

# NOT DESIGNATED FOR PUBLICATION

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F802933

CLEVELAND ELLIS, EMPLOYEE	CLAIMANT
LITTLE ROCK SCHOOL DISTRICT, SELF-INSURED EMPLOYER	RESPONDENT
ARKANSAS MUNICIPAL LEAGUE WCT, INSURANCE CARRIER/TPA	RESPONDENT

OPINION FILED JUNE 7, 2011

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

Claimant represented by the HONORABLE STEVEN McNEELY, Attorney at Law, Little Rock, Arkansas.

Respondents represented by the HONORABLE J. CHRIS BRADLEY, Attorney at Law, North Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

## OPINION AND ORDER

Respondents appeal an opinion and order of the Administrative Law Judge filed December 13, 2010.

In said order, the Administrative Law Judge made the following findings of fact and conclusions of law:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 20, 2008, the employment relationship existed between the parties when the claimant earned an average weekly wage of \$206.68, generating a

weekly compensation benefit rate of \$139.00, for temporary total/permanent partial disability.

3. On March 20, 2008, the claimant sustained injuries to his right knee, low back and left shoulder which were accepted as compensable by respondent.
4. The evidence preponderates that the claimant sustained injuries to his right shoulder and left knee in the March 20, 2008, compensable accidental fall.
5. The claimant has remained temporarily totally disabled with regard to his right shoulder and left knee injuries growing out of the March 20, 2008 compensable accident since May 29, 2009, and continuing through his healing period, a date to be determined.
6. The claimant was appropriately referred to Dr. William Hefley by Dr. Bernard Crowell for the treatment of the compensable injuries to both shoulders. The medical treatment rendered to the claimant by Dr. Hefley has been reasonably necessary in connection with the treatment of the claimant's compensable injuries of March 20, 2008.
7. Respondent shall pay all reasonable hospital and medical expenses arising out of the injury of March 20, 2008.
8. The respondent has controverted the claimant's entitlement to temporary total disability benefits subsequent to May 29, 2009; the compensability of the claimant's left knee and right shoulder injuries; the claimant's entitlement to further treatment of his right knee under the care of Dr. William Hefley; and treatment relative to the claimant's left shoulder under the care of Dr. Hefley.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

We therefore affirm the December 13, 2010, decision of the Administrative Law Judge, including all findings of fact and conclusions of law therein, and adopt the opinion as the decision of the Full Commission on appeal.

All accrued benefits shall be paid in a lump sum without discount and with interest thereon at the lawful rate from the date of the Administrative Law Judge's decision in accordance with Ark. Code Ann. § 11-9-809 (Repl. 2002).

Since the claimant's injury occurred after July 1, 2001, the claimant's attorney's fee is governed by the provisions of Ark. Code Ann. § 11-9-715 as amended by Act 1281 of 2001. Compare Ark. Code Ann. § 11-9-715 (Repl. 1996) with Ark. Code Ann. § 11-9-715 (Repl. 2002). For prevailing on this appeal before the

Full Commission, claimant's attorney is hereby awarded an additional attorney's fee in the amount of \$500.00 in accordance with Ark. Code Ann. § 11-9-715(b) (Repl. 2002).

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's opinion finding that the claimant proved by a preponderance of the evidence that he was entitled to medical treatment for his left knee and right shoulder and a finding that the claimant was appropriately referred to Dr. William Hefley by Dr. Bernard Crowell. Based upon my de novo review of the record, I find that the claimant has failed to meet his burden of proof.

The claimant was employed by the respondent employer as a substitute teacher. On March 20, 2008, the claimant was substituting at Horace Mann Middle School when he asked another teacher for some pencils because

several students did not have pencils. The claimant was writing on the board and was tapped on the shoulder by another teacher, Ms. Anita Paul, who was returning to give the claimant the pencils for the students who needed them. The claimant was startled and fell backwards, landing on his buttocks. There was conflicting testimony regarding how the claimant fell. The claimant stated that he was so startled by Ms. Paul's touch that he fell forward into a desk, hitting the desk with his right shoulder and landing on the concrete floor with both his knees. However, Ms. Paul testified that the claimant fell backwards into a teaching stool that was in the room and fell and hit his buttocks.

