BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NOS. G505437, G505438, & G500980

MARGARET WATSON, EMPLOYEE	CLAIMANT
SOUTHWEST ARKANSAS DEVELOPMENT, EMPLOYER	RESPONDENT NO. 1
RISK MANAGEMENT RESOURCES, INSURANCE CARRIER/TPA	RESPONDENT NO. 1
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT NO. 2

OPINION FILED OCTOBER 11, 2021

Hearing held before Administrative Law Judge Chandra L. Black, in Texarkana, Miller County, Arkansas.

Claimant represented by Mr. Andy Caldwell, Attorney at Law, Little Rock, Arkansas.

Respondents No. 1 represented by Ms. Karen H. McKinney, Attorney at Law, Little Rock, Arkansas.

Respondent No. 2 represented by Ms. Christy L. King, Attorney at Law, Little Rock, Arkansas. Ms. King waived her appearance at the hearing.

Statement of the Case

On July 13, 2021, the above-captioned claim came on for a hearing in Texarkana, Arkansas. A prehearing telephone conference was conducted on April 20, 2021, from which a Prehearing Order was filed on April 21, 2021. Said order and the responsive filings by the parties have been marked as Commission's Exhibit No. 1.

Stipulations

During the prehearing telephone conference, and/or the hearing, the parties agreed to the following stipulations:

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 on or about December 2, 2014; December 19, 2014; and January 23, 2015, when the Claimant alleges to have sustained compensable injuries to her back.
3. Respondents No. 1 initially accepted the January 23, 2015, incident as compensable for injuries to the Claimant's back, hip, and left arm for which they paid some medical and indemnity benefits. Specifically, Respondents No. 1 have paid eight weeks and four days of temporary total disability compensations from the date after the injury through April 10, 2015.
4. Respondents No. 1 have now controverted the Claimant's alleged injuries to her back/lumbar spine.
5. The Claimant's average weekly wage of $246.44, entitles her to compensation rates of $164.00 and $154.00.
6. The Claimant reached the end of her healing period and/or maximum medical improvement (MMI) on January 10, 2017.
7. All issues not litigated herein are reserved under the Arkansas Workers' Compensation Act.

<u>Issues</u>

The parties agreed to litigate the following issues:

1. Whether the Claimant sustained compensable injuries to her back on December 2, 2014; December 19, 2014; and January 23, 2015.

2. In the alternative, whether the Claimant sustained a gradual onset back injury.
3. Whether the Claimant is entitled to temporary total disability from April 8, 2015 through January 10, 2017.
4. Whether the Claimant is entitled to medical treatment for her back.
5. Whether the Claimant is entitled to an anatomical impairment rating for her back.
6. Whether the Claimant is entitled to permanent and total disability compensation or in the alternative, wage loss disability.
7. Whether the Claimant's attorney is entitled to a controverted attorney's fee.

Contentions

The respective contentions of the parties are as follows:

Claimant:

The Claimant contends that she sustained injuries to her back on December 2, 2014 (G500980); December 19, 2014 (G505437); and January 23, 2015 (G500980). The Respondents controverted the December 2, 2014 (G500980) and the December 19, 2014 claims. The Respondents initially accepted the January 23, 2015 (G500980) claim and paid medical and 8 weeks and 5 days of TTD from February 10, 2015 until April 7, 2015. The Claimant further contends that she is entitled to TTD from April 8, 2015 (when the Respondents terminated indemnity benefits) through January 10, 2017, additional medical treatment (including reimbursement for out of pocket expenses and mileage) in the form of ongoing pain management; PPD for the Claimant's lumbar fusion which was performed on March 16, 2016. Dr. Burson assigned the Claimant a 30% impairment rating; Permanent and total disability or, in the alternative, wage loss and a controverted attorney's fee. The Claimant reserves all other issues at this time.

Respondents No. 1(referred to herein as "Respondents"):

Respondents contend that the Claimant did not sustain a compensable injury either on December 2, 2014, or December 19, 2014. Respondents accepted a compensable injury to the low back in the form of a strain which occurred on January 23, 2015. Respondents contend that the Claimant's current condition is not related to the minor strain injury on January 23, 2015. The Claimant experienced these same symptoms prior to January 23, 2015 as well as prior to any of her alleged injuries. Respondents further contend that the Claimant was diagnosed with chronic low back pain with an opiate dependency on December 2, 2014, by her primary prior care physician. Finally, Respondents contend that the Claimant's pain, her underlying objective finding of spondylolisthesis, and the medical treatment she obtained after April 15, 2015 is not causally related to her minor strain injury on January 23, 2015.

Respondent No. 2:

The Trust Fund deferred to the outcome of litigation.

Based on my review of the record as a whole, to include the aforementioned documentary evidence, other matters properly before the Commission, and after having had an opportunity to hear the Claimant's testimony and observe her demeanor, I hereby make the following findings of fact and conclusions of law in accordance with Ark. Code Ann. §11-9-704 (Repl. 2012).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction over this claim.

2. I hereby accept the aforementioned stipulations as fact.

3. The Claimant failed to prove by a preponderance of the evidence that she sustained a compensable injury to her back on December 2, 2014 and December 19, 2014 while working for the respondent-employer.

4. The Claimant proved by a preponderance of the evidence that on January 23, 2015, she sustained a compensable temporary aggravation of her preexisting degenerative condition of the back, which resolved no later than April 8, 2015.

5. All other issues have been rendered moot and not discussed in the Opinion.

Summary of Evidence

Ms. Margaret Watson (the Claimant) was the sole witness.

Additionally, the record consists of the hearing transcript of the July 13, 2021, and the exhibits contained therein. Specifically, the following exhibits have been made a part of the record: Commission's Exhibit No. 1 includes the Commission's Prehearing Order of April 21, 2021, and the parties' respective response to the Prehearing Questionnaire; Claimant's Medical Exhibit, consisting of 422 numbered pages was marked as Claimant's Exhibit 1; Claimant's Non-Medical Exhibit, consisting of 34 numbered pages was marked as Claimant's Exhibit 2; Respondents No. 1's Medical Records, consisting of 27 numbered pages was marked as Respondents' Exhibit 1; Respondents No. 1 introduced into evidence a compilation of Non-Medicals, consisting of 43 numbered pages, which has been marked Respondents' Exhibit 2; and Respondents No. 1's Correspondence and Non-Medical Records were marked as Respondents' Exhibit 3.

