after his hip replacement, Claimant stated that this job requires more than that.

Claimant testified that his last day at Respondent Unimin was roughly one week after he was injured. But he stated that he just sat in the office and did not do anything. He never drew temporary total disability benefits, but he did draw disability benefits from Unimin that amounted to approximately \$200.00 per month and lasted until January 2007. Claimant stated that he no longer received workers’ compensation coverage for his medical bills once it was discovered that he had an infection. Thereafter, they were covered by his private insurance.

He testified that his only hospitalization while in the military was for a food allergy. While his medical records reflect that he had a boil, he denied having one. To his knowledge, he was never exposed to staph or Methicillin-resistant Staph Aureus (“MRSA”) bacteria while in the military or thereafter. Nor was he aware of being infected with staph or MRSA.

When questioned by Respondents, Claimant clarified he was actually injured on June 10, 2006, since the incident occurred at approximately 1:00 a.m. that Saturday morning. He was 23 years old at the time. On Sunday morning, he was so stiff he could

not get out of the chair in the front of the computer at work. That was when he was taken to the emergency room at Mountain View. On Monday, he went to Dr. Zini.

Asked to explain how the accident occurred, Claimant testified that he was “turning on top of the bucket.” He explained that this was how he climbed into the Bobcat. The bucket of the Bobcat was propped on a concrete step approximately six to eight inches high. He stepped from there to the top of the bucket. From there, “I—I put both feet kind of on one side and then turned to the outside, and then just stepped back in there [into the seat of the Bobcat].” He did this using the hand holds on the machine. Claimant explained that this awkward maneuvering, turning 180 degrees on top of the bucket before proceeding backwards into the seat, was necessary for him because he is so long-legged. When shown Photograph 5 from Joint Exhibit 5, Claimant explained that he did not turn on the top of the Bobcat, as the person depicted in that photograph did, because the bucket in his case was in a different position. Claimant stated that he thought the Bobcat in the photograph was not the one he was using at the time of the accident because the one depicted appeared to him to be larger than the one he used. But he added that Steve Bell would know if it was the same Bobcat. He also admitted that the one shown in Photograph 5 would require an additional step past the top of the bucket before one could turn around. He agreed that the top of the bucket was smooth, but only if it were level.

Claimant stated that it was one of the “toe holds” that caught his foot. The bucket was tilted at the time, and he caught his boot on one of the holds when he was turning. He could not recall what the position of his toes or feet were, vis-a-vis the top of the bucket, but knew that “[w]hen I turned around, I caught my toe.” When shown Photograph 4, Claimant explained:

I was standing to one side just maybe over six or eight inches from where he's standing. And then my right foot was turned into the side of the foot hold. And whenever I turned, my toe caught it . . . [t]he side of it.

When asked whether his boot was pointing toward or away from the Bobcat at the crucial moment, he stated: "I don't know. It was dark. It hurt. And I turned back towards it before I realized—before I looked down to see which way my boot was pointing." He was unsure if he dislocated his hip, but knew that it popped and then did so again when he "turned back to it."

Claimant testified that "[i]t very well could have been" that he only told the emergency room physician that he moved his hip wrong and it popped—without ever mentioning the Bobcat. He agreed that at the time of the accident, he was young, strong, in good shape and good health, and had to pivot and turn on his feet all of the time.

Asked to explain why he testified that he told Bobby Cannon about his injury before his shift ended, when his deposition testimony was that he did not recall telling anyone, he stated, "I recalled it. I remember some things one day and not so many the next." Claimant stated that he did not seek medical attention before returning for his Saturday night shift. Once at work that night, he spent about eight hours replacing fan bearings in the dryer area. The fan is on an elevated platform about three or four feet off the ground. He had to go up and down from the platform during that period multiple times. Sometimes he used a ladder; sometimes he did not. When asked how he was able to do this with a sore hip, Claimant testified, "It was sore, but I went on with it." It was not until he sat down at the computer for an hour that he could not get up.

He went to the emergency room that morning, and was running a fever by that night. At that time, he was not aware of having an infection, and had no exterior bodily injury. The fever remained, he lost his appetite, and he dropped 35 pounds over the next week and a half. He again denied having a boil, and stated that he was fairly certain that Dr. Cummins had made that up. Claimant did not recall at the hearing if he had a scratch, but he testified in his deposition that he did, that it bled, and that the wound healed approximately a week before he hurt his hip.

Claimant reiterated that Dr. Evans is the last doctor he has seen, and that he released him following his last visit. This occurred approximately six weeks following his hip surgery, and before he began work at Turner. With respect to his disability benefits, he again stated that while he received approximately \$200.00 per month, he did not know what the source was.

When questioned by me, Claimant testified that because the bucket of the Bobcat was resting on a step when he stepped up on it, the bucket, and the perforated steps were tilted back. I had him take a red pen and mark on Photograph 1 with a circle where he was stepping when his toe became hung, and mark with an "X" where his toe was at the time. His marks reflect that he was about to step on, and got his toe hung on, the right side of the perforated step on the left (if one is facing the front of the bucket). However, he insisted that the bucket depicted in the picture was different than the one he was on because he believed the perforated steps were raised above the bucket he had been atop. Regardless, he was sure that his toe was hung on the side of the step, on the edge. At the time, he was wearing leather boots with a 3/4-inch waffle soles and rounded toes.

On redirect, Claimant stated that the size of the gentleman depicted in the photographs might be skewing his perception of the Bobcat. Also, his attorney had him mark with a red pen the perforated step to show that if tilted, the step would stand out somewhat from the bucket.

Steven Mark Bell. Called by Respondents, Bell testified that he is the plant superintendent for the Unimin plant in Guion. He explained the Unimin mines sand from sandstone and cleans and separates the product into separate grain sizes for sale. Part of the drying process is to scoop the sand with a front end loader and “feed it to the process that [Claimant] was running.”

Bell stated that he took the photographs that comprise Joint Exhibit 5, and that the Bobcat depicted therein was the same one that Claimant was using during his June 9-10, 2006 shift. The plant has two Bobcats, and the one shown was the one typically at the dryer. He testified that the worker shown in the vast majority of the photographs is Mike Maloney, the plant manager, who stands approximately five feet seven inches tall. The worker in Photograph 14 is Jamie Cannon, and stands around six feet tall.

