

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E914169

EDITH M. TAYLOR,
EMPLOYEE

CLAIMANT

CITY OF LITTLE ROCK,
EMPLOYER

RESPONDENT

RISK MANAGEMENT RESOURCES,
INSURANCE CARRIER/TPA

RESPONDENT

OPINION FILED MARCH 15, 2004

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

Claimant represented by HONORABLE PHILIP M. WILSON, Attorney
at Law, Little Rock, Arkansas.

Respondents represented by HONORABLE BETTY J. DEMORY,
Attorney at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Affirmed in part
and reversed in part.

OPINION AND ORDER

The claimant appeals an administrative law judge's
opinion filed April 21, 2003. The administrative law judge
found that total knee replacement surgery and gastric bypass
surgery were not reasonably necessary. The administrative
law judge found that the claimant was not entitled to
temporary total disability compensation from August 20, 2001
to April 8, 2002. The administrative law judge also found
that the claimant was not entitled to permanent partial
disability. After reviewing the entire record *de novo*, the
Full Commission reverses the opinion of the administrative

law judge regarding denial of knee surgery, temporary total disability, and impairment rating, but affirm as to denial of gastric bypass surgery. We find that the claimant proved she was entitled to total knee replacement surgery. We find that the claimant proved she was entitled to temporary total disability compensation from August 20, 2001 to April 8, 2002, and that the claimant proved she sustained permanent impairment in the amount of 37%.

I. HISTORY

Edith Taylor, age 47, informed Dr. James W. Bryan, IV in June 1996 that she had been having increased pain in her left knee. The past medical history reported to Dr. Bryan included arthritis of the right knee, and Dr. Bryan indicated that the claimant had undergone "Arthroscopic meniscectomy right knee 2/1995." Dr. Bryan noted that the claimant was "morbidly obese with genu valgum knee alignment, she has a mild effusion with moderate patellar apprehension." Dr. Bryan recommended surgery on the claimant's left knee.

Dr. J. Roger Clark reported on August 1, 1996, "Two weeks ago, she slipped on a wet floor and hit her right knee which she had scoped about a year ago and has had a lot of trouble with her right knee, almost equaling the left knee

symptoms. She is here because she is scheduled for a left knee arthroscopy and wants to review her right knee findings....She has a positive patellar apprehension sign, 2+ crepitation, hurts with McMurray maneuver, has no apparent instability or effusion. X-rays are reviewed and she has subluxation of this patella that matches her opposite side." Dr. Clark's impression was "Contusion, right knee with subluxation patella....If this will settle down, I would not recommend any procedure in the right knee. If, however, when her surgery date arrives for the left, if she continues to be plagued equally with the right knee, I would recommend a scope at that time and possible (sic) a lateral release."

Dr. Clark performed surgery on both knees on August 16, 1996. Surgery on the right consisted of "Right knee, lateral tibial plateau, medial/lateral femoral condyle and patellar chondroplasties using the laser," "Right knee partial lateral meniscectomy," and "Right knee lateral retinacular release."

The parties stipulated that the claimant sustained a right knee injury on November 2, 1999. The claimant testified, "I was hit by a car. She hit me with the bumper of her car across both of my knees....When she hit me, it

rocked me back, but I fell forward onto the hood of her car." The claimant presented to Dr. Jimmy Tucker on November 16, 1999:

She was struck by a car at work approximately two weeks ago on 11/2/99. The vehicle apparently struck both of her knees with the bumper. She has had increasing pain symptoms of popping and catching since that time in both knees....

On physical examination today on the right side she has slight effusion. She has full extension....No varus or valgus instability. She is neurovascularly intact distally and skin is in good condition.

Dr. Tucker assessed "Possible lateral meniscal tears in both right and left knees," and he arranged diagnostic testing. An MR of the right knee was taken on November 30, 1999, with the following impression:

1. Degenerative type tear of the body of the lateral meniscus associated, with moderate degenerative arthritic changes in the lateral compartment. There is mild subchondral femoral marrow edema.
2. Moderate lateral patellofemoral chondromalacia.
3. Small joint effusion.

An MR of the left knee also showed "Tear of the body and posterior horn of the lateral meniscus, probably degenerative in type" and "Small joint effusion."

Dr. Tucker reported on December 1, 1999:

X-RAYS: They were reviewed from last week. Again, she has some mild degenerative changes of the

patella and some mild peaking of the intercondylar notches, however, there are no signs of any fracture or other pathology on rosenberg, merchant, AP and lateral views.

MRI report of the right knee shows a lateral meniscal tear with some moderate changes of the articular cartilages in the lateral compartment. On the left knee, it shows a tear of the posterolateral meniscus. There are no signs of any ligamentous injuries.

Dr. Tucker assessed "Bilateral meniscal tears," and he planned "bilateral arthroscopies and partial lateral meniscectomies." Dr. Tucker performed surgery on both knees on January 6, 2000. This surgery included "diagnostic arthroscopy, right knee," "partial lateral meniscectomy, right knee," "laser chondroplasty of the medial femoral condyle (separate compartment), right knee," and "laser chondroplasty of the lateral femoral condyle (same compartment), right knee."

The respondents initially controverted liability for the January 6, 2000 surgery.

The claimant informed Dr. Tucker on February 8, 2000, "she is having some instability problems with the right knee. The right knee buckled and she fell." Dr. Tucker noted "a moderate effusion on the right side" and planned continued "aggressive physical therapy." Dr. Tucker stated on March 7, 2000 that there was "chondral damage to the

right knee" which "would be improved using a lateral J brace." The claimant continued to follow up with Dr. Tucker. On April 4, 2000, Dr. Tucker noted after reviewing x-rays, "The patient has a severe increase in degeneration in the lateral compartment, post injury. I think there is a significant component of synovitis to this injury."

