BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

ROMINEE FLORES (RYALS)	)	
Claimant	)	
V.	)	
	)	
MEDICALODGES, INC.	)	AP-00-0462-201/CS-00-0452-730
Respondent	)	AP-00-0462-202/CS-00-0452-731
AND	)	
	)	
UNITED WISCONSIN INS. CO.	)	
Insurance Carrier	)	

ORDER

The respondent and its insurance carrier (respondent), through Benjamin Gary, requested review of Administrative Law Judge (ALJ) Steven Roth's preliminary hearing Order, dated November 2, 2021. William Phalen appeared for the claimant.

RECORD AND STIPULATIONS

The Board adopted the same stipulations and considered the same record as the ALJ, consisting of the following exhibits and the case file:

Claimant:

- A1– Deposition Transcript of Dr. Lowry Jones, M.D. (9/14/21)
- A2– Discovery Deposition of Claimant (1/5/21)
- A3– Medical report of Dr. Lowry Jones, M.D. (3/15/21)
- A4– Medical report of Dr. Pedro A. Murati, M.D. (10/14/20)
- A5– Notice of Intent (6/15/21)
- A6– Preliminary Hearing testimony of Claimant (9/23/21), with exhibits B1-B3
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Respondent:

- B1– Deposition Transcript of Megan Lawrence (10/13/21)
- B2– 5/19/20 medical report from Independence RHC
- B3– 6/15/20 medical report from Coffeyville Regional Medical Center
- B4– Employee Statement of Injury

The parties stipulated to the admission of the following exhibits filed in HE-00-0039-076:

- C1– 5/19/20 medical report from Independence RHC (duplicative of B2)
- C2– 6/15/2020 medical report from Coffeyville Regional Medical Center (duplicative of B3)
- C3– Accident Investigation Report
- C4– Claimant (PH) Worksheet (1/29/21)
- C5– Employee Voluntary Separation Agreement
- C6– Employee Statement of Injury (duplicative of B4)
- C7– Employee Warning Notice
- C8– Investigation Witness Statement of Facts by Jami Daniels
- C9– Medical Report of Dr. Pedro A. Murati, M.D. dated 10/14/20 (duplicative of A4)
- C10– Investigation Witness Statement of Facts by Megan Lawrence

ISSUE

Did the claimant sustain injuries by accidents occurring on May 17, 2020, and May 29, 2020, which arose out of and in the course of her employment?

FINDINGS OF FACT

The respondent is a residential care facility. The claimant worked for the respondent as a CNA/CMA from April 2020 to November 2020.

In 2015, the claimant injured her left shoulder while working for Dollar General. In 2017 or 2018, she injured her shoulder in a tubing accident. The claimant testified her symptoms completely resolved after these prior accidents and she was pain free with no restrictions. On March 12, 2019, the claimant was seen at NetWare Urgent Care. She reported assisting a patient lift when she heard a pop and felt pain in her left shoulder and neck. She was diagnosed with a left shoulder strain. The claimant testified she made a complete recovery.

Regarding the first asserted accident of May 17, 2020, the claimant testified she assisted a male resident from his wheelchair to his bed. During the transfer, the male resident fell back into the wheelchair and pulled the claimant down with him. The claimant testified she felt a pop and sharp pain in her left shoulder, extending into the base of her neck. She testified she immediately reported the accident, as described, to Megan Lawrence, the respondent's administrator. According to the claimant, Ms. Lawrence told the claimant she would have to use her own insurance for medical treatment because of her prior shoulder accidents. The claimant testified she filled out an accident report and left it in Ms. Lawrence's box. The claimant did not retain a copy. All additional dates refer to 2020, unless specified otherwise.

The claimant testified she worked the next two days, but her condition worsened. On May 19, she went on her own to Lori Isle, ARNP, at Independence Regional Health Center. She reported left shoulder and neck pain after stretching her arms above her head and feeling a pop. The history provided was a left shoulder injury a year earlier, with multiple reinjuries, and neck pain starting 3-4 days ago after stretching and hearing a pop. The claimant was diagnosed with a left shoulder injury and cervical spine pain. Nurse Isle prescribed medications and ordered an MRI. Nurse Isle stated, "Patient states that she has had the cervical spine pain in the past and resolves on its own. Patient's main concern is the shoulder since she has already completed 2 rounds of PT and is having continued pain in shoulder."[1] The claimant was assessed with a left shoulder injury and cervical pain, prescribed pain medication, taken off work for a few days, and told to follow up with her primary care physician if there was no improvement.