Bell corroborated Claimant’s testimony that the Bobcat’s bucket typically rests on a step in the dryer house. When asked to describe the process for climbing into the Bobcat, he stated:

Well, I think there’s probably a couple ways to get into the Bobcat. Obviously, you’re facing—you’re going to have to turn around some time. I think most generally someone is going to step on those treads that are built into the bucket. For myself, I would step up on both treads, left foot on the left one, right foot on the right one. And then I’m going to have to step into the—the cab area. You know, kind of like stepping into a bathtub or something, you know. You’re going to step [sic] in and begin to pivot. Once one leg is stepped into the cab, then I’m pivoting and bringing the other one in as I’m holding on. In these photographs, we see Mike stepping up on

these built-in treads. And he steps up a little further on the—oh, this structure of the Bobcat, and he does pivot there in these photographs. I don't know how it would be that someone would pivot out, you know, out on the bucket and then step back in. I don't think that would be real typical.

He stated that the perforated steps are flush with the top of the bucket, and that even when tilted, there was nothing raised that a person could catch his toe on. Bell added that when stepping on the perforated step, the ball of the foot would strike the center of the step.

Bell testified that Claimant signed up for "ANS," which paid approximately \$200.00 per week.

When questioned by Claimant, Bell stated that the perforated steps protrude forward from the bucket and that if the bucket were tipped, the steps would be at an angle.

#### Testimony-Deposition

Dr. James Zini. Deposed by Respondents on September 7, 2007, Dr. Zini testified that he is a doctor of osteopathy and practices in Mountain Home. He described his practice as "General medicine . . . Internal medicine, family medicine. Birth to death." He stated that Claimant on June 12, 2006 complained of "right inguinal pain after getting into equipment." Zini described the inguinal area as "an area between the lower part of the abdomen and the upper part of the leg on the right in the front of the body." He opined that a hip injury can cause inguinal pain, and vice versa. He found right inguinal swelling on Claimant. Dr. Zini ordered an MRI of the right hip/inguinal area, and diagnosed Claimant as having a strained right hip and inguinal.

Claimant returned on June 14, 2006 at the request of the plant supervisor. His condition had not improved in that he still had pain in his right groin and leg and could not bear weight. Dr. Zini noted that Claimant's sartorius muscle was tight and tender and

symptomatic. The next day, the MRI results showed that he had a significant increase in the amount of fluid in his right hip as compared to his left. However, there were no changes to indicated a specific etiology for the fluid, and there was no indication of inflammation or edema in the soft tissues around the hip joint. He continued Claimant on alternate work duty and referred him to Dr. Jeff Angel, an orthopedic specialist, because Zini “could not explain his symptoms, and he did not seem to be clearing as I would have expected him to with what we had done.”

When asked whether he had any other information concerning whether this was a work-related injury other than Claimant’s statement above, Dr. Zini testified:

I can remember asking him about—I didn’t understand how that would have caused him this problem. And it is my—as I remember at this point—because I didn’t document anything else. It was like he had to move in contortion profiling to get into this equipment. And that was the only reason that I could ascertain that it might have been related to his work.

But Zini could not opine whether Claimant’s hip injury was work-related, based on his history of objective medical data. Asked about whether the injury as Claimant had described would explain the fluid on his hip without soft tissue inflammation, Zini noted that for three of the five days preceding the MRI, he had him on anti-inflammatories.

Dr. Zini did not know until the deposition that Claimant was found to have a staph infection in his hip. But the doctor stated that he was not sure how that would have happened, since his examination revealed no skin break. He did not locate a boil when he examined Claimant. However, Zini opined that if Claimant had a healed scratch a week or two before the accident, the scratch could have been a portal for staph; once the hip injury occurred, the infection could have gone to that area of increased activity. Zini stated that this would be unusual, that he would have expected the infection to instead settle in

the elbow because of its proximity to an arm wound. But he added that Dr. Angel was in the best position to render an opinion as to what occurred.

Zini testified that the excess joint fluid was the only objective evidence of a hip injury. But he added that an infected hip joint capsule could produce such a fluid buildup. Based on the pain Claimant presented with, Dr. Zini expected the MRI to show a derangement of the right hip. But this did not happen. From this, Zini concluded that something else was causing the problem and that Claimant needed to see an orthopedic specialist. Presented with Dr. Angel's findings, Dr. Zini stated:

I think the best medical evidence suggests that there must have been fluid there when he hurt his hip, when he—whatever he did in the equipment, that he did, indeed, have that fluid there. That was pretty quick for fluid to have presented when there was no obvious tissue injury . . . I think it's safe to say we have radiographic evidence, by MRI, of the fluid in the joint, the capsule, but not damage or problems in the tissue that holds the hip together and makes it work and that therefore it did not seem to be related to his hip injury.

When questioned by Claimant, Dr. Zini testified that based on Claimant's version of how he hurt his hip, he believed that correlated with what he observed. He had no prior history of hip problems. While Claimant was in severe pain, that was normal for such an injury. But he did not believe that Claimant dislocated his hip, because of the absence of edema and swelling in the tissues around the joint. While his use of ibuprofen and prednisone would have reduced these symptoms, according to Zini, they would not have eliminated them entirely.

He opined that

I would surmise with a reasonable medical understanding that if [Claimant] had had an infection and then he was getting over that infection and then hurt his hip that that disruption of normal hip function, it could have gone to his hip and infected it.

But again, he added that he saw no evidence of breakage in Claimant's skin to allow staph to enter his body.

Dr. Jeff Angel. Deposed by Respondents, Angel testified that is an orthopedic surgeon in Batesville. He first saw Claimant on July 3, 2006. After examining him, Angel scheduled him for an aspiration of his right hip joint based on the June 15, 2006 MRI report and because Claimant's pain had not improved. He never saw Dr. Zini's notes.

Because the test results showed that the hip fluid had a high white cell count, Angel operated on him that same evening, July 3. Dr. Angel performed an arthrotomy, draining and cleaning the joint. He did not cut into the bone because it was soft and did not have infection requiring drainage. Angel stated that because the blood supply to the femoral head is tenuous, quick action to remove infection is necessary. A culture of the fluid showed that staph was present.

Dr. Angel consulted Dr. Cummins, an internal medicine physician, who had training in infectious diseases. Another MRI on July 5, 2006 showed osteomyelitis, which was confirmed during follow-up surgery the next day. The osteomyelitis was located where the metaphysis and epiphysis meet in the femoral neck. This condition, an infection of the bone, is unusual in someone Claimant's age.