Testimony

The Claimant is a 54-year-old high school graduate. She spent several years as a homemaker after getting married in 1985. The Claimant began working in 1990. According to the Claimant, she worked for Tyson for seven months on the assembly line. She began working for the respondent-employer, Southwest Arkansas Development Center (SWADC) in 1991. While working there, the Claimant performed employment duties as a CNA. According to the Claimant,

she bathed, groomed, cooked, cleaned, shopped, and performed various other tasks for clients, such as helping them with the proper dosage of medications, errands, shopping, laundry, bill paying, and mobility transfer, along with other basic upkeep and home management tasks. The Claimant worked 40 to 60 hours per week. Her employment ended with the respondent-employer in 2015. The Claimant has alleged three separate incidents while working for SWADC, which alleged resulted in injury to her back.

Specifically, the Claimant's first alleged incident occurred on December 2, 2014. She gave the following explanation for the mechanism of her injury:

> A I was cleaning for my client, and she yelled – she yelled at me, told me I missed a spot. And without turning my body, I just turned quickly to assist what she was saying and I heard a popping and I couldn't straight back up.

The Claimant testified that she sought treatment on December 2, 2014 from Dr. Patrick Antoon, and he referred her to a chiropractor. She returned to work after this incident. On December 19, 2014, the Claimant was involved in another alleged work-related incident. This incident occurred as the Claimant assisted a patient inside of her small bathroom. According to the Claimant, the client pulled the space rug with her as she got up from the toilet. The Claimant testified that she fell forward toward the sink. She stated that she reported both incidents to management.

On January 23, 2015, the Claimant was involved in a third incident. According to the Claimant, she has not returned work since the January 2015 work-related incident. The Claimant confirmed that she reported on the Form AR-N that she felt a pop in her low back while mopping. She confirmed that the respondent-insurance carrier accepted the claim and paid some benefits. The Claimant treated with Dr. Rodney Griffin and he ordered some physical therapy. The Claimant also treated with Dr. Justin Seale. He initially told the Claimant she needed surgery.

However, the Claimant testified that Dr. Seale changed his recommendation the next day. Following this treatment, Respondents No. 1 did not pay for any additional medical treatment for her back condition.

The Claimant confirmed that she began treating on her own. Ultimately, the Claimant came under the care of Dr. Timothy Burson. In March of 2016, Dr. Burson performed surgery on the Claimant's back. He referred the Claimant to Dr. Ahmad Rafi for an injection. After this treatment, the Claimant followed up with Dr. Burson and he released the Claimant from his care. Since this time, the Claimant has been under the medical care of her primary care physician, Dr. Antoon. He continues to prescribe the Claimant's pain medications and follow-up care for her back injury and other non-work-related medical conditions.

According to the Claimant, Dr. Antoon has opined that she is not able to return to work. She denied that she is able to return to work in any capacity. The Claimant testified that she has problems on a day-to-day basis with basic house cleaning, cooking, self-care (such as styling her hair), and being active with her grandkids. She has guardianship of one of her grandsons. The Claimant receives $57.00 a week in child support for him, and she gets food stamps in the amount of about $388.00 a month. Although the Claimant applied for Social Security Disability benefits, her claim has not been approved. While working, the Claimant purchased a mobile home and paid cash ($1,800.00) for it. She lives on part of some land owned by her mother, who lives across the street from her. The Claimant's mother pays for the upkeep of the yard. According to the Claimant, her grandson and live-in-friend perform the chores around the house.

The Claimant testified that she occasionally has problems getting out of bed due to her back. She confirmed that she continues to have problems with stooping, bending, and lifting. The Claimant is able to go to the grocery store, but she has difficulty walking and lifting items.

The Claimant takes hydrocodone and muscle relaxers for her back. She confirmed that she went in to see Dr. Ivy McGee about her hip problems and other unrelated conditions to this claim on January 29, 2013. She confirmed that she treated with Dr. Antoon on May 3, 2013. At that time, the Claimant confirmed that she was negative for back pain. She also saw Dr. Antoon on October 24, 2013. At that time, she was having leg pain due to varicose veins in her lower extremity. The Claimant confirmed that she has been diagnosed with venous insufficiency, pedal edema, hypertension, and tobacco abuse. However, under the musculoskeletal exam, there is no mention of any back problems.

On January 2, 2014, the Claimant saw Dr. Antoon due to back pain. The Claimant testified that at that time, she was unable to straighten her body up. At that time, she heard popping in her back, and felt a burning sensation. The Claimant was diagnosed with, among other things, low back pain. She returned to see Dr. McGee on January 9, 2014. She was diagnosed with right hip osteoarthritis and right leg pain, but there is no mention of any back pain. The Claimant complained to Dr. McGee on April 8, 2014, of back pain. She admitted to seeing Dr. Antoon and/or Dr. McGee on January 2; April 3; May 5; and November 3, of 2014, but they never did any studies of her back.

She admitted that after her December 2, 2014 incident, she continued to treat for back problems. Ultimately, the Claimant had surgery on her back. The Claimant confirmed that since her final incident of January 23, 2015, she has been completely unable to return to work.

On cross examination, the Claimant was asked about Dr. McGee's January 9, 2014 report wherein she diagnosed her with hip osteoarthritis. The Claimant was also having a difficult time working per these clinic notes, but she did not independently recall this.

She verified that she earned $7.50 an hour. She worked approximately 32 hours per week before her injury according to the payroll records. The Claimant confirmed that she has applied for Social Security Disability benefits several times and been denied each time.

Under further questioning, the Claimant admitted that she does not use a walker. Instead, the Claimant essentially testified that she uses a cane to ambulate. However, the Claimant did not have it with her at the hearing. Nor did the Claimant have it with her at her deposition in April 2021. The Claimant admitted that she uses it only when she needs it.

She confirmed that she has a Facebook (FB) page. The Claimant further confirmed that her FB profile states that she works at Southwest Arkansas Development Council. However, she basically admitted that she is not employed by the respondent-employer. The Claimant also admitted that she is shown on Facebook pictures squatting down with kids and on another picture, she is standing up with a big smile on her face. However, the Claimant explained that she can stand and squat when she is happy and feels good.

The Claimant disputed that during her deposition, she was unable to remember what happened during the first injury. During her deposition testimony, the Claimant was asked how she got hurt, and her reply was "I was just working and hurt myself. Most likely I was probably getting her[client] out of the shower. I don't remember."