Dr. Tucker wrote to the claimant's attorney on April 10, 2000:

In regards to Ms. Edith Taylor she indicated to me that she was struck by a car at work, hitting both knees. I certainly think this is a significant degree to cause lateral meniscal tears along with chondral damage to both knees. She has had some previous problems with her knee, but according to the patient was doing well after her previous treatment until she was struck by the car.

With this information it is my opinion that the major cause of the damage to Ms. Taylor's knees were (sic) the result of being struck by an automobile at work. She is not anywhere close to reaching maximal medical improvement, so there is no way to give you an opinion regarding permanent partial impairment.

A bone scan was taken on April 20, 2000, with the impression, "Findings in the right knee suggest mild synovitis, particularly laterally over the femoral condyle. There is also mild arthritic change in the right tibial articular surface." Dr. Tucker noted on May 2, 2000, "She is still having some swelling even in her lateral J

brace....After her previous bone scan, which noted a large amount of synovitis, she continues to have symptoms of synovitis along the lateral side of the joint. She is only mildly improved with physical therapy and iontophoresis."

Dr. Kenneth M. Rosenzweig independently evaluated the claimant on May 10, 2000:

[T]he patient has had two episodes of bilateral knee arthroscopies. There is mention in Dr. Clark's note two weeks prior to her surgery in August 1996 that she had had previous right knee arthroscopy a year prior to this but the patient did not reveal in history and was specifically asked if she had had any other knee surgeries other than the two bilateral procedures in question. There are no medical records available for my perusal regarding the 'prior knee surgery on the right' that would make a total of three surgeries on the right as opposed to two as reported by the examinee....

She has been back to work for the past month with restricted activities with limited time on her feet and lifting restriction over 15 lbs. She has had two corticosteroid injections to her knees, the last one last week....

Clinical Diagnosis Include pedestrian trauma secondary to alleged vehicular assault by a robbery suspect while on the job as a security officer for the city at a local library, bilateral knee contusions with resulting chondromalacia, chondral fractures, meniscal tears and contusions with pre-existing degenerative arthritis of both knees with previous surgeries that were apparently asymptomatic, non-insulin dependent diabetes, progressive degenerative/traumatic arthritis of her right more so than left knee....

The patients (sic) presenting complaints of knee pain post-operatively are consistent with her arthroscopic findings and history of trauma. It is certainly a possibility had (sic) asymptomatic arthritic changes in both knees secondary to patellofemoral syndrome from genu valgus excessive Q angle and morbid obesity. It is within expectations that the vehicular assault that she sustained to both knees could have exacerbated and aggravated her underlying arthritic changes but there is no question that there were pre-existing problems to her knees prior to this date or injury in question as documented by previous arthroscopic reports....

Prognosis for recovery from these injuries is somewhat guarded on the right knee. X-rays reviewed that were brought in by the patient show progressive joint space narrowing of the lateral compartment of the right knee with genu valgus. Her post knee injury film reveals narrowing of the lateral compartment but joint space remaining approximately 5 months post op in April 2000 of the lateral compartment of the right knee appears to be very close to bone on bone changes.

Ms. Taylor reports that she was functioning fine prior to this injury but the degenerative arthritis is progressive documented by a series of x-rays. Her persistent pain, stiffness and swelling is consistent with the radiographs and arthroscopic findings....It is felt due to severe cartilaginous injuries, meniscectomies, abnormal joint forces with near complete loss of joint space in the lateral compartment suggests that the right knee will continue to degenerate and debilitate to the point that she may require at some point in time total joint arthroplasties for complete restoration of her knee motion, function and relief of pain....

In conclusion, it appears that the major cause of Ms. Taylor's treatment and subsequent surgery as a result of the vehicular-pedestrian trauma on November 2, 1999 is within reasonable medical

certainty. The findings on MRI and subsequent surgery would suggest a portion to be pre-existing but without question the mechanism of the trauma is contributory to permanent aggravation of her knees. It is not out of the realm of medical expectation that anterior injuries to the knee with direct blows can generate a latent onset of problems and a similar concept as a parallel, if you drop an apple to the floor and immediately look at it, it looks fine, but a few days or weeks later the area of contact has softened and bruised. The secondary fissuring and delamination would be consistent with that form of impact....

An adjuster testified that the respondents accepted compensability of the claim in about May 2000, including the medical treatment the respondents had initially controverted and temporary total disability compensation.

On June 9, 2000, Dr. Tucker assessed "Severe degenerative changes in the lateral compartment of the left (sic) knee secondary to being struck by a car. I would like to avoid any other surgery on Ms. Taylor. I do not think we have a lot to offer her surgical wise besides a osteotomy or a total knee replacement." The impression of Dr. Bryan on July 12, 2000 was "Exacerbation of DJD of the right knee." Dr. Bryan planned additional conservative treatment.

Dr. Tucker assessed the following on September 26, 2000:

Lateral compartment degenerative joint disease. I discussed this patient with Dr. Lowry Barnes. I am sending her to him for a second opinion. I

think we have exhausted all conservative measures and feel this patient is too young for a total knee if we could possibly do an osteotomy. He is going to evaluate her for a femoral osteotomy.

The claimant began treating with Dr. C. Lowry Barnes on September 28, 2000, who wrote, "I have explained to her that weight loss is going to be very important. She has already lost 50 pounds." Dr. Barnes arranged additional diagnostic testing, and wrote on October 10, 2000, "Her MRI showed no evidence of avascular necrosis."

After diagnosing "morbid obesity," Dr. Rex E. Luttrell performed a "cholecystectomy" and "Roux-En-Y gastric bypass" on November 16, 2000. The claimant testified that she underwent the gastric bypass "To reduce my body weight so that the surgery on my knee would be more successful."