But the reason it can occur in the location where Claimant had it is because of the vascular loops that exist at the end of the femur that make the blood supply to the femoral neck poor. Angel stated that the bacteria that is usually associated with osteomyelitis is staph aureus—that type Claimant had. He opined that because Claimant did not have a skin penetration or an exposed bone, the infection had to come from blood-borne bacteria. Once in the bloodstream, the bacteria can circulate throughout the body. It can also settle

and seed in the looping vessels at the upper distal end of the femur. If such seeding takes place, the body will try to fight off the bacteria; and if the body is not winning that battle, that can cause a sympathetic effusion in the hip joint. A sympathetic effusion is distinguishable from a traumatic effusion. This process can then result in the bacteria getting out of the bone and into the fluid in the hip joint, leading to a septic joint.

Dr. Angel testified that such an occurrence is usually preceded by a noticeable boil or lesion, or an illness such as influenza or strep throat. The rate at which an infection develops can vary. Osteomyelitis is often associated with fever and weight loss, and does not only appear in an area of trauma.

Angel stated that he was aware that Claimant attributed his hip injury to twisting it while getting into a Bobcat. But the only objective evidence of such an injury was effusion in the joint; there was no damage to the bone or surrounding tissues. And the effusion, in Dr. Angel's opinion, could have been sympathetic or traumatic. But in looking at Claimant's symptoms, Angel was adamant that he could not have had osteomyelitis at the time of the first MRI because while it showed effusion, it was "stone cold normal" regarding the femur, despite the fact that such a test is "very, very sensitive" (in the words of Dr. Angel). And he was thus doubtful that Claimant had a sympathetic effusion because such a condition is a reaction by the nerves to something in that area. When asked what was causing the hip joint effusion on June 15, 2006, Dr. Angel stated that "[a]ccording to [Claimant's] history, I would have to say an injury to his hip joint . . . [a] sprain, strain." The evidence of the sprain or strain, was the tenderness and the effusion—and the effusion could have caused the tenderness. When asked to explain how the infection could have happened in that instance, Dr. Angel stated:

By hematogenous route. It most commonly occurs in the AC joint, the acromioclavicular joint in the shoulder. We'll see it get sprained or have fluid in it, and then someone will get sick and the actual joint fluid we can see, just like any other bone. So that's common for joints to seed with hematogenous infection.

The infection would travel through the synovial lining and deposit in the lining of the lining.

From there, a staph infection could go into the bone in a matter of days.

Dr. Angel thus opined that Claimant twisted his hip in a way sufficient to cause joint effusion, and that this occurred at a time when he had blood-borne staph aureus. He explained how the injury occurred:

Well, I mean, it's just common sense from my standpoint. Those—I imagine something that's three or four feet off the ground where you're sitting and so you have to climb. And if you have your body weight—it wouldn't be just from turning your leg in space, of course wouldn't give you severe injury, but from a twisting motion, it can cause severe injuries. We have patients who twist on a water hose and break their bones. Because twisting and torque is a lot, it gives you a lot more pressure than just, you know, just bending something or stretching on it, pulling on it. So in my mind, his whole body at some point twisted, and twisted his hip, the way he described it. He didn't describe a minor thing to me. He said it really hurt, it popped.

When questioned by Claimant, Dr. Angel stated that there can be any number of causes of a staph infection, from the sinuses to an ingrown toenail. The incubation period for this bacteria is about seven days. He would not venture a guess as to how Claimant acquired this methicillin-resistant strain. But he did state that the bacteria going to the hip in this case would be a problem because “[t]he joint fluid is the key . . . it doesn't have a good blood supply to fight off an infection.” He closed by opining that Claimant's hip replacement was necessary.

Dr. Thomas Hunt Cummins. Deposed by Respondents on October 26, 2007, Dr. Cummins testified that he is board-certified in internal medicine and practices at White

River Diagnostic Clinic in Batesville. He has had training in infectious diseases, and thus gets consulted in this area.

Dr. Cummins saw Claimant approximately ten times while he was hospitalized July 14-17, 2006. Dr. Angel consulted him because Claimant was running a fever, losing weight, and had purulent material aspirated from his right hip. Dr. Cummins modified the antibiotics Claimant was on and waited for the results of the culture of the aspirated material. The culture showed that the bacteria was staph aureus.

The questions for Dr. Cummins were why Claimant had pus, staph aureus, in his joint, and what was its source? He stated that this bacteria does not grow in joints normally. Claimant did not have an IV, and was not an IV drug abuser. The only source Dr. Cummins could identify was that Claimant had what appeared to be an old boil on his left elbow. There were no other open wounds. Dr. Cummins presumed

that, perhaps, because most boils are staph species, was that staph had transiently gotten into his bloodstream from this boil and because his hip was inflamed, fed into the joint space, where he developed he osteomyelitis and the infected hip and all those things.

The proximal end of the femur, where Claimant had osteomyelitis, is not a highly vascular area and not a common place for such an infection. Dr. Cummins testified that he did not believe he had previously seen this condition where there was no opening such as a wound in proximity to it. When asked which came first, the osteomyelitis or the joint space infection, the doctor stated:

I guess that's for the lawyers and the judge to decide. I don't know that anybody can answer that. It is more typical—or I would expect it more likely to have the joint space first, and then the bone, because bone is very difficult to infect, because it is not very vascular . . . There is more access for infection through the joint space tissue, than there is in the bone. The membranes and the cartilage and things, when inflamed, can allow bacteria

in much more easily than bone. Bone takes time to get infected . . . It's very uncommon for bone to become infected first. It usually—bone is infected outside in, through the skin into the bone through a joint into the bone, as opposed to the bone spreading infection outward, physiologically.

Because Claimant had no wound near the hip, the staph had to be blood-borne. With the boil, he would have had bacteria in his blood, circulating throughout his body. Cummins stated that if a membrane such as at the bursa or the joint linings are inflamed, they become more easily to penetrate because they would be dilated. Thus, the staph aureus could have seeded in Claimant's hip under this scenario.

On the other hand, the bacterial could not, in Cummins' opinion, have seeded easily in the proximal end of the femur because of the poor blood supply there. While Dr. Cummins agreed that had the osteomyelitis came before the infected joint space, it could have caused a sympathetic effusion in the space, he added that Claimant's initial MRI did not show osteomyelitis. He deferred on the question of how an effusion could be identified as sympathetic or traumatic, stating that that is Dr. Angel's field. But he did opine that while it was possible for the sequence to be bone infection to effusion to septic hip joint, he stated that it would be statistically a much higher probability that the osteomyelitis came last. Moreover, through the objective evidence supplied by the MRI, which showed effusion but no osteomyelitis (which an MRI is used to diagnose), this is what Dr. Cummins believed happened. Dr. Cummins' conclusion may be summed up in this exchange:

Q. He just had the misfortune of spraining his hip at the same time that he had a blood-borne staph in his body?

A. It would seem that way, yeah.

In addition, the doctor opined that the reason for Claimant's hip replacement was that the infection caused the death of the bone.