Specifically, the Claimant explained:

> A … So when I took your deposition, you didn't remember how you got hurt, did you?
>
> Q I might have – yes. I know – yes, I know how I got hurt. Yes.

She admitted that at this point, she and her attorney went out in the hallway and talked. Following their discussion, the Claimant's attorney instructed her to say, "I don't know," if she did not know the answer to something. Initially, the Claimant stated that she does know if this is

what happened during her deposition. However, next, she admitted that this happened. She disputed having testified at her deposition that she was at a client's house helping her to get out of the shower when the incident occurred on December 2, 2014.

The Claimant testified that she reported her injury, that very day. She further testified that she sought treatment from for her injury from Dr. Antoon that very day as well. Next, she was shown a copy of the Form AR-N, which is dated December 4, 2014. The Claimant admitted that it bears her signature. Per the Form AR-N, the Claimant reported her injury on December 3, 2014, the day after the incident. According to the Claimant, she went to the chiropractor on December 3, 2014, and he told her to return to work on December 4, 2014.

Regarding Dr. Antoon's report of December 2, 2014, the Claimant disputed that it does not mention that she got hurt at work. She also denied that Dr. Antoon examined her and refilled her prescription for hydrocodone. Upon being presented with Dr. Antoon's report that states that he refilled her Norco on December 2, 2014, the Claimant replied, "I don't know." The Claimant vehemently denied calling her supervisor, Ms. Brenda McKamie, on December 3, 2014 and telling her that she was under the care of Dr. Antoon for back pain, and he wanted her to see Dr. Butler (a chiropractor) and that she might need to take a few days off. According to the Claimant, Ms. Brenda forced her back to work and told her to "suck it up," because she had back injuries too.

The Claimant denied telling Ms. McKamie that her back condition was from "long time of working." She also denied that Dr. Butler told her to go back and report her condition as a work-related injury so that workers' comp could direct her care. Next, she admitted that he told her to do so after she saw him on referral from Dr. Antoon. According to the Claimant, she saw Dr. Butler and after he performed some X-rays, he told her she got hurt at work and needed to file for workers' compensation. She essentially testified that after this, she went and reported to her

supervisor, Brenda, that she was hurt, but she told her to go back to work. The Claimant maintained that she did not recall telling the adjuster in a recorded telephone conversation that Dr. Butler told her to file for a back injury.

Under further questioning the Claimant testified:

Q Did Dr. Butler tell you to report this as work-related?

A Yes.

Q So that's when you reported it as work-related was after you talked to Dr. Butler?

A I reported it as work-related when I called her when I go hurt at work.

Regarding the December 19, 2014 incident, the Claimant admitted that a client pulled the rug out from under her when this alleged incident occurred. She admitted that she did not fall all the way to the floor. Per the Claimant's testimony, she grabbed a hold of the sink to keep from falling. The Claimant admitted to calling and reporting the incident to Latesha Carter. According to the Claimant, she went back to Dr. Antoon for treatment. While Dr. Antoon was in prison for Medicare fraud, the Claimant treated with Dr. Ivy McGee. When Dr. Antoon got out of prison, the Claimant started seeing him again in May of 2014. She admitted to complaining of hip pain, burning and tingling of the feet, and that she was having a hard time standing up. The Claimant further admitted to telling Dr. McGee it takes her two hours in the morning to get up and to warm-up just to be able to ambulate around the house.

She essentially agreed that she was having difficulty with movement before she ever had a work incident. The Claimant essentially confirmed that Dr. McGee was prescribing her hydrocodone before any of the incidents. She denied getting hydrocodone from both doctors during the same period.

The Claimant admitted to treating with Dr. Burson. He performed back surgery on her. Following her surgery, Dr. Burson referred the Claimant to Dr. Rafi for pain management. Dr. Rafi performed an injection on the Claimant's lumbar spine.

Next, the Claimant was asked about Dr. Rafi's report of December 2016. Specifically, the Claimant testified:

> Q Under "History of Present Illness" Dr. Rafi says you told him "Ms. Watson presents today for assessment of chronic pain as a new referral. The patient complains of pain lower back, buttocks, and hips for the last several years. At time it radiates down both legs." Is that a true statement?
>
> A Yes.
>
> Q All right. "Reports onset of pain as gradual. "So it says your onset was gradual. Isn't that what you told Dr. Rafi?
>
> A Meaning?
>
> Q Meaning it happened over time.
>
> A I assume yes in 2014.
>
> Q So you didn't tell Dr. Rafi you got hurt at a specific time on December 2, 2014, did you?
>
> A I don't remember.
>
> Q All right. You said it just happened, it just kind of gradually gets worse and worse. Is that what you told him?
>
> A I don't remember, ma'am.

Per a report from Dr. Antoon in June of 2017, the Claimant reported that she had gone on vacation and gained some weight. She confirmed that she felt well enough to go vacation. The Claimant was unable to confirm that last medical report of her using a cane was from Dr. Burson's medical report, of January of 2017. She was unable to recall if Dr. Antoon prescribed her cane.

The Claimant denied that Dr. Antoon explained to her that the problem with her back is long-term due to wear and tear from working over the years. She denied telling this to Ms. McKamie.

The Claimant denied that on December 19, 2014, Ms. Carter asked her to come by the office but she could not because she was having car trouble. According to the Claimant, she disputes this because this is the day that she went back to the doctor. The Claimant continued to maintain that she went to the doctor on December 19, 2014, although there is not a medical report demonstrating that she went to the doctor on that day.

She verified that she had one client that weighed 600 pounds. she admitted that she worked for Southwest Arkansas Development for 22 years. According to the Claimant she did not have to lift the 600-pound patient, but she had to roll her. The Claimant admitted she did not hurt herself lifting this patient.

With respect to her job duties, the Claimant admitted that not every client required lifting, needed help using the bathroom, or bathing. She agreed that she does not do every single task for every client. Her job duties are tailored to the needs of each client. The Claimant admitted that after she got hurt, she went to the next client and just sat around and visited with them. The Claimant denied that part of her job is being a companion.

On redirect examination, the Claimant testified that the Facebook picture was from Mother's Day, of this year. The Claimant testified that her vacation entailed a trip to Little Rock to see her brother.

Deposition Testimony

Dr. George Timothy Burson's deposition was taken on February 18, 2020. He is a local Neurosurgeon, who treated the Claimant in the course of his practice. Dr. Burson first medical visit with the Claimant was on May 12, 2015. At that time, the Claimant complained of low back

pain in her buttocks going down her posterior thigh into her calf. She also had numbness and tingling in her toes along with other related symptoms.

