BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F704764 & F807757

MARK OWEN, EMPLOYEE	CLAIMANT
PEOPLEASE CORPORATION, EMPLOYER	RESPONDENT NO. 1
AMERICAN HOME INSURANCE COMPANY, INSURANCE CARRIER	RESPONDENT NO. 1
ARCH INSURANCE COMPANY INSURANCE CARRIER	RESPONDENT NO. 2

OPINION FILED MARCH 18, 2010

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

Claimant represented by the HONORABLE KENNETH OSBORNE, Attorney at Law, Fayetteville, Arkansas.

Respondents No. 1 represented by the HONORABLE FRANK B. NEWELL, Attorney at Law, Little Rock, Arkansas.

Respondent No. 2 represented by the HONORABLE WILLIAM C. FRYE, Attorney at Law, North Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed as modified.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed July 24, 2009. The administrative law judge found that the claimant proved he was entitled to additional medical treatment recommended by Dr. Tomlinson, and that "each respondent/carrier is liable for one half of the

expense of these medical services." The administrative law judge found that the claimant was temporarily totally disabled from December 10, 2008 through a date yet to be determined, and that Respondent No. 2 was solely liable for temporary total disability benefits. After reviewing the entire record *de novo*, the Full Commission affirms the administrative law judge's award of additional medical treatment and temporary total disability benefits. However, we find that Respondent-Carrier No. 2, Arch Insurance Company, shall be solely liable for additional medical treatment and temporary total disability benefits.

I. HISTORY

Mark Nathan Owen, now age 36, underwent an MRI of his right knee in May 2000: "REASON: Pain and swelling in right knee after patient slipped off truck and twisted his knee. The patient denies any previous knee surgery....IMPRESSION: TORN ACL BUCKET HANDLE TEAR OF THE MEDIAL MENISCUS WITH DISPLACED FRAGMENT IN THE INTERCONDYLAR NOTCH. DEGENERATIVE CHANGES OF THE MEDIAL FEMORAL CONDYLE. KNEE JOINT EFFUSION."

Dr. Nathan P. Cohen examined the claimant in August 2000:

> The patient is a 27 year old gentleman who sustained injury to his right knee on 5/7/00. He slipped on diesel fuel and twisted his right knee....MRI was performed disclosing multiple abnormalities in reference to his knee....
> The patient denies any previous difficulties beyond age 15 when he sustained to the knee riding an AVT (sic). He apparently saw a physician at that time. A contusion was identified. No sequela has occurred. The patient has been active in martial arts in the interim without difficulty....
> X-ray examination was performed disclosing old radiodensity in the region of the MCL medially....

Dr. Cohen diagnosed "1. ACL disruption - right knee. 2. Medial meniscus tear, right knee. 3. Potential old MCL injury, right knee." Dr. Cohen recommended "arthroscopic surgery of his knee to manage meniscus. I would favor managing the ACL at the same time with reconstructive procedure."

The record indicates that Dr. Cohen performed an anterior cruciate ligament reconstruction of the claimant's right knee on September 29, 2000. The pre- and post-operative diagnosis was "1. Anterior cruciate ligament insufficiency right knee. 2. Medial meniscus tear."

Dr. Cohen noted on December 6, 2000, "The patient underwent ACL reconstruction on 9/29/00. He is now 10 weeks postop. He denies any significant complaints in reference

to his knee. He denies any insecurity sensation. He states that the knee feels much better than preop."

Dr. Cohen noted on January 4, 2001, "I feel the patient may return to light duty with the restriction of no unloading of trucks for one month. He may return to full work duties. Disability is minimal based on his present findings. The patient is discharged at this time and will be followed on a p.r.n. basis in the future."

Dr. Tom Patrick Coker examined the claimant in October 2003: "Mark is about three years status post right ACL. He's been doing well and was at work. Pivoting on it, twisted and felt something pop on the inside. This was last week. He had sharp onset of pain, primarily medial. He was placed on a knee immobilizer....I don't feel any loose bodies but he has some spurs medially that are a little tender....His graft feels stable so I don't think he's hurt his graft and we discussed the possibility of scar tissue. I want him to start some physical therapy, anti-inflammatories, wear a neoprene brace with hinges might help it work and see how he does over the next few weeks."

The claimant testified that he began working for the respondent-employer in about November 2006. The claimant testified that he was an over-the-road truck driver for the respondent-employer. The parties stipulated that the employee-employer-carrier relationship existed between the claimant, Peoplease Corp., and Respondent-Carrier No. 1, American Home Assurance Company on May 4, 2007. The parties stipulated that the claimant sustained a compensable injury to his right knee on May 4, 2007. The claimant testified, "I was exiting a trailer and I stepped on my ICC bumper and my foot slipped off the ICC bumper and I landed on my right heel with my right leg locked, and it put a fracture inside of the knee and tore some cartilage inside of the knee, and I saw Dr. Tomlinson for that injury."

An MRI of the claimant's right knee was taken on May 4, 2007:

> HISTORY: This is a 33-year-old male with history of prior ACL repair and menisectomy with new onset knee swelling....
> IMPRESSION:
> 1. CORTICAL STEP-OFF ALONG THE POSTERIOR LATERAL TIBIAL PLATEAU WITH UNDERLYING BONE EDEMA SUGGESTING STRESS FRACTURE.
> 2. INTACT ACL GRAFT WITH EVIDENCE OF PRIOR MEDIAL MENISCECTOMY.
> 3. MULTIPLE FOCAL CARTILAGE DEFECT ALONG THE MEDIAL CONDYLE WITH GRADE IV DEGENERATIVE CHANGES.
> 4. LARGE JOINT EFFUSION.