Under questioning by Claimant, Dr. Cummins stated that everyone has staph growing on his or her skin. Claimant had methicillin-sensitive staph aureus. Dr. Cummins was also insistent that Claimant told him that he had had a boil on his elbow. While he was of the opinion that Claimant could not have had an active staph aureus infection for six months without symptomology, he could have had it for one week. But the doctor did not try to discover how long ago Claimant had the boil.

### Records

The medical records of Claimant that were introduced at the hearing and are part of Joint Exhibit 1 reflect the following:

On June 11, 2006 at 8:05 a.m., Claimant presented to the emergency room at Stone County Medical Center with right hip pain since the previous Friday night, "when he moved it wrong & it popped. Pain came back last night." He was diagnosed with a hip strain. A hip x-ray taken that day was normal. When Claimant went to Dr. Zini the next day, he presented with right inguinal swelling. He stated that he was injured on June 10, 2006 at 1:00 a.m. The plant supervisor requested that he return to the doctor on June 14, 2006, where he presented with the same pain in the right groin. He was unable to bear weight on his right leg without severe pain. He was diagnosed with a right hip and inguinal strain and sartorius and was placed on crutches. Dr. Zini requested that Claimant be administered an MRI. That test, conducted on June 15, 2006, showed a significant increase in the amount of fluid in the right hip joint as compared to the left. Dr. Aubrey Joseph, the radiologist, did not see an apparent etiology for the fluid. Nor did he see inflammation or edema in the soft tissues around the joint. Dr. Zini imposed numerous restrictions, stating that Claimant was to use crutches and not do any lifting, climbing,

pulling, etc. On June 21, 2006, Claimant reported that he had returned to work and felt better but had "hot sweats" over the weekend.

Dr. Zini recommended that Dr. Angel be brought in for a consultation. He examined Claimant on July 3, 2006 and found no abnormalities on his skin near the hip. A history on July 4, 2006 stated that Claimant "relates 3 wks. ago at work went to step up on some equipment, foot was caught, hip twisted felt 'pop,' has had fever, chills and wt. loss due to no appetite." Aspiration of the joint showed that it contained a thick purulence, so Dr. Angel performed an arthrotomy with incision capsulotomy and debridement with placement of a drain. He diagnosed Claimant as having a septic hip. A second aspiration on July 7, 2006 showed that the hip contained a yellowish cloudy fluid that was "unquestionably related to pus aspirated from the hip" earlier. A note from Dr. Angel reads "old boil (L) elbow."

Dr. Cummins came in for a consultation on July 4, 2006. His report reads in pertinent part:

The patient is a 22-year-old gentleman who works at the sand mine in Guion. About 3 weeks ago, he was stepping up on some equipment and his foot got caught, his hip twisted, and he felt a pop. He has been having pain in that hip ever since that time. About a week after the injury, he was found by MRI to have an effusion in that joint. At his request, he was referred to Dr. Angel for evaluation, who saw him yesterday.

In the interim, he has begun running fever and having weight loss. He has had a high fever subjectively; he has not documented how high his fever has gone. He has had a very poor appetite, and, in fact, has lost somewhere around 30 pounds over the last week or so. He has not had any nausea or vomiting, but simply has no appetite.

On further questioning, he reports that he may have had a boil or subcutaneous abscess on his left elbow somewhere during this time. He is not sure whether this was there prior, during, or after the development of

fever. This area has resolved. He reports no penile discharges. He reports no IV drug use or other major open wounds.

The report reflects that Claimant's fever was 100.3 degrees, that he was "a well-developed, well-nourished man who appears in no distress and does not appear chronically ill," and that "[t]here is a questionable old subcutaneous abscess on his left elbow." Dr. Cummins' assessment reads:

Septic right hip. This may reflect seeding from a previous boil on his left elbow with transient bacteremia with entrance into an inflamed joint. Certainly, other possibilities include gonococcal arthritis, although he is engaged in no other high-risk behaviors. There is nothing in his history or physical to suggest an endocarditis.

An echocardiogram on July 6, 2006 ruled out endocarditis as the source of the bacteria.

A follow-up MRI on July 5, 2006 showed inflammation and edema in the musculature around the hip joint, a considerable amount of fluid around the adductor and pectineus muscle medial to the right femoral neck, possible osteomyelitis in the proximal right femur and acetabulum, and fluid extending around the iliopsoas muscles.

Claimant underwent a second surgery on July 6. Dr. Angel irrigated and debrided the hip and performed a resection of osteomyelitis through opening of the anterior femoral cortex. He diagnosed Claimant as having a right hip abscess and osteomyelitis in the right femoral neck. A CT scan on July 8 showed cortical erosion along the femoral head, neck, and within the roof of the acetabulum consistent with osteomyelitis. Another MRI on July 14, 2006 showed little change in the osteomyelitis but less joint effusion.

On July 17, 2006, Dr. Angel discharged Claimant from the hospital. At the time, he was found to be stable, with the hip drains discontinued but a PICC line placed. The

cultures of the drainage showed “staph aureus sensitive.” He was to return to Dr. Angel on July 19. Dr. Evans consulted by phone regarding the case.

In answers to questions submitted by the third party administrator about Claimant’s injury, Dr. Angel wrote the following:

If a boil or abscess was present, this was more than likely the source of infection. I think he infected an effusion. The work injury could have caused the effusion and then it was seeded by bacteria from the arm lesion. According to patient’s history and time line of data, I think he injured hip—fluid on hip, then the fluid became infected from arm lesion. The sepsis in the scenario is not pre-existing. It complicated a pre-existing work comp injury.

A follow-up x-ray on July 24, 2006 showed chondrolysis with narrowing of joint and an indistinct acetabulum. When asked on that date whether the hip injury arose out of Claimant’s employment, Dr. Angel wrote, “uncertain.”

When Claimant underwent x-rays on August 7, 2006, the showed degenerative arthritis of the right hip with nearly total loss of the cartilage in the hip. Dr. Richard Evans saw Claimant and assessed him as having septic arthritis and in need of a total hip replacement in the future. On August 8, he wrote Dr. Angel a letter that reads in pertinent part:

Clearly, as you know, this very young man has severe residual arthritis in his right hip post rather freak onset of right septic native hip.

