BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G101501

DAVID DONAHUE, EMPLOYEE	CLAIMANT
BENTON COUNTY, EMPLOYER	RESPONDENT
ASSOCIATION OF ARKANSAS COUNTIES WCT, INSURANCE CARRIER	RESPONDENT

OPINION FILED JULY 31, 2012

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

Claimant represented by the HONORABLE JASON HATFIELD, Attorney at Law, Fayetteville, Arkansas.

Respondent represented by the HONORABLE J. LESLIE EVITTS, III, Attorney at Law, Fort Smith, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed February 1, 2012. The administrative law judge found that the claimant proved he was entitled to additional medical treatment for his compensable injury. After reviewing the entire record *de novo*, the Full Commission affirms the administrative law judge's opinion.

I. HISTORY

David Patrick Donahue, now age 57, testified that he became employed with Benton County Sheriff's Department in 1999. Mr. Donahue testified that he was employed with the respondents as a work-detail deputy and that he supervised inmates on construction projects.

The parties stipulated that the claimant sustained a compensable injury to his right knee on July 19, 2010. The claimant testified that he injured his right knee as the result of stepping into a work van: "Stepped onto the running board, went to lift with my right leg, and it just popped and went into severe pain." The claimant signed a Form AR-N, Employee's Notice Of Injury, on July 19, 2010: "As I was getting into work van and stepping on running board my right knee popped and has hurt since." Dr. John A. Huskins saw the claimant on July 21, 2010 and planned an orthopedic referral.

Dr. John D. Mertz began treating the claimant on August 5, 2010: "55 year old male who was working getting in and out of a work van 2 weeks ago and felt a pop in his right knee. Has been very painful since that time....X-rays: Standing AP, lateral and sunrise view of the right knee

reveal mild degenerative changes patellofemoral and tibial femoral. Otherwise unremarkable. IMPRESSION: Internal derangement of the right knee secondary to work." Dr. Mertz placed the claimant on sitting duty for two weeks. The claimant testified that the respondent-employer accommodated his work restrictions.

An MRI of the claimant's right knee was done on August 16, 2010, with the following impression:

> 1. Probable complex tears of the menisci with the medial meniscal tear most severely involving the posterior horn where a vertically oriented tear is suspected. The lateral meniscus appears most severely involved at the junction of the anterior horn with the body along its inferior articular margin.
> 2. Edema about the medial collateral ligament could reflect strain or sprain of this ligament if the patient has had trauma.
> 3. Medial popliteal space Baker's cyst.
> 4. Moderate joint effusion.
> 5. Mild chondromalacia of the patella and slight lateral patellar tilting.

Dr. Mertz's impression on August 19, 2010 was "Acute tears of the medial and lateral menisci of the right knee with moderate effusion. Work related." Dr. Mertz recommended a "Right knee arthroscopy on Friday the 27th." Dr. Mertz performed surgery on August 27, 2010: "1. Arthroscopic shaving/chondroplasty patella and trochlea,

right knee. 2. Arthroscopic partial posterior horn medial meniscectomy with extensive shaving/chondroplasty of the medial femoral condyle and medial tibial plateau, right knee. 3. Arthroscopic partial lateral meniscectomy anterior horn." The postoperative diagnoses were "1. Moderate chondromalacia of patella and trochlea, right knee. 2. A flap and horizontal tear of the posterior horn medial meniscus right knee with moderate chondromalacia of the medial femoral condyle and mild chondromalacia of the medial tibial plateau. 3. Flap tear of the anterior horn of the lateral meniscus, right knee."

The claimant testified that he returned to work on August 30, 2010. The claimant was provided physical therapy following surgery. Dr. Mertz saw the claimant on September 9, 2010 and recommended "Synvisc One injection in 3 months. Regular duty now."

The claimant followed up with Dr. Mertz on December 9, 2010: "55 year old male in today for evaluation of his right knee. He has some recurrent pain, some thigh spasms, some calf spasm." Dr. Mertz's impression was "4 months post arthroscopic shaving of moderate patellar and trochlear changes with partial medial and lateral meniscectomy,

moderate medial femoral condyle changes, mild medial tibial plateau changes. RECOMMENDATIONS: He's headed for knee arthroplasty some time in the future."