Dr. Barnes reevaluated the claimant on June 4, 2001:

She is having pain about her right knee. She had done well. She had lost 75# following her gastric bypass by Dr. Luttrell.

She had rather acute onset of right knee pain...

RADIOGRAPHS: Do not show significant change. She has bone on bone changes, lateral compartment.

We discussed treatment options at length. We will proceed with arthroscopy and open osteotomy of her distal femur. We will try to arrange this with Dr. Jimmy Tucker as well.

The parties stipulated that the claimant was last paid benefits through August 20, 2001.

Dr. Tucker informed the claimant's attorney on August 20, 2001, "I do not believe that Edith Taylor has reached her maximal medical improvement at this time. She is scheduled for a distal femoral osteotomy with Dr. Lowry Barnes for extreme degenerative changes of the lateral compartment of the right knee."

Dr. Barnes reported on August 27, 2001:

She underwent arthroscopy last week by Dr. Tucker and myself. We had planned to do a distal femoral osteotomy for her.

Once she was asleep, we were told that she had significant clunking medially. Arthroscopically, she was found to have a large lesion in the medial compartment as well as the lateral compartment.

She is not a candidate for osteotomy. She will ultimately (sic) require total knee replacement.

Dr. Luttrell told the claimant's attorney on September 5, 2001, "Regarding your question as the reason for the gastric bypass for Ms. Taylor, her knee problems were most definitely related to her weight. It is my understanding that knee replacement surgery is not as successful in the morbidly obese patient unless they lose an adequate amount of weight. Once this occurs, knee surgery is much easier,

recovery is faster, and the return to a more functional level of activity is achievable.”

Ms. Taylor claimed entitlement to additional worker's compensation. The claimant contended that she was entitled to reasonably necessary medical treatment. The respondents controverted liability for the claimant's knee replacement on the right. The respondents contended that the claimant's treatment was not causally related to the injury, but was due to a pre-existing condition. The respondents contended that the claimant's gastric bypass surgery was not a compensable consequence and was not causally related to the compensable injury. The respondents contended that the claimant did not obtain "preauthorization" for gastric bypass surgery or knee replacement surgery. The respondents contended that if compensability was found, then the claimant was not entitled to an anatomical impairment rating.

The parties deposed Dr. Barnes on April 16, 2002. Dr. Barnes testified on questioning by the respondents:

Q. Was the total knee basically due to the degenerative condition in her knee?

A. The fact that she had arthritis. Again, how much of that is post-traumatic and how much of it is just degenerative, you can't tell by looking....

Q. When you did the total knee replacement, did you also see the large lesion or the other problems going on in the knee joint when you went in?

A. Yes.

Q. Could you identify from that point what had caused those conditions to develop?

A. No. Once you have the end point, you can't really tell how it got there....

Q. How has she progressed after the knee replacement?

A. Great functional range of motion, good strength, but pain.

Q. Is that something you would expect from a total knee replacement?

A. No. Not the pain part....

Q. Have you released Ms. Taylor back to any type of employment at this time?

A. I don't think that's been addressed actually. Certainly, she could do lots of sedentary activity. As with all knee replacements, I don't recommend strenuous activities that require a lot of bending, squatting, stooping, that kind of thing or heavy lifting.

Q. Okay. But, based upon your examination of her last week, you feel like she could perform some employment activities?

A. I do....

Q. But, as far as you're concerned from the total knee she recovered well from objective standpoint?

A. Yes....

Q. So, at this point, she's not, as far as your standpoint is concerned, required to use any type of device?

A. She's not.

Q. So, doctor, I guess as I understand from your testimony here today, the total knee replacement was due to just the overall degenerative condition, arthritic condition, in her knee and that you can't state within a reasonable degree of medical certainty what caused her to have the arthritic condition that lead (sic) to the total knee replacement, is that a fair assessment?

A. That's correct. My observation from day one was that somebody had already determined that this was related to her injury and that's why the patient was being treated by workers' comp when I saw her.

The claimant's attorney queried Dr. Barnes:

Q. Doctor, are you aware that in November of 1999, this patient was struck by a car on both knees?

A. Yes, I knew that she had had treatment for that in the past by Dr. Tucker. I didn't treat her at the time....

Q. Assuming that her symptoms, her severe symptoms, began with that blow, would you have an opinion as to whether or not the need for your treatment, the major cause, and legal major cause is one over 50%, the major cause for your care and treatment was in fact that blow to the knee?

MS. DEMORY: Objection, calls for speculation on the part of the physician since he did not evaluate her immediately or in fact almost a year after the incident.

A. My treatment was based upon the fact that she was referred to me by Dr. Tucker for treatment for

what he had been treating and a continuation of that problem. It was his impression that she had had normal knees up until the time she got hit by the car, and then she required medical treatment and it sounds as if that was when she started having problems and needed to be treated.

Q. Okay. Again, here's what I think the facts are, and this is a hypothetical, she had the prior problem with the kneecaps that you explained and it appears that she is overweight. So, I would assume there would be some normal degeneration because of her weight and she had that prior kneecap injury. I believe that to be the only two problems she had prior to getting struck by an automobile. But, she began having severe symptoms very shortly thereafter, a couple of days thereafter, had some symptoms immediately and some severe symptoms a couple of days after she went to the doctor and from that point forward has been having severe problems with her knees. Assuming that's the facts, assuming that's the facts presented to the judge and the judge accepts those, would you have an opinion based upon those facts as to whether or not the need for your treatment was in fact the trauma caused by the blow to the knees?

A. Most likely what I normally say when I'm asked this question is we have a period of time, I think you said 1996 when she had her first treatment and this injury was in 1999.