Dr. Robert J. Tomlinson, Jr. began treating the claimant on May 9, 2007:

> Mark is a 33-year-old gentleman who misstepped, while working for People Lease as a driver, out of a trailer and twisted his right knee. He experienced immediate pain since that time....An MRI scan suggested a lateral tibial plateau fracture. He has had an ACL reconstruction on the right back on September of 2000 and has done quite well since that time. He says that the pain is 8/10 in intensity and nearly constant in frequency and is associated with motion....Evaluation of his x-rays is essentially normal. He does have a tibial tunnel and a femoral tunnel for an ACL graft.

Dr. Tomlinson's impression was "Lateral tibial plateau fracture." Dr. Tomlinson planned conservative treatment and returned the claimant to sit-down only work. Dr. Tomlinson returned the claimant to work without restrictions on July 20, 2007.

Dr. Tomlinson reported on August 17, 2007, "If Mark's symptoms warrant I would recommend arthroscopic evaluation and treatment of his right knee. I think the likelihood of having some intra-articular pathology, such as articular or meniscal damage, is fairly high because he continues to be symptomatic at three and a half months. We will proceed as per his wishes."

Dr. Tomlinson performed surgery on September 18, 2007: "1. Partial medial and lateral meniscectomy of the right knee. 2. Chondroplasty of the patellofemoral joint. 3. Major synovectomy." The post-operative diagnosis was "1. Medial and lateral meniscus tears of the right knee. 2. Chondromalacia of the patella. 3. Extensive synovitis."

Dr. Tomlinson returned the claimant to restricted work on September 21, 2007.

Dr. Tomlinson reported on November 2, 2007:

> Mark Owen is seen six and a half weeks following his right knee arthroscopy with partial medial and lateral meniscectomy of the right knee. He is doing well. He is pain free....He has full range of motion. Quadriceps tone is excellent.
>
> Objective factors of impairment: Status post partial medial and lateral meniscectomy of the right knee....
>
> Permanent Impairment: Based on the AMA Guide to Evaluation of Permanent Impairment, Mark would receive a 10% right lower extremity impairment, which would equal a 4% total body impairment.
>
> Work Status: He may return to work without restrictions.
>
> Future Medical Care: I do not anticipate Mark will require any future medical care for this condition.

The parties stipulated that Respondent-Carrier No. 1 "paid all medical benefits through November 2, 2007, all

temporary disability benefits through November 2, 2007, and permanent partial disability benefits for a permanent physical impairment of 10% to the body as a whole."

The claimant testified that he returned to full-duty work for the respondent-employer. On cross-examination by counsel for Respondent-Carrier No. 1, the claimant testified that he had no problems with his knee between November 2, 2007 and July 29, 2008.

The parties stipulated that an employee-employer-carrier relationship existed between the claimant, Peoplease Corp., and Respondent-Carrier No. 2, Arch Insurance Company on July 29, 2008. The parties stipulated that the claimant "again sustained a compensable injury to his right knee" on July 29, 2008. The claimant testified, "I slipped and fell in a Flying J truck stop in Hubbard, Ohio, and landed on my right knee with my right knee flexed....The employer's insurance sent me to Dr. Tomlinson." The claimant saw Dr. Tomlinson on August 1, 2008:

> Mark Owen is a 34-year-old gentleman who, while working for Comstar Enterprises as a truck driver, slipped and fell onto a flexed right knee on 07/29/2008. He experienced immediate pain and since that time has had pain 2/10 to 3/10 in intensity and nearly constant in frequency. He has had two knee surgeries, one an ACL reconstruction in 2000 and a right knee

> arthroscopy in 2007. He has fully recovered from those surgeries.
>
> Physical Examination: He has a trace antalgic gait on the right. He is tender along the inferior pole of the patella he has trace positive patellofemoral crepitus and grind. Evaluation of his x-rays reveals mild patellofemoral tilting.

Dr. Tomlinson's impression was "Patellofemoral contusion....We will set Mark up for therapy....He may return to work. Sit down only. No climbing."

Dr. Tomlinson reported on August 18, 2008, "Mark Owen is seen three weeks following his right knee patellofemoral contusion. He is still having pain in his knee. He says by the end of the day he has sharp pain behind his kneecap....He has a 1+ positive patellofemoral crepitus and grind. He has no laxity. Impression: Patellofemoral contusion, possible chondral injury." Dr. Tomlinson planned an MRI scan of the right knee and kept the claimant on restricted work status. An MRI of the claimant's right knee was done on August 20, 2008, with the following impression:

> 1. POST ACL REPAIR WITH MUCOID DEGENERATION OF THE ENTIRE ANTERIOR CRUCIATE LIGAMENT.
> 2. DEGENERATIVE CHANGES INVOLVING THE MEDIAL AND LATERAL TIBIOFEMORAL JOINT COMPARTMENT.
> 3. CALCIFICATION OR OSSIFICATION INVOLVING THE DEEP FIBERS OF THE MEDIAL COLLATERAL LIGAMENT.
> 4. BONE CONTUSIONS, LIKELY ACUTE SEEN IN PROXIMAL TIBIA JUST POSTERIOR TO THE TIBIAL TUNNEL AND POSTEROLATERAL FEMORAL CONDYLE.