On December 16, 2010, a nurse case manager corresponded with Dr. Mertz and asked Dr. Mertz to address several questions regarding the claimant's right knee injury and medical treatment. Dr. Mertz replied on December 20, 2010:

> 1) The pathology identified intra-operatively that was considered resultant of his 7/19/2010 injury was the medial and lateral meniscal tears.
> 2) I would say that his current symptoms are mostly related to pre-existing pathology or at least 75%.
> 3) The Synvisc injection is indicated as a result of the exacerbation of his wear and tear changes from his 7/19/2010 pre-existing degenerative joint disease. The patient was not having enough difficulty prior to his injury to need Synvisc injection so I have stated that the Synvisc injection relates intimately to his 7/19/2010 injury.
> 4) Future knee arthroplasty is resultant of his pre-existing pathology although he apparently was doing fine until he exacerbated his arthritic condition with new cartilage tears on 7/19/2010.
> 5) I would expect David Donahue to reach maximum medical improvement as of March 1, 2011. I recommend that some time in February you help us find a physical therapist who does functional capacity evaluations so we can have a better idea of what his impairment rating is if he has one at all.

Dr. Terry J. Sites performed an Independent Medical Examination and reported on January 24, 2011:

Updated x-rays were obtained today as he has had no x-rays following his surgery on 08-27-10. Standing right knee films today show some medial joint space narrowing, a medial joint space of 3 mm on the right, 6 mm on the left, the patellofemoral and lateral joint spaces appear normal. This is consistent with his mild-to-moderate right knee osteoarthritis noted at the time of his arthroscopy....

QUESTIONS:
#1. Based on radiographic studies and operative note, what pathology was considered resultant of his 07-19-injury? Pre-existing?

The torn medial and lateral menisci were more-likely-than-not a result of his 07-19-10 work injury to his right knee. The chondromalacia patellae and chondromalacia of the medial femoral condyle were more-likely-than-not a pre-existing degenerative arthritis condition.

#2. In your opinion is his current symptoms resultant from the 07-19-10 injury vs. pre-existing pathlogy/degenerative joint disease?

Assuming that the medial meniscus tear had been fully addressed at the time of the right knee arthroscopy, and that there is no lingering pathology as it relates to the medial meniscus it is more-likely-than-not that his current right knee symptoms are a result of his pre-existing degenerative arthritis.

#3. Is the proposed Synvisc injection indicated as a direct result of his 07-19-10 injury vs. his pre-existing pathology? Please explain and provide rationale.

Synvisc injections are a treatment for osteoarthritis. The osteoarthritis is more-likely-than-not a pre-existing condition. However, his right knee injury on 07-19-10 and the subsequent surgery on 08-27-10 more-likely-than-

not created an exacerbation of his arthritis. I would recommend a one-time treatment for this exacerbation of his pre-existing arthritis, with any subsequent need for treatment of his right knee more-likely-than-not a result of the natural symptomatic progression of a pre-existing arthritis, less-likely-than not due to an ongoing exacerbation of said pre-existing arthritis.

#4. Would the anticipated future knee arthroscopy be resultant of the 07-19-10 injury or pre-existing pathology? Please provide rationale.

Future knee arthroplasty would more-likely-than-not be the result of a progression of his right knee moderate pre-existing arthritis. The patient noted that he did have right knee symptoms prior to the injury date, consisting of pain with occasional OTC ibuprofen use. He suffered a twisting injury while stepping onto a running board, there was no impaction or other more violent trauma that one may associate with a posttraumatic arthritis. In addition, the period of time from his injury date of 07-19-10 to his operative date of 08-27-10 was less than six weeks. One does not develop significant osteoarthritis in six weeks from any kind of injury, much less a twisting, low-load, non-impact injury. The natural history of moderately severe arthritic change such as what was documented at the time of arthroscopy by Dr. Mertz is a progression that may occur quickly or slowly or somewhere in between. Progression of his arthritis is more-likely-than-not the natural history of moderately severe osteoarthritis and less-likely-than-not from the injury mechanism as described above.

#5. If there is no additional treatment indicated as a result of the 07-19-10 injury, has Mr. Donahue achieved maximum medical improvement? If not, when would you anticipate achievement of maximum medical improvement?