The claimant returned to work on May 22. She testified she was told to copy in her own handwriting an employee statement of injury from a completed pre-statement. The "Employee Statement of Injury" stated: "I stretched my arms above head & neck & shoulder popped. Sharp shooting pain down neck & shoulder."[2] The document states "not work related" in the right margin.[3] The claimant testified Ms. Lawrence told her to write the incident was not work related because she had prior shoulder injuries.

On May 25, Ms. Lawrence completed an investigation report and submitted it to the respondent's workers compensation carrier. The claimant testified she soon received a call from the workers compensation case manager telling her they were setting her up with a doctor.

According to the claimant, on May 29, she sustained a second accident while helping a female resident move from her chair to the bed. The claimant was told the resident was full weight bearing, so she was only there to assist if needed. The claimant testified when the resident was halfway to the bed, she fell on top of the claimant, pinning her against the wall. The claimant testified she was in this position for almost ten minutes before she was able to get out from underneath the resident. The claimant testified she reported the accident to Ms. Lawrence, who told her to fill out an accident report and put it in her box. The claimant did not retain a copy.

The claimant originally testified the second accident was on July 9, but conceded it could have occurred May 29, based on the medical records. The claimant amended her Application for Benefits to assert an accident on May 29, not July 9.

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[1] Resp. Ex. B2.

[2] Resp. Ex. B4.

[3] *Id.*

At the respondent's request, the claimant saw Mary Beth Hartley, ARNP, at Coffeyville Regional Medical Center, on June 15. The history provided was the claimant stretched her arm above head on May 17, and heard a loud pop and had immediate pain in her left shoulder which radiated up her neck and down her left arm. The claimant also reported assisting a resident back to bed from a chair on May 29, when the resident dropped her weight and pinned the claimant against the wall for about ten minutes. The claimant was diagnosed with an acute left shoulder strain. Nurse Hartley ordered physical therapy and an MRI, provided work restrictions, and referred the claimant to a specialist, Dr. Lin.

The claimant testified she saw Dr. Lin on July 21, July 29, August 11 and September 3. The doctor recommended physical therapy, administered a cortisone injection and recommended nerve testing. Shortly after August 11, the claimant received a call from the workers compensation case manager indicating they were placing her medical treatment on hold pending further investigation. No medical records from Dr. Lin are in evidence.

On September 9, the respondent completed an "Employee Voluntary Separation Agreement" indicating the claimant quit her employment with the respondent during a phone conversation. The claimant denied resigning.

At her attorney's request, the claimant saw Dr. Pedro Murati on October 14. The doctor diagnosed: (1) left ulnar cubital syndrome; (2) left lateral epicondylitis; (3) left radial nerve entrapment; (4) left shoulder impingement; (5) left bicipital tendonosis; (6) left AC sprain; (7) myofascial pain syndrome of the left shoulder girdle extending into the cervical paraspinals; (8) neck pain with signs of radiculopathy; and (9) left occipital neuropathy. Dr. Murati opined the two work accidents were the prevailing factor in the development of the claimant's conditions. The doctor recommended a bilateral upper extremity NCS/EMG, an MRI of the cervical spine, physical therapy, anti-inflammatory and pain medications, a tennis elbow splint, cortisone injections, occipital blocks and referral to an upper extremity orthopedic specialist.

Following a preliminary hearing, the ALJ appointed Dr. Lowry Jones to perform a Court-ordered independent medical examination. The claimant saw Dr. Jones on March 15, 2021. The claimant told Dr. Jones her first accident involved attempting to move a resident from a wheelchair, but the resident fell back into the wheelchair, pulling the claimant down with the resident, and the second accident involved a resident pinning her against a wall in a failed wheelchair to bed transfer. Dr. Jones diagnosed the claimant with: (1) left-sided cervical myofascial injury, with associated possible cervical radiculopathy; (2) left shoulder injury, which appears to be mostly bicipital pain, with possible SLAP tear of the left shoulder; and (3) possible ulnar neuropathy of the left upper extremity at the elbow. Dr. Jones opined the two accidents were the prevailing cause for the claimant's present ongoing neck and left upper extremity pain and need for further evaluation and/or treatment. The doctor issued temporary work restrictions and

recommended a cervical MRI scan, a left upper extremity EMG, and referral to a physiatrist. Pending results of the MRI and EMG, the doctor recommended possible injections and referral to an upper extremity surgeon.