The claimant was taken by ambulance to UAMS. The claimant complained of pain in his back, right leg and right shoulder. The claimant was treated at St. Vincent Family Clinic on March 28, 2008, which reflected the claimant had pain in his right hip and right leg with edema of the right knee. The claimant's X-rays were unable to be taken due to the claimant's weight and the limits of the X-ray machine. Radiology reports of the lumbar spine and the right knee done at UAMS revealed no fracture, but did reveal the effects of degenerative disease. The claimant was ultimately diagnosed on April

1, 2008, with cervical strain, upper thoracic strain, lumbar strain, sacral contusion and soft tissue injury to the right knee.

Dr. William Joseph referred the claimant for physical therapy on April 3, 2008. The physical therapist reported that the claimant told him he fell on his right side, injuring his lumbar spine, right tail bone, right knee with swelling, his right shoulder, cervical spine, and he had tenderness of both shoulders although the left was greater than the right. The therapist wrote that there were "signs and symptoms consistent of lumbosacral, cervical, thoracic sprain/strain, sacral contusion, soft tissue injury of R knee and R knee sprain." The therapist did not note what signs were seen and reports only the claimant's complaints of pain and tenderness. Additional physical therapy was provided on following days with no substantive changes reported. On the April 14, 2008 visit the claimant reported that he had attempted prone press-ups over the weekend and had swelling of the right knee. The claimant was reminded not to leave his knee brace on overnight. None of the physical therapy reports noted the claimant having injured his right shoulder while in physical therapy or while performing his exercises.

On April 17, 2008, the claimant was seen at UAMS at 11:37 with a chief complaint of upper extremity pain. Specifically, the triage note reflects that the claimant's left shoulder was "out of socket" and he was unable to tolerate the pain. The discharge report reflects a clinical impression of the claimant's complaint as left shoulder pain. The claimant was directed to follow up with his primary care physician for an MRI. The physical exam showed abdomen/back as being soft, non-tender, with both the right and left upper extremities as being without swelling, full range of motion, with non-tenderness of the neck, chest, shoulder, upper arm, elbow, forearm, wrist, hand, fingers and thumb. The claimant was diagnosed with degenerative disc disease and tendonitis/bursitis.

Nearly one month from the date of injury, the only objective finding of injury is the presence of swelling in the claimant's right knee. There is a reference to swelling to the right shoulder in the physical therapists' report, but this is not a finding but rather the claimant's report to the physical therapist of swelling. There were no other findings of objective injury nor were there objective findings related to the left shoulder when the claimant complained that it felt as though it was out of the

socket. When Dr. William Joseph saw the claimant on April 18, 2008, he wrote:

I need to add objectivity to his complaints. I will, therefore, arrange a functional capacity evaluation to be performed as soon as possible.

The functional capacity examination bore out Dr. Joseph's concerns. The functional capacity evaluation was done on April 30, 2008. The examiner wrote in part:

Mr. Ellis demonstrated the ability to perform work in at least the Sedentary classification as defined by the US Department of Labor's guidelines, he also exhibited numerous signs of inconsistent effort and self-limiting behavior which were sufficient to completely invalidate his evacuation due to unreliable effort.

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The results of this evaluation indicate that Mr. Ellis gave an unreliable effort, with 20 of 45 consistency measures within expected limits. Analysis of the data collected during Mr. Ellis's evaluation indicates that he did not put forth reliable effort during his test.

During his evaluation, Mr. Ellis exhibited an extreme amount of inconsistencies and signs of self limiting behavior. Mr. Ellis failed to exhibit a significant cardiovascular response to physical testing with a maximum measured heart rate of only 120 bpm. This is

only 10 bpm over his resting level as measured prior to the beginning of his evaluation and is not consistent with any significant degree of effort particularly considering Mr. Ellis' weight and overall level of conditioning. Mr. Ellis also exhibited numerous signs of self-limiting behavior including an observed functional range of motion for both cervical and lumbar range of motion which greatly exceeded his formal range of motion measures taken prior to his evaluation. During Mr. Ellis' formal range of motion testing, he reports that he was not able to forward flex past 21 degrees at his lumbar spine. However, prior to that during his interview, Mr. Ellis was observed in a seated position, picking up papers that he had dropped on the floor, requiring near full lumbar flexion. In addition, Mr. Ellis reports extreme ROM limitations in his cervical spine which were greatly exceeding during functional testing. Mr. Ellis also reports that he could not participate in an isometric floor lift from 13 inches above the ground because he could not reach the dynamometer. He would not even attempt this test. However, during dynamic lifting tests, he was observed reaching down to a level of 6 inches above the floor in an attempt to pick up a weight. Mr. Ellis also participated in a series of tests to identify the presence of non-physiological symptoms of low back pain. These tests were stopped after 4 tests in row were positive. These tests included axial loading; seated vs. supine leg raise; Passive plantar/Dorsi-flexion of the ankle; and rotation at the ankles. Mr. Ellis also reports very high pain levels even for those activities which were not related to his