> I would recommend additional treatment of a one-time Synvisc injection for exacerbation of his underlying arthritis from the 07-19-10 work injury. Approximately eight weeks following the Synvisc injection I would consider his right knee as having reached maximum medical improvement as it relates to his 07-19-10 injury....
>
> At the time of maximum medical improvement and utilizing AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, and based on the objective treatments at surgery of a partial medial and lateral meniscectomies, table 64 on page 85 would result in a right lower extremity impairment of 10%, 4% whole person if applicable....

The claimant followed up with Dr. Mertz on February 8, 2011: "David is a 55-year-old male who is seen back today for Synvisc injection. PHYSICAL EXAMINATION: He has a 2+ effusion. Through a lateral intra-articular approach, we drained off 15 cc of serosanguineous fluid and placed Synvisc-One into his right knee. IMPRESSION: Six months post arthroscopic shaving of moderate patellar and trochlear changes with partial and lateral meniscectomy with moderate medial femoral condyle changes and mild medial tibial plateau changes. RECOMMENDATIONS: We will see how the Synvisc works. He will come back in four months for reevaluation."

The claimant testified that the Synvisc injection on February 8, 2011 provided only temporary relief. Dr. Mertz

noted on April 11, 2011 regarding the claimant, "Overdoing it at work which is hurting his knee quite a bit....IMPRESSION: 8 months post arthroscopic shaving of moderate patellar and trochlear changes with partial medial and lateral meniscectomy with moderate medial femoral condyle changes and mild medial tibial plateau changes. RECOMMENDATIONS: I would like to see him go through vocational rehab to get trained to do a lighter duty type of job with sitting in the future. I'm in agreement that Mr. Donahue has reached maximum medical improvement in regards to his 7/19/10 injury and I would tend to agree with Dr. Sites that Mr. Donahue is entitled to a 10% permanent partial physical impairment rating as the result of his 7/19/10 injury and subsequent surgery." The claimant testified that he was paid benefits for a 10% anatomical impairment rating.

Dr. Mertz noted on May 12, 2011 that the claimant had "a painful effusion 2+ of the right knee....Apparently worker's comp is not putting him through vocational rehab to do a lighter type of job that is more suitable for the future. All in all, the patient would benefit from aspiration, steroid injection to try to jump start his

Synvisc after June 13th. Ultimately he would also benefit from Neurontin or Lyrica for chronic pain syndrome if Dr. Huskins feels like that's a reasonable option. He would also benefit from consideration of a right knee replacement some time in the future and he's going to get more facts and get back with us in June."

Dr. Huskins noted on May 26, 2011, "X-ray showed some medial joint space narrowing on the right. Discussed work-up, referral options. May need surgical repair." Dr. Huskins performed an injection on June 1, 2011 and diagnosed "Knee pain." Dr. Huskins reported in part on June 30, 2011, "He relates that he had surgery on his knee on August 27, 2010 of the previous year. He has had some initial improvement but has now had progressive symptoms in the right knee. X-rays at this time showed degenerative changes in the right knee. At this time he had a joint injection. He has follow-up visit with orthopedist in a week or two. I would suspect that he may need a partial joint replacement. This appears to be a progressive problem related to his injury on July 19, 2010."

Dr. Mertz reported on July 14, 2011:

> David had his right knee injury July 19, 2010. He had been doing quite satisfactory until then but

> he had been carrying at least 20 lbs. of duty equipment since 1999 while working for the county. Even though we found what appeared to be some chronic changes of his right knee in the patella and trochlear region and medial compartment with some new meniscal tears, I believe that at least 51% of his need for a right knee replacement comes from work related activity carrying the excess duty weight and lots of walking and squatting. For this reason, I would support a right knee replacement through worker's compensation and will let the insurance companies go through this thought process. The patient will get back with me on an as needed basis.