Dr. Jones acknowledged the history given to him by the claimant differed from the employee statement form and Nurse Isle's note dated May 19. Particularly, the aforementioned documents refer to an injury from stretching without mention of lifting a resident. The doctor agreed the claimant likely would not have hurt herself simply from stretching her arms above her head, unless she already had a symptomatic left shoulder, and testified, "it's kind of pending on what the truth of the mechanism of injury was."[4] Dr. Jones agreed medical records and injury reports sometimes describe an accident inaccurately. Dr. Jones maintained his opinion the claimant sustained work-related injuries necessitating medical treatment.

Megan Lawrence still works for the respondent. She was the respondent's administrator for over seven years. She handled workers compensation issues and was in charge of the entire facility, residents and staff.

Ms. Lawrence testified she was not at the facility on May 17. She testified she was first notified of the claimant's accident the next day, May 18, when the claimant said "she was stretching at the med cart and had reached up and felt her shoulder pop."[5] The claimant told her she had gone to the emergency room because the left shoulder was bothering her and provided her personal insurance information to them, but the emergency room had asked if it was workers compensation. Ms. Lawrence denied telling the claimant she could not file a workers compensation claim and denied receiving an accident report the claimant had filled out and put in her box. Ms. Lawrence testified the normal procedure when a workers compensation claim is alleged is for her to fill out a link on the intranet and print out paperwork for completion. Ms. Lawrence filled out a link on the intranet on May 18. She admitted the paperwork may have been completed on May 22, but denied providing the claimant with a pre-statement filled out or telling the claimant to write it was not work related. Ms. Lawrence denied any knowledge of the claimant subsequently being pinned against a wall by a resident or the claimant having informed her of such incident.

Following the submission of evidence, the ALJ stated:

> The Court finds that these two accidents happened. One on May 17, 2020, and another on May 29, 2020; they happened at work, and by work being done by the Claimant for the Respondent.

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[4] Cl. Ex. A1 at 23.

[5] Resp. Ex. B1 at 7.

> At this point, all the medical records now on file which address prevailing factor find those two work accidents to be the prevailing factor, despite Claimant's past shoulder accidents. They also hold that Claimant needs treatment. While causation and prevailing factor might be challenged later by other medical professionals, that is how things stand today.

The respondent argues the claimant did not sustain personal injury by accident arising out of and in the course of her employment. The respondent asserts the claimant is not credible as her story and dates have changed throughout her testimony. The claimant maintains the Order should be affirmed.

PRINCIPLES OF LAW AND ANALYSIS

An employer is liable to pay compensation to an employee incurring personal injury by accident arising out of and in the course of employment.[6] A claimant must prove his or her right to an award based on the whole record under a "more probably true than not true" standard.[7]

K.S.A. 44-508(f) states, in part:

> (1) "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.
>
> (2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.
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> . . .
>
> (B) An injury by accident shall be deemed to arise out of employment only if:
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> (i) There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
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> (ii) the accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment.

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[6] See K.S.A. 44-501b(b).

[7] See K.S.A. 44-501b(c) and K.S.A. 44-508(h).

There are discrepancies in the evidentiary record. There is a difference between the claimant being initially injured simply from stretching her arms above her head, as opposed to having the weight of a resident fall into a wheelchair during a transfer. As noted by Dr. Jones, it would be unlikely the claimant was injured simply from stretching her arms above her head. Dr. Jones maintained his opinion the claimant was injured at work and the prevailing cause was her work injuries.

There is a difference between the second event occurring on May 29, as compared to July 9. However, the June 15 report from Nurse Hartley references the incident as occurring on May 29. The second accident could not have happened on July 9.

The fact Ms. Lawrence was not at work on a day the claimant says she informed Ms. Lawrence of the initial accidental injury, May 17, is of small consequence. Ms. Lawrence was aware of the asserted accident on May 18 and completed computer work and paper work for a workers compensation claim.

The undersigned Board Member concludes claimant was injured as alleged, namely transferring residents, and not from merely stretching her arms above her head. Largely based on the opinion of the Court-ordered physician, Dr. Jones, the undersigned Board Member finds the claimant was initially injured at work when transferring a resident on May 17, 2020, and injured again transferring a resident on May 29, 2020. The claimant was injured in accidents arising out of and in the course of her employment on both occasions. The claimant proved the prevailing factor component of K.S.A. 44-508.

WHEREFORE, the undersigned Board Member affirms the November 2, 2021, Order.

IT IS SO ORDERED.

Dated this _____ day of January, 2022.

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JOHN F. CARPINELLI
BOARD MEMBER

c: (via OSCAR)
William Phalen
Benjamin Gary
ALJ Steven Roth