According to Dr. Burson, the Claimant gave a history of an onset of symptoms that started while mopping and she felt a pop and burning sensation in her back. Dr. Burson was unable to find a history of the Claimant's back problem being the result of a gradual onset over her lifetime. Per Dr. Burson's clinic note, the Claimant gave a history of only one incident, which occurred on December 2, 2014.

Dr. Burson agreed that if a person has back problems, they sometimes have knee and hip problems. He agreed that Dr. Antoon's note of May 3, 2013 demonstrates that the Claimant has OA (which usually stands for osteoarthritis) of the hip. Dr. Burson agreed that the Claimant complained of leg pain on October 24, 2013. He agreed that the Claimant complained of low back pain on January 2, 2014 to Dr. Antoon, for which he prescribed hydrocodone.

The Claimant also complained to Dr. Ivy on April 3, 2014 of burning and tingling in both feet. In addition to this, the Claimant reported that she had hip pain, bilaterally for the last years, which was worse now. According to these notes, the Claimant was without fall or heavy lifting, but both legs and feet felt heavy plus tired. At that time, the Claimant also had burning, tingling in both feet. According to Dr. Burson, this causes concern for some kind of back problems where there are nerves being pinched or facet joint disease causing the back, legs, and hip to hurt.

On May 15, 2014, the Claimant presented to Dr. Antoon and complained of chronic ongoing pain and inability to work on her feet for long hours. She also had decreased range of motion in the back. Dr. Burson was of the opinion that these symptoms would trigger thoughts of possible back problems for which some kind of objective testing should have been done. On

<u>November 3, 2014, the Claimant complained to Dr. Antoon of low back pain. She continued with decreased range of motion. At that time, the Claimant was diagnosed with low back pain</u>.

The next treatment of record demonstrates that the Claimant complained of chronic back pain on December 2, 2014 to Dr. Antoon. At that point, Dr. Antoon noted that the Claimant was dependent on narcotics. He agreed that Dr. Antoon stated that the Claimant had chronic preexisting low back pain. Dr. Burson confirmed that he performed surgery on the Claimant's lumbar spine. He agreed that the Claimant did not have complications from the surgery. Dr. Burson declared the Claimant to be at MMI in February 2017.

Dr. Burson confirmed that the Claimant was still having problems with some weakness. He assessed the Claimant with an impairment rating of 30 percent. He noted that the rating could be more accurate if she had undergone an FCE. However, Dr. Burson opined that the Claimant is not permanently and totally incapacitated or permanently and totally disabled from her work-related injury of January 23, 2014.

According to Dr. Burson, the Claimant aggravated something. However, he stated, "I don't think she had a traumatic type of injury." He was unable to find in his notes where the Claimant told him what happened on January 23, 2015. <u>Dr. Burson was also unable to opine whether the Claimant's symptoms was caused by an injury</u>. He also could not state whether the Claimant's symptoms were caused by the December 2, 2014 incident because she had prior back pain. Dr. Burson denied that the Claimant gave a history of injuring her back by a rug being pulled out from underneath her on December 19, 2014. As a result, Dr. Burson was unable to offer an opinion with regard to whether this alleged incident is related to the condition for which he treated the Claimant.

Dr. Burson denied that the Claimant provided him a history that on January 23, 2015, she had a mopping incident where she twisted and felt a pop and had pain in her back. As a result, he was unable to offer an opinion within a reasonable degree of medical certainty as to whether the January 23, 2015 incident caused the Claimant's back problems.

Next, Dr. Burson was shown a copy of Dr. Justin Seale's report from April 6, 2015, where he examined the Claimant. Per this report, the Claimant reported having injured herself on January 23, 2015 while mopping along with an initial work injury on December 2, 2014. Per said report, the Claimant provided a history of pain that radiated down both legs. According to this report, Dr. Seale assessed the Claimant with "Grade 2 spondylolisthesis, with degeneration at L4-5 with left facet cyst and neurogenic claudication and severe degenerative disc disease at L5-S1. He agreed that this is consistent with his assessment after examining the Claimant.

Dr. Seale opined that from a workers' compensation standpoint, the Claimant was at maximum medical improvement and did not have any objective findings of an injury. In addition, Dr. Seale opined that the Claimant's as well as her underlying objective findings of spondylolisthesis, "preexisted her work injury." Dr. Burson chiefly agreed that spondylolisthesis is more likely a gradual onset condition. However, he explained that it could happened traumatically due to trauma, such as a motor vehicle accident.

An MRI of the Claimant's back was performed, which the Claimant presented to Dr. Burson. The findings of this diagnostic test revealed, among other things, a cyst. Dr. Burson confirmed that this is usually a sign of arthritis. Another part of this MRI revealed that the Claimant had a disc protrusion with more prominent protrusion on one side pushing up against the nerve. This report also states that the Claimant has arthritis in the joints. At the bottom, the impression is degenerative disease. Dr. Burson opined that the findings of L4-L5 and L5-S1 are

more consistent with degenerative findings. He went on to opine that a cyst could result from repetitive twisting and turning.

On examination by the Claimant's attorney, he explained to Dr. Burson that the Claimant has alleged three separate injuries: one on December 2, 2014, one on December 19, 2014, and another one on January 23, 2015. Dr. Burson agreed that if someone has an acute incident, objective findings of muscle spasms usually show up the day of or the next day.

Dr. Burson was shown a copy of the Claimant's medical record dated December 3, 2014 from Butler Chiropractic Center. This report makes reference to the Claimant being involved in activities of mopping, sweeping, bending, lifting, and stooping. Dr. Burson agreed that the chiropractor, J. Rob Butler, stated that the Claimant had muscle spasms and he at least deemed it an acute injury. Dr. Burson further agreed that this report of a muscle spam is consistent with the findings that one sees in a patient one day following an acute incident.

Regarding a report from Dr. Griffin dated January 27, 2015, it indicates that the Claimant has mild straightening of the lordotic curve. Dr. Burson agreed that this is consistent with a muscle spasm. On February 9, 2015, Dr. Antoon assessed the Claimant with low-back strain and continued the Claimant on Flexeril and Tylenol No. 3.