Dr. Sites corresponded with AAC Risk Management on August 25, 2011:

> This is in response to a request from Ms. Ann Wilson in a letter dated August 12, 2011 regarding David Donahue.
>
> In preparation for my response I have reviewed my original Independent Medical Examination dated January 24, 2011, as well as some additional information from Ms. Wilson as it relates to opinions from Dr. Huskins and Dr. Mertz regarding the patient's need for knee arthroplasty....
>
> Following my review of additional information provided I would not change my opinion from that expressed in my IME on 01-24-11. At that time I expressed that assuming the medial meniscus tear had been fully addressed at the time of the right knee arthroscopy and that there is no lingering pathology as it relates to the medial meniscus, it is more-likely-than-not that Mr. Donahue's ongoing right knee symptoms are a result of his pre-existing degenerative arthritis.
>
> My opinion remains the same that future knee arthroplasty would more-likely-than-not be the result of a progression of Mr. Donahue's pre-

> existing right knee moderate arthritis. Mr. Donahue noted he had right knee symptoms prior to his injury date consisting of pain with occasional OTC ibuprofen use. He sustained a twisting injury while stepping onto a running board, there was no impaction or other more violent trauma that one may associate with a posttraumatic arthritis. In addition, the period of time from his injury date of 07-19-10 to his operative date of 08-27-10 was less than six weeks. One does not develop significant osteoarthritis in six weeks from any kind of injury, much less from a twisting, low-load, non-impact injury.
>
> The natural history of moderately severe arthritic change such as what was documented at the time of arthroscopy by Dr. Mertz is a progression which may occur more quickly or more slowly, or somewhere in between. In addition, sometimes the process of shaving or chondroplasty performed at the time of surgery can quicken the progression of symptomatic arthritis.
>
> Progression of his arthritis is more-likely-than-not the natural history of moderately severe osteoarthritis as objectively documented at the time of surgery and less-likely-than-not from the injury mechanism described above for 07-19-10. Also, there is no objective way to separate vigorous work activities from activities of daily living outside the work place.
>
> These statements are made within a reasonable degree of medical certainty based upon the objective factors above.

Dr. Huskins performed procedures on October 4, 2011 which included an injection of the claimant's right knee.

A pre-hearing order was filed on October 14, 2011. The claimant contended that "as a result of his compensable

injury Dr. John Huskins and Dr. John Mertz have both recommended additional treatment and surgical intervention for his right knee." The respondents contended, among other things, that all medical benefits to which the claimant was entitled had been paid. The respondents contended that "no compensable event is the major cause of the claimant's current disability or need for medical treatment, and that any additional medical treatment sought by the claimant is not reasonable or necessary as a result of his compensable injury."

The parties agreed to litigate the following issue: "1. The claimant's entitlement to additional medical treatment for his compensable right knee injury."

After a hearing, an administrative law judge filed an opinion on February 1, 2012. The administrative law judge found that the claimant proved he was entitled to additional medical treatment for his compensable injury. The respondents appeal to the Full Commission.

II. ADJUDICATION

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 has the burden of proving by a preponderance of the evidence that medical treatment is reasonably necessary. *Stone v. Dollar General Stores*, 91 Ark. App. 260, 209 S.W.3d 445 (2005). Preponderance of the evidence means the evidence having greater weight or convincing force. *Metropolitan Nat'l Bank v. La Sher Oil Co.*, 81 Ark. App. 269, 101 S.W.3d 252 (2003). 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).

An administrative law judge found in the present matter, "2. Claimant has met his burden of proving by a preponderance of the evidence that he is entitled to additional medical treatment for his compensable right knee injury." The Full Commission affirms this finding. The parties stipulated that the claimant sustained a compensable injury to his right knee on July 19, 2010. There is no evidence of record demonstrating that the claimant required any medical treatment for his right knee prior to the July 19, 2010 compensable injury. The claimant treated with Dr. Huskins and Dr. Mertz following the compensable injury. Dr.

Mertz stated on August 5, 2010 that an x-ray showed mild degenerative changes in the claimant's right knee. An MRI on August 16, 2010 showed meniscal tears and mild chondromalacia of the patella. Dr. Mertz performed arthroscopic surgery on August 27, 2010.

The claimant returned to work for the respondents on August 30, 2010 but continued to suffer from pain in his right knee. Dr. Mertz arranged physical therapy and provided follow-up treatment. Dr. Mertz opined on December 20, 2010 that the claimant's symptoms and need for a possible future knee arthroplasty were "mostly related to pre-existing pathology or at least 75%." However, Dr. Mertz also stated that a Synvisc injection was related to the compensable injury. Dr. Mertz also stated that the claimant "was doing fine until he exacerbated his arthritic condition with new cartilage tears on 7/19/10."