Q. Right.

A. Then, to me it's a matter of the employee record, doctor visits, prior - between 1996 and 1999, we knew that the lady worked every day for three years and never had a knee problem and never missed work to go to the doctor because of her knee, didn't take medication for her knee, and, functioned normally, and then there's acute changes and didn't do that anymore, then that appears so....

Q. But, as my letter indicated, if that history is correct, then would it be your opinion that the major cause, again legal major cause -

A. I understand the question. Yes, it would be.

Q. That opinion would be stated within a reasonable degree of medical certainty?

A. Correct.

Q. As I understand what you also told Ms. Demory, that the end of the healing period would be approximately April the 8th of this year, is that correct?

A. Six months following surgery.

Q. At that point in time you would release her to sedentary sit down type work, is that correct?

A. Or walking type activities on a limited basis, but no heavy lifting, squatting, stooping.

The parties deposed Dr. Tucker on November 13, 2002.

Dr. Tucker testified for the respondents with regard to the surgery he performed in January 2000:

Q. What type of procedure did you perform on the right knee?

A. On the right knee we did debridement of a meniscal tear. We did debridement of a toggle tear which is the articular cartilage of both the medial side and debridement of a degenerative area on the lateral side....

Q. Okay, and could you determine from the surgery that you performed what caused the damages. Was it something that had developed over time?

A. As far as the chondral tear, the medial from chondral and the meniscual (sic) tear appeared to

be acute injuries with the chondrosis from the lateral femoral chondral and its that's (sic) an uncertain origin, it could either be a traumatic injury or degenerative....

Q. It looks like you authored one more report on August 20, 2001.

A. Yes, this is my report.

Q. Okay, and in that report it looks like you indicated that her need for additional treatment was due to her extreme degenerative condition.

A. Yes. Extreme degenerative changes in the lateral compartment.

Q. Okay. And Doctor, can you state within a reasonable degree of medical certainty that the degenerative condition is something that just developed over time and is not related to the automobile accident that she initially described to you in November of 1999?

A. No. I can't state within a reasonable degree of medical certainty that it's not related to the accident. That's what you asked for. I can't state within a reasonable degree of medical certainty that it's not related to the accident.

Q. Okay. Are you then saying that the degenerative condition is related to the accident?

A. It's my feeling that the degenerative condition was at least partially caused, if not significantly caused, by the accident, including the need for menisctomy (sic) which causes in and of itself, degenerative changes.

Q. Would it not be true if she had had that same type procedure in 1995 of (sic) 1996 that the degeneration would have continued from that point?

A. If she had had a meniscectomy.

Q. Yes.

A. Yes it could have certainly.

Q. So there is really no way of determining how much degeneration came from the 1995 or 1996 surgery on the right knee as opposed to your surgery that you performed in January 2000, is that true?

A. There is no absolute way to tell that.

Q. And also, there is no way to tell how much of the degeneration was caused by her weight as opposed to the surgery in accident she had in late 1999 and early 2000?

A. No.

The claimant's attorney examined Dr. Tucker:

Q. I'm gonna show you a report that you authored in April 10, 2000 and I'm gonna ask you a few questions about this report, and this is in the records. In this report you indicated that Ms. Taylor indicated to you or told you that she was struck was a car at work and that would have been in November of 1999 to the best of you (sic) knowledge?

A. Yes.

Q. And, she had also indicated to you that she did have previous problems with one knee but was getting along fine before this accident, is that correct?

A. Yes.

Q. You said with this information it was your opinion that the major cause of the damage to Ms. Taylor's knees was the result of being struck by the automobile while at work. Does that remain you (sic) opinion?

A. Yes.

After a hearing before the Commission, the administrative law judge found, "The preponderance of the evidence reflects that the total knee replacement surgery for the claimant's right knee, and gastric by-pass surgery were not reasonably necessary or related to the claimant's compensable injury." The administrative law judge found that the claimant was not entitled to temporary total disability or permanent partial disability. The claimant appeals to the Full Commission.

II. ADJUDICATION

A. Reasonably necessary medical treatment

An employer must promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). The claimant must prove by a preponderance of the evidence that she is entitled to additional medical treatment. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.3d 543 (1999). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W.2d 750 (1984).

In the present matter, the Full Commission finds that the claimant proved she was entitled to right knee

replacement surgery. The parties stipulated that the claimant sustained a right knee injury in November 1999. The claimant testified that she was struck on both knees by the bumper of a car. The claimant testified that this specific incident arose out of and in the course of her employment with the respondents. Dr. Tucker performed bilateral knee surgery in January 2000. The respondents eventually accepted compensability of this surgery and provided medical treatment related to the claimant's resulting physical condition. Dr. Tucker opined in March 2000 that the claimant had sustained "chondral damage" to her right knee. Dr. Tucker wrote in April 2000, "it is my opinion that the major cause of the damage to Ms. Taylor's knees" was "the result of being struck by an automobile at work." The Full Commission expressly notes that we are not analyzing this claim pursuant to the "major cause" provisions of Act 796 of 1993. We cite Dr. Tucker's "major cause" opinion as evidence that Dr. Tucker causally related the claimant's right knee condition to the November 1999 compensable injury.

In May 2000, Dr. Rosenzweig opined that the claimant's post-operative complaints of knee pain were consistent with the claimant's arthroscopic findings and history of trauma.

Dr. Rosenzweig described "bone on bone" changes in the claimant's knee, and stated, "the right knee will continue to degenerate and debilitate to the point that she may require at some point in time total joint arthroplasties for complete restoration of her knee motion, function and relief of pain." Dr. Rosenzweig was aware that there was a pre-existing component to the claimant's condition.

