

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F602233

JOSE AVALOS, EMPLOYEE	CLAIMANT
GEORGE'S INC., A SELF INSURED EMPLOYER	RESPONDENT
CROCKET ADJUSTMENT, TPA	RESPONDENT

OPINION FILED OCTOBER 23, 2007

Upon review before the FULL COMMISSION, Little Rock, Pulaski County, Arkansas.

Claimant represented by HONORABLE EVELYN BROOKS, Attorney at Law, Fayetteville, Arkansas.

Respondent represented by HONORABLE TOD BASSETT, Attorney at Law, Fayetteville, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

The claimant appeals from a decision of the Administrative Law Judge filed November 27, 2006.

The Administrative Law Judge entered the following findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On December 28, 2004, the relationship of employee-self insured employer-TPA existed between the parties.

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

4. The claimant has failed to prove by the greater weight of the credible evidence that on December 28, 2004, he sustained "compensable injuries," as that term is defined by the Act, to either his left knee, left hip, or left foot. Specifically, he has failed to "establish" by medical evidence, which is supported by "objective findings," the actual existence of any physical injury or damage to his left hip or left foot. He has also failed to prove by the greater weight of the credible evidence that he sustained any physical injury to his left knee that required medical services or resulted in any disability. Finally, he has failed to prove that any difficulties, which he may have experienced with his left knee on and after January 28, 2005, and which may have required medical services and/or resulted in disability, were causally related to the specific employment related incident or accident of December 28, 2004.

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

The claimant alleges that he sustained a compensable injury that is governed by the Arkansas Workers' Compensation Act, A.C.A. § 11-9-101 et seq. The claimant's alleged injury is, indeed, an injury that is covered by the Act; however, the claimant has failed to establish the elements necessary to prove a compensable injury by a preponderance of the evidence.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings of fact made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority's finding that the claimant is not entitled to receive medical or temporary total disability benefits because he did not sustain a compensable, work-related injury to his left knee, hip, or foot. More specifically, the Majority found that the claimant failed to prove by a preponderance of the evidence that he sustained any physical injury that required medical services or resulted in disability. Based upon a de novo review of the record in its entirety, I find the claimant suffered a compensable work-related left knee injury. As such, I must respectfully dissent.

The claimant testified that while in the employment of the respondent, he sustained an injury to his left knee. The claimant testified that on December 28, 2004, while at work, he was hit in the knee with a cart, which was being pushed by a co-worker. The claimant is a citizen of the United States of America, however, his primary language is Spanish, and an interpreter was used for both the claimant's deposition and his testimony at trial.

The claimant testified that following the accident on December 28, 2004, his leg was swollen. The claimant was given blue gel to rub on his knee and given two pills (assumably Aleve, as that is what the other witnesses testified to) by his supervisor. The claimant testified that the nurse was not there at that time, so his supervisor told him to go to the hospital, which he states is really a medical clinic at the Intersection of Highway 412 and 40th Street in Springdale. He testified that on that same day or several days thereafter went to this clinic, but that he was not seen at that time and was only given an appointment for some 10 to 15 days later. He testified that he ultimately

saw the doctor at this clinic only one time and was referred to an orthopaedic surgeon. He stated that he continued to work for the respondent at his regular job between the date of the accident and the time he was taken off work by the doctor at the medical clinic, a period which he described as being 10 days. He stated that during this period that he continued to work, he was given 2 pills a day by an "interpreter" in the employ of the respondent. These pills were brought to him between 3:00 and 4:00 in the morning, as his shift lasted from 10:00 pm to 7:00 am. It was his testimony that he could stand the pain and do his work because of the pills he was being given. He testified that throughout this period of time, he continued to experience substantial pain in his knee. In his deposition and at the hearing, the claimant initially testified that he had never experienced any prior problems with his left knee (including pain, soreness, weakness, swelling, etc.) Prior to the accident on December 28, 2004.

