

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F602222

ERIC STILES, EMPLOYEE	CLAIMANT
LONG AGO ANTIQUES, EMPLOYER	RESPONDENT
ONE BEACON INSURANCE, CARRIER	RESPONDENT

OPINION FILED AUGUST 27, 2007

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

Claimant is not represented by counsel, but appears, *pro se*.

Respondent represented by HONORABLE MICHAEL E. RYBURN, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

The claimant appeals from a decision of the Administrative Law Judge filed October 10, 2006.

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

1. The Arkansas Workers' Compensation Commission has jurisdiction of the within claim.
2. The employee-employer-carrier relationship existed between the parties at all relevant times.

3. Claimant was earning sufficient wages to entitle him to compensation at the weekly rates of \$250.00 for temporary total disability benefits and \$180.00 for permanent partial disability benefits.

4. The claimant has failed to prove by a preponderance of the evidence that he suffered a compensable injury to his back on November 23, 1999; specifically, there are no objective findings establishing an injury as required by Arkansas law.

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 opinion, finding that the claimant is not entitled to receive medical benefits because he did not sustain a compensable, work-related injury on November 23, 1999. More specifically, the Majority found that the claimant failed to

prove that he sustained an injury supported by objective medical findings. Based upon a de novo review of the record, I find the claimant suffered a compensable work-related injury, supported by objective medical findings. Additionally, I find that as the respondents failed to controvert the claim for seven years, equity prevents the respondents from now asserting that the claimant's injury is not supported by objective medical findings. As such, I must respectfully dissent.

The claimant testified that on November 23, 1999, while in the employment of the Respondent, he sustained an injury. The claimant was employed as a furniture refinisher at a sole proprietorship, owned and operated by his parents. The claimant testified that on November 23, 1999, he injured his back when lifting a desk into a strip tank at work. At the time of his injury, he was informed that he was not covered by worker's compensation. However, he remained off of work approximately six weeks after the initial injury, due to the pain in his back. Approximately two years after the accident, Long Ago Antiques was informed by One Beacon

Insurance Company that they did need to provide worker's compensation insurance for the claimant, and that Long Ago Antiques would need to pay the back premiums. One Beacon Insurance was aware of the claimant's injury, and they began paying for his medical bills, prescription medications, and all of his previous out-of-pocket expenses approximately two years after the injury. Long Ago Antiques does not dispute that the injury is compensable. However, One Beacon Insurance Company, the respondent carrier does.

The claimant testified that before November 23, 1999, he had no previous back injury or problems. He was able to return to work approximately six weeks after the initial injury, however, the claimant testified that he has been in a substantial amount of pain since that time, which has limited his daily activities. For example, the claimant testified that when he drives down the road and hits a bump, it jars him and really hurts. In fact, he does not do anything that could cause a jarring motion due to the pain that he feels for several days afterward.

The claimant also testified about the medical treatment which he has received over the years. The claimant testified that the best treatment for alleviation of his pain was water therapy at Trinity Rehab, which he had visited 84 times. Additionally, he was put in a traction device, which took pressure off of his back. The traction, in combination with water therapy gave him the most relief. Even when the respondents stopped paying for therapy, he continued going to therapy at a pool club on his own. At that point, he began getting epidural steroid shots approximately once a year. The claimant testified that he should have had the shots two or three times a year, but he disliked needles and he did not want the insurance premiums for Long Ago Antiques to go up. Furthermore, the claimant testified that he has been taking prescription medication for pain since the date of the accident. He currently takes Ultram and Bextra for pain. The claimant testified, however, that even though he is in substantial pain, he has continued to work.

Initially, the respondents accepted liability for the claim and paid for the claimant's medical treatment. The respondents continued paying for seven years. However, the claimant had waited a little over one year between epidural shots. The respondents initially contended that the claimant was not receiving medical care any longer, and as such, they were no longer going to pay for his medical care in association with the 1999 injury. The claimant then informed the respondents that he had been receiving medical care and prescription medication since the date of the accident. At that time however, the respondents decided after seven years of providing care, that the claim was barred by statute of limitations.