Dr. Sites performed an Independent Medical Examination on January 24, 2011 and opined that the claimant's "lingering pathology" was "a result of his pre-existing degenerative arthritis." Dr. Sites also concluded that a knee arthroplasty would be related to "a progression of his right knee moderate pre-existing arthritis." Dr. Sites

stated that the claimant had reached maximum medical improvement and assigned the claimant a 10% permanent anatomical impairment rating on January 24, 2011. Dr. Mertz concurred with Dr. Sites' assignment of a permanent impairment rating. Permanent impairment is any permanent functional or anatomical loss remaining after the healing period has ended. *Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994). The record in the present matter therefore indicates that the claimant reached the end of a healing period for his compensable injury no later than January 24, 2011.

Nevertheless, it is well-settled that a claimant may be entitled to ongoing medical treatment after the healing period has ended, if the medical treatment is geared toward management of the claimant's injury. *Patchell v. Wal-Mart Stores, Inc.*, 86 Ark. App. 230, 184 S.W.3d 31 (2004), citing *Hydrophonics, Inc. v. Pippin*, 8 Ark. App. 200, 649 S.W.2d 845 (1983).

In the present matter, Dr. Mertz noted on April 11, 2011 that the claimant's knee was hurting as a result of his work duties for the respondent-employer. Both Dr. Mertz and Dr. Huskins stated that additional surgery to the claimant's

knee might become necessary. Dr. Huskins opined on May 26, 2011 that the condition of the claimant's right knee was "a progressive problem related to his injury on July 19, 2010." Dr. Mertz reported on July 14, 2011, "I believe that at least 51% of his need for a right knee replacement comes from work related activity carrying the excess duty weight and lots of walking and squatting. For this reason, I would support a right knee replacement through worker's compensation and will let the insurance companies go through this thought process."

The Commission has the duty of weighing medical evidence and, if the evidence is conflicting, its resolution is a question of fact for the Commission. *Green Bay Packaging v. Bartlett*, 67 Ark. App. 332, 999 S.W.2d 695 (1999). It is within the Commission's province to weigh all of the medical evidence and to determine what is most credible. *Minnesota Mining & Mfg. v. Baker*, 337 Ark. 94, 989 S.W.2d 151 (1999). Moreover, in workers' compensation law, an employer takes the employee as he finds him, and employment circumstances that aggravate preexisting conditions are compensable. *Heritage Baptist Temple v. Robison*, 82 Ark. App. 460, 120 S.W.3d 150 (2003).

In the present matter, the Full Commission attaches significant evidentiary weight to the opinions of Dr. Huskins and Dr. Mertz. Dr. Huskins and Dr. Mertz have opined that the claimant needs additional medical treatment which is related to the July 19, 2010 compensable injury. The Full Commission finds that the July 19, 2010 compensable injury aggravated a pre-existing condition in the claimant's right knee, and that additional medical treatment is reasonably necessary in connection with the compensable injury. The Full Commission finds that the compensable injury is at least "a factor" in the claimant's need for additional treatment, including possible surgery. *See Williams v. L & W Janitorial*, 85 Ark. App. 1, 145 S.W.3d 383 (2004). We find that the opinions of Dr. Huskins and Dr. Mertz in the present matter are entitled to more evidentiary weight than the opinion of Dr. Sites.

Based on our *de novo* review of the entire record, the Full Commission affirms the administrative law judge's opinion that the claimant proved additional medical treatment was reasonably necessary. The Full Commission finds that the claimant proved by a preponderance of the evidence that he was entitled to additional medical

treatment as recommended by Dr. Huskins and Dr. Mertz. Said reasonably necessary medical treatment includes possible additional surgery as recommended by Dr. Mertz. For prevailing on appeal, the claimant's attorney is entitled to a fee of five hundred dollars ($500), in accordance with Ark. Code Ann. §11-9-715(b)(Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority's finding that the claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment for his right knee injury. My carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to meet his burden of proof.