5. MODERATE JOINT EFFUSION.

Dr. Tomlinson reported on August 27, 2008:

> Mark Owen returns with his MRI scan, which shows grade 4 changes of the medial femoral condyle with subchondral cyst formation and chondromalacia patella. He says his knee continues to bother him on the medial side. The graft looks okay, that is, the ACL....
>
> Impression: Degenerative joint disease, medial femoral condyle.
>
> Discussion: It was noted on Mark's last arthroscopy that the medial femoral condyle had significant chondromalacic changes at the time of surgery on 09/18/2007. I think Mark would be an excellent candidate for a chondral transplant. We have discussed autograft and allograft versus microfracture. I think his symptoms are related to cartilage defect on the medial femoral condyle, which is pretty clear. I think he would benefit from this procedure.

Dr. Tomlinson assigned the claimant a Work Status of "He may return to work. Sit down only."

Dr. Tomlinson corresponded with Gallagher Bassett Services, Inc. on September 17, 2008:

> Please consider this a strong appeal for the surgery denied Mr. Mark Owen for an osteochondral allograft. As per his arthroscopy on 09/18/2007, he had significant chondromalacic changes of both the medial and lateral femoral condyles of the right knee. His MRI scan suggests subsequently diffuse increase in marrow signal intensity of the lateral femoral condyle suggestive of over pressure changes due to chondromalacia.

> As per the Arkansas Blue Cross and Blue Shield's coverage policy manual, Mr. Mark Owen has an acute cartilage injury. The combined defect is larger than 2.5 cm squared. The patient is less than 40 years of age. His knee is stable and aligned. Additionally, his BMI is les than 30.
>
> I think mark would be an excellent candidate due to the symptomatology of his knee to have this procedure.

Dr. Tomlinson wrote to Gallagher Bassett on October 15, 2008:

> Mark Owen's current symptomatology, I believe, is due to his injury on 07/29/2008. As noted in his dictation of 08/01/2008, he had complete recovery from his two previous surgeries, an ACL reconstruction in 2000 and a right knee arthroscopy in 2007. Currently his MRI scan shows grade 4 changes in the medial femoral condyle with unloading metabolic change in the medial femoral condyle.

Dr. Terry J. Sites provided an Independent Medical Examination on October 16, 2008:

> This evaluation includes review of medical records provided and patient history. This is a 35 year old truck driver for Comstar Enterprises who slipped and fell onto the anterior aspect of his flexed right knee on 07-29-08. He was seen by Dr. Robert Tomlinson on 08-01-08, having pain of 2-3 on a scale of 0-10 and nearly constant, with the impression of a patellofemoral contusion. He was set up for therapy three times a week for two weeks, returning to see Dr. Tomlinson on 08-18-08 noting he was still having pain, with positive patellofemoral crepitus.
>
> An MRI was obtained, showing a moderate joint effusion, a bone contusion over the posterolateral

femoral condyle, degenerative changes involving the medial and lateral tib-fib joint compartment, and an intact ACL reconstruction. On a review of these films by me I see a bone contusion in the femoral trochlea, consistent with an acute impaction injury to the anterior aspect of the knee, with postsurgical changes noted as well.

His history is significant for having two previous knee surgeries, an ACL reconstruction on 09-29-00 by Dr. Nathan Cohen, M.D. at the Center for Orthopedics in Louisiana, and an arthroscopy by Dr. Tomlinson on 09-18-07. He recovered well from both surgeries and has been back to full duties as a long-haul truck driver. Both previous injuries were Worker's Compensation. Review of his original right knee surgery in 2000 shows an arthroscopically-assisted anterior cruciate ligament reconstruction and partial medal (sic) meniscectomy for a meniscus tear. He was noted to have a minimal grade II chondromalacia at the medial compartment. His second surgery was a partial medial and lateral meniscectomy with chondroplasty of the patellofemoral joint for grade II-III chondromalacia involving 10% of the patella, inferior aspect of the medial facet, a chondroplasty of the lateral femoral condyle for 1 x 1 grade II-III chondral surface changes, debridement of a 1 x 1 cm grade II-III chondral surface changes at the medial femoral condyle.

This surgery was performed due to a right knee injury occurring in or about 05-04-07 when his miss-stepped out of a trailer and twisted his knee. He had a full course of postoperative therapy. On 11-02-07 he was released with a 10% right lower extremity impairment, 4% whole person impairment, due to his partial medial and lateral meniscectomy.

He has undergone approximately two weeks of therapy since his last surgery, this was stopped following the MRI. Dr. Tomlinson had recommended

proceeding to a chondral transplant. He was placed on sit-down duties. The patient currently describes pain in his knee anteriorly, anteromedially and anterolaterally, the pain is nearly constant. He notes some weakness in the right lower extremity with partial giving way. There has been no locking. He denies any significant knee pain in the several months prior to his most recent injury on 07-29-08. He notes litigation against the Flying J restaurant where he slipped and fell.

X-RAY: He apparently had an evaluation of x-rays at Dr. Tomlinson's office on 08-01-08, with the evaluation by Dr. Tomlinson of mild patellofemoral tilting, there are no plain films of his right knee enclosed, there are films from 2007 showing mild peripheral spur formation of the medial and lateral compartments with good preservation of joint space.

PE: Examination reveals an alert and cooperative male. There is no effusion, he has a good straight leg raise with noted quad atrophy. He has a decrease of 2.5 cm at his mid thigh on the right as compared to the left....There is mild patellofemoral crepitation, and a positive patella compression test....