Interestingly, a pre-hearing conference was conducted on June 28, 2006 where the respondents stipulated to the fact that the claimant sustained a compensable injury to his back on November 23, 1999. On July 10, 2006, the respondents withdrew their contention that the claimant was barred by a statute of limitations. On July 25, 2006, in a letter to the claimant, the respondents withdrew their

stipulation regarding compensability. At that time, the respondents decided after seven years of providing care, that the claimant did not sustain a compensable injury. At the trial, the claimant questioned how this was possible, and the court went off the record. When the parties went back on the record, the issue of compensability was tried.

The claimant testified that the first doctor he saw was Dr. Hart, who diagnosed a soft-tissue tear. Dr. Hart prescribed exercises, which the claimant felt made his condition worse. Dr. Hart, according to the claimant's testimony, prescribed swimming therapy and an anti-inflammatory. Dr. Hart referred the claimant to Dr. Runnel, who ordered an MRI on March 22, 2000. This MRI showed that the claimant's lumbar spine was within its normal limits. The claimant eventually sought treatment from Dr. Blankenship.

The claimant testified that his pain had not subsided, and in 2002, he began treating with Dr. Blankenship, who noted that the claimant was taking Ultram, Arthrotec, and Zanaflex. Dr. Blankenship also noted

that the claimant had three ESI's with good relief.

Dr. Blankenship also ordered another MRI, which revealed:

...a straightening of the lumbar lordosis. There is an anterior wedging of T11, T12 and L1 compatible with old injuries.

In response to the MRI, Dr. Blankenship ordered physical therapy. In September 2002, Dr. Blankenship's medical notes indicate that even though the claimant has attempted to improve his symptoms, he continued to have severe pain. Dr. Blankenship, noting that the claimant had significant disc space changes at L5-S1 and that the claimant still experienced severe pain, ordered that the claimant undergo a discogram. The discogram revealed that at L4-5 had nuclear degeneration with no demonstration of annular disruption. It was noted that the claimant had no pain at that level. Additionally, the discogram revealed that there was air in the soft tissues on the left-hand side of L5-S1, but no contrast was injected into the L5-S1 intervertebral disc space.

After reviewing the discogram results, Dr. Blankenship's medical records note that although the

claimant suffered from Grade 1 to 2 nuclear degeneration at L4-5, he did not feel that it was the pain generator. As such, Dr. Blankenship reviewed the claimant's MRI again, which showed disc space changes at L5-S1 with bulging. Dr. Blankenship recommended conservative treatment of physical therapy, along with the prescription medications of Ultram and Bextra.

Ultimately, even with conservative treatment, the claimant's pain continued, and on July 29, 2003, Dr. Blankenship diagnosed the claimant as having zygapophyseal joint pain. As such, Dr. Blankenship recommended zygapophyseal joint injections. By October 7, 2003, Dr. Blankenship's medical records note that several weeks post L4-5 and L5-S1 zygapophyseal joint injections, the claimant was doing extremely well. Dr. Blankenship's recommendation was that if the claimant's pain returned, that he should repeat the zygapophyseal joint injection. Dr. Blankenship also opined that the claimant had reached Maximum Medical Improvement, but that the AMA Guidelines

Table 75 Fourth Edition Revised did not list an impairment rating for Z joint pain. _____

The Majority, by affirming and adopting the Administrative Law Judge's opinion, found that the claimant did not satisfy the statutory requirement of Ark. Code Ann. § 11-9-102(4)(D), where a "compensable injury must be established by medical evidence supported by objective findings" in regard to his work-related back injury. Although there is clearly a dispute over the extent of the claimant's injury, it is evident that the claimant has shown objective signs of a work-related injury. Furthermore, the respondents only decided that the claimant's injury was not compensable after learning that the statute of limitations defense was not applicable. As the respondents had initially accepted compensability and paid the claimant's related medical bills for seven years, the respondents should be estopped from now arguing compensability. Additionally, pursuant to the doctrine of laches, the respondent's neglect for an unreasonable and unexplained length of time under circumstances permitting diligence should now bar the

respondents from asserting that the injury is not compensable.