diagnoses. Mr. Ellis reports that he could not complete a dynamic lifting test with only 1 lb. with his left arm. This was a test which enabled Mr. Ellis to keep his left elbow at his side throughout the test and required no active shoulder movement.

Dr. Joseph had not only suspected the claimant's motivation, but had also advised the claimant that it was inappropriate to take taxi cabs to emergency rooms and ambulances home. Six days later, April 24, 2008, the claimant requested a change of physician.

The claimant obtained a change of physician to Dr. Harold Betton, who referred the claimant to Dr. Bernard Cowell. The claimant testified about his perception of his right knee condition between April 2008 and an August 2008 arthroscopy of the right knee done by Dr. Crowell. He said that before the surgery, he was in constant pain and could not walk on the right knee without pain, and that surgery provided a little comfort. Two months after his procedure, he had more problems with pain. Shortly after he testified that the surgery helped, he said, "I have not had comfort with the right knee since Dr. Crowell did the surgery. I get a little comfort from the medication I take."

The medical evidence demonstrates that the claimant began treating with Dr. Crowell on June 26,

2008. Dr. Crowell's notes indicate that the claimant fell "off a platform while at school when he was startled by a teacher and fell off the platform and landed on a desk, injuring his back and extremities." The claimant complained that physical therapy to his right knee gave him no relief; he also complained of left shoulder and low back pain. Dr. Crowell's examination produced complaints of tenderness to the left shoulder joint upon palpation, complaints of tenderness to the lumbar spine on palpation, and complaints of tenderness to palpation over the medial and lateral joint line of the left knee, and the finding a mild effusion as well as that the patella was mildly ballottable. An MRI scan of the right knee was ordered as well as other radiological studies.

The June 26, 2008, report refers to the left knee as having the effusion; however, the claimant's complaints had referred to the right knee. The claimant had received treatment for the right knee, he wore a right knee brace and Dr. Crowell called for an MRI scan of the right knee which he had reported to have, in the same report, internal derangement. It seems probable that the referral to the left knee in the report of the examination is in error and Dr. Crowell actually was referring to his physical examination fo the right knee.

Apparently, X-rays were done before the MRI of the right knee. Radiological interpretation revealed significant arthritic changes in the three compartments and possible joint effusion. The study of the right knee revealed osteoarthritic changes with moderate retropatellar spurring and a question of effusion, yielding an impression of moderate tricompartmental osteoarthritic changes. Findings on the left knee study showed osteoarthritic changes with questionable joint effusion. Radiology reports of the right shoulder findings revealed mild osteophyte formation present and no definite acute abnormality. The left shoulder revealed mild arthritic type changes. The cervical spine showed osteophytes, narrowing of the interspace and a questions of some narrowing extension of osteophytes into the neural exit foramina. The lumbar spine showed multilevel degenerative changes and possible some muscular spasm.

Three months post injury the predominate findings indicate significant osteoarthritis in a man weighing 370 pounds. The MRI of the claimant's right knee, however, did reveal a tearing of the posterior horn medial meniscus, mostly intrameniscal and pattelofemoral arthrosis with regions of class 4 chondromalacia, giving rise to a loose body of the

posterior joint capsule. Surgery done by Dr. Crowell on August 6, 2008, confirmed MRI findings of a medial meniscal tear of the right knee. The respondents accepted the right knee as compensable.

The September 2, 2008 MRI of the claimant's lumbar spine revealed a herniated disc at the L5-S1 level and a central protrusion at the L4-L5 level. This finding is the first objective finding other than post-surgical and osteoarthritic changes to spine, but the respondents also accepted the low back as compensable.

On September 24, 2008, while in physical therapy, the claimant reported that his left knee was killing him. On September 30, 2008, Dr. Crowell injected his right knee and recommended continued physical therapy as well as epidural steroid injections for the lumbar spine. Return visits to Dr. Crowell addressed the claimant's low back and right knee. In the claimant's return to physical therapy on November 10, 2008, he complained of lumbar pain and knee pain with tingling down the left extremity to the foot. The therapist wrote in the therapy discharge note that the claimant had shown minimal effort with physical therapy.