I do agree with you that the only likely source is his elbow and arm abrasion/bursitis which is apparently work-related. Although as you know, this is extremely unusual, it apparently did result in sepsis of an otherwise normal healthy hip joint.

Claimant underwent physical therapy and at total of 11 weeks of antibiotics. He was assessed by Dr. Evans as having “a great deal of limitations of his activity through his right hip pain. Previously the patient worked as a miner and a farmer, but he is unable to do

most of these activities because of his hip pain.” Dr. Evans placed Claimant on the surgical schedule for right total hip arthroplasty, metal-on-metal prosthesis, for November 30, 2006.

The records reflect that Claimant continued to present with very painful arthritis in the hip and ultimately underwent the replacement on January 19, 2007. He was discharged from the hospital on January 22, 2007 with numerous pain medications and was given the diagnosis of “right hip degenerative joint disease secondary to previously infected right hip which was positive for MRSA.” He continued physical therapy he began after surgery. On March 15, 2007, on a follow-up visit to Dr. Evans, Claimant reported having no pain. On March 19, he stated that he was taking no medications, and Dr. Evans instructed him to return in one year.

Respondents asked Dr. Earl Peebles to review Claimant’s records and render an opinion. On October 30, 2007, he wrote:

You have asked me to review records regarding Christopher Tate as they relate to an infection of his hip. You have specifically asked me to correlate as to any connection between his incident at work and the later presence of infection of the hip joint and proximal femur requiring surgery.

.....

The record most closely related to the incident was that of Dr. Zini. On June 12 his handwritten records indicate that the incident actually occurred June 10, 2006 at 1 a.m. and was “right inguinal pain after getting onto equipment.” This history does not relate specific injury and, in fact, it is notable that the initial entry of “hip” is struck out and replaced by handwritten “inguinal” correction. Right inguinal swelling was noted on physical exam. A diagnosis of right hip and inguinal strain was entered. He was given a prescription for narcotic analgesic and steroid medication.

Reevaluation on June 14 indicated commenting on the sartorius. There was no change in diagnosis.

On June 21, although he continued to have pain, he was somewhat improved and back to work.

MRI performed on June 15 was noted to have an increased amount of fluid in the joint, an effusion.

The MRI report interpreted by Dr. Aubrey June [sic] indicated the presence of effusion but specifically no identifiable etiology for this effusion. Specifically, there is an absence of evidence of traumatic injury.

Examination by Dr. Angel on July 3 indicated full muscle strength with mild limited range of motion of the right hip and no evidence of hip laxity. Operation for hip sepsis, that is, infection in the hip joint was undertaken that day. *Staph aureus* was the bacteriologic cause of the infection.

A consultation dated July 7 by Dr. Tom Cummins indicated a history of fever and weight loss, "around 30 lb." Of singular interest is, "He may have had a boil or subcutaneous abscess on his left elbow somewhere during this time." Mr. Tate denied IV drug use.

MRI performed July 5 indicated evidence of proximal femoral osteomyelitis and a second surgery with windowing of the cortex was performed. The hip progressed to post septic arthritis and later required hip replacement.

**SUMMARY:**

I have been asked as to whether the incident of stepping up onto the machinery June 10, 2006 was the proximate cause of the septic hip July 3.

General medical knowledge and medical literature supports the common occurrence of effusion, ecchymoses, bruising and hematoma after soft tissue strains, sprains, and, in some cases, after normal activity. It is unclear to me that a specific trauma occurred, that is, the minimal records describe only that, while engaging in apparently normal activities, stepping on machinery, a pop was felt, (as described in later records), or that discomfort was felt. I do not see identified a specific trauma.

On a later date after some medication had been prescribed, an effusion of the right hip was noted on MRI. Effusions of the joints, both hips and knees, are commonly seen in orthopedic patients, from inflammatory, degenerative or traumatic conditions. It is remarkably rare for these effusions to become infected. A risk of infection is not a probable or even occasional outcome of effusions. It is a rare outcome.

Osteomyelitis is known to occur with a predilection for the proximal and distal ends of the long bones of the lower extremities and humerus. This has to do with the anatomy of the small vessels near the epiphyses of these bones. In the case of the proximal femur, that location is intracapsular so that infection or inflammation in the femoral head could produce a spontaneous effusion. Intracapsular osteomyelitis of the proximal femur proceeds to septic hip in a great many cases. It would be less common for an initial infection in the hip joint, especially if drained, to proceed through intact cartilage and bone and produce an infection or osteomyelitis in the femoral neck.

Osteomyelitis in the healthy, young male is an extremely unusual, if not rare, condition. Many orthopedists will practice an entire career and never see a healthy male present with proximal femoral osteomyelitis.

The cause of septic hip, or osteomyelitis, is not trauma, but rather bacterial infection. Mr. Tate's medical records document the presence of a cutaneous abnormality near the elbow, almost certainly statistically a *Staph* infection. This provides in the record a source and explanation or proximate cause for the infection in the right hip. It is well known that cellulitis or furuncles, small abscesses, can seed or metastasize to parts of the body. Sometimes this seeding will involve an area that has previously sustained trauma, other times an area with no memorable trauma. It is not the history or lack of history of previous trauma that is the explanation for the infection, it is the bacterial seeding.

It is my opinion that the substantial cause of this infection is the bacterial source, that is, the abscess or cellulitis in the arm or other location, and not the mere presence of an effusion. It should be remembered that effusions routinely resolve without developing infection.

It is [sic] notable that this case is unusual and rare and I think that supports the lack of explanation for a hip pop or trauma, which is common. If trauma, which is common to the hip, were the proximate cause of an infected hip, then this condition should be seen frequently. It is rare. I think it is a mistake in medicine to apply "*Post hoc ergo propter hoc*" (after the thing therefore because of the thing) reasoning. Once this false logic is removed from my analysis of this file, it is my opinion that the proximate cause of the infection is the *Staph* bacteria with septic embolization, not the mild incident or possible trauma one month earlier at work.

It should be noted that Mr. Tate received an excellent evaluation from his primary care and orthopedic physicians with appropriate transfer for

reconstructive surgery at a later date once infection had been adequately controlled. I have no criticism of their treatment.

There has been recent public interest in aggressive *Staphylococcal* bacterial that are causing infections in parts of the body where they were previously uncommon. MRSA organisms will continue to be a source of illness and serious sources of infection. I think it is important to focus on the culprit as the bacteria, rather than a minor trauma, as these future cases are analyzed and handled by the medical/legal system. Minor trauma does not cause infection.