Nevertheless, Dr. Rosenzweig opined, "without question the mechanism of the trauma is contributory to permanent aggravation of her knees." In June 2000, Dr. Tucker opined that the claimant's degenerative changes were "secondary to being struck by a car." Dr. Bryan likewise wrote in July 2000 that the claimant's degenerative condition had been exacerbated. In August 2001, Dr. Barnes described "extreme degenerative changes of the lateral compartment of the right knee." Both Dr. Barnes and Dr. Tucker opined at deposition that the claimant's compensable injury aggravated her pre-existing arthritic condition. Dr. Barnes essentially opined that the knee replacement surgery he performed was causally related to the November 1999 compensable injury. Dr. Barnes also opined that the claimant's physical condition improved following surgery. Post-surgical improvement is a relevant consideration in determining whether treatment is reasonably

necessary. Hill v. Baptist Medical Center, 74 Ark. App. 250, 48 S.W.3d 544 (2001), citing Winslow v. D&B Mech. Contractors, 69 Ark. App. 285, 13 S.W.3d 180 (2000).

The Full Commission recognizes that the claimant suffered from pre-existing degenerative arthritis in both knees. The claimant had in fact undergone two surgeries to the right knee before the November 1999 compensable injury. However, the employer takes the employee as she is found, and circumstances which aggravate pre-existing conditions are compensable. Nashville Livestock Comm'n v. Cox, 302 Ark. 69, 787 S.W.2d 664 (1990). The opinions of Dr. Tucker, Dr. Rosenzweig, Dr. Bryan, and Dr. Barnes all show that the claimant's need for medical treatment after November 1999 was the natural and probable result of her compensable injury. See, Bearden Lumber Co. v. Bond, 7 Ark. App. 65, 644 S.W.2d 321 (1983). Even if a finder of fact did somehow construe that the testimony of Dr. Barnes and Dr. Tucker was not stated within a reasonable degree of medical certainty, which the Commission does not find, a finding of causation in a worker's compensation case does not need to be expressed in terms of a reasonable degree of medical certainty when there is supplemental evidence supporting the causal connection. Heptinstall v. Asplundh Tree Expert Co.,

CA-0311 (Ark. App. 12-10-2003). Further, if the Commission were to find that the instant claimant would have eventually required knee replacement surgery whether or not the November 1999 specific incident occurred, such a finding would be the result of speculation and conjecture, which cannot supply the place of proof. Dena Construction Co. v. Herndon, 264 Ark. 791, 575 S.W.2d 155 (1979).

Pursuant to Ark. Code Ann. § 11-9-508(a), the Full Commission finds that the right knee replacement performed by Dr. Barnes was reasonably necessary in connection with the claimant's compensable injury. The respondents contended during the pre-hearing conference that the claimant's knee replacement was not "pre-authorized" pursuant to Commission Rule 30. Rule 30 is a comprehensive measure with extensive provisions regarding proper procedures for payment of medical costs. Cyphers v. United Parcel Service, 68 Ark. App. 62, 3 S.W.3d 698 (1999), citing Burlington Indus. v. Pickett, 336 Ark. 515, 988 S.W.2d 3 (1999). Rule 30 does not apply to a determination of whether a particular medical service is reasonably necessary, but simply states the respondents' duty to review itemized bills prior to payment for services. Brown v. Arkansas Trucking Services, Workers' Compensation Commission

E216726 (Sept. 26, 1995). Moreover, the record shows that Dr. Tucker, an authorized treating physician, expressly referred the claimant to Dr. Barnes for further treatment. The "pre-authorization" requirement of Ark. Code Ann. § 11-9-514 does not apply if an authorized treating physician refers a claimant to another doctor for examination or treatment. Byars Construction Co. v. Byars, 72 Ark. App. 158, 34 S.W.3d 797 (2000).

Pursuant to Ark. Code Ann. § 11-9-508(a), the Full Commission finds that the gastric bypass performed by Dr. Luttrell was not reasonably necessary in connection with the claimant's compensable injury. The claimant's election to undergo this operation did not arise as a result of the November 1999 compensable injury. Even if the gastric bypass did enable the claimant to more successfully recover from surgery, the perceived need for such an operation was not a natural and probable result of the claimant's compensable injury to her knee. The respondents are not liable for the treatment provided by Dr. Luttrell.

B. Temporary disability

The claimant sustained a scheduled injury, and she is therefore entitled to temporary total disability compensation during the time that she remains within her

healing period and has not returned to work. Wheeler Construction Co. v. Armstrong, 73 Ark. App. 146, 41 S.W.3d 822 (2001). The claimant apparently received some temporary total disability compensation through August 20, 2001, at which time the respondents controverted additional benefits. However, the record indicates that the claimant remained within her healing period at that time. Dr. Tucker specifically opined on August 20, 2001 that the claimant had not reached maximum medical improvement, and that the claimant was scheduled for additional surgery. Nor had the claimant returned to work at that time. Dr. Barnes subsequently testified that the claimant reached the end of her healing period from the knee replacement surgery on or about April 8, 2002. Temporary disability cannot be awarded after the healing period has ended. Trader v. Single Source Transportation, Workers' Compensation Commission E507484 (Feb. 12, 1999). Dr. Barnes also opined that the claimant could return to restricted work duty. The Full Commission therefore finds that the claimant proved she was entitled to additional temporary total disability compensation from August 20, 2001 through April 8, 2002.

C. Anatomical impairment

An injured worker must prove by a preponderance of the evidence that she is entitled to an award for a permanent physical impairment. Weber v. Best Western of Arkadelphia, Workers' Compensation Commission F100472 (Nov. 20, 2003). Ark. Code Ann. § 11-9-102(4)(F)(ii)(a) provides that permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment. Pursuant to Ark. Code Ann. § 11-9-522(g), the Commission has adopted the Guides to the Evaluation of Permanent Impairment (4th Ed. 1993) as an impairment rating guide. Any determination of the existence or extent of physical impairment must be supported by objective and measurable physical findings. Ark. Code Ann. § 11-9-704(c)(1).