In my opinion, the Majority's findings are simply not consistent with the respondents' actions. The respondents accepted the claim as compensable and continued paying for the claimant's medical for seven years. As such, the equitable doctrines of estoppel and laches should prevent the respondents from asserting that the claimant did not suffer a compensable injury.

Pursuant to the doctrine of estoppel, the respondents should be barred from arguing that the injury is not compensable. There are four necessary elements of equitable estoppel:

(1) the party to be estopped must know the facts; (2) the party to be estopped must intend that his or her conduct be acted on or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the latter must be ignorant of the true facts; and (4) must rely on the former's conduct to his or her injury. Miller County v. Opportunities, Inc., 334 Ark. 88, 96, 971 S.W.2d 781, 786 (1998).

First, the respondents were well aware of the claimant's ongoing medical treatment. When the claimant was originally injured, he was told that he was not covered by workers' compensation insurance. Two years later, the respondents informed the claimant that he should have been covered, which allowed Long Ago Antiques to pay the back premiums to cover the claimant. The respondents, having all of the claimant's medical records available to them two years after the accident, accepted that the injury was compensable to the extent that they even paid for his previous medical care.

Second, the respondents continued paying for the claimant's medical treatment for seven years and never once controverted the claim. Had the respondents ever felt that the injury was not compensable, it stands to reason that they would have controverted the claim sometime during those seven years. As such, the claimant relied on the respondents continued payment for his medical bills and prescription medication related to treatment of his compensable injury. In fact, the claimant felt that he was entitled to this

compensation, as evidenced by his testimony that he could not understand how the respondents were now arguing after seven years of accepting liability, that he did not have a compensable injury.

Third, as the respondents did not controvert the claim until after they determined that the statute of limitations had not tolled, they were forced to come up with another argument in order to deny the claim. It stands to reason that the claimant did not understand why the claim was controverted after seven years, because the respondents gave no warning that this was even an issue. In fact, the respondents had to withdraw their stipulation that the claimant had sustained a compensable injury in order to base their denial of additional medical benefits on something.

Fourth, the claimant relied on the respondents' initial acceptance that the injury was compensable. This is evidenced by the claimant's confusion at trial as to how the respondents could withdraw their stipulation. It is reasonable to believe that you cannot pay for a claim for seven years, stipulate to its compensability, and then

change your mind at the last minute. As such, it is understandable to see the claimant's confused remarks at trial when the respondents argued that the claim was not compensable. Even though the respondents gave notice of the stipulation change, the claimant relied on the respondents past actions and stipulations in determining that it was impossible for the respondents to now controvert the compensability. Furthermore, the claimant had no opportunity to properly defend his claim due to the last minute withdrawal of the stipulation.

Essentially, the claimant raised the issue of estoppel at the trial when he testified that he could not understand how the respondents were now arguing, after seven years of accepting liability, that he did not have a compensable injury. If the respondents truly felt that the claimant's injury was not compensable, they never would have started paying for the injury two years after the accident, nor would they have continued to pay for seven years. As such, the respondents should now be estopped from asserting that the injury is not compensable because it would

constitute in an inequitable result, in that the claimant was unable to obtain many of his medical records due to the respondents unnecessary delay.

Additionally, according to the doctrine of laches, the respondents should be barred from arguing that the injury is not compensable. Blacks Law Dictionary defines the "Doctrine of laches" as:

...based upon a maxim that equity aids the vigilant and not those who slumber on their rights. It is defined as neglect to assert right or claim which, taken together with lapse of time and other circumstances causing prejudice to adverse party, operates as a bar in court of equity. Wooded Shores Property Owners Ass'n v. Mathews, 37 Ill. App. 3d 334, 345 N.E.2d 186, 189. The neglect for an unreasonable and unexplained length of time under circumstances permitting diligence, to what in law, should have been done. Lake Development Enterprises, Inc. v. Kojetinsky, Mo. App., 410 S.W.2d 361, 367.