The claimant testified that on January 13, 2005, he got permission from the respondents to be off of work so

that he could go to his brother's funeral in Arizona. The claimant also testified, however, that he continued to call in to work. He would speak to either a woman or sometimes an answering machine would pick up. The claimant testified that he returned to work on January 20th, 2005, and he was told that he did not have a job any longer.

The claimant testified that he went back to the respondents at one point to ask for work and to bring the respondents the medical bills for his previous injury to his teeth, but that Gary Clayton ran him off. The claimant testified that he informed Mr. Clayton that they did not need to call security, that he would just leave. The claimant also testified that he was not there asking for money from other employees.

The claimant testified that he did experience some health problems prior to the accident on December 28, 2004. First, the claimant suffers from diabetes. This disease has effected his eyesight, and the claimant is now legally blind in both eyes from severe diabetic neuropathy. Second, the claimant was injured at work in a previous accident, where

he was struck in the face. This resulted in the claimant losing all of his teeth. Third, the claimant suffered a previous accident at work in 2001, where he was struck in the left knee with a hammer. An MRI was obtained in 2001, which revealed that the claimant suffered some degeneration of that joint. The claimant testified that despite these ailments, he continued to work.

Gary Clayton, the Human Resource Manager for the respondents, also testified that the hearing. Mr. Clayton testified that he was not present at the time of the accident. Mr. Clayton testified that the claimant was fired from his job for not calling in every day that he was not required to work. Mr. Clayton testified that if a person cannot be at work, they are required to call in every night and report it to the receptionist. Mr. Clayton testified that even if a person called in and was permitted to have a few days off of work, that person would still have to call in every night. Mr. Clayton testified that if the person calling in did not reach the receptionist, their call would be directed to an answering machine. Should an employee not

call in for three days in a row, that employee would be terminated. Mr. Clayton testified that even though the claimant was given permission to be off of work while at his brother's funeral, he was still required to call in every day. Due to the fact that the claimant did not call in on those days, his employment was terminated. Mr. Clayton testified that the claimant was terminated in January of 2005. Mr. Clayton also testified that he was not familiar with a note in the claimant's employee file that he was to remain off work. That note was dated January 28, 2005.

Later, Mr. Clayton testified that he was familiar with the medical form from January 28, noting that the claimant should remain off work for a week. In fact, Mr. Clayton also testified that he was familiar with even another doctor's note dated February 5, 2005.

Mr. Clayton testified that James Pratt was the head charge supervisor when the claimant was injured. Mr. Pratt was fluent in Spanish and wrote up the initial injury assessment for the claimant. Mr. Clayton testified that Mr. Pratt gave the claimant blue gel to put on his knee

and two Aleve. Mr. Clayton was also aware that the respondents did not send the claimant to the doctor until March 21, 2005. Mr. Clayton stated that it took that long for the claimant to see a doctor because at the time, they had no evidence of the claimant sustaining an injury, despite the fact that an initial injury assessment was filed.

Mr. Clayton also testified that he once called Security to remove the claimant from the work premises. Mr. Clayton testified that the claimant was coming to work and asking other employees for money.

Misty Hankins, the plant EMT, testified on the respondents behalf. Ms. Hankins testified that she arrives at work at 6:00 in the morning. On the date of the claimant's injury, Ms. Hankins came into work and saw that James Pratt had left the claimant's injury assessment form on her desk. Ms. Hankins testified that she met with the claimant and observed no bruising or swelling of the claimant's left knee at that time. There are no records of this. Ms. Hankins testified that, according to company

policies, if the claimant still needed treatment, he should have reported it to her. However, she testified that he never came to her and asked permission to see a doctor.

Ms. Hankins testified that the claimant did bring in an off-work slip from January 28, but that it's possible that she wouldn't see such a slip for a week. It was not until mid-February that Ms. Hankins made a doctor's appointment for the claimant, and she testified that the earliest she could get him in to see the doctor was late in March of 2005. Interestingly, the respondents could only provide a Treatment Authorization Form dated March 23, 2005. There are no records from February 2005, which the respondents can prove that they made an appointment for the claimant to see a doctor.