IMPRESSION
1. Right knee pain and weakness following direct impaction injury to the anterior aspect on 07-29-08.

He has evidence of chondral and bone marrow contusions by MRI. He could have a full thickness chondral injury as well. However, the MRI is often times not reliable with chondral surface injuries. Should he have a bone marrow contusion without significant chondral surface injury he is likely to improve with time and physical therapy. He has as much weakness as he does pain. He has weakness, with 2.5 cm of atrophy on the right. He

notes having responded well in the past with exercise.

Prior to considering further surgery I would recommend completing a course of therapy such as outpatient therapy two times a week for six weeks, in an effort to restore his strength and eliminate the atrophy. After that, should he be unable to restore his strength or if he had persistent pain it would be medially appropriate to proceed with arthroscopic intervention.

Should he have a full thickness chondral defect I would recommend an attempt at bone marrow stimulation with micro-fracture technique prior to considering a chondral transplant, especially if this would involve the medial femoral condyle. Micro-fracture is likely much cheaper than a chondral transplant and he has a history of success in attending to isolated chondral lesions of the lateral compartment of the femur. Micro-fracture has been less effective for addressing chondral pathology of the patella.

It is more-likely-than-not that his current right knee pain and weakness is a result of the injury sustained on 07-29-08. Mr. Owen is not at maximum medical improvement. Therapy may be all that he needs, otherwise proceeding with the above outlined course of surgical intervention. Obviously medications such as anti-inflammatories and others may be useful.

These statements are made within a reasonable degree of medical certainty based upon the objective factors above. All portions of this exam and review have been conducted by me. I reserve the right to modify my opinion based on any additional information. All was fully discussed.

A Medical Case Manager for Gallagher Bassett Services provided an Initial Report for the Activity Dates of

September 12, 2008 through October 28, 2008. The following Case Management Goals were identified: "The claimant will be released from medical care at maximum medical improvement no later than 3/31/09. The claimant will attend physical therapy 3 times a week for 2 weeks, pending account's approval. The claimant will attend follow-up appointment with Dr. Sites at a date to be determined."

Dr. Sites corresponded with Gallagher Bassett Services on November 3, 2008 and reported in part:

> This is in response to your letter dated 10-31-08 as it relates to an IME performed by me on Mr. Owen 10-16-08....
>
> On your second question you asked about the need for therapy and whether this was related to a degenerative condition or directly related to the injury from 07-29-08. In the second to last paragraph of the IME I noted that it is more-likely-than-not that his current right knee pain and weakness is a result of the injury sustained on 07-29-08....
>
> You ask if microfracture would be related to his 07-29-08 injury. Should he need micro-fracture from a new, acute injury identified at the time of arthroscopy, it would be more-likely-than-not that the new area of involvement would be from the 07-29-08 injury. Should the area needing microfracture treatment be recognized as one of the 1 x 1 cm chondral areas previously noted by Dr. Tomlinson during the arthroscopic surgery on 09-18-07, it would be more-likely-than-not that the microfracture would be a result of the injury sustained on 05-04-07.

> I am hopeful that the patient's 07-29-08 injury will not result in any additional permanent impairment, but I am unable to answer that question at this time.
>
> In terms of work capacity, I would consider this patient to be temporarily partially impaired, he would be unable to do long-haul truck driving at this time, I would recommend sit-down duties only until he gains more strength in his leg, with occasional standing and walking on uneven ground. His work capacity could probably be better expressed on the short term by his treating physician.

The record indicates that Dr. Sites arranged physical therapy for the claimant beginning November 7, 2008. A physical therapist noted that the frequency/duration of therapy would be two times weekly for six weeks. The claimant testified that the condition of his knee was "the same" after approximately six weeks of physical therapy.

Dr. Tom Patrick Coker noted on December 9, 2008:

> Mark Owen is a 35 year old male with a history of knee injury in July. He's had an old knee problem related to an ACL injury in 2000. He's had a 'scope in 2007. He had a meniscectomy, ACL reconstruction and multiple procedures done and fell this time in July with a twisting weightbearing injury at a truck stop. It may have popped. It swelled for a while. Felt stiff and he has been doing physical therapy and he hurts with activity. It's better with rest....Pain is diffuse in the knee; not well localized. It's not really bucking or giving out.
>
> **XRAYS:** He has xrays that show degenerative arthritis. He had a MRI recently that shows an

> ACL graft that is probably non-functional. No acute injuries....I don't think his injury from July is causing any permanent damage.
>
> **DISCUSSION:** I would agree with Dr. Sites that he would benefit from physical therapy and that his knee problems are probably related to his pre-July worker's comp injury and he wanted to discuss an abrasion arthroplasty versus an autograft, OATS procedure versus a chondral site transplant and we discussed the fact that I'm not an expert on chondral site transplants other than the fact that it's expensive and if they talked about using fetal transplants, then that is fairly experimental and I've not seen any papers on it that suggests that it will be any better than the type of chondral site transplants that are being done now which are difficult and not very reliable. An OATS procedure would be more reliable and abrasion arthroplasty would be the easiest but that is the least long lasting effect but these are issues between he and Dr. Tomlinson regarding his pre-July knee.

The parties stipulated that "all appropriate medical benefits have been paid through December 9, 2008 and all temporary disability benefits have been paid through December 9, 2008." The claimant testified that his temporary total disability benefits were cut off after December 9, 2008, after his visit with Dr. Coker.