In the present matter, Dr. Barnes testified that the claimant was entitled to a 37% impairment to the right lower extremity following knee surgery. Dr. Barnes based his opinion on objective physical findings which he observed. The Full Commission finds that the impairment rating assigned by Dr. Barnes was based on objective medical findings. We find that the claimant's compensable injury was the major cause of her anatomical impairment, pursuant to Ark. Code § 11-9-102(4)(F)(ii)(a).

Based on our *de novo* review of the entire record, the Full Commission reverses the opinion of the administrative law judge. The Full Commission finds that the claimant proved she was entitled to the total knee replacement surgery performed by Dr. Barnes. The claimant also proved that she was entitled to all of the other medical treatment provided for her knee by Dr. Barnes, Dr. Tucker, Dr. Rosenzweig, and Dr. Bryan. The claimant failed to prove that she was entitled to the gastric bypass surgery performed by Dr. Luttrell. We find that the claimant proved she was entitled to temporary total disability compensation from August 20, 2001 through April 8, 2002. The claimant proved that she was entitled to a 37% anatomical impairment rating, and that the claimant's compensable injury was the major cause of her anatomical impairment. The claimant's attorney is entitled to a fee on the amount of compensation pursuant to Ark. Code Ann. § 11-9-715(Repl. 1996). For prevailing on appeal, the claimant's attorney is entitled to an additional fee of two hundred fifty dollars (\$250), pursuant to Ark. Code Ann. § 11-9-715(b)(2)(Repl. 1996).

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

Commissioner Turner concurs in part and dissents in part.

CONCURRING AND DISSENTING OPINION

_____I concur with the findings in the principal opinion that respondent is liable for claimant's total knee replacement surgery; that claimant is entitled to benefits for temporary total disability from August 20, 2001 to April 8, 2002; and that claimant is entitled to benefits for a permanent anatomical impairment of 37% to the lower extremity. However, I must respectfully dissent from the finding that respondent is not liable for claimant's gastric bypass surgery.

With regard to respondent's argument that it is not liable for the expenses of the total knee replacement surgery because claimant did not obtain preauthorization pursuant to Commission Rule 30, I note, initially, that respondent has always zealously controverted claimant's entitlement to this surgery as not being causally related to the compensable injury. Respondent would not have preauthorized the surgery even if someone had submitted such a request. This argument is similar to a frequent assertion by some respondents that even though it has controverted a claim in its entirety, it will only be liable for treatment it has authorized if the claim is subsequently found to be

compensable. In other words, respondent controverts claimant's entitlement to any benefits but insists that claimant must receive treatment by the company doctor or another doctor it chooses. The Commission has rejected this argument and should likewise reject the argument in the present case.

Further, there is another reason respondent cannot prevail on this argument. In addition to the requirement in Commission Rule 30, Subpart S, that preauthorization is required for the designated services expected to exceed \$1,000, this provision states, "See Arkansas Workers' Compensation Hospital Inpatient Fee Schedule Part III for procedures for requesting preauthorization." Part III, Subpart A (Procedures for Requesting Preauthorization) provides the following:

1. The insurance carrier is liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subsection (7) of this section required to treat a compensable injury, where any of the following situations occur:

- (a) there is a documented life-threatening degree of a medical emergency necessitating one of the treatments or services listed in subsection (7) of this section;

- (b) the treating doctor, his/her designated representative, or

injured employee has received preauthorization from the carrier prior to the health care treatments or services; or

(c) when ordered by the Commission.

Thus, according to the plain language of this section, the insurance carrier is liable for reasonably necessary treatment when respondent has preauthorized the treatment or when ordered by the Commission. In the present case, since the Commission has found that respondent is liable for the medical expenses related to the total knee replacement surgery, preauthorization was not required.

Finally, I find that respondent is liable for the expenses associated with claimant's gastric bypass surgery. At the time of the compensable injury, claimant was morbidly obese. Claimant's preexisting obesity clearly does not disqualify this claim for benefits and any weight loss program that is reasonably necessary for treatment of her knee condition would be compensable. Conway Convalescent Center v. Murphree, 266 Ark. 985, 588 S.W.2d 462 (1979); Artex Hydroponics, Inc. v. Pippin, 8 Ark. App. 200, 649 S.W.2d 845 (1983); Weller v. Darling Store Fixtures, 38 Ark. App. 95, 828 S.W.2d 858 (1992). "The law does not require the employer to pay for medical expenses for the treatment of a preexisting disease not aggravated by the injury except

to the extent it may be necessary to accomplish treatment of the injury." Artex Hydroponics, Inc. v. Pippin, 267 Ark. 1014, 593 S.W.2d 473 (Ark. App. 1980). In my opinion, claimant has proven by a preponderance of the evidence that the gastric bypass surgery was reasonably necessary for treatment of her compensable knee injury.

For the foregoing reasons, I concur in part and respectfully dissent in part.

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents in part and concurs in part.

DISSENTING & CONCURRING OPINION

I must respectfully dissent in part and concur in part from the majority's opinion. It is undisputed that the claimant suffered a compensable knee injury in November of 1999. Evidence shows that she received proper treatment for this injury, and that the respondent provided all appropriate benefits. However, I find that the weight of the evidence simply does not prove that the total knee replacement of the claimant's right knee in 2000 and the gastric bypass surgery in 2001 were reasonably necessary or related to the claimant's compensable injury, in that a causal connection was not conclusively established by a

preponderance of the evidence. In my opinion, the claimant has failed to prove by a preponderance of the evidence that the total knee replacement and the gastric bypass surgery were reasonably necessary treatment for her compensable injury.