The claimant continued in follow-up with Dr. Crowell and on the December 9, 2008 office visit, the doctor assessed a permanent anatomical impairment rating

of 2% for the lower right extremity and an impairment rating of 7% to the body as a whole for his lumbar spine. He also recommended a functional capacity evaluation. Once again, though, with a different examiner from the earlier functional capacity exam, the claimant gave "sub-maximal" effort. In describing sub-maximal effort, the evaluator wrote that the claimant could do more physically than he demonstrated during the testing day so that vocational or rehabilitation decisions from the claimant should be made with that in mind.

Mr. Ellis' presentation and functional tolerances present significant challenges for recommendation. Based on his observations during testing, Mr. Ellis's right knee does not present significant limitations related to function. There was weakness demonstrated during manual muscle testing, but he demonstrated ability to stand unilaterally. Certainly getting his right leg stronger would be in his best benefit. There was no post-test swelling appreciated. The low back pain and left radicular pain significantly limited his function related to bending, standing and walking. It is difficult to say that he is at MMI based on the fact that there are reliability questions and effort concerns.

Mr. Ellis upper extremity pain and dysfunction are of unknown etiology. Mr. Ellis reports that his left rotator cuff was "popped" during his

initial therapy visits. Further investigation may be warranted, but again, reliability becomes a concern as assessment during the musculoskeletal exam was hampered.

Overall, a graded return to work would be suggested at this time. Any further therapy intervention would not be recommended due to his intolerance and lack of improvement. Mr. Ellis limitations were limited specifically by pain. Addressing this area of dysfunction may also be of some benefit as he returns to maximum function.

The claimant was again seen by Dr. Crowell on January 13, 2009, in a follow-up to the functional capacity evaluation. Dr. Crowell made no comment as to his view of the examination, but went back to the claimant's complaints. When Dr. Crowell saw the claimant on December 9, 2008, he wrote that in addition to the low back, leg pain and right knee pain, the claimant complained of left shoulder pain. Dr. Crowell wrote that the claimant had not complained of his left shoulder before the visit.

On the January 13, 2009 visit, the chart note reports that the claimant complained of bilateal shoulder pain which Dr. Corwell commented upon saying that "this was a known initial injury. We have not addressed it secondary to his pain in the knee and lower back." Dr. Crowell's impression was of bilateral

shoulder strain, left greater than right. The claimant requested physical therapy for his shoulders so the doctor made the arrangement.

Physical therapy notes indicated that the claimant had a "Repetitive strain" type of injury. The specific injury was shown to be "bilateral supraspinatus tendinopathy." The therapist reported that the "patient presents with a rotator cuff tendinopathy due to faulty biomechanics of the GH, AC, SG joints and the cervical/thoracic spines. These joint impairments have lead to improper movement patterns of the humeral head in the glenoid fossa and atrophy of the rotator cuff muscles." There is no reference to traumatic injury either in the fall at school or during physical therapy.

On a February 10, 2009 visit with Dr. Crowell, the claimant complained of neck pain, shoulder pain and left knee pain. In addition to the cervical spine diagnosis of degenerative disc disease, Dr. Crowell diagnosed the claimant with tricompartmental osteoarthritis of the left knee and subacromial bursitis of the shoulder bilaterally. The claimant was discharged from physical therapy as having reached the goals established in the initial visit. Dr. Crowell saw the claimant on March 10, 2009, with complaints of left shoulder pain, left leg pain and left knee pain and that

he could not stand or walk any great distance. Dr. Crowell reminded him of the history of osteoarthritis of the knee, severe chondromalacia of the other knee as well as the surgically corrected meniscal tear, history of obesity, disc protrusions. He recommended the claimant see Dr. Kevin Collins for pain management, noting that after Dr. Collins evaluated the claimant, he would see no problems with him being seen by a second spine surgeon for his lower spine if a second surgical opinion were warranted.

The claimant was next seen by Dr. Justin Seale for an Independent Medical Exam on April 6, 2009. Dr. Seale focused on the claimant's spine and ordered another MRI of the lumbar spine. In his April 27, 2009 report, Dr. Seale noted his impression that the claimant had foraminal stenosis and degenerative disc disease at the L4-5, L5-S1 levels, both most likely pre-existing conditions aggravated by the March 20, 2008 injury. Dr. Seale continued the claimant's work restrictions.