The claimant, a veteran employee of the Benton County Sheriff's Department, whose duty it was to transport

and supervise inmates on work-detail, sustained an admittedly compensable injury to his right knee on July 19, 2010. This injury, which was shown by an MRI taken on August 16, 2010, to be a torn meniscus, was arthroscopically repaired on August 27, 2010, by orthopedic surgeon, Dr. John D. Mertz with the Ozark Orthopaedics clinic. Thereafter, the claimant underwent physical therapy until September 7, 2010.

The claimant was next seen by Dr. Mertz in post-operative follow-up treatment for his right knee on September 9, 2010. Although the claimant reported to Dr. Mertz some general pain relief as a result of his surgery, he further reported some recurrent medial pain with associated thigh and calf spasms. In his report of that visit, Dr. Mertz noted that, in addition to acute tears, mild to moderate chondromalacia (degenerative pathology) was confirmed throughout the claimant's right knee during the surgical procedure. Dr. Mertz instructed the claimant to return to the clinic in three months for a Synvisc-One injection, and he released him to regular duty.

On September 23, 2010, the claimant returned to Dr. Mertz with pain in the medial region of his **left** knee.

The record reveals that the claimant had injured his left knee on March 31, 2010, while running at a law enforcement training facility. In addition, it is noted that the claimant's July 21, 2010, appointment with his personal physician, Dr. John A. Huskins, at which he was initially seen for his right knee injury, was originally scheduled for follow-up treatment of his March, 2010, left knee injury. It was after this appointment that Dr. Huskins referred the claimant to Dr. Mertz.

Upon his September 23rd visit, Dr. Mertz assessed the claimant with intrameniscal degenerative changes of the left medial meniscus with mild chondromalacia of the patella, as had been indicated on a previous MRI report. Dr. Mertz treated the claimant's symptoms with a steroid injection and instructed him to return thereafter on a per-as-needed basis for his left knee complaints.

Upon his return visit to the Ozark clinic on December 9, 2010, Dr. Mertz noted that the claimant was "headed for [right] knee arthroplasty some time in the future." (NOTE: Although this clinic note reflects that the claimant received a Synvisc injection at that appointment,

it was confirmed and agreed that the claimant actually received this injection in February of 2011.)

In response to this prognosis, case manager for the respondent, Ann Wilson, sent Dr. Mertz a questionnaire dated December 16, 2010, to which he promptly responded. In relevant part, Dr. Mertz's responses reflect that:

> (1) the pathology identified that was considered resultant from his July 19, 2010, right knee injury were medial and lateral meniscal tears;
>
> (2) the claimant's current right knee symptoms were "75%" related to pre-existing pathology;
>
> (3) the recommended Synvisc injection was to address the claimant's pre-existing degenerative condition, which Dr. Mertz stated was not problematic enough prior to his injury to warrant such treatment;
>
> (4) future knee replacement surgery was necessary in order to address the claimant's pre-existing pathology, which Dr. Mertz opined was exacerbated by his July 19th injury; and,
>
> (5) Dr. Mertz expected the claimant to reach maximum medical improvement for his right knee injury on March 1, 2011. Finally, Dr. Mertz recommended that the claimant undergo a functional capacity evaluation sometime in February of 2011, in order to accurately assess the claimant's permanent impairment, if any.

Dr. Terry Sites conducted an independent medical evaluation of the claimant's condition on January 24, 2011. According to Dr. Sites, the claimant admitted occasional right knee symptoms prior to his July 19, 2010, injury for a period spanning several years, which he treated with OTC ibuprofen. At the time of his evaluation, the claimant reported taking at least one ibuprofen per day, and sometimes two, for control of medial right knee pain. Further, in response to questions similar to those that had been presented to Dr. Mertz, Dr. Stiles stated that while the claimant's surgically repaired meniscal tears were "more-likely-than-not" resultant from his July 19, 2010, work-related injury, his chondromalacia was more than likely resultant from his pre-existing arthritic condition. In addition, Dr. Stiles confirmed that the proposed Synvisc injection was for the treatment of the claimant's osteoarthritis, which likely pre-existed the claimant's injury. In addition, while Dr. Stiles opined that the claimant's injury may have exacerbated the claimant's arthritic condition, he believed that one Synvisc treatment should address that issue. Dr. Stiles added that should any further treatment be necessary after the Synvisc injection, this additional treatment would

