

NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F905669

JUDY K. GREER, EMPLOYEE	CLAIMANT
NATIONWIDE NURSES, LLC, EMPLOYER	RESPONDENT
CHARTIS CLAIMS, CARRIER/TPA	RESPONDENT

OPINION FILED JUNE 7, 2011

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

Claimant represented by the HONORABLE FREDERICK S. "RICK" SPENCER, Attorney at Law, Mountain Home, Arkansas.

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

Decision of Administrative Law Judge: Affirmed and Adopted.

OPINION AND ORDER

Claimant appeals from a decision of the Administrative Law Judge filed January 7, 2011.

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-insurance carrier relationship existed at all relevant times, including October 14, 2008.
3. The claimant sustained a compensable injury to her

left knee.

4. The claimant has been assigned a 4% permanent partial impairment rating, which was accepted and paid by the respondent-insurance carrier.
5. The claimant's average weekly wage at the time of her injury was \$469.66, and her compensation rates for temporary total disability and permanent partial disability are \$313.00/\$235.00, respectively.
6. This claim for additional benefits has been controverted in its entirety.
7. The claimant's Motion to Recuse is hereby denied. I find the Act to be constitutional.
8. The claimant did not prove by a preponderance of the that she sustained a compensable consequence injury to her right knee which arose out of the course of her employment, which is established by medical evidence supported by objective findings.
9. The claimant failed to prove her entitlement to additional medical treatment for her compensable left knee injury.
10. All issues not litigated herein are reserved under the Arkansas Workers' Compensation Act, including, but not limited to temporary total disability compensation for both of her knees.

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.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood concurs, in part, and dissents, in part.

CONCURRING AND DISSENTING OPINION

After my de novo review of the entire record, I must respectfully dissent, in part, from the majority opinion. I would reverse the Administrative Law Judge, because I find that the claimant is entitled to additional medical benefits for her compensable left knee injury. I concur, in part, because the record does not reveal objective findings to support an injury to the her right knee, despite careful review.

The record reflects that, prior to the claimant's compensable injury, she only had a history of degenerative arthritis in her hips in 1999, a soft tissue injury in 2000 which

resolved within a month, chest pain in 2005, and dizziness and difficulty walking in September 2008.

On October 16, 2008, the claimant developed left leg pain and swelling after working fifty-nine hours straight, as a traveling nurse, and falling into a bed to avoid a physical altercation with an AIDS patient. On October 17, she was diagnosed with left lower extremity pain and swelling, which was still present on October 28, 2008. She underwent physical therapy in January 2009. On March 10, 2009, Dr. Knox released her at maximum medical improvement.

On April 2, 2009, Dr. Knox reviewed the claimant's history, noting an injury in 2007 when she struck and twisted her knee. Dr. Knox saw the claimant on November 11, 2008, and observed range of motion limitations, tenderness, and mostly resolved lymphedema. An MRI showed a tear of the medial meniscus, which he repaired in December 2008. In January, 2009, the claimant began physical therapy. In February, the claimant still had soreness in her medial knee and, although her physical therapy was progressing nicely, she still had motion and strength limitations, edema, and an antalgic gait. He went on to say that he released the claimant on March 10, 2009 and:

She noted she still had soreness in her knee, pretty much her left lower extremity. At that point, she was about three months postop. Given her age and the surgical

findings of early chondromalacia, she may continue to have problems from degenerative changes. However, I felt that she was at maximum medical improvement from her on-the-job injury.

After her compensable injury, the claimant was treated for a left wrist injury in July 2009. The next record reflects that the claimant had been seeing Dr. Eyster for knee pain. He noted in September 2009 that the claimant had right knee pain. Since she "previously did improve with a left knee joint injection," Dr. Eyster planned an injection in the right knee.

The claimant reported pain in her elbow and shoulder on September 29, 2009 to Dr. Eyster's clinic. Dr. Eyster prepared a statement on October 30, 2009, stating that his diagnosis of the claimant was bilateral knee degenerative changes. He limited her to no walking more that one hundred yards at a time and no repetitive stair climbing or squatting.

The claimant was seen in December 2009 and January and February 2010 with joint pain. She was assessed with chronic arthritis and, by February 2010, with rheumatoid arthritis. Her complaints included pain in her elbows, left wrist, right knee, neck, shoulders, wrist and hand. Dr. Wang observed warmth in both knees. In April, the claimant's pain was in her shoulder and wrist, and Dr. Wang mentioned that knee replacement could proceed once her inflammation was controlled. She was seen again

in June, with no mention of her knees.