The Claimant underwent an MRI of her lumbar spine on March 2, 2015. Dr. Burson agreed that this MRI showed a broad-based protrusion at L5-S1. Dr. Burson confirmed that the findings at L4-5 and L4-S1 are in fact degenerative in nature. However, Dr. Burson agreed that these degenerative findings could be exacerbated by an acute incident. Dr. Burson was not able to opine if the broad-based disc protrusion is chronic or acute because this is the first MRI of the Claimant's lumbar spine. He was also unable to opine if the spondylolisthesis preexisted the

Claimant's work injury. On April 8, 2015, Dr. Seale placed the Claimant at maximum medical improvement and returned her to work at full duty.

Dr. Burson also placed the Claimant at maximum medical improvement following her surgery. However, since the Claimant had ongoing symptoms, her referred her to pain management and has not followed-up with her since. Dr. Burson denied that his assessment of a 30% permanent impairment has changed based on anything presented to him during his deposition. He confirmed that he performed surgery at L5-S1. Dr. Burson agreed that the Claimant continued with symptoms of radiculopathy when her last saw her. Based on the history presented to Dr. Burson by the Claimant, he opined that the incident at work was the major cause of her need for treatment and permanent impairment.

Under further questioning by the Respondents' attorney, Dr. Burson confirmed that since the X-ray ordered by Dr. Ivy (McGee) failed to reveal osteoarthritis of the hips, that the Claimant's complaints would lead him to believe that there is an indication that the Claimant had something going on consistent with low-back pain radiating into the hips. He further agreed that it is possible that the diagnosis of osteoarthritis of the hips was a misdiagnosis of a low-back injury.

<u>Dr. Burson agreed that on page 2 of the exhibit, Dr. McGee noted abnormal findings on her examination of the Claimant's back. The date of service was January 29, 2013. Again, Dr. McGee noted the same thing on January 9, 2014</u>. Dr. Burson agreed that muscle spasms are consistent with a muscle strain.

<u>Medical Evidence</u>

My review of the medical record shows that on January 29, 2013, the Claimant sought medical treatment from Dr. Ivy McGee due to musculoskeletal-joint stiffness in the hip and leg.

On January 2, 2014 the Claimant sought medical treatment from her primary care physician, Dr. Patrick Antoon, due to low back pain. The Claimant reported that she had chronic back pain and was able to work only part-time, due to chronic lumbar pain.

The Claimant returned to Dr. McGee for a follow-up visit on January 9, 2014. At that time, she complained of hip stiffness.

On January 23, 2014, the Claimant sought treatment from Butler Chiropractor Center due to low back pain, general stiffness, hip pain, and various other complaints.

The Claimant complained of back, hip, leg and foot problems on April 3, 2014 to Dr. Ivy McGee. As a result, X-rays of the Claimant's hip was ordered. On April 10, 2014, X-rays of the Claimant's right hip revealed no acute findings.

On December 2, 2014, the Claimant presented to Dr. Antoon due to low back pain. There is no mention of a work injury. However, Dr. Antoon assessed the Claimant with, among other things, chronic pain syndrome, low back pain and lumbosacral radiculopathy. At that time, Dr. Antoon refilled the Claimant's prescriptions of Norco. He also noted that the Claimant was dependent on narcotics from previous use.

Further review of the medical records reveal that on December 3, 2014**,** the Claimant sought treatment from Chiropractor Butler for her back. At that time, she complained of acute low back and leg pain while moving a patient and mopping the floor on December 2, 2014. On palpation of the Claimant's back, Butler noted, in relevant part, that a muscle spasm was apparent in the lumbar and bilateral lower lumbar regions. Specifically, Butler wrote, in part:

> RADIODRAPHIC ANALYSIS
>
> The lumbar curve is increased. There is no scoliosis of the lumbar spine. X-rays were reviewed by Dr. Antoon. A Grade 1.5 spondylolisthesis is noted at L4.

> Diminished disc height with associated osseous changes is consistent with the following levels: L5-S1.
>
> The diminished disc height with associated osseous changes is consistent with the middle stages of degenerative joint disease.
>
> CONCLUSIONS
>
> The radiographs do not indicate that there are any contraindications to osseous adjustments; physiotherapeutic modalities or other procedures included in chiropractic care.
>
> After a review of the subjective and objective findings for Ms. Watson, the following diagnosis was established on December 3, 2014.
>
> Primary Spondylolisthesis, Lumbosacral 756.12
> Secondary Disc Degeneration, Lumbar 722.52
>
> ***
>
> FREQUENCY OF TREATMENT
>
> Margaret [sic] stated that she would report her injury to her supervisor.

Dr. Rodney Griffin evaluated the Claimant on January 23, 2015 due to severe pain of the upper back, mid back, lower back, hip, thigh, lower leg, and foot. The Claimant described her injury as: "I was mopping I was in a twist couldn't untwist." Dr. Griffin assessed the Claimant with low back strain, for which he ordered a medication regimen and physical therapy, which was done at Quantum Rehabilitation. The medical records demonstrate that this therapy was performed from January 18, 2015 through February 11, 2015.

An MRI was performed of the Claimant's lumbar spine on March 2, 2015, with the following relevant findings:

> L2-3: Mild to moderate facet arthropathy. No canal or foraminal stenosis.
> L3-4: Mild to moderate facet arthropathy without canal or foraminal stenosis.
> L4-5: Very severe facet arthropathy. Hypertrophy of posterior ligamentum flavum. Small synovial cyst long the medial aspect of the left facet joints. Broad-based disc bulge. Moderate to severe canal stenosis.
> L5-S1: There is a broad based subligamentous disc protrusion somewhat more prominent in a posterior left paracentral location. There is mild to moderate effacement of the ventral thecal sac which is quite small at this level. Disc material abuts the anterior margin of both

> S1 nerve roots. No significant central canal stenosis. Mild compromise of the inferior aspect of both lateral recesses and mild to moderate right foraminal narrowing.
>
> IMPRESSION:
> Degenerative disease, as described above.

The Claimant saw Dr. Griffin on March 4, 2015 for a follow-up visit due to back pain. He opined that the MRI of the Claimant's lumbar spine revealed very severe facet arthropathy at L4-5, L5-S1 with broad based disc protrusion. Dr. Griffin assessed the Claimant with "DDD of the lumbar spine and chronic back pain," for which he ordered a medication regimen.

On March 13, 2015, the Claimant presented to Dr. Antoon for a follow-up visit. The Claimant complained of low back pain, muscle weakness, and numbness. He assessed the Claimant with "low back pain, muscle weakness, paresthesia, spinal stenosis, and lumbar region, with neurogenic claudication." As a result, Dr. Antoon referred the Claimant to Dr. Timothy Burson, a neurosurgeon.