In Summit Mall Co. v. Lemond, 355 Ark. 190, 132 S.W.3d 725 (2003), our Supreme Court explained:

This court has summarized the laches defense by stating that it is based upon the equitable principle that an unreasonable delay by the party seeking

relief precludes recovery when the circumstances are such as to make it inequitable or unjust for the party to seek relief now. The laches defense requires a detrimental change in the position of the one asserting the doctrine, as well as an unreasonable delay by the one asserting his or her rights against whom laches is invoked.

In the present case, the respondents should be barred from asserting that the claimant did not sustain a compensable injury, as they had neglected to controvert the claim for seven years. Due to the fact that seven years had passed since the accident, the claimant was unable to obtain all of his medical records. As such, he was unable to present critical medical records to the court by the time of the hearing. For example, the claimant testified that Dr. Hart originally diagnosed him as having a soft-tissue tear and prescribed an anti-inflammatory. However, the claimant was unable to present these documents to the court because of the respondents seven year delay in controverting the claim. The respondents delay was detrimental to the claimant due to the fact that he was unable to timely obtain essential medical records that were necessary to his case.

Additionally, the respondents unduly prejudiced the claimant by changing their stipulation regarding compensability at the last minute, which further prevented the claimant from obtaining relevant medical records prior to the trial.

Had the claimant been able to obtain all of his medical records by the time of the trial, he would have been in a better position to prove that objective medical findings existed at that time of injury. Yet, due to the respondents unreasonable delay, the Commission must accept the testimony of the claimant that he was diagnosed as having a soft-tissue tear and was prescribed an anti-inflammatory, or else it creates an unfair prejudice against the claimant. Furthermore, the claimant tried to submit via Motion to the Full Commission, a letter from Dr. Hart dated February 7, 2002, that clearly identified that he prescribed an anti-inflammatory, as well as a prescription from HealthSouth on November 30, 1999 which specifically noted muscle spasms. Yet, the Full Commission denied the motion.

It is important to note that the claimant filed a Motion to Submit Additional Evidence due to his lack of

understanding what was occurring at the time of the trial, and the respondents questionable antics of withdrawing a stipulation. A letter was sent on July 10, 2006 by counsel for the respondents stating that the statute of limitations was no longer a defense since prescriptions medications had been continuously paid by a separate unit of the respondent-carrier.

On July 25, 2006, counsel for respondents sent a letter to the Administrative Law Judge with a copy to the Claimant taking the position that the claimant had no objective medical findings that corroborate the injury from 1999 and controverting medical benefits including prescription medications from the date of the letter and that the hearing scheduled for September 13, 2006, would still be necessary. A second pre-hearing conference was not held after the withdrawal of the stipulation.

At the beginning of the hearing on September 13, 2006, the claimant stated that he did not understand respondents' position as to the compensability of his claim. However, the Administrative Law Judge went off the record.

As such, it is unclear what was said to the claimant at that time. What is clear, however, is that the claimant did not understand how the respondents could now change their position by arguing that the injury was not compensable. The Administrative Law Judge should have stayed on the record during that time and continued the case in order to give the claimant ample opportunity to introduce additional medical. This is not, however, what occurred. Instead, the claimant had to present what limited evidence he had, despite his obvious lack of understanding regarding the issues to be presented in the case. The claimant was then forced to file a Motion for the Full Commission to consider additional evidence.

Most interestingly, the respondents sent notice of withdrawing their stipulation of compensability on July 25th, 2006. In the claimant's appeal, he states that the records were from as far back as 1999 and that these records were archived and would take at least 30 days to receive from the doctors. In order for the claimant to introduce the medical in accordance with the seven day rule, pursuant to

the pre-hearing order, it is unlikely that the claimant could have even obtained the additional medical documents in accordance with the rule and prior to trial on September 13, 2006. As such, it is apparent that the claimant's ability to present his case was seriously damaged. Then the claimant attempted to overcome prejudice due to the withdrawal of the stipulation by filing a Motion.