"more-likely-than-not" be necessary for the treatment of the claimant's "natural symptomatic progression of a pre-existing arthritis" as opposed to an "ongoing exacerbation of said pre-existing arthritis." In response to an inquiry as to whether the claimant's anticipated future knee arthroplasty was resultant of his injury of July, 2010, or from his pre-existing pathology, Dr. Stiles stated as follows:

> Future knee arthroplasty would more-likely-than-not be the result of a progression of his right knee moderate pre-existing arthritis. The patient noted that he did have right knee symptoms prior to the injury date, consisting of pain with occasional OTC ibuprofen use. He suffered a twisting injury while stepping onto a running board, there was no impaction or other more violent trauma that one may associate with a posttraumatic arthritis. In addition, the period of time from his injury date of 07-19-10 to his operative date of 08-27-10 was less than six weeks. One does not develop significant osteoarthritis in six weeks from any kind of injury, much less a twisting, low-load, non-impact injury. The natural history of moderately severe arthritic change such as what was documented at the time of arthroscopy by Dr. Mertz is a progression that may occur quickly or slowly or somewhere in between. Progression of his

> arthritis is more-likely-than-not the natural history of moderately severe osteoarthritis and less-likely-than-not from the injury mechanism as described above.

In conclusion of his report, Dr. Stiles stated that the claimant should reach maximum medical improvement for his July, 2010, right knee injury eight weeks post-Synvisc injection, and, based upon the objective treatments at surgery of a partial medial and lateral menisectomies, he rated the claimant with 10% permanent physical impairment.

Upon returning to the Ozark clinic on February 8, 2011, the claimant received a Synvisc injection in his right knee. On April 11, 2011, the claimant returned to Dr. Mertz with complaints of knee pain from "overdoing it" at work. At that time, Dr. Mertz opined that the claimant had reached maximum medical improvement with regard to his right knee injury, and he agreed with Dr. Stiles's 10% permanent physical impairment rating, which the respondent thereafter accepted and paid.

On May 12, 2011, the claimant returned to Dr. Mertz with bilateral knee complaints. Dr. Mertz

noted then that the claimant "seems quite depressed over his right knee arthritis." Dr. Mertz treated the claimant with a steroid injection, which was intended to "jump start" his Synvisc treatment. Further, Dr. Mertz stated that the claimant would benefit from consideration of a right knee replacement sometime in the future. Thereafter, the claimant continued receiving medical treatment for bilateral knee complaints, primarily with his PCP, Dr. Huskins, who took x-rays of the claimant's knees on May 26, 2011. These films showed advanced degenerative changes in both of the claimant's knees. On June 1, 2011, Dr. Huskins gave the claimant a steroid injection and took him off work.

In response to a request by the claimant, Dr. Huskins drafted a letter on June 13, 2011, stating that, in his opinion, the claimant's right knee problem appeared to be a "progressive problem related to his injury on July 19, 2010." Likewise, the claimant requested a letter from Dr. Mertz, who responded on July 14, 2011, that, in his opinion, "at least 51% of his need for a right knee replacement comes from work

related activity carrying the excess duty weight and lots of walking and squatting." However, in response to a similar request by Ms. Wilson for his opinion, Dr. Stiles stated in a letter dated August 25, 2011, the following:

> Following my review of additional information provided I would not change my opinion from that expressed in my IME on 1-24-11. At that time I expressed that assuming the medical meniscus tear had been fully addressed at the time of the right knee arthroscopy and that there is no lingering pathology as it relates to the medical meniscus, it is more-likely-than-not that Mr. Donahue's ongoing right knee symptoms are a result of his pre-existing degenerative arthritis.

Dr. Stiles stated his opinion within a reasonable degree of medical certainty.