The facts in this case do not support a finding that the claimant's total knee replacement and bariatric surgeries were reasonable, necessary, and/or causally related to the claimant's compensable injury. Although the law is well established that "you take the claimant as you find them," the law does not require respondent to correct every pre-existing problem just to treat a compensable injury. As the Administrative Law Judge pointed out, no unequivocal medical evidence was presented in this case from which an accurate determination of the condition of the claimant's knees at time of the injury could be made. Moreover, the testimony and facts presented here strongly support the above-stated conclusion. First, evidence shows that this claimant had severe and chronic health problems, including the onset of degeneration and arthritis in her knees, well before her compensable injury of November 1999. She admitted to having injured her right knee prior to her surgery of 1996, which resulted in a tear like the one

repaired in her surgery after her compensable injury. Moreover, the claimant had arthroscopic knee surgery twice before her compensable injury to correct multiple problems with her knees. These surgeries were supposedly successful, at least in that the claimant did not receive treatment again relative to her knees until the time of her compensable injury. According to the testimony of Doctors Tucker and Barnes, however, the condition of the claimant's knees apparently continued to deteriorate during that time between her surgery of 1996 and her compensable injury of 1999, as evidenced by the advanced state of arthritis and degeneration found in her right knee at the time of her last two surgeries. Additionally, Dr. Barnes stated that there is no way of determining operatively how much damage is post-traumatic and how much of it is degenerative. The extent to which the claimant's pre-existing conditions contributed to her post-injury problems is, therefore, essentially unknown. This would lead reasonable minds to conclude that the claimant's arthritis had developed slowly over a period of time.

Further, as to the issue of causation, Dr. Barnes admitted having "assumed" that the claimant's compensable injury was the reason for her treatment. He testified that

his "observation from day one was that somebody had already determined that this was related to her injury and that's why the patient was being treated by worker's comp... ." Not suspecting that "anything else had gone on," he stated, "I didn't go back and take a full history as to [the claimant's] prior knee history,... , because it really wasn't relevant to my medical treatment of her."

Dr. Barnes testified that the decision for the claimant's total knee replacement was based upon the claimant's complaints of pain, X-rays, and findings commencing with the medical history that started with her compensable injury. According to Dr. Barnes, the knee replacement was to correct an arthritic condition which could have been caused by a number of factors, including obesity. The record also reveals that, due the claimant's relatively young age as opposed to the average life of total knee replacement, Dr. Barnes was initially opposed to the total knee replacement. Stating in pertinent part that it is "simply an elective operation to treat [a patient's] pain and get them some kind of function," factors that influenced the decision for total knee replacement versus osteotomy in this case included the claimant's symptoms and how she tolerated her functional activities secondary to pain from

the knee. Admittedly, the arthritic condition of the claimant's right knee was a key factor in making this determination. As for the claimant's prognosis, Dr. Barnes testified that she now has "great functional range of motion, good strength but *continued pain*" (emphasis added) which Barnes said, "is not expected from TKR." Dr. Evans, one of claimant's previous physicians, had predicted "chronic pain" for the claimant subsequent to her back injury in 1986.

I would agree with the Administrative law Judge that the evidence fails to support a finding that the total knee replacement was causally related to the claimant's compensable injury. I note, finally, that the MRI of the claimant's right knee taken immediately after her 1999 injury revealed that the meniscus tears were degenerative; the 1996 surgery indicated that the claimant had chondromalacia of both the medial and lateral femoral condyle; and, the evidence overwhelmingly shows that the claimant suffered from injury, arthritis, and other debilitating conditions for years before her compensable injury. In his testimony, Dr. Tucker admitted that a meniscectomy, which is the type of surgery that the claimant had on her knees prior to her injury, causes degenerative

changes. He further stated that "there is absolutely no way to tell" how much degeneration was caused by the 1995 or 1996 surgery on claimant's right knee, as opposed to the surgery that he performed in 2000. He also admitted that there is no way to tell how much of the degeneration was caused by the claimant's weight as opposed to her compensable injury.

Arguably, the recent Court of Appeals decision in Williams v. L& W Janitorial Inc., ___ Ark. App. ___, ___ S.W.3d ___ (Feb.4, 2004), may be seen to support the argument that the surgery is compensable because the compensable injury was "a factor" in causing a need for a knee replacement. However, I find that the facts in this claim are distinguishable from the facts in Williams. In Williams, both the claimant's doctors testified that the compensable injury was a factor in the claimant's resulting need for knee replacement surgery. Doctors Barnes and Tucker, the two surgeons to operate on the claimant's knee after her compensable injury, offer causation opinions which seem to support a finding that the claimant's degenerative changes were partially or significantly caused by the claimant's compensable injury. However, when the entire context of both Drs. Tucker and Barnes's medical reports and

depositions are read, I am not persuaded by this argument. As previously noted, I find Dr. Tucker's opinion to be equivocal. Dr. Tucker cannot state how much the claimant's previous knee surgeries in 1995 and 1996 attributed to the degenerative changes that lead to the need for knee replacement surgery. Likewise, Dr. Tucker cannot state how much the degenerative changes leading to the need for knee replacement surgery were caused by claimant's obesity or by the arthroscopic surgery necessitated by the compensable injury. In short, Dr. Tucker admitted that he cannot tell how much of the degenerative changes resulted or were caused by the accident. While Dr. Tucker opined that the compensable injury partially or significantly caused the claimant's need for knee replacement, Dr. Tucker admitted that there is no way to tell how much degenerative condition came from the 1995 or 1996 surgeries, claimant's obesity, or her post injury surgery. Accordingly, I find Dr. Tucker's opinion concerning the need for surgery to be speculative and unsupported by the evidence. Conjecture and speculation, even if plausible, cannot take the place of proof. Ark. Dept. of Correction v. Glover, 35 Ark. App. 32, 812 S.W.2d 692 (1991). Likewise, Dr. Barnes testified that one cannot tell by looking how much of the degeneration that

necessitated surgery was arthritic degeneration or post-traumatic degeneration. Dr. Barnes further testified that he could not identify how the degeneration developed. Dr. Barnes unequivocally agreed with the statement that "[he] could not state within a reasonable degree of medical certainty what caused her to have the arthritic condition that lead (sic) to the total knee replacement..." Accordingly, I do not accord any weight to the arbitrary opinion of these physicians.