A pre-hearing order was filed on February 9, 2009. The claimant contended, among other things, that he was entitled to additional temporary total disability, additional permanent partial disability, and attorney's fees. The

claimant contended that he was entitled to ongoing temporary total disability benefits and additional medical treatment regardless of which respondent-carrier was responsible.

Respondent-Carrier No. 1, American Home Assurance Company, contended that the claimant sustained an aggravation or new injury on July 29, 2008. Respondent-Carrier No. 1 contended that it was not liable for medical or weekly benefits flowing from the July 29, 2008 accident.

Respondent-Carrier No. 2, Arch Insurance Company, contended, among other things, that the claimant was initially injured while working for Butler Transportation in 2000 and underwent extensive knee surgery including an ACL repair. Respondent-Carrier No. 2 contended that the claimant had a second injury in 2007 which resulted in another surgery for removal of meniscus, and that Dr. Tomlinson treated the claimant for the injury and assigned a 10% rating. Respondent-Carrier No. 2 contended that the chondral site transplant recommended by Dr. Tomlinson was not reasonably necessary, but that if said treatment was necessary, then it was not related to the claimant’s injury in July 2008. Respondent-Carrier No. 2 alternately

contended that surgery should be apportioned between the respondent-carriers.

The parties agreed to litigate the following issues:

> 1. The claimant's entitlement to additional medical services and additional temporary total disability benefits from December 10, 2008 through a date yet to be determined.
> 2. Liability between the carriers for any additional benefits.
> 3. Appropriate attorney's fees.

The attorney for Respondent-Carrier No. 1 questioned Dr. Coker at a deposition taken March 25, 2009:

> Q. Dr. Coker, we just took this gentleman's deposition, Mr. Owen's deposition, and I would represent to you that at his deposition he said that he was - he had had an injury in 2007 by Dr. Tomlinson, and was released to return to work in November of 2007, on November 2, 2007, and that he had no knee pain from November 2, 2007, when he returned to work, until July 29, 2008 when he had the slip and fall that brought him to your office. If you assume that's correct, is it fair to assume that whatever happened in June 2008 is what caused him to be having pain in his knee?
>
> A. I guess you could assume so, but I wasn't impressed with his fall or how he - I mean, he didn't seem that bad, and his exam was, to me, unremarkable. Of course, I'm seeing him five months after he fell in July, you know, and then I've seen him in December....But I'm not impressed with what I was looking at. I guess we just have to go by his word....

The attorney for Respondent-Carrier No. 2 questioned Dr. Coker:

Q. His diagnosis after the August or, excuse me, the June '08 injury was a contusion, patellofemoral contusion. That's the kneecap, correct?

A. Correct.

Q. Would that be something that would lead to the need for the transplant of cartilage?

A. Not normally.

Q. All right. And his diagnosis was degenerative joint disease of the knee which was requiring the need for the transplant. Would that be due to his arthritis?

A. Yes.

Q. Okay. And that would not be, in your estimation, due to his incident in June of 2008?

A. Correct.

The parties deposed Dr. Tomlinson on April 20, 2009. The attorney for Respondent-Carrier No. 2 questioned Dr. Tomlinson regarding medical treatment of the claimant beginning May 9, 2007. The attorney for Respondent No. 2 questioned Dr. Tomlinson:

Q. I've got you seeing him again on August 1st, 2008....Your impression was at that point?

A. Patellofemoral contusion.

Q. And that's the kneecap?

A. Yes, sir.

Q. Okay. How do you normally treat a patellofemoral contusion?

A. Usually therapy, try to let the inflammation resolve to keep the knee strong....

Q. The [August 20, 2008] MRI shows osteoarthritis in the medial and lateral compartments, is that correct?

A. That's what the report says, yes sir....

Q. The findings we just talked about, the degenerative changes and the osteophyte, are those things that have occurred because of his prior injuries, loss of cartilage?

A. Well, I'm sure they're highly suggestive of all the problems that he's had and the surgeries that he's had.

Q. Okay. Well, is there anything in that list of findings as far as degenerative changes or osteophyte that was caused by his fall in August of '08?

A. Well, it's hard to say....

Q. The degenerative changes would be from the prior surgeries and injuries, the finding on the MRI?

A. Well, you know, if you want to split hairs and that's what we're here to do, degenerative suggests over time. Now, if they're taking a cartilage defect and then they're calling that degenerative, I mean, the degenerative changes they're talking about here are probably referring to the osteophytes and the cartilage thinning.

Q. Okay.

A. So you can have cartilage thinning that occurs all at once, you can have cartilage thinning that

occurs over time. So to answer your question, I think there's probably a component of this description that may or may not be acute. So to just suggest that this whole - that their description of the degenerative changes is a wholly chronic preexisting is, I think, inaccurate.

Q. Don't know at this point?

A. Well, by saying degenerative, that by definition is over time, but what I think they're doing is I think they're describing the cartilage thinning and the osteophytes, and I think there's a component of that description that may be acute....

Q. But the bone contusion that they see on the MRI and the joint effusion, that would be related to his trauma he had in August of -

A. Not necessarily. Sometimes it is and sometimes it's not....that may be related to all these previous surgeries and the fact that he has less cartilage, and as a result of less cartilage, that bone stress is a little bit more and it looks like a contusion. I like to call it a bony edema because a contusion suggests a cause. We don't know what caused this edema in the bone, so I don't like to say contusion. I like to say edema....