The opinions stated in this report are based on the medical information in the form of medical records provided to me and on physical exam. Should additional medical information or records be provided, it is possible my opinions might be modified or changed. Medicine is an inexact science, however, the opinions stated above are based on a reasonable degree of medical certainty.

Joint Exhibits 2-4. These are the depositions of Drs. Zini, Angel and Cummins summarized above.

Joint Exhibit 5. This exhibit is comprised of 17 individually numbered photographs that depicting workers climbing into a Bobcat loader.

Blue-backed Materials. In Respondents' prehearing questionnaire response filed on April 18, 2007, they proposed to stipulate to, *inter alia*, the "Compensability of the claim[.]" On September 11, 2007, following the prehearing conference and entry of the prehearing order (Commission Exhibit 1), Respondents wrote me and stated:

Please consider this letter as an amendment to the Respondent's [sic] Prehearing Questionnaire Response. We amend our contention to allege that the Claimant will be unable to meet his burden of proving that he sustained a compensable right hip injury on June 10, 2006 for want of medical evidence establishing objective evidence of a right hip injury.

**ADJUDICATION**A. Compensability

Claimant has contended that he suffered a compensable injury to his right hip on June 9, 2006 and that this was the precipitating cause of his right hip infection and ultimate replacement. On the other hand, Respondents argue that Claimant did not sustain a compensable injury at the outset; in the alternative, they contend that the infection was an independent intervening cause, relieving them of liability.

As the prehearing order and Respondents' prehearing questionnaire reflect, they stipulated that Claimant sustained a compensable injury on June 9, 2006. However, on September 11, 2007—well in advance of the hearing—they wrote me to add a contention that no medical evidence, supported by objective findings, shows that Claimant sustained a compensable injury on June 10, 2006.

At the outset of the hearing, I listed the stipulations, including the one that Claimant sustained a compensable injury on June 9, 2006. I added other stipulations at the prompting of the parties. At no time did Respondents ask that the compensability stipulation be withdrawn. They merely asked that the contention be added that Claimant lacks objective medical findings to support a compensable injury.

A stipulation is an agreement between counsels concerning the conduct of the legal proceedings. *Dinwiddie v. Syler*, 230 Ark. 405, 323 S.W.2d 548 (1959). The Commission has the discretion to allow a party to withdraw a stipulation. *Jackson v. Circle T. Express*, 49 Ark. App. 94, 896 S.W.2d 602 (1995). This is consistent with the Commission's statutory duty under Ark. Code Ann. § 11-9-705(a)(1) (Repl. 2002)" to conduct the hearing

. . . in a manner as will best ascertain the rights of the parties.” But again, Respondents did not request to withdraw the stipulation. And I have located no authority to permit me to, *sua sponte*, treat the addition of the contention as an implied withdrawal. Hence, the compensability of the incident in June 2006 was stipulated to, foreclosing Respondents from arguing otherwise.

Even if this were not the case, the evidence nonetheless shows that Claimant sustained a compensable right hip injury on June 10, 2006. Arkansas Code Annotated § 11-9-102(4)(A)(i) (Repl. 2002), which the I find applies to the analysis of Claimant’s alleged injury, defines "compensable injury":

(i) An accidental injury causing internal or external 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. An injury is "accidental" only if it is caused by a specific incident and is identifiable by time and place of occurrence[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. § 11-9-102(4)(D) (Repl. 2002). "Objective findings" are those findings that cannot come under the voluntary control of the patient. *Id.* § 11-9-102(16). The element “arising out of . . . [the] employment” relates to the causal connection between the claimant’s injury and his or her employment. *City of El Dorado v. Sartor*, 21 Ark. App. 143, 729 S.W.2d 430 (1987). An injury arises out of a claimant’s employment “when a causal connection between work conditions and the injury is apparent to the rational mind.” *Id.* A causal relationship may be established between an employment-related incident and a subsequent physical injury based on the evidence that the injury manifested itself within a reasonable period of time following the incident, so that the injury is logically attributable

to the incident, where there is no other reasonable explanation for the injury. *Hall v. Pittman Construction Co.*, 234 Ark. 104, 357 S.W.2d 263 (1962).

If the claimant fails to establish by a preponderance of the evidence any of the requirements for establishing compensability, compensation must be denied. *Mikel v. Engineered Specialty Plastics*, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

The determination of a witness' credibility and how much weight to accord to that person's testimony are solely up to the Commission. *White v. Gregg Agricultural Ent.*, 72 Ark. App. 309, 37 S.W.3d 649 (2001). The Commission must sort through conflicting evidence and determine the true facts. *Id.* In so doing, the Commission is not required to believe the testimony of the claimant or any other witness, but may accept and translate into findings of fact only those portions of the testimony that it deems worthy of belief. *Id.*

Claimant credibly testified that he injured his right hip on June 10, 2006 at approximately 1:00 a.m. while getting into a Bobcat loader. After stepping into the loader's bucket, which Claimant and Steven Bell agreed was resting on a concrete step in the dryer area, he stepped onto the top of the Bobcat and started to make a 180-degree turn in order to step back and sit in the seat of the loader. While according to Bell such a maneuver was not the usual fashion of getting into a Bobcat, Claimant testified that due to his being long-legged, this was the method he had adopted. He testified that he injured his hip when the toe of his right boot got hung in one of the perforated steps on the bucket—specifically, the right side of the left step from the perspective of one climbing into the Bobcat. Photograph 1 in Joint Exhibit 5 shows where he marked this location. I have reviewed all of the photographs. Claimant's medical records reflect that he is 73 1/4 inches tall. This

is, according to the testimony of Bell, roughly the size of the gentleman depicted in Photographs 13 and 14. While Respondents have argued that Claimant would not have begun to turn while on top of the bucket because of the necessity of taking an additional step back into the seat, the height of the subject in Photograph 14 illustrates that Claimant would have great difficulty in stepping into the cab of the Bobcat from the front because of his height. While awkward, it appears that his tactic of stepping backwards into the cab was a plausible manner of getting in. Photograph 11 provides the best view of the side of the perforated step in question and shows how he could have hung his boot in it. The boots Claimant was wearing that night appear to be similar to the ones depicted in that photograph.