Moreover, I do not read the court's decision in Williams, supra, to alter or change the manner in which we are required to analyze whether medical treatment is reasonably necessary when a pre-existing condition is present. The court in Williams held that the Commission's findings were not supported by a preponderance of the evidence. The Full Commission found in Williams that the appellant failed to prove a causal connection between the compensable injury and need for surgery. Rather, the court found that the compensable injury was "a factor" in the appellants need for surgery. I do not read this use of language to alter or change the well established analysis applied in these type cases. The issue continues to remain whether the medical treatment is "...reasonably necessary in

connection with the injury received by the employee.”

A.C.A. § 11-9-508(a). Many things factor into one's need for surgery. Is the patient symptomatic, asymptomatic, a diabetic, HIV positive, obese, a smoker, in critical condition, suffering from a chronic condition, in pain, or running a fever, just to name a few. These factors may in no way relate to the actual condition for which surgery is required. Likewise, a compensable injury to a pre-existing degenerative process may be a factor in determining the need for surgery. However, pursuant to statute, the relevant question has always been and continues to be, whether the compensable injury is causally related or causally connected to the need for treatment. In finding that the claimant prevailed in Williams, the court merely found that the commission erred in its interpretation of the evidence, it did not liberalize, broaden, or narrow the statutory provision, as it is specifically prohibited from so doing by A.C.A. § 11-9-1001.

As for the issue of preauthorization and Rule 30, I must respectfully disagree with the majority's dismissal of the argument. While Rule 30 may not apply to a determination of whether a particular medical service is reasonably necessary, Rule 30 certainly applies to whether

or not a carrier is liable for the charges incurred. The majority opinion equates Rule 30 with the Change of Physician law and authorized medical treatment. However, these two aspects of workers' compensation are as different as apples and oranges. Respondents do not argue that Dr. Tucker was not an authorized treating physician. Rather, respondents rightly argue that this authorized physician performed a procedure for which pre-authorization is required by Rule 30.

Rule 30, Part I, Subpart S, of this Rule states, in pertinent part:

Preauthorization is required for all nonemergency hospitalizations, transfers between facilities, and outpatient services expected to exceed \$1000.00 in billed charges for a single date of service by a provider.

It is illogical in this case to suggest that the claimant did not have, at the very least, some idea that her total knee replacement surgery was expected to exceed \$1,000.00 in billed charges. After all, she had become very familiar with these surgical procedures in the past, and she must have been aware of the costs involved. Even if she had not concerned herself with the cost issue, this was not emergency surgery. As noted by claimant's physicians, the

claimant's total knee replacement was "simply an *elective* operation to treat [a patient's] pain and get them some kind of function."

Furthermore, I cannot agree with Commissioner Turner's interpretation of Part III, Subpart A of the Fee Schedule. First, neither Rule 30 nor the Fee Schedule should be used to accomplish through the back door what cannot be achieved through the front. Part III, entitled Preauthorization, Subpart A sets forth the Procedures for Requesting Preauthorization. This very title presupposes that the procedure has not yet taken place. Obviously, preauthorization is not necessary for emergency treatment. Likewise preauthorization would be redundant following a hearing and Commission order finding that certain medical treatment is reasonable and necessary and must be provided at the carriers' expense. Preauthorization of medical treatment regardless of whether or not that treatment is reasonable and necessary is required under the provisions of Rule 30. Whether or not the treatment is reasonable and necessary is a statutory issue which is a completely separate issue and should be treated as such. The Fee schedule outlines the appropriate fees carriers can pay for treatment for workers' compensation injuries. It does not

abdicate to a claimant with an admittedly compensable injury for which medical benefits are being paid the right to ignore the requirement for preauthorization and obtain such treatment without the knowledge of the carrier. Such interpretation would render Rule 30 and preauthorization meaningless. Moreover, such interpretation would amount to a "back door policy" as a way around Rule 30 and the Fee schedule that was never intended.

Accordingly, even if the total knee replacement was reasonable and necessary medical treatment in connection with claimant's compensable injury, a finding I specifically do not make, I find that in accordance with Rule 30, claimant has failed to prove entitlement for the charges incurred with this hospitalization and treatment. Rule 30 practically mimics many health insurance policies which require pre-authorization for many services. Before undergoing non-emergency surgery many policies require the insured to notify the carrier of the treatment for pre-authorization. Without such pre-authorization, the carrier will not pay for the treatment. The claimant in this claim did not abide by Rule 30 and acquire pre-authorization. Since the claimant did not comply with the pre-authorization requirement of Commission Rule 30, I cannot find that the

respondent are responsible for the charges related to the total knee replacement even if the treatment is otherwise found compensable.

Since I find that the total knee replacement was not reasonable and necessary medical treatment, I must also respectfully dissent from the majority's finding that the claimant is entitled to temporary total disability benefits related to this period of healing.

With regard to the majority's finding that the gastric bypass procedure was not reasonably necessary, I whole-heartedly agree. Therefore I concur in this finding.

Therefore, for all the reasons set forth herein, I respectfully dissent in part and concur in part from the majority's opinion.

KAREN H. MCKINNEY, Commissioner