The claimant was also seen by Dr. Sunder Krishman on May 20, 2009. He also focused on the lumbar spine. Dr. Krishman wrote that Dr. Kevin Collins had referred the claimant to Dr. Ackerman, a pain specialist. The only report in the record from Dr. Collins is a June 3, 2009, office note. Dr. Collins

wrote that the claimant should follow with Dr. Ackerman. Dr. Krishman recommended that the claimant continue with Dr. Ackerman for pain relief.

Dr. Crowel's last office visit was on May 28, 2009. He noted the claimant's complaint of left knee and back pain. Apparently, the claimant asked for a referral for pain management. Dr. Crowell wrote:

He is to see Dr. Hefley on May 29, 2009. I also plan to refer him to Dr. William Ackerman for pain management.

There is no other document in the record showing a referral to Dr. Hefley by Dr. Crowell other than this ambiguous statement that the claimant was to see Dr. Hefley on May 29<sup>th</sup>. At the hearing, the claimant testified regarding how he came to be under the care of Dr. Hefley for his right knee injury. He testified that Dr. Crowell had referred him to Dr. Hefley. On cross-examination, the claimant read his deposition testimony where he had testified:

Q You can read along with me. The questions, "How did you get to Dr. Hefley for your right knee?" I was referred by Dr. Crowell."

A Correct.

Q Question, "For both your right and left knees?" Answer, "No,

for my left knee." That's what it says, yes?

A Yes, he stated that he was going --

Q No, I'm not asking you that. You can talk about that when your attorney asks you. But that's what that deposition testimony for that day in the presence of your attorney and myself and the court reporter says, doesn't it?

A Yes, it does.

Q All right. And then the questions of right now about how, and the answer, "When I got up here, I was still having problems, and he started looking into my right knee.

A Uh-huh.

Q That's correct, isn't it?

A Okay.

The claimant then testified:

Well, I see, but I was probably a little confused at that time, but Dr. Crowell referred me with my left knee to Dr. Hefley, because he had done the first knee. And I wasn't having too much problem after he did the surgery for a month afterwards, and I started having trouble afterwards. And I was telling Dr. Hefley that I was still having problems with my right knee.

The claimant began seeing Dr. Hefley on May 29, 2009. On that date, he reported to Dr. Crowell noting bilateral knee pain, greater on the left with a

history of the claimant having landed on both knees on a concrete floor; a history of a right knee arthroscopy and injections, but nothing for the left knee, not even physical therapy. Dr. Hefley found a range of motion for both knees of 10 to 90 degrees, full extension with assistance, a mild effusion bilaterally, greater on left, etc. Radiology revealed "moderate to advanced tricompartmental degenerative changes with what seems to be some calcifications on the lateral view of the left knee; there is osteophytosis of both knees." Dr. Hefley concluded that the claimant had tricompartmental degenerative changes of the right knee status post medial meniscectomy, but an MRI was ordered with respect to the left knee's trimompartmental degenerative changes of the left knee, with respect to calcifications versus osteophytosis and possible meniscus tear.

The claimant underwent an MRI of the left knee on June 2, 2009. Findings were most consistent with an oblique horizontal tear of the posterior horn of the medial meniscus. The claimant was then seen by Dr. Hefley on June 12, 2009; a knee arthroscopy was recommended given the mild to moderate varus patellofemoral chondromalacia and torn medial meniscus. Dr. Hefley opined that the claimant had knee replacement surgery in his future as he weighed too much, (370

pounds) to have a knee replacement at that time. Surgery on the left knee was done June 18, 2009. A partial medial meniscectomy, removal of loose bodies, chondroplasty of the medial and patellofemoral compartments was performed by Dr. Hefley. When seeing Dr. Hefley on August 5, 2009, the claimant complained of additional right knee pain and was treated for that. The claimant informed Dr. Hefley that he could not make it through a day of getting up and down; going up and down the hallways, even sitting at a desk for long periods. Dr. Hefley kept the claimant off work for another four weeks. In subsequent visits, Dr. Hefley injected the claimant with Orthovisc into the left knee.

On September 23, 2009 visit, Dr. Hefley wrote that:

He comes in today bringing up a fairly new problem involving the right shoulder. He actually says that it is not a new problem, but he has not mentioned this to us previously.