The claimant was seen by Dr. Stephanie Baggett for the first time on January 28, 2005. Dr. Baggett's medical records state that the claimant was hit with a cart on the left knee and that there has been swelling ever since. The claimant denied falling, but reported some pain with walking. The medical records state that the claimant

complained that his knee and calf had been swelling intermittently, but that he had not missed work. Dr. Baggett prescribed Ultram and took the claimant off of work until the x-ray results were available.

On February 2, 2005, a medical report from Dr. Bob Wilson, III, notes that the claimant suffers left knee and calf pain and swelling. Dr. Wilson reported a normal venous doppler, and referred the claimant to an orthopedic surgeon. Additionally, Dr. Wilson wrote a note asking for the claimant to avoid standing for long periods at work.

On February 8, 2005, Peggy (a receptionist for the respondents) made a note on the February 2, 2005 note from Dr. Wilson. Peggy's note states, "Jose knows he need to bring in Dr. note with no restrictions."

On February 14, 2005, the claimant was seen by Dr. Christopher Arnold, who noted that the claimant had been hit in the knee with a cart while at work two months earlier. Dr. Arnold reported that the radiographs revealed medial joint space narrowing. Dr. Arnold noted that he was concerned about a meniscus tear and recommended an

injection, quadsets, and anti-inflammatories. Dr. Arnold also ordered an MRI.

On February 14, 2005, Dr. Arnold also wrote out a Certificate of Release For Return to Work or School. Dr. Arnold circled the option that the claimant was "not released to return to work." On the side of that note, there was a hand written note made the respondents that reads, "Jose told Eddie his MRI appointment is for 2-15-05. Told he needs note with no restrictions. P.S." Presumably, the "P.S." stands for Peggy.

On March 23, 2005, the claimant was seen by Dr. Gary Moffitt. The claimant was referred to Dr. Moffitt by the respondents, and Ms. Hankins accompanied the claimant to the doctor's appointment. Dr. Moffitt's notes on the Referral and Treatment Authorization Form reflect the radiological findings as degenerative and osteoarthritic changes, which are worse when compared to the claimant's 2001 records. Dr. Moffitt's notes reflect that he needs the claimant's medical records and an MRI. He diagnosed the claimant as having a contused knee.

In a letter to the respondents on March 23, 2005, Dr. Moffitt noted that the orthopedic surgeon had injected the claimant's knee and that the claimant reported that it did help. However, the claimant complained that he was having trouble running and going down stairs. Not only did the claimant complain of swelling, but Dr. Moffitt noted that he observed swelling of the knee.

On March 30, 2005, Dr. Moffitt again recommended that the claimant have an MRI. On the Referral and Treatment Authorization Form, Dr. Moffitt noted that the claimant had a contused knee and that he could return to work with limitations. In a letter to the respondents on March 30, 2005, Dr. Moffitt noted that he felt that the claimant's changes appear to be degenerative, but that he would like to obtain an MRI to delineate the problem. Furthermore, he allowed the claimant to return to work without restrictions.

On April 1, 2005, an MRI was performed. The MRI revealed that a small Baker's cyst was present. Additionally, the MRI revealed, "Questionable signal abnormalities are demonstrated within the posterior horn of

the medial meniscus. This may extend to a meniscal surface, to indicate a chronic tear."