Dr. Justin Seale performed an initial evaluation of the Claimant's lumbar spine on April 6, 2015. The Claimant reported a twisting work-related injury while mopping on January 23, 2015. She reported that her initial injury was on December 2, 2014, which was reported as a workers' compensation injury. At that time, the Claimant had pain in the back that radiated down both legs, which was worse on the left. The pain was aching and burning in nature. The Claimant had gone through physical therapy with no improvement of her pain. After reviewing the Claimant's lumbar X-rays and MRI, Dr. Seale assessed the Claimant with "1. Highly mobile grade 2 spondylolisthesis, degenerative, L4-5 with left facet cyst and neurogenic claudication[sic] 2. Moderate to severe degenerative disc disease with disc protrusion, L5-S1. However, Dr. Seale returned the Claimant to work with restrictions of no bending, no lifting over 20 pounds and no twisting. At that time, Dr. Seale opined:

> The patient's MRI does not show fracture or disc protrusion. There are signs of spondylolisthesis which is pre-existing. There are no objective findings of acute injury. However, the patient's symptoms began on and after work injury. The patient has no <u>history of pain in the low back or down the leg prior to the work injury</u>. Therefore, it is within a certain degree of medical certainty that at least 51% of the patient's current symptoms are directly related to her work injury.
>
> On April 8, 2015, Dr. Seale opined wrote the following letter:
>
> To Whom It May Concern,
>
> Today I was provided with a clinic note from this Watsons [sic] primary care physician dated December 2, 2014. This note stated that the patient has chronic low back pain and leg with opiate dependence secondary to this. Thus, the patient's pain as well as her underlying objective findings of spondylolisthesis or existing to her work injury.
>
> Therefore, the patient is at maximum medical improvement from a workers comp standpoint.
>
> The patient's work restrictions are to return back to work full duty without restrictions.
>
> The patient's impairment rating will be 0% because her condition is pre-existing.
>
> I'm releasing the patient from my medical care but would like to see her back outside of the Worker's [sic] Compensation setting to help her with her problem.
>
> I will see the patient back only as needed.
>
> If there are any questions or concerns, please contact my clinic at 501-663-8900.

Dr. Tim Burson evaluated the Claimant on May 12, 2015 due to low back pain. The Claimant gave an onset date of December 2, 2014. The severity of the Claimant's pain was moderate, and the occurrence was worsening and persistently. She further described her pain as burning, deep, sharp, shooting, stabbing, and throbbing. The Claimant gave an injury of mobbing[sic] and felt a pop and burning sensation. Dr. Burson assessed the Claimant with "Lumbar spinal stenosis and lumbago." The Claimant requested an epidural steroid injection (ESI) before undergoing surgery.

On June 8, 2015, the Claimant underwent “1. Fluoroscopically guided needle localization of the L4-5 bilateral and lumbar facet injection. 2. Fluoroscopic guided lumbar translaminar epidural steroid injection,” by Dr. Thomas A. Hunley. Findings included concordant provocation L4-5 facets.

The Claimant followed-up with Dr. Antoon on June 9, 2015. At that time, he opined that the Claimant did not get relief from the ESI. He assessed the Claimant with “Low back pain; Neuropathy of lower extremity; Lumbar spondylolysis; Acquired spondylolysis, and Lumbosacral radiculopathy.”

On June 23, 2015, the Claimant presented to Dr. Burson due to continued complaints of low back pain. The problem was worsening and occurring more persistently. The Claimant reported that she was mopping and heard a pop. Her symptoms were noted to be relieved by hydrocodone. Aggravating activities included bending and daily activities. Dr. Burson assessed the Claimant with “lumbago and DDD (degenerative disc disease) lumbar.” He noted that the Claimant’s MRI showed significant DDD at L5-S1. At that time, Dr. Burson opined that the Claimant failed conservative measures to this point. He discussed surgical intervention with the Claimant, in the form of a PLIF at this level and after much discussion she requested that he schedule it.

The Claimant continued to follow-up with Dr. Antoon for her back pain and refills on her pain medication prescriptions. On October 6, 2015, Dr. Antoon noted that the Claimant’s discomfort was most prominent in her lower lumbar spine. This radiated to her left buttock. She characterized it as constant, severe, dull, and aching. She also had left hip pain, which was chronic and ongoing, along with bilateral leg and hip pain. The Claimant used a walker to ambulate.

On March 16, 2016, Dr. Burson authored an operative report, which reads in relevant part:

PREOPERATIVE DIAGNOSIS: Degenerative disk disease L5-S1 with right lower extremity radiculopathy.

POSTOPERATIVE DIAGNOSIS: Degenerative disk disease L5-S1 with right lower extremity radiculopathy.

PROCEDURES:
1. Posterior lumbar interbody fusion, right L5-S1 with allograft spacer 9 mm Stryker dowel.
2. Arthrodesis L5-S1 with autograft and allograft bone.
3. Allograft spacer placement x1.
4. Interoperative spinal navigation.

The Claimant saw Dr. Burson for a follow-up visit on March 29, 2016 following her back surgery. She complained of pain in her low back. The Claimant ambulated without assistance. Her incision was healing well. However, the Claimant was in quite a bit of back and RLE pain, for which she was taking Flexeril, but it was not helping. His assessment was intervertebral disc degeneration, lumbosacral region.

On May 10, 2016 the Claimant presented to Dr. Burson. He opined that the status of the patient had not changed. The Claimant reported pain in the LBP/left shin. The frequency of her pain was persistent. At that time, the Claimant ambulated with a rolling walker. X-rays were performed that same day, with an impression of: "8 mm of L4-5 anterolisthesis."

The Claimant presented to Dr Burson on June 16, 2016 with some improvement. She reported pain in both hips and feet. X-rays were performed with an impression of "Fixed overall alignment on flexion versus extension." Dr. Burson opined that the X-rays looked ok. His assessment was "Other intervertebral disc degeneration, lumbosacral region." She stated to Dr. Burson that she wanted to go to pain management.

On December 12, 2016, the Claimant underwent initial evaluation by Dr. Ahmad Rafi, with Pain Treatment Centers of America for chronic pain as a new referral. She complained of pain in her lower back, buttocks, and hips for several years. The Claimant reported that her low back pain,

which was manageable with rest, activity, medication, home exercise problems and current medications. Dr. Rafi's assessment included "Lumbago; Lumbosacral spondylosis with radiculopathy; Failed back syndrome, lumbosacral; Sacroiliitis; Chronic pain syndrome; and Long-term current use of opiate analgesic. The Claimant continued to have low back pain despite surgical intervention. At that time, the claimant was being prescribed hydrocodone 10/325. Dr. Rafi continued the Claimant on a medication regimen which included hydrocodone.