Dr. Hefley's exam of the left knee was basically unchanged, but the exam of the right shoulder showed the claimant to have "an extremely difficult time with his active ranges of motion." Dr. Hefley wrote that radiology (X-rays) showed a:

... type II acromion with a noticeable anterior osteophyte off

the acromion. He does have some moderate AC arthrosis changes; otherwise, the views are unremarkable.

An MRI was ordered. The October 2, 2009 MRI of the claimant's right shoulder yielded findings of supraspinatus tendinosis without full thickness rotator cuff tear and a small amount of fluid within the subdeltoid space, which might have been due to prior injection or mild bursal inflammation. Then, in a follow-up on October 7, 2009, Dr. Hefley addressed the right knee as well as the right shoulder. Dr. Hefley opined that the right shoulder had impingement, acromioclavicular degenerative joint disease and supraspinatus tendinosis; that the right knee had moderate to advanced valgus tricompartmental arthritis with osteophytosis and the left knee had tricompartmental grader 3 osteoarthritis.

On November 4, 2009, the claimant complained to Dr. Hefley about his left knee and left shoulder. According to the claimant, his left knee had done very well after the viscosupplementation, but then, he just developed some spontaneous pain and swelling in the left knee, with no awareness of any cause. Dr. Hefley wrote:

... with regard to the left shoulder, this has just bothered him off and on for a few months. He says that he strained the shoulder during

physical therapy back in April. He was doing some press ups during the PT session for the right shoulder, but he did so [sic] something at that point that he felt that he had hurt the left shoulder." (Emphasis supplied)

Examination of the left knee revealed a moderate effusion without erythema or warmth, a good range of motion, and good varus and valgus stability without significant crepitation. The exam of the left shoulder revealed no obvious deformity, no atrophy and no crepitation and good strength though with a little bit of discomfort. The claimant requested physical therapy so an order was written.

On November 18, 2009, the claimant complained of pain in the right shoulder and both knees. A right shoulder arthroscopy, subacromial decompression, and distal clavicle excision was planned with surgery done on January 5, 2010. The postoperative diagnoses reflected in the January 5, 2010 operative report included right shoulder impingement, acromioclavicular degenerative joint disease, partial rotator cuff tear, posterior inferior capsular contracture and adhesive capsulitis type 2 SLAP lesion.

The claimant was seen by Dr. Hefley on January 12, 2010. Dr. Hefley kept the claimant off from work due to the right shoulder and increasing problems with his

right knee. On February 2, 2010, Dr. Hefley wrote that the claimant's:

... complaints of pain seem to be a bit exaggerated given the level of pathology. He now tells me that he might be able to go back to work if we can obtain a motorized scooter for him. I do not think that would be in his best interest. I think he would be better served by committing to a conditioning and strengthening program and weight loss.

Dr. Hefley reduced the claimant's Lortab and kept the claimant off work.

On April 7, 2010, the claimant was seen again with directions to return as needed, but a month later, on May 5, 2010, Dr. Hefley wrote that the claimant was in for his right knee pain and that he was not working. An MRI of the right knee was ordered and then done on May 11, 2010. The radiologist report ruled out a potential meniscal tear.

Regarding the May 14, 2010 visit, Dr. Hefley wrote that the claimant was happy with the left knee and right shoulder but unhappy with his right knee. In the office note, Dr. Hefley wrote in light of the MRI, he suspected a torn remnant of the medial meniscus with locking episode. A right knee arthroscopy was ordered. There is no record that addresses a May 2010 right knee arthroscopy.

Dr. Hefley's May 25, 2010 note does not address whether a right knee arthroscopy was performed. He did write that the claimant reported having a right knee give away incident so that he fell on his left knee. Abrasions were found and treated. The claimant was advised to follow-up on an as-needed basis if there was any unresolved pain in the left knee after a reasonable healing period.

On July 16, 2010, the claimant reported terrible pain in the right knee and more and more pain in the left shoulder and that the pain had been worse for he last few weeks. An MRI of the left shoulder was ordered and a right knee arthroscopy was planned.

On July 22, 2010, the claimant underwent the MRI of the left shoulder. The July 22, 2010 radiology report indicated a possible partial thickness tear and possible inflammation. There are no records pertaining to the performance of a right knee arthroscopy after that date.