On April 13, 2006, Dr. Moffitt wrote a letter to the respondents, stating:

In your letter you relate that Mr. Avalos-Oregel was found to have a Baker's cyst on MRI. You are wanting to know if it is possible that the mild swelling the patient presented with is due to the Baker's cyst caused by degenerative osteoarthritic knee. The answer is yes, it could have been the cause of the swelling. Your second question was whether a potential acute cartilage tear could appear differently on MRI than a chronic one, and the answer to that is yes. However, it is sometimes difficult to tell with certainty whether a cartilage tear is chronic or acute. Your third question was whether a degenerated knee like this patient had could cause mild intermittent swelling in and of itself even if there was no cartilage tear or of there was no Baker's cyst. The answer to that question is yes. One can see intermittent swelling in knees that have degenerative changes and osteoarthritis.

On March 3, 2005, the respondents filed a Separation Notice. Th respondents cited the claimant's firing as the claimant having "quit without notice."

Furthermore, the respondents cite that the claimant's last worked was January 30, 2005. The separation notice does state that they would re-employ.

The Majority, by affirming the opinion of the Administrative Law Judge, found that the claimant did not satisfy the statutory requirements of a compensable injury as found in of Ark. Code Ann. § 11-9-102(4) (A) (i). The Majority found that the claimant did not prove by a greater weight of credible evidence, the presence of a casual relationship between the claimant's employment and the injury that he sustained. The Majority's findings are simply not consistent with the credible testimony of the claimant.

In order to prove a compensable injury as a result of a specific incident which is identifiable by time and place of occurrence, the claimant must establish by a preponderance of the evidence: (1) an injury arising out of and in the course of employment; (2) that the injury caused internal or external harm to the body which required medical services or resulted in disability or death; (3) medical evidence supported by objective findings, as defined in Ark.

Code Ann. § 11-9-102(16), establishing the injury; and (4) that the injury was caused by a specific incident and identifiable by time and place of occurrence. Ark. Code Ann. § 11-9-102(4) (A) (i) (Repl. 2002).

First, the evidence shows that the claimant sustained an injury while in the course and scope of employment was caused by a specific incident and identifiable by time and place of occurrence. The claimant testified that he was hit with a cart while at work, injuring his knee. There is no dispute that the claimant was injured in the scope of his employment or that the claimant was hit with a cart while at work. Even Mr. Clayton testified that James Pratt had given the claimant two Aleve and a blue gel to rub on the injury that he sustained at work.

Second, the injury caused internal harm to the body which required medical services. The claimant credibly testified that following the accident on December 28, 2004, his leg was swollen. The claimant testified that the nurse was not there at that time, so his supervisor told him to go

to the hospital, which he states is really a medical clinic at the Intersection of Highway 412 and 40th Street in Springdale. He testified that on that same day or several days thereafter went to this clinic, but that he was not seen at that time and was only given an appointment for some 10 to 15 days later. He testified that he ultimately saw the doctor at this clinic only one time and was referred to an orthopaedic surgeon. He stated that he continued to work for the respondent at his regular job between the date of the accident and the time he was taken off work by the doctor at the medical clinic, a period which he described as being 10 days. He stated that during this period that he continued to work, he was given 2 pills a day by an "interpreter" in the employ of the respondent.

The Majority found that the claimant is not credible, as there are no records of the claimant ever complaining that his knee was bothering him following the initial date of the accident. In fact, the claimant testified that he did not see Ms. Hankins on December 28, 2004, because she was not there. Ms. Hankins, however,

testified that she did see the claimant that day and that his knee was not swollen. In interestingly, there are no medical records or reports from Ms. Hankins stating that she had ever observed the claimant that day. Ms. Hankins testified that it was their company policy not to do any paperwork unless the claimant was taken to the hospital. I find Ms. Hankins testimony questionable at best. I do not believe that if Ms. Hankins had actually observed the claimant on December 28, 2004, and not seen any swelling, that she would not have made a report of such. It is much more probable that the claimant was simply not seen by Ms. Hankins. This further explains why the claimant was not seen by Ms. Hankins again - he was never seen by her to begin with.