The attorney for Respondent-Carrier No. 1 questioned Dr. Tomlinson:

Q. So, in other words, if you had to say based on the patient's history whether -

A. Everything is based on the patient's history.

Q. - whether the July 29 accident caused his pain, you would say yes, if you had to, if somebody put a gun to your ear?

A. Yeah, if I would say this is pain due to the accident, I would say yeah.

Q. Okay. And you indicated earlier that you can have cartilage thinning that arises as a result of an acute trauma, and it can -

A. Absolutely.

Q. - arise fairly rapidly as a result of an acute trauma?

A. You can chip a piece off like a piece of paint, yeah.

Q. And could he when he fell on July 28, 2008 - I mean, you weren't there and didn't have - he didn't fall on it while he was undergoing the MRI unfortunately, but could he have in that July 28, 2008 fall, could he have sustained an acute injury that resulted in cartilage thinning -

A. Yes.

Q. - and bone swelling -

A. Yes.

Q. - and that could be causing his pain?

A. Yes, sir....I don't have any reason to believe that his reports of pain are inaccurate....

A hearing was held on April 27, 2009. The claimant testified, "I would prefer to follow up with Dr. Tomlinson....Because he has performed surgery on my knee before and I was very satisfied with the results." The claimant testified on direct examination:

Q. Has anybody released you at this point?

A. No, sir. Not to my knowledge.

Q. If you are released to go back to work, who do you understand you're supposed to report to and who would give you the green light to go back to duty?

A. Glen Miller.

Q. And what's your understanding as to whether you can go back? What has to happen before you can go back?

A. I need a total release to full duty by a medical physician.

Q. At this point, has Dr. Tomlinson, Sites or Coker given you a full release to return back?

A. Not to me, no sir.

An administrative law judge filed an opinion on July 24, 2009. The administrative law judge found that the claimant proved he was entitled to additional medical treatment recommended by Dr. Tomlinson. The administrative law judge found, "each respondent/carrier is liable for one half of the expense of these medical services." The administrative law judge found that the claimant proved he was entitled to temporary total disability benefits beginning December 10, 2008 through a date yet to be determined. The administrative law judge found that Respondent-Carrier No. 2 was "solely liable for these temporary total disability benefits."

The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Medical Treatment

The employer shall 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)(Repl. 2002). The employee must prove by a preponderance of the evidence that he is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In the present matter, the Full Commission finds that the claimant proved he was entitled to additional medical treatment as recommended by Dr. Tomlinson. The claimant has been suffering from occasional right knee difficulties as early as age 15. The claimant injured his knee in May 2000 and underwent surgery in September 2000. The claimant was returned to full work duties in about January 2001. The claimant began working for the respondent-employer, PeopLease Corporation, in about November 2006. The parties

stipulated that the claimant sustained a compensable injury to his right knee on May 4, 2007. Dr. Tomlinson performed right knee surgery in September 2007. Dr. Tomlinson assigned a permanent impairment rating on November 2, 2007 and returned the claimant to work without restrictions. The claimant testified that he returned to full duty work and did not experience further problems with his knee.

The parties stipulated that the claimant sustained another compensable injury to his right knee on July 29, 2008. The claimant testified that he had not suffered any right knee problems since his prior release on November 2, 2007. The evidence corroborates the claimant's testimony, in that there was no record of medical treatment provided the claimant from November 2, 2007 until July 29, 2008. The parties stipulated that Respondent-Carrier No. 2 was providing coverage on July 29, 2008. Dr. Tomlinson noted on August 1, 2008 that the claimant had "fully recovered" from prior knee surgeries. X-rays on or about August 1, 2008 showed "mild patellofemoral tilting" and Dr. Tomlinson's impression was "Patellofemoral contusion." We note that there was no evidence of "Patellofemoral contusion" in the claimant's knee prior to the July 29, 2008 compensable

injury. An MRI of the claimant's right knee in August 2008 included a finding of "4. Bone contusions, likely acute seen in proximal tibia just posterior to the tibial tunnel and posterolateral femoral condyle." Dr. Tomlinson recommended a "chondral transplant."

Dr. Tomlinson noted in September 2008 that the claimant had sustained an "acute cartilage injury." Dr. Tomlinson noted in October 2008, "Mark Owen's current symptomatology, I believe, is due to his injury on 07/29/2008. As noted in his dictation of 08/01/2008, he had complete recovery from his two previous surgeries, an ACL reconstruction in 2000 and a right knee arthroscopy in 2007." Dr. Sites independently reported in October 2008 that the claimant had sustained "an acute impaction injury to the anterior aspect of the knee, with postsurgical changes noted as well....He denies any significant knee pain in the several months prior to his most recent injury on 07/29/08." Dr. Sites' impression was "1. Right knee pain and weakness following direct impaction injury to the anterior aspect on 07-29-08....It is more-likely-than-not that his current knee pain and weakness is a result of the injury sustained on 07-29-08."

Dr. Sites and Dr. Coker have suggested different treatment alternatives than those recommended by Dr. Tomlinson. The Commission's authority to resolve conflicting evidence also extends to medical testimony. *Maverick Transp. v. Buzzard*, 69 Ark. App. 128, 10 S.W.3d 467 (2000). Dr. Tomlinson was the primary treating physician for the claimant's May 4, 2007 compensable injury. The claimant credibly testified that Respondent-Carrier No. 2 sent him back to Dr. Tomlinson after the claimant's compensable injury sustained o July 29, 2008. We find in the present matter that Dr. Tomlinson's recommendations are entitled to more weight than the treatment recommendations of Dr. Sites and Dr. Coker. The record also demonstrates that the claimant's current need for medical treatment is causally related to the July 29, 2008 compensable injury. Dr. Tomlinson's deposition testimony was not always consistent or clear with regard to the etiology of the claimant's symptoms and need for treatment. The preponderance of evidence before the Commission, however, demonstrates that the claimant had fully recovered from his prior compensable injury at the time of the July 29, 2008 compensable injury, when Respondent-Carrier No. 2 was

providing coverage. The Full Commission does not affirm the administrative law judge’s decision to apportion medical benefits. Instead, we find that Respondent-Carrier No. 2 shall be solely liable for the treatment recommendations of Dr. Tomlinson.