In my opinion, a review of the evidence does not demonstrate that the claimant had a valid referral to Dr. Hefley. First and foremost, the testimony of the claimant stating that he was referred to Dr. Hefley by Dr. Crowell is suspect. The claimant testified that he was a little confused when questioned about it, whether

or not he was referred by Dr. Crowell to Dr. Hefley. When the claimant was questioned regarding the referral at the hearing, the following testimony is enlightening.

Q So according to your testimony at a prior time with your attorney representing you, you testified that you got to Dr. Hefley for your left knee, not your right knee. And not as you've testified today that Dr. Crowell referred you to Dr. Hefley for treatment of your right knee?

A And he did.

Q That's not what you said on the prior occasion, Mr. Ellis?  
[sic]

A Well, I see, but I was probably a little confused at that time, but Dr. Crowell referred me with my left knee to Dr. Hefley, because he had done the first knee. And I wasn't having too much problem after he did the surgery for a month afterwards, and I started having trouble afterwards. And I was telling Dr. Hefley that I was still having problems with my right knee.

Q So you were wrong that day in the deposition, and you were just confused then. You didn't know what you were saying that day?

A Yeah. He didn't have a note here, but he referred me for my left knee.

Q All right. Not your right knee....

The only medical note that we have is a notation from Dr. Crowell dated May 28, 2009, where Dr. Crowell stated, "He is to see Dr. Hefley on May 29, 2009." In my opinion, this is not a referral. The claimant was to see Dr. Hefley the day after he last saw Dr. Crowell, which was May 28, 2009. This is also a referral from one orthopedic specialist to another orthopedic specialist. Dr. Crowell had previously referred the claimant to Dr. Kevin Collins for pain management and that was on March 10, 2009. There are no medical records between March 10, 2009 and May 28, 2009, from Dr. Crowell indicating that the claimant was referred by Dr. Crowell to Dr. Hefley. I submit that in one day, the claimant would not be able to get an appointment with Dr. Hefley. The note does not say he made an appointment for the claimant to see Dr. Hefley on May 29, 2009. It merely says the claimant is to see Dr. Hefley on May 29, 2009. Therefore, it is speculation and conjecture to conclude that Dr. Crowell's notation in his medical records of May 28, 2009, was a valid referral to Dr. William Hefley. There is absolutely no other evidence in the record that indicates that Dr. Crowell referred the claimant to Dr. Hefley. Therefore, any medical treatment rendered to the claimant by Dr. Hefley is unauthorized medical treatment and is not the

responsibility of the respondents. Even if I were to find that the claimant had a valid referral to Dr. Hefley, a finding which I do not make, I find that the evidence indicates that the claimant's treatment with Dr. Hefley is not for his compensable injuries.

The evidence demonstrates that the respondents accepted as compensable the claimant's right knee, left shoulder, and his back. It is not disputed that the claimant fell at work. However, the description of how the claimant fell and what was injured and what was reported as injured are in controversy. The claimant says he turned and fell hitting a student desk with his right upper extremity then fell to the floor on both knees, jamming his left arm in an effort to catch himself. The version the claimant first told to the physical therapist was that he had fallen on his right side injuring his lumbar spine, right tail bone, right knee with swelling, his right shoulder, cervical spine, and had some tenderness in both shoulders although left was greater. The physical therapist reports are also consistent with the report from MEMS, who reported the origin of the pain as being the back, right leg and right shoulder. The testimony of Ms. Paul states that she tapped the claimant on the shoulder and he stumbled back into a tall stool and fell on his bottom. She did

not recall him stretching out his left arm or hitting a desk or whether his knees collided with the floor, but she did know that he fell on his bottom. The medical records are replete with complaints of the claimant to his treating physician regarding symptoms to his left knee and right shoulder.

The evidence demonstrates that Dr. Crowell released the claimant on December 9, 2008, having reached maximum medical improvement. The claimant underwent a functional capacity evaluation on January 2, 2009, where he gave, once again, submaximal effort. The report states:

Rather, it is simply stated that Mr. Ellis can do more physically at times than was demonstrated during this testing date. Any final vocational or rehabilitations discussions for Mr. Ellis should be done with this in mind.

The claimant has significant osteoarthritis. Based upon my de novo review of the record, I find that the claimant has failed to meet his burden of proof. Accordingly, for all the reasons set forth herein, I respectfully dissent from the majority's award of benefits.

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KAREN H. MCKINNEY, Commissioner