Furthermore, the claimant testified that the respondents provided him with two pills in the middle of every shift. The claimant testified that the pills helped with the pain. Presumably, these pills were Aleve or Tylenol. The claimant testified that the interpreter would bring these out to him. Ms. Hankins testified that this

never happened. However, Ms. Hankins testimony was that they never made a report of anything unless a person was taken to the hospital. Therefore, it is abundantly clear that if Ms. Hankins is telling the truth, they would have no records of providing the medication. Thus, denying such actions is in the respondents own self interest. On the other hand, the claimant had no reason to lie about this. He testified that the medication helped him get through his work, and that he continued to work, despite his legitimate health problems.

Third, the claimant provided medical evidence supported by objective findings. Not only was swelling observed, but two doctors opined that the claimant could have a meniscus tear. First of all, swelling was observed, and anti-inflammatories were prescribed. The claimant first saw Dr. Baggett, whose medical records state that the claimant was hit with a cart on the left knee and that there has been swelling ever since. Dr. Baggett prescribed Ultram and took the claimant off of work. The claimant was then seen by Dr. Bob Wilson, III, who notes that the claimant suffers left knee and calf pain and swelling. Additionally,

Dr. Wilson wrote a note asking for the claimant to avoid standing for long periods at work. Additionally, the claimant was then seen by Dr. Arnold, who recommended an injection, quadsets, and anti-inflammatories. Furthermore, the respondents sent the claimant to Dr. Moffitt, who noted that he observed swelling of the knee.

Additionally, two doctor's opined that the claimant may have a meniscus tear. Dr. Arnold first noted that he was concerned about a meniscus tear. Dr. Moffitt also found that the claimant may suffer a meniscus tear. On April 1, 2005, an MRI was performed. The MRI revealed that a small Baker's cyst was present. Additionally, the MRI revealed, "Questionable signal abnormalities are demonstrated within the posterior horn of the medial meniscus. This may extend to a meniscal surface, to indicate a chronic tear."

It is therefore apparent that not only was swelling observed and anti-inflammatories prescribed, but that the claimant may have a meniscus tear, which would be

consistent with the claimant's complaints. Therefore, there was objective medical evidence.

The Majority found that the claimant's knee problems are attributable to the natural progression and the period of years of ongoing arthritic process in the claimant's knee. The Majority further suggests that the Baker's cyst found in the claimant's knee cannot be attributed to the employment related accident. Although the claimant did suffer from diabetic neuropathy, a previous knee injury, and a Baker's cyst, the claimant testified that he was not symptomatic prior to the December 28, 2004 incident. Therefore, the only reasonable explanation for the claimant's pain would be a possible meniscus tear, as the MRI revealed.

The Majority found that the claimant was simply not credible. This is erroneous, as it appears the claimant is being punished for his inability to speak English. The claimant had to rely on a translator at both the deposition and the hearing. It is obvious from several of his answers that the translations were not accurate. The claimant should

not be denied benefits simply because the answers that he gave to a few irrelevant questions were somewhat inconsistent.

The Majority found that the claimant's poor grasp of English cannot explain all his inconsistencies, but those inconsistencies are mostly about minor things that have no relevance to the main issue here, or that would make no difference in any event. The claimant thought he reported to Mr. Clayton, when he actually reported to Mr. Pratt. This was not a deception, but was obviously confusion. He calls the Arkansas Occupational Health Clinic a hospital, which is also clearly not a lie meant to aid his cause. He cannot remember the names of any of his doctors. However, the incident which occurred at work, which caused the injury is undisputed. There was an incident report completed, but the employer-respondent never filed anything with this Commission.