The Claimant returned to Dr. Burson's office on January 10, 2017 due to a worsening of pain in her low back. She was using medication as prescribed with fair response. Hannah Ellis, APRN, assessed the Claimant with "Other intervertebral disc degeneration, lumbosacral region. AP/Lat X-rays showed hardware intact and good alignment and fusion. Ellis opined that the Claimant's had Grade 1 L4/5 spondylolisthesis, but this was not consistent with her low back pain complaints. The Claimant refused to pursue further injections.

Dr. Antoon continued to see the Claimant on a monthly basis for refills of medications relating to her back and other unrelated conditions.

On September 29, 2017 Dr. Antoon saw the Claimant for a follow-up visit for medications. She continued to complain of low back pain and other related symptoms of stiffness, numbness in the legs, radicular pain and weakness in the legs. At that time, Dr. Antoon opined that this was a chronic problem. He opined that the event that precipitated with pain was job- related repetitive lifting. Dr. Antoon stated, "This occurred at home."

The Claimant continued to follow-up with Dr. Antoon on a monthly basis for refills of medications relating to her chronic back pain and other unrelated conditions.

Dr. Burson opined on July 5, 2019 that the Claimant had reached MMI. He also stated that the Claimant had a 30% impairment rating based on the *A.M.A. Guides to Evaluation of Permanent*

Impairment, 4th Edition. He also opined that the Claimant was not totally incapacitated from working due to her injury of January 23, 2015. Dr. Burson noted that a formal FCE/IME was needed, but the Claimant should be able to perform sedentary work. He stated that his opinions were based upon a reasonable degree of medical certainty.

Counsel for Respondents No.1 wrote to Dr. Steven Nokes on April 19, 2021 asking him to review the MRI disc from March 2, 2015 of the Claimant's lumbar spine and advise what objective medical findings are observable. She also asked him if the disc revealed any objective medical findings traceable to the injury dates of December 2, and December 19, 2014; and January 23, 2015. Finally, counsel asked him to advise if the findings on the MRI are chronic and thus preexisting the earliest date of injury of December 2, 2014, which was four (4) months prior to the MRI.

On May 14, 2021 Dr. Steven Nokes rendered an opinion in this claim after reviewing the March 2, 2015 MRI of the Claimant's lumbar spine and film of the lumbar spine dated December 2, 2014 and January 27, 2015. Dr. Nokes opined that the studies were identical, revealing grade 1-2 spondylolisthesis at L4-5 with severe degenerative changes at L5-S1 with moderate to severe facet arthropathy at L4-5 and L5-S1. Per Dr. Nokes, the MRI of the lumbar spine dated March 2, 2015 was interpreted as: Degenerative disease, as described above. Dr. Nokes opined, in relevant part:

> By history the patient has had several injuries dated 12/2/2014, 12/19/2014 and 1/23/2015. The findings on the MR of the lumbar spine reveal no changes that could be attributable to the acute trauma 3-4 months before this scan. The severe facet arthritis at L4-5 has taken years to develop as has the anterolisthesis of L4 on L5 secondary to this facet arthritis. The L4-5 synovial cyst is also chronic. The grade 4/5 degenerative disc changes at L5-S1 with accompanying Modic type 1 endplate changes are long-standing as is the left paracentral disc protrusion with facet arthritis and bony hypertrophy (enlargement) of the facets. The findings correlate exactly with the plain film previously interpreted on 12/2/2014 and 1/27/2015.

> In conclusion to a reasonable degree of medical certainty and more likely than not the findings on the patient's MR of the lumbar spine date 3/2/2015 are all long-standing and chronic and are not attributable to injuries 3-4 months prior to the examination.
>
> Note the form report conclusion was also: Degenerative disease.

<u>Documentary</u>

A Form AR-N was completed on December 4, 2014. The Claimant reported that she was mopping when a client yelled to her, and she twisted her back. Per this document, the Claimant's accident date was December 2, 2014. She notified her employer of her alleged injury on December 3, 2014.

The Claimant reported to Brenda McKamie, her supervisor, on December 22, 2014 that she slipped on an area rug, injuring her lower back. Her date of injury was December 19, 2014 and she reported the incident that same day.

On January 23, 2015, the Claimant reported to Ms. (Brenda) McKamie that on that earlier that day, she injured her low back again while mopping. She essentially stated while mopping she began having uncontrollable pain running up and down her lower back.

<u>Adjudication</u>

<u>Compensability</u>

The Claimant contends that she suffered injuries to her low back as a result of her employment with the respondent-employer/Southwest Arkansas Development Council (SWADC) during three separate incidents, specifically on December 2, 2014; December 19, 2014; and on January 23, 2015.

In that regard, "Compensable injury" means an accidental injury causing 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. Ark. Code Ann. § 11-9-102(4)(A)(i) (Repl. 2012). A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4)(D). The Claimant must prove by a preponderance of the evidence that she sustained a compensable injury. Ark. Code Ann. § 11-9-102(4)(E)(i).

Here, the Claimant worked for the respondent-employer from 1991 until 2015. She performed employment duties of a CNA. The Claimant has alleged that she sustained an injury to her low back on December 2, 2014, while performing duties at the home of a client. Her testimony demonstrates that she injured her back when a client yelled to her, and she turned suddenly and heard a pop in her back. Per the Claimant, she had a hard time straightening back up. The Claimant testified that she promptly reported the incident to her supervisor that day and sought treatment for her back that same day.

In fact, the medical evidence demonstrates that the Claimant was diagnosed with muscle spasms by Chiropractor Butler on December 3, 2014. This muscle spasm was established by Butler's physical examination of the Claimant's lumbar spine and X-rays. As such the medical evidence establishes the existence of an injury. However, neither the medical nor non-medical evidence establishes a causal relation between the alleged December 2, 2014 incident and Claimant's low back problem (a muscle spasm) revealed by Butler.

In other words, the Claimant's assertion of an injury on December 2, 2014 does not comport with the evidence of record. The Claimant's own self-serving testimony and unsubstantiated assertion that she sustained an injury specific incident injury on December 2, 2014 as a result of her employment is the only evidence in this claim that might theoretically, support such a finding. However, after having observed the Claimant's demeanor during the hearing and

comparing her testimony with the other evidence of record, I found that the Claimant was not a credible witness for the following reasons.