Claimant testified that when his boot became hung, his hip “popped.” This is reflected multiple times in his medical records. While it hurt, he finished his shift and returned the next evening. After working on an elevated platform for an extended period of time, he sat in front of a computer. Thereafter, he discovered that he was unable to stand. He was helped to the office and was taken to the hospital. He first presented for treatment on June 11, 2006 at 8:05 a.m. (approximately 31 hours after the injury) at the emergency room with right hip pain since the previous Friday night, “when he moved it wrong & it popped. Pain came back last night.” Claimant was diagnosed with a hip strain. A hip x-ray taken that day was normal. However, when Claimant went to Dr. Zini on June 12, the day after the hospital visit and two days after the accident, he presented with right inguinal swelling. Dr. Zini testified that a hip injury would cause inguinal pain, and vice versa. The plant supervisor had Claimant return to the doctor on June 14, 2006, where he presented with the same pain in the right groin. He was unable to stand on his right leg

without intense pain. Claimant was diagnosed with a right hip and inguinal strain and sartorius and was placed on crutches. The June 15, 2006 MRI showed a significant increase in the amount of fluid in the right hip joint as compared to the left. Dr. Angel credibly testified that this was a “traumatic effusion”—a product of the June 10 injury. Dr. Zini, on the other hand, testified that the effusion happened too quickly to have been the product of the June 10 incident, especially in the absence of evidence of trauma to the tissues surrounding the hip. But Zini admitted that the Ibuprofen and Prednisone that Claimant had taken in the days preceding the MRI would have alleviated much of the tissue swelling. Angel was of the opinion that the twisting described by Claimant would have easily been sufficient to cause injury.

In *Cooper v. Textron*, 2005 AWCC 31, Claim No. F213354 (Full Commission Opinion filed February 14, 2005), the Commission addressed the standard when examining medical opinions concerning causation:

Medical evidence is not ordinarily required to prove causation, *i.e.*, a connection between an injury and the claimant's employment, *Wal-Mart v. Van Wagner*, 337 Ark. 443, 990 S.W.2d 522 (1999), but if a medical opinion is offered on causation, the opinion must be stated within a reasonable degree of medical certainty. This medical opinion must do more than state that the causal relationship between the work and the injury is a possibility. Doctors' medical opinions need not be absolute. The Supreme Court has never required that a doctor be absolute in an opinion or that the magic words "within a reasonable degree of medical certainty" even be used by the doctor; rather, the Supreme Court has simply held that the medical opinion be more than speculation; if the doctor renders an opinion about causation with language that goes beyond possibilities and establishes that work was the reasonable cause of the injury, this evidence should pass muster. *See, Freeman v. Con-Agra Frozen Foods*, 344 Ark. 296, 40 S.W.3d 760 (2001). However, where the only evidence of a causal connection is a speculative and indefinite medical opinion, it is insufficient to meet the claimant's burden of proving causation. *Crudup v. Regal Ware, Inc.*, 341, Ark. 804, 20 S.W.3d 900 (2000); *KII Construction Company v. Crabtree*, 78 Ark. App. 222, 79 S.W.3d 414 (2002).

Furthermore, the Commission is authorized to accept or reject a medical opinion and is authorized to determine its medical soundness and probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002); *Green Bay Packing v. Bartlett*, 67 Ark. App. 332, 999 S.W.2d 692 (1999). Based upon my review of the evidence, I am not inclined to credit Dr. Zini's testimony on this point because it was equivocal and inconsistent. However, I credit the testimony of Dr. Angel based upon my review of his treatment records and the transcript of his depositions.

In sum, I find that Claimant has proven by a preponderance of the evidence that he sustained a compensable injury to his right hip on June 10, 2006.

That leaves, however, the question of whether his hip infection and replacement are compensable. Drs. Angel and Cummins opined that the most likely cause of what occurred was that Claimant had a pre-existing blood-borne staph aureus infection in his body. While Claimant insisted that he did not have a boil, but admitted that he may have had a healed scratch, I credit Dr. Cummins' testimony that Claimant had a boil on his left elbow. Dr. Angel's records refer to a possible boil. Both doctors stated that this was the source of the infection. They testified credibly that Claimant's hip injury likely caused the infection to seed there. As quoted above, Dr. Cummins best summarized what took place:

Q. [Claimant] must have had the misfortune of spraining his hip at the same time that he had a blood-borne staph in his body?

A. It would seem that way, yeah.

Dr. Zini, I note, agreed with this being a viable scenario, and stated that Dr. Angel was in the best position to render an opinion on what happened. The staph infection in the joint, diagnosed once the hip was aspirated and found to contain purulent material, spread from

there to the bone, resulting in osteomyelitis. This and the septic arthritis he developed from the infection necessitated his having hip replacement surgery.

Dr. Peeples in his report opined, and Respondents repeatedly posited to Drs. Angel and Cummins, that the hip infection was secondary to the osteomyelitis, and that it was caused by the bacterial settling in the looping vessels there. But Dr. Angel credibly testified that had the osteomyelitis come first, the June 15, 2006 MRI would have detected it. However, the MRI was, in his words, "stone cold normal." Also, because of the poor blood supply to the bone, he stated that it was highly doubtful that the infection first went to the bone. In fact, it was the inflammation of the joint that allowed the infection to pass through and enter the bone more easily. Dr. Cummins agreed with this.

I note that, as the parties stipulated, that Dr. Peeples did not treat Claimant. However, while he states in his report that his opinions are based in part on his examination of the Claimant. But in keeping with the above stipulation, I find no reference in the report to his conducting such an examination. There are no records of such an examination. It appears that he merely reviewed Claimant's records. Thus, I am not inclined to credit his opinion.

The evidence shows, and I find, that Claimant had a pre-existing staph aureus infection, which traveled to and seeded in his right hip because of the trauma suffered to the joint because of the compensable June 10, 2006 injury.

Respondents argue that the infection is an independent intervening cause, relieving them from liability. The pertinent section of the Arkansas Workers' Compensation Act provides:

Under this subdivision (4)(F), benefits shall not be payable for a condition which results from a nonwork-related independent intervening cause following a compensable injury which causes or prolongs disability or a need for treatment. A nonwork-related independent intervening cause does not require negligence or recklessness on the part of a claimant.

Ark. Code Ann. § 11-9-102(f)(F)(iii) (Repl. 2002). This provision did not repeal, but instead codified, preexisting case law. *Davis v. Old Dominion Freight Line, Inc.*, 341 Ark. 751, 757-58, 20 S.W.3d 326 (2000). The operative test remains the one set forth in *Guidry v. J&R Eads Const. Co.*, 11 Ark. App. 219, 223, 669 S.W.2d 483 (1984): the question is whether a causal connection between the primary injury and the subsequent disability exists, and provided such a connection is established, there is no independent intervening cause unless the subsequent disability is triggered by activity by the claimant that is unreasonable under the circumstances. The causal connection between the initial compensable injury and the infection has been shown. Respondents have not pointed to, and the evidence does not reveal, any unreasonable activity on the part of Claimant that led to the infection—or to its seeding in his right hip. Thus, no independent intervening cause has been shown here.