Mr. Clayton, human resource manager for the plant, testified at the hearing. He had the benefit of sitting in on the testimony of the claimant, but also seems to have

been confused. He testified he had no notice of an off-work note, even though it was in the claimant's file. He did not know why it would have taken two months to get the claimant an appointment with the company doctor. He testified that he did not call security on the claimant when he came to the plant asking for his bills to be paid, but then testified, when asked if he threatened the claimant with security, that the claimant was told to leave the property. Mr. Clayton also had problems with his explanation of why he didn't inquire about the nature of the claimant's injury once the claimant was bringing notes to his supervisor from doctors. The claimant had notes from doctors and he took them to work and turned them in. He was never sent to the doctor by his employer until March 23, 2006. He had been submitting doctors' notes for over six weeks by then, and had also been fired. Mr. Clayton testified one minute that he *believes* he asked the claimant whether his knee was work-related, and in the next minute, he says, "yes, I did..." (Emphasis added.) Then, in the next breath, he stated that he wasn't sure whether the time line was in January or with the second note

or when any of this took place, and there is no documentation of any of this by the employer. These inconsistencies are not addressed by the Majority. The employer has the burden to document these injuries and to report the injuries, once notified by a claimant. This injury was never reported to the Arkansas Workers' Compensation Commission at the discretion of the employer. It was not the choice of the Spanish-speaking claimant. The exchange at the hearing between counsel and Mr. Clayton was as follows:

- Q. So, if it's a work-related incident, you don't fill out some kind of workers' compensation paper or form?
- A. Not if it's considered a first aid type item, no, ma'am. Once he goes into a medical, where we're actually going to be taking someone to a doctor, then we go through the usual workers' compensation forms: The N form, the first injury report, all that type of thing.
- Q. So, if you never send anybody to a doctor, then you never have to fill out any of those papers, do you?

- A. No, ma'am. We usually don't. It's usually what's stated with the injury assessment.

The employer clearly had sloppy record-keeping, which may impact the number of claims they have.

The nurse, Misty Hankins, testified at the hearing. She had no notes on her examination from two years earlier, yet seemed to have amazing recall concerning the examination of the claimant's knee. She did not have such clear recall of who the trainer was at the time. Her recounting of her exam of the claimant also varied from one account to the next. She testified that the claimant lifted his pant leg and she looked at his knee and "felt around." She said absolutely nothing about comparing one knee to the other, even though she was specifically asked to describe her examination. Later in her testimony, however, she stated that she compared both knees.

Ms. Hankins also had other inconsistencies. She stated that when the claimant brought in his first note, she made an appointment for him with Dr. Moffitt. She testified that the time delay was "maybe a day or so." When she was

confronted with evidence that at least one note was brought in as early as February 8, 2005, yet the appointment was not had until March 23, 2005, and all she could do is confirm it usually didn't take that long to get to a doctor.

The respondents were informed that there was an injury to the claimant's left knee. The respondents were informed that there were restrictions given by doctors and off-work notes for x-rays of his knee. The respondents knew that the claimant was seeing doctors for his knee, but he was fired and told to stay away from the plant. He was not provided treatment by the respondents, although they knew all this. Furthermore, the respondents made up bogus stories that the claimant was going to the plant, seeking money from co-workers, after he had been fired. The claimant's testimony is clear that he had gone to the respondents with medical bills from his previous work-related injury and to inquire about work. Yes, the claimant has some inconsistencies, but they are more honest mistakes than the inconsistencies of the respondents, who are charged with the reporting and provision of medical care for work-related

injuries. The claimant must not be penalized for being unable to see a doctor for one month after his injury. He never had problems with his knee before. Yes, he has had a cut and bruise from a hammer hitting his knee, but he did not lose work, and he had no continuing complaints during the three-and-a-half-year period in between that minor injury and this major one.

Ultimately, the evidence indicates the claimant injured his left knee after being hit with a metal cart while at work in December 28, 2004. The claimant was not symptomatic prior to this accident, despite several health issues. As such, it is evident that the claimant's injury was caused by the work-related accident. Additionally, several doctors observed that the claimant's knee was swollen, and he was prescribed anti-inflammatories, and that the claimant had a possible meniscus tear.

_____ For the aforementioned reasons, I respectfully dissent.

PHILIP A. HOOD, Commissioner