The Motion, however, was denied due to the claimant's failure to attach the additional medical records to his actual motion. However, the records appear in the file and indicate that Dr. Hart did in fact prescribe an anti-inflammatory. It therefore stands to reason that the Majority should now accept the claimant's testimony as fact or else it will have arbitrarily disregarded credible testimony and evidence the claimant did not have due to the respondent's withdrawal of their stipulation.

In the alternative, the Majority should bar the respondents from asserting that the claimant did not sustain a compensable injury, as they unreasonably neglected to controvert the claim for seven years, which unfairly

hindered the claimant from presenting all of the medical records. As such, the doctrine of laches should prevent the respondents from asserting that the claimant did not sustain a compensable injury, as seven years constitutes an unreasonable delay, which produced an inequitable result.

In my opinion, the Majority's findings are simply not consistent with the objective medical findings of several doctors. Existence of an injury is supported by objective evidence such as Dr. Hart's opinion that the claimant suffered a soft-tissue tear, as well as Dr. Hart's prescription of swimming therapy and an anti-inflammatory, and an MRI which shows a bulging disk at L5-S1. Though there is some validity to the Majority's assertion that the MRI was taken two years after the initial injury, I find that there is significant medical evidence and other corroborative evidence to show that the claimant sustained a compensable injury. Specifically, I find that since the claimant was admittedly involved in an accident and presented with objective medical findings of an injury, he

has met his burden of proof in showing that he sustained a compensable injury.

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). Should the claimant fail to establish by a preponderance of the evidence any of the requirements for establishing the compensability of the claim, compensation must be denied. Mickel v. Engineering Speciality Plastics, 56 Ark. App. 126, 938 S.W.2d 876 (1997).

First, the evidence shows that the claimant sustained an injury while in the course and scope of employment. The owners of Long Ago Antiques do not dispute that the claimant was injured while working. Additionally, in a letter from Mr. Bill Stiles, owner of Long Ago Antiques, to the respondents, Mr. Stiles questions how an insurance company, that essentially works for him, can deny a claim that he does not dispute. As such, it is evident that the owners of Long Ago Antiques accept that the injury occurred within the scope of employment.

Specifically, I find that the claimant sustained an injury to his back. This is evidenced by the objective medical findings found in the record. First, the claimant testified that Dr. Hart diagnosed a soft-tissue tear and prescribed an anti-inflammatory. Additionally, a doctor's note, a mere seven days after the accident, specifically stated that the claimant suffered from muscle spasms. As previously discussed, although these medical records were not in the record, they are in the file, and the claimant has taken reasonable steps to introduce them once he became

aware that the issue was compensability. As such, the claimant's testimony should suffice. In fact, had these medical records not contained objective medical findings, the respondents most likely would have introduced those records into the record. As such, under Huffy Service First v. Ledbetter, 76 Ark. App. 533, 69 S.W.3d 449 (2002), and Estridge v. Waste Management, 343 Ark. App. 276, 33 S.W.3d 167 (2000), Dr. Hart's findings are objective medical findings.

Additionally, an MRI taken in 2002 revealed that the claimant suffered from a straightening of the lumbar lordosis and an anterior wedging of T11, T12 and L1 compatible with old injuries. Lumbar lordosis has previously been held to be an objective finding. *Dorland's Illustrated Medical Dictionary, 28th Ed.*, defines "lordosis" as an "abnormally increased curvature" of the spine. Furthermore, the Arkansas Court of Appeals held that "a physical therapist's notation of 'decreased lumbar lordosis' is an objective medical finding." King v. Peopleworks, ___ Ark.

App. ___, ___ S.W.3d ___ (2006); citing Continental Express v. Freeman, 339 Ark. 142, 4 S.W.3d 124 (1999).