B. Temporary Disability

An employee who has suffered a scheduled injury is to receive temporary total or temporary partial disability benefits during his healing period or until he returns to work. *Wheeler Constr. Co. v. Armstrong*, 73 Ark. App. 146, 41 S.W.3d 822 (2001); Ark. Code Ann. §11-9-521(a)(Repl. 2002). The healing period is that period for healing of the injury which continues until the employee is as far restored as the permanent character of the injury will permit. *Nix v. Wilson World Hotel*, 46 Ark. App. 303, 879 S.W.2d 457 (1994). Whether an employee’s healing period has ended is a factual determination to be made by the Commission. *Ketcher Roofing Co. v. Johnson*, 50 Ark. App. 63, 901 S.W.2d 25 (1995).

In the present matter, the parties stipulated that the claimant sustained a compensable scheduled injury on July 29, 2008. Respondent-Carrier No. 2 initially provided

medical benefits in the form of treatment from Dr. Tomlinson as well as temporary total disability benefits. Dr. Sites opined on November 3, 2008 that the claimant was unable to perform long-haul truck driving. Dr. Sites recommended sit-down duties only. Following the claimant's examination by Dr. Coker, Respondent-Carrier No. 2 stopped paying temporary total disability benefits after December 9, 2008. The claimant credibly testified at hearing that he had not been released to return to work as an over-the-road truck driver. The claimant testified that the respondent-employer would not allow him to return to work until he received "a total release to full duty by a medical physician." The record demonstrates that the claimant remained within his healing period for the compensable injury and had not returned to work after December 9, 2008. The Full Commission affirms the administrative law judge's award of temporary total disability benefits beginning December 10, 2008 until a date yet to be determined.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant proved he was entitled to additional medical treatment as recommended by Dr. Tomlinson. The Full Commission finds that Respondent-

Carrier No. 2, Arch Insurance Company, shall be solely liable and responsible for reasonably necessary medical treatment recommended by Dr. Tomlinson. We find that the claimant proved he was entitled to temporary total disability benefits beginning December 10, 2008 until a date yet to be determined. The Full Commission therefore affirms the administrative law judge's opinion as modified. The claimant's attorney is entitled to fees for legal services in accordance with Ark. Code Ann. §11-9-715(a)(Repl. 2002). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to an additional fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b)(Repl. 2002). Respondent-Carrier No. 2 has controverted the claim for additional benefits and shall be liable for statutory fees for legal services.

IT IS SO ORDERED.

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A. WATSON BELL, Chairman

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PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion finding that the treatment recommended by claimant's treating physician is reasonable and necessary in connection with the claimant's July 29, 2008, compensable injury. This finding, while in accordance with Williams v. L & W Janitorial, Inc., 85 Ark. App. 1, 145 S.W.3d 383 (2004), clearly emphasizes the medical and legal fallacies imposed by the court.

It is undisputed that the claimant has severe degenerative changes in his right knee. The claimant even had a anterior cruciate ligament tear and repair in 2000, prior to either of his present injuries that are the subject of this claim. On May 5, 2007, the claimant sustained his first compensable injury with this employer when his foot slipped and he sustained a stress fracture of the lateral tibial plateau and medial and lateral meniscus tears. Claimant initially reported his pain as 8/10 in intensity and nearly constant in frequency. On September 18, 2007, the claimant underwent arthroscopic surgery performed by Dr. Robert Tomlinson, the claimant's treating orthopeadic

surgeon. During surgery, Dr. Tomlinson made the following findings:

A. Medial compartment - extensive synovitis.

B. Medial meniscus - tear, 10 percent of 20 percent remnant, anterior horn.

C. Medial femoral condyle - chondromalacic changes grade II to III, 1x1cm distribution.

D. Medial tibial plateau - intact.

E. Notch - extensive synovitis.

F. Anterior cruciate ligament - graft; small Cyclops lesion.

G. Posterior cruciate ligament - intact.

H. Lateral compartment - extensive synovitis.

I. Lateral meniscus - complex tear, 100 percent, posterior and middle horn.

J. Lateral fermoral condyle - chondromalacic changes grade II to III, 1x1 cm distribution medial aspect.

K. Lateral tibial plateau - intact.

L. Suprapatellar pouch - extensive synovitis medially and laterally as well as medial and lateral parapatellar gutter.

M. Patellofemoral joint - extensive synovitis; chondromalacic changes grade II to III, 10 percent, inferior aspect medial patella facet.

N. Trochlear groove - intact.

Following successful surgery of a partial medial and lateral meniscectomy, chondroplasy of the patellofemoral joint, and extensive synovitis, the claimant advised Dr. Tomlinson on each of his follow-up visits that he was doing well. By November 2, 2007, the claimant advised that he was pain free and he was released to return to work without restrictions. Dr. Tomlinson assessed the claimant with a 10% right lower extremity impairment as a result of this injury and surgery.