There is no question that the claimant sustained a compensable injury to her left knee which resulted in an "impressive" meniscal tear. The claimant had chondromalacia and degenerative changes in her left knee, which can be safely assumed to exist in the right knee too. Neither knee was symptomatic prior to October 16, 2008, except for a brief and resolved right knee soft tissue injury in 2000. The claimant was treated for pain in both knees after her release by Dr. Knox. Dr. Eyster felt that her right knee pain was a direct result of the damage done to her left knee on October 16, 2008, which caused extra stress on her right knee over time.

The claimant's left and right knee pain did not arise at the same time as her other joint symptoms. There is no notation of joint problems from the time of her injury until Dr. Eyster's report in September 2009, other than in June 2009, when she injured her wrist lifting a box. Her left knee pain began on October 16, 2008, and her right knee pain began sometime before her September 2009 visit to Dr. Eyster. Dr. Eyster felt that her left knee problems were more than 50% of the cause of her right knee problems. Later, Dr. Eyster stated that rheumatoid arthritis would "also" account for her right knee pain and some of her left knee pain. This does not mean that her rheumatoid

arthritis is the whole cause of her current left and right knee pain, or the original source of her right knee pain.

Rheumatoid arthritis is a chronic inflammatory disorder that most typically affects the small joints of the hands and feet. Osteoarthritis is "wear-and-tear damage." Rheumatoid arthritis is an autoimmune disorder in which the immune system attacks tissue, in particular, joint linings, which causes painful swelling that can eventually result in bone erosion, joint deformity, fevers, and fatigue. Signs and symptoms of rheumatoid arthritis include joint pain, joint swelling, and joints that are tender to the touch. Early rheumatoid arthritis tends to affect smaller joints first, such as those in wrists, hands, ankles and feet. As the disease progresses, shoulders, elbows, knees, hips, jaw, and neck also can become involved. Symptoms usually occur in the same joints on both sides of the body. Health Information: Rheumatoid Arthritis, The Mayo Clinic, November 3, 2009

(<http://www.mayoclinic.com/health/rheumatoid-arthritis/DS00020>)

The claimant had right knee pain in September 2009. She was seen in December 2009 and, at that time, she presented with a new complaint of right knee pain. It was noted by the medical provider that she had bilateral knee pain, as she had continuing left knee pain and the new complaint of right knee

pain. She had swelling of the left, but not right knee. The claimant's complaints of pain in her small joints did not arise until in December 2009. At that time, the claimant's condition quickly deteriorated, and she communicated to Dr. Wang how difficult it was for her to have her life changed so abruptly from active to inactive and painful. These facts are inconsistent with the conclusion that the claimant's left knee pain was solely due to rheumatoid arthritis. Her right and left knee pain predated the symptoms consistent with the onset of rheumatoid arthritis.

Dr. Eyster was asked to clarify his opinion, in light of the rheumatoid arthritis diagnosis. He stated:

She was having knee pain on the right as compensable for the protection and weight stress relief from the left leg. Since that note in regards to having increased pain in the right knee, the patient has also been diagnosed as having rheumatoid arthritis. This accounts for the pain also in the right knee and also to some extent the pain in the left knee.

Dr. Eyster did not say that her rheumatoid arthritis accounted solely for the left knee pain. He used the words "also to some extent." While not the most well-crafted grammatical structure, Dr. Eyster's sentence is clear enough. He did not say that her meniscus tear in the left knee did not cause her left knee pain. He said that, indeed, rheumatoid arthritis would also cause knee pain. She had two causes for knee pain. Several

factors support a finding that the major cause of her left knee pain was her compensable injury: her history of left knee injury, continued pain and swelling, her significant work limitations as a result, her ability to work as a traveling nurse up until her compensable injury, the onset of rheumatoid arthritis symptoms more than a year after her injury, and the absence of any change in her left knee symptoms in that time. She had pain and swelling after her surgery, which were the same complaints in 2009 and 2010. She did not voice any change in the quality or quantity of her left knee symptoms.

I disagree with the Administrative Law Judge's statement, affirmed and adopted by the majority, that all the treatment since her release was for her rheumatoid arthritis. The claimant continued to have knee pain, despite her release by Dr. Knox. The claimant saw Dr. Eyster, whose notes indicate that his prior injections helped her left knee. Her left and right knee pain arose prior to the onset of the symptoms of rheumatoid arthritis. The fact that she has rheumatoid arthritis is not enough to absolve the respondents of responsibility for the damage done to her knee in October 2008. The claimant had swelling in her left knee as a symptom of her meniscus tear. She did not have swelling in her painful right knee. If rheumatoid arthritis was causing the left knee swelling, it would also have

caused her right knee to swell.

I would award the claimant additional medical benefits for her left knee pain as a result of her compensable 2008 injury.

For the foregoing reasons, I must respectfully dissent, in part, from, and concur, in part, with the majority opinion.

PHILIP A. HOOD, Commissioner