To the contrary, I find the staph aureus was a pre-existing, though asymptomatic, condition that Claimant's compensable injury aggravated by leading the infection to seed in his right hip. Causal connection is generally a matter of inference, and possibilities may play a proper and important role in establishing that relationship. *Osmose Wood Preserving v. Jones*, 40 Ark. App. 190, 843 S.W.2d 875 (1992). The determination of whether a causal connection exists is a matter for the Commission to determine. *Jeter v. B.R. McGinty Mechanical*, 62 Ark. App. 53, 968 S.W.2d 645 (1998). The basic test is

whether a causal connection between the two episodes exists. *Air Compressor Equip. v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000). As shown from the above, I find a causal connection between Claimant's June 10, 2006 compensable hip injury and the staph aureus infection of the hip, which in turn led to the hip replacement; thus, the infection and ultimate replacement of the right hip was a compensable consequence of the initial compensable injury.

B. Reasonable and Necessary Medical Treatment

Claimant contends that he is entitled to continued medical treatment, including, but not limited to, all surgeries and complications arising from his compensable injury. Arkansas Code Annotated Section 11-9-508(a) (Repl. 2002) provides that an employer shall provide for an injured employee such medical treatment as may be necessary in connection with the injury received by the employee. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). But employers are liable only for such treatment and services as are deemed necessary for the treatment of the claimant's injuries. *DeBoard v. Colson Co.*, 20 Ark. App. 166, 725 S.W.2d 857 (1987). The claimant must prove by a preponderance of the evidence that medical treatment is reasonable and necessary for the treatment of a compensable injury. *Brown, supra*; *Geo Specialty Chem. v. Clingan*, 69 Ark. App. 369, 13 S.W.3d 218 (2000). What constitutes reasonable and necessary medical treatment is a question of fact for the Commission. *White Consolidated Indus. v. Galloway*, 74 Ark. App. 13, 45 S.W.3d 396 (2001); *Wackenhut Corp. v. Jones*, 73 Ark. App. 158, 40 S.W.3d 333 (2001).

Based on the evidence adduced at the hearing, I find that all of the treatment provided Claimant from June 11, 2006, when he first sought treatment at the emergency room, through March 19, 2007, when he was released, to be reasonable and necessary for the treatment of his compensable injury and the compensable consequences thereto. Dr. Evans instructed Claimant return in one year for a checkup on his hip. "Medical treatments which are required so as to stabilize or maintain an injured worker are the responsibility of the employer." *Artex Hydrophonics, Inc. v. Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983). I thus find this checkup to be reasonable and necessary as well.

C. Temporary Total Disability

Claimant has contended that he is entitled to temporary total disability benefits from June 11, 2006 to a date yet to be determined. Claimant's compensable injury to his hip is unscheduled. See Ark. Code Ann. § 11-9-521 (Repl. 2002). An employee who suffers a compensable unscheduled injury is entitled to temporary total disability compensation for that period within the healing period in which he has suffered a total incapacity to earn wages. *Ark. State Hwy. & Transp. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period ends when the underlying condition causing the disability has become stable and nothing further in the way of treatment will improve that condition. *Mad Butcher, Inc. v. Parker*, 4 Ark. App. 124, 628 S.W.2d 582 (1982).

Claimant testified that the last day that he worked at Respondent Unimin was approximately a week after his injury. But the record reflects that Dr. Zini placed him on numerous restrictions on June 19, 2006. When he presented to Dr. Zini on June 21, 2006, he reported that he had returned to work that day but had "hot sweats" over the weekend.

Zini continued his restrictions, stating that Claimant was to use crutches and not do any lifting, climbing, pulling, etc. He did not return for treatment until July 3, 2006, when his hip was aspirated. Thereafter, he underwent two surgical procedures to irrigate his hip and then remained for a period on antibiotics to treat his septic hip. However, his hip continued to deteriorate and he developed septic arthritis, resulting in his having to undergo a right hip replacement. He was released from treatment, subject to returning on an annual basis for checkups, on March 19, 2007. I thus find that he is entitled to temporary total disability benefits from June 11, 2006 to June 21, 2006, and from July 3, 2006 to March 19, 2007, when he reached maximum medical improvement, at the stipulated maximum rate of \$488.00 per week.

D. Offset

Respondents have argued that in the event Claimant is awarded temporary total disability benefits, there must be an offset under Ark. Code Ann. § 11-9-411 for the short-term benefits Claimant drew. Section 11-9-411 provides in pertinent part:

(a) Any benefits payable to an injured worker under this chapter shall be reduced in an amount equal to, dollar-for-dollar, the amount of benefits the injured worker has previously received for the same medical services or period of disability, whether those benefits were paid under a group health care service plan of whatever form or nature, a group disability policy, a group loss of income policy, a group accident, health, or accident and health policy, a self-insured employee health or welfare benefit plan, or a group hospital or medical service contract.

Claimant testified that he received short-term disability benefits in the amount of \$200.00 per month through Respondent Unimin. Steve Bell stated this was called "ANS," but stated that Claimant's benefits were closer to \$200.00 per week. I find that Respondents are entitled to a dollar-for-dollar offset for disability benefits paid to Claimant.

D. Attorney's Fee

I find that Respondents have controverted Claimant's entitlement to temporary total disability benefits. Claimant's attorney is thus entitled to a controverted attorney's fee on all indemnity benefits awarded to Claimant, pursuant to Ark. Code Ann. § 11-9-715.

**CONCLUSION AND AWARD**

Respondents are directed to pay benefits in accordance with the findings of fact set forth above. All accrued sums shall be paid in a lump sum without discount, and this award shall earn interest at the legal rate until paid, pursuant to Ark. Code Ann. § 11-9-809. See *Couch v. First State Bank of Newport*, 49 Ark. App. 102, 898 S.W.2d 57 (1995).

Claimant's attorney is entitled to a 25 percent (25%) attorney's fee on the indemnity benefits awarded herein, one-half of which is to be paid by Claimant and one-half to be paid by Respondents, in accordance with Ark. Code Ann. § 11-9-715. See *Death & Permanent Total Disability Trust Fund v. Brewer*, 76 Ark. App. 348, 65 S.W.3d 463 (2002).

**IT IS SO ORDERED.**

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Hon. O. Milton Fine II  
Administrative Law Judge