Claimant returned to work for this employer and did not suffer any symptoms or complaints with his right knee until he was involved in a second incident on July 29, 2008, when he fell and landed directly on his right kneecap. Claimant returned to Dr. Tomlinson on August 1, 2008 where he was diagnosed with a patellofemoral contusion for which and physical therapy ordered. Claimant reported at that time that his pain was only a 2 or 3 out of 10 in intensity but nearly constant in frequency. Dr. Tomlinson noted that

upon the claimant's follow-up visit on August 18, 2008, the claimant's symptoms had not improved so he ordered an MRI. This diagnostic study revealed:

> 1. POST ACL REPAIR WITH MUCOID DEGENERATION OF THE ENTIRE ANTERIOR CRUCIATE LIGAMENT.
>
> 2. DEGENERATIVE CHANGES INVOLVING THE MEDIAL AND LATERAL TIBIOFEMORAL JOINT COMPARTMENT.
>
> 3. CALCIFICATION OR OSSIFICATION INVOLVING THE DEEP FIBERS OF THE MEDIAL COLLATERAL LIGAMENT.
>
> 4. BONE CONTUSIONS, LIKELY ACUTE SEEN IN PROXIMAL TIBIA JUST POSTERIOR TO THE TIBIAL TUNNEL AND POSTEROLATERAL FEMORAL CONDYLE.
>
> 5. MODERATE JOINT EFFUSION.

In a letter dated August 27, 2008, Dr. Tomlinson recommended that the claimant undergo a chondral transplant based upon this MRI which showed grade 4 changes of the medial femoral condyle with subchondral cyst formation and chondromalacia patella. In further correspondence dated September 17, 2008, pleading for workers' compensation approval Dr. Tomlinson supported his request for an osteochondral allograft by referring to the claimant's previous arthroscopy on September 18, 2007 wherein he observed the "significant chondromalacic changes of both the

medial and lateral femoral condyles of the right knee" as well as the claimant's more recent MRI scan that revealed "diffuse increase in marrow signal intensity of the lateral femoral condyle suggestive of over pressure changes due to chondromalacia." When asked whether the proposed surgery was due to the claimant's last compensable injury, Dr. Tomlinson stated in correspondence dated October 15, 2008, that it was. However, in his deposition testimony, Dr. Tomlinson was less sure of his causation opinion. In this regard he testified that from an objective standpoint, the cartilage thinning and degenerative changes that are to be addressed through this replacement surgery were all present during the claimant's arthroscopy in 2007. When asked whether the cartilage replacement surgery was necessary because of the previous removal of cartilage, Dr. Tomlinson specifically stated:

> Well, I think some of it wasn't removed. I think some of it broke off or chipped off or wore off or from a lack of nutrition came off. So I think it's a combination of what was gone before and what was taken away that was impending loosened. So I think it's a combination, but I think the bottom line is there's cartilage loss in that knee.

In describing the claimant's latest MRI findings, Dr. Tomlinson opined that the finding of bone contusion in the posterior lateral aspect of the femoral condyle, was the result of edema or swelling of the bone marrow. According to Dr. Tomlinson this is not an acute finding of a contusion, but rather of changes within the bone from the loss of cartilage to protect the bone. It is this edema or swelling that is causing the claimant pain, because the mere loss of cartilage does not cause pain as there are no nerve ending in the cartilage.

With regard to the claimant's last compensable injury of June 2008 which resulted in a patella contusion, Dr. Tomlinson clearly stated, "A patellofemoral contusion, we wouldn't be doing a transplant for a patelleofemoral contusion. I wouldn't be doing it." Moreover, when asked to explain his statement in his September 17, 2008, correspondence wherein he was attempting to get the workers' compensation carrier to cover the transplant surgery, in which he described the claimant's last compensable injury as "an acute cartilage injury" from the fall, Dr. Tomlinson back tracked from this statement during his deposition commenting that that sentence did not make sense to him.

When the objective need for the transplant surgery is considered, it is clear that Dr. Tomlinson is basing the need for surgery upon the findings which are clearly unrelated to the claimant's last compensable injury. However, when pushed by the attorney's to attribute the need for cartilage transplant surgery to a specific cause, Dr. Tomlinson concluded that simply based upon the claimant's history that he did not have pain in his knee until after his last compensable injury, this injury is responsible for the claimant's need for a cartilage transplant. Thus, the only factor resulting in the need for the claimant's proposed cartilage transplant surgery is the subjective factor of pain. Nothing about the claimant's July 29, 2008, fall resulted in his loss of cartilage for which he now requires a cartilage implant. Dr. Tomlinson has related the need for this surgery to the claimant's July 29, 2008, fall merely because the claimant now complains of pain. However, Dr. Tomlinson clearly testified that this pain is generated from the bone marrow edema which is related to the loss of cartilage, not the claimant's fall. As such, in my humble opinion, it is a gross miscarriage of justice to rely upon the factor test as set forth in Williams v. L & W

Janitorial, supra. in finding that the claimant's cartilage transplant is reasonable and necessary in connection with the claimant's July 29, 2008, compensable injury. The overwhelming medical evidence clearly shows that there was no pathology resulting from the compensable injury that required surgery. Claimant's need for a cartilage transplant is not medically connected to her work related injury, but her pre-existing degenerative disease and her loss of cartilage. Therefore, I must respectfully dissent.

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KAREN H. MCKINNEY, COMMISSIONER