In my opinion, the Majority errs in failing to acknowledge the entire MRI. Although the Administrative Law Judge cites that the claimant suffers from lumbar lordosis, he dismisses the MRI due to it occurring two years after the accident. This is completely arbitrary for two reasons. First, the MRI reveals that the injury is consistent with an old injury. As the claimant's accident occurred two years earlier and his pain had not subsided since that time, it is evident that the diagnosis of lumbar lordosis is consistent with the claimant's injury. Second, as the respondents did not accept the claim until two years after the injury, it stands to reason that the respondents had this MRI in their records when they initially decided to pay the claimant's medical. As such, the should be barred from arguing that changes in the MRI did not occur until two years after the accident.

Additionally, it is apparent that the claimant's injury is at L5-S1. A discogram revealed that there was air

in the soft tissues on the left-hand side of L5-S1, but no contrast was injected into the L5-S1 intervertebral disc space. Afterwards, Dr. Blankenship reviewed the claimant's MRI again, which showed disc space changes at L5-S1 with bulging. It is evident that the claimant's pain stems from his L5-S1, yet the discogram could not be performed at that level. Accordingly, the only objective medical findings available to Dr. Blankenship were the MRI results. It is also important to note that the results of the discogram should not be used against the claimant, as the dye was unable to be cast at L5-S1, which made it impossible to perform an adequate study of that level. However, it is evident that the claimant suffered a compensable injury supported by the objective medical findings.

As Long Ago Antiques does not dispute that the claimant sustained a compensable injury, the claimant should be awarded ongoing pain medication. Objective medical findings are not needed to award ongoing pain medication. Injured employees must prove that medical services are reasonably necessary by a preponderance of the evidence;

however, those services may include that necessary to accurately diagnose the nature and extent of the compensable injury; to reduce or alleviate symptoms resulting from the compensable injury; to maintain the level of healing achieved; or to prevent further deterioration of the damage produced by the compensable injury. Ark. Code Ann. § 11-9-705(a)(3) (Repl. 2002); Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911 S.W.2d 593 (1995); and See Artex Hydroponics, Inc. v. Pippin, 8 Ark. App. 200, 649 S.W.2d 845 (1983). The Court of Appeals has noted that even if the healing period has ended, a claimant may be entitled to ongoing medical treatment if the treatment is geared toward management of the claimant's compensable injury. See, Patchell v. Wal-Mart Stores, Inc., 86 Ark App. 230; 184 S.W.3d 31 (2004), citing Pippin, supra. Furthermore, this Commission has found that, treatment intended to help a claimant cope with chronic pain attributable to a compensable injury may be reasonable and necessary. See, Maynard v. Belden Wire & Cable Company, Full Workers' Compensation Commission Opinion filed April 28, 1998

(E502002); See also, Billy Chronister v. Lavaca Vault, Full Workers' Compensation Commission opinion filed June 20, 1991 (Claim No. D704562). Additionally, a claimant does not have to support a continued need for medical treatment with objective findings. Chamber Door Industries, Inc. v. Graham, 59 Ark. App. 224, 956 S.W.2d 196 (1997).

There is no dispute that the claimant has continued to suffer from pain associated with a back injury. Furthermore, since the occurrence of the injury, the claimant has undergone treatment in the form of an anti-inflammatory, prescription pain medication, water therapy, and epidural injections. In fact, the claimant was still taking Ultram and Bextra when the respondents cut off his benefits. Additionally, he was having epidural steroid injections approximately once a year to assist with his pain. Additionally, Dr. Blankenship's notes indicated that any future back pain without an interim event would still be related to his original injury. In denying the claimant additional medical treatment, the Majority erred in finding that the claimant did not relate his pain to the injury. As

such, the claimant should be awarded ongoing pain medication, which is reasonably necessary to alleviate symptoms resulting from the compensable injury, to maintain the level of healing achieved, and to prevent further deterioration of the damage produced by the compensable injury.

In conclusion, I find the claimant suffered a compensable work-related injury, supported by objective medical findings. Additionally, I find that as the respondents failed to controvert the claim for seven years, the equitable doctrines of estoppel and laches prevent the respondents from now asserting that the claimant's injury is not supported by objective medical findings. Furthermore, the claimant should have been awarded ongoing pain medication.

_____ For the aforementioned reasons, I respectfully dissent.

PHILIP A. HOOD, Commissioner