The medical reports and documentary evidence of record do not support the Claimant's contention she sustained an injury on December 2, 2014 incident. Although the Claimant sought medical treatment from Dr. Antoon on December 2, 2014, there is absolutely no mention of a work injury. She also testified that she reported the alleged incident to her supervisor on the day of the event. However, the Form AR-N (dated December 4, 2014) establishes that the incident was reported to management after the Claimant's office visit with Chiropractor Butler on December 3, 2014. Per the Claimant's deposition testimony, she was unable to recall how the December 2, 2014 incident occurred. However, ultimately her deposition testimony demonstrates that she indicated that she injured her back "just working, probably helping a client out of the shower." This account of what happened differs from the one wherein the Claimant testified during the hearing that she was mopping and twisted her back.

Moreover, the Claimant complained of similar back and related symptoms just months prior to the alleged incident. The medical records indicate that the Claimant was being prescribed hydrocodone and other prescription medications for her chronic pain. In light of the prescription for such a strong narcotic medication, this leads me to conclude that the Claimant was experiencing significant back and other related symptomology prior to the alleged incident. Additionally, the medical evidence (particularly the X-rays and MRI) clearly shows that the Claimant suffered from significant preexisting degenerative disc disease prior to December 2, 2014. Under these circumstances and considering all of the foregoing inconsistencies and discrepancies in the Claimant's testimony, I am persuaded that it would require speculation and conjecture to conclude that the Claimant's low back condition (a muscle spasm) was caused by

her employment duties on December 2, 2014. Hence, conjecture and speculation, even if plausible, cannot take the place proof. *Dena Construction Company v. Herndon*, 264 Ark. 791, 575 S.W. 2d 155 (1979). Therefore, on the basis of the record as a whole, I find that the Claimant failed to establish a causal relationship between her back aliment and her work activities on December 2, 2014.

Accordingly, the Claimant failed to prove by a preponderance of the evidence that her need for treatment and disability for her low back arose out of and during the course of her employment, and that her low back ailment was the result of the alleged specific incident of December 2, 2014. As a result, this claim for a low back injury on December 2, 2014 is hereby respectfully denied and dismissed in its entirety. All other issues related to this claim for a low back injury on December 2, 2014, have been rendered moot and not discussed herein.

Regarding the December 19, 2014 alleged incident, the Claimant alleges to have injured her back while performing employment duties for the respondent-employer when a client pulled a rug out from under her and she almost fell. The Claimant testified on cross examination that she saw Dr. Antoon on December 19, 2014, for her back condition; however, I am unable to find this alleged medical record in any of the documentary medical evidence of record. In fact, during the period of time from December 19, 2014 until the Claimant's next incident of January 23, 2015, she did not seek any medical treatment. Under these circumstances, I am compelled to find that the Claimant failed to establish a compensable low back injury by medical evidence support by objective findings.

Therefore, this claim for a low back injury on December 19, 2014 is hereby respectfully denied and dismissed in its entirety. All other issues related to this claim for a low back injury on December 19, 2014, have been rendered moot and not discussed herein.

With respect to the Claimant's incident of January 23, 2015, the respondent-carrier initially accepted this as a compensable injury and paid some benefits as noted above. Since this time, Respondents No. 1 have controverted this claim in its entirety.

I find that the Claimant proved by a preponderance of the evidence that she sustained a temporary aggravation of her preexisting degenerative disease of the lumbar spine. The Claimant essentially testified that she injured her back while mopping the home of a client. She promptly reported this incident and sought medical treatment from Dr. Griffin on that same day. At that time, Dr. Griffin assessed the Claimant with low back strain, for which he ordered a medication regimen along with other conservative care of physical therapy treatment. The Claimant has objective medical findings of a muscle spasm as noted by Dr Burson during his deposition. Specifically, Dr. Burson opined that per Dr. Griffin's report of January 27, 2015, he indicated that the Claimant had mild straightening of the lordotic curve, which is consistent with a muscle spasm. The medical evidence and non-medical evidence establish that the Claimant sustained a lumbar strain in the course of her employment. Under these circumstances, I find that the Claimant has established all the necessary elements for a compensable lumbar stain on January 23, 2015.

Subsequently, on April 8, 2015, Dr. Seale opined that the Claimant reached the end of her healing period/MMI for her work incident of January 23, 2015.

The Claimant underwent an MRI of the lumbar spine on March 2, 2015 which revealed, among other things, very severe preexisting degenerative disc disease for which Dr. Burson performed lumbar surgery. However, all of these degenerative abnormalities on said MRI preexisted the Claimant's compensable incident and are not causally related to her January 23, 2015 work-related incident. In addition to this, the Claimant was symptomatic prior to the first

alleged incident of December 2, 2014, for which she sought medical treatment and was prescribed hydrocodone. As such, I have attached significant weight to Dr. Seale's April 2015 expert opinion considering that the abnormalities revealed on the MRI are longstanding and chronic in nature and are consistent with the natural process of aging and those changes that naturally result from degenerative disc disease. I have also attached significant weight to Dr. Nokes' expert opinion since it comports with Dr. Seale's opinion and in light of the significant preexisting degenerative changes displayed on the MRI.

Of note, Dr. Burson opined that he was unable to attribute the MRI findings to the Claimant's work since there was no prior MRI.

To summarize, I find that the Claimant's proved all the necessary element for a lumbar strain injury on January 23, 2015, which resolved no later than April 8, 2015. As such, Respondents No. 1 have paid all appropriate benefits. All other issues have been rendered moot and are not discussed in this Opinion.

Alternatively, the Claimant alleged a gradual onset injury to her back, however, since the Claimant proved she sustained a compensable temporary aggravation of her preexisting degenerative disc disease condition of her lumbar spine on January 23, 2014, the issue of a gradual onset injury has been rendered moot and not discussed in this Opinion.

Order

The Claimant failed to prove by a preponderance of the evidence that she sustained a compensable back injury on December 2, 2014 and December 19, 2014. The Claimant proved by a preponderance of the evidence that she sustained a temporary aggravation of her preexisting degenerative condition of the lumbar spine while working for the respondent-employer on January

23, 2015, which resolved no later than April 8, 2015. All other issues have been rendered moot and not discussed herein this Opinion.

IT IS SO ORDERED.

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CHANDRA L. BLACK
Administrative Law Judge