Employers must promptly provide medical services which are reasonably necessary for treatment of compensable injuries. Ark. Code Ann. § 11-9-508(a)(Supp. 2009). However, injured employees have the burden of proving by a preponderance of the evidence that the medical treatment is reasonably necessary for the treatment of the compensable injury. Owens Plating Co.v. Graham, 102 Ark. App. 299, 284

S.W.3d 537 (2008). What constitutes reasonable and necessary treatment is a questions of fact for the Commission. Id.; Anaya v. Newberry's 3N Mill, 102 Ark. App. 119, 282 S.W.3d 269 (2008). When assessing whether medical treatment is reasonably necessary for the treatment of a compensable injury, we must analyze both the proposed procedure and the condition it is sought to remedy. Deborah Jones v. Seba, Inc., Full Workers' Compensation Commission Opinion filed December 13, 1989 (Claim No. D512553). Also, the respondent is only responsible for medical services which are causally related to the compensable injury. Treatments to reduce or alleviate symptoms resulting from a compensable injury, to maintain the level of healing achieved, or to prevent further deterioration of the damage produced by the compensable injury are considered reasonable medical services. Foster v. Kann Enterprises, 2009 Ark. App. 746, 350 S.W.2d 796(2009). Liability for additional medical treatment may extend beyond the treatment healing period as long as the treatment is geared toward management of the

compensable injury. Patchell v. Wal-Mart Stores, Inc., 86 Ark. App. 230, 184 S.W.3d 31 (2004).

In this claim, as the respondent correctly contends that although Dr. Sites and Dr. Mertz each opined that the claimant's right knee injury had created an exacerbation of his arthritis, they each stated that such was a temporary exacerbation. Moreover, both Dr. Mertz and Dr. Sites opined that the claimant had reached maximum medical improvement for his compensable right knee injury as of April 11, 2011, upon which date he was released for his compensable injury and assigned a 10% permanent physical impairment rating.

The medical records clearly indicate that the claimant sustained right knee, meniscal tears pursuant to the work-related incident of July 19, 2010. These tears, were surgically repaired that same August, and, according to the record, that surgery was successful. However, the claimant continued to receive treatment thereafter for symptoms in both knees, his left knee having been similarly injured in March of 2010. This ongoing treatment was confirmed by various diagnostic

studies to be necessitated by the presence of pre-existing degenerative pathology in both of the claimant's knees. And while, according to Dr. Mertz, the claimant's continuing daily work activities caused "at least 51% of his need for a right knee replacement," this suggests a gradually worsening of a pre-existing condition, as opposed to a specific-incident-type causation. Dr. Mertz's opinion is, therefore, consistent with Dr. Stiles' opinion that "it is more-likely-than-not that Mr. Donahue's ongoing right knee symptoms are a result of his pre-existing degenerative arthritis." Thus, it naturally follows that any surgery related thereto is necessitated by the claimant's pre-existing arthritic pathology rather than his meniscal tears, which were properly and appropriately addressed through prior surgery, and concerning which he reached maximum medical improvement as of April 11, 2011.

In addition, I note that a review of the medical records strongly suggests some frustration on Dr. Mertz's part that the claimant's arthroplasty which, by all accounts is warranted due to his

arthritis, was contested by the respondent carrier, and also on an assumption that the respondent carrier was not acting as per his recommendations. For example, in his report dated April 11, 2011, Dr. Mertz stated:

> I would like to see him go through vocational rehab to get trained to do a lighter type of job with more sitting in the future.

Then in his report of May 12, 2011, Dr. Mertz stated:

> Apparently workers' comp is not putting him through vocational rehab to do a lighter type of job that is more suitable for the future.

Finally, in his report dated June 13, 2011, Dr. Mertz stated:

> I told him [the claimant] that if we did a knee replacement on him that we could help him by discounting the fees ... .

Notwithstanding the above, however, I again note that the respondent carrier is only legally liable for additional medical treatment that is geared toward management of the compensable injury, and that, according to Dr. Mertz, the claimant had reached the end of his healing period for his compensable right knee injury as of April 11, 2011. Moreover, I

reiterate that the credible medical evidence in this claim indicates that the claimant's current need for any additional medical treatment for his right knee, including right-knee arthroplasty, is necessitated by his pre-existing arthritic pathology.

It is well established that the Commission has a duty to translate the evidence on all the issues before it into findings of fact. Stone v. Dollar General Stores, 91 Ark. App. 260, 209 S.W.3d 445 (2005); Weldon v. Pierce Bros. Const. Co., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Moreover, the Commission has the authority to resolve conflicting evidence and this extends to medical testimony. Foxx v. American Transp., 54 Ark. App. 115, 924 S.W.2d 814 (1996). The Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. Emerson Electric v. Gaston, 75 Ark. App. 232, 58 S.W.3d 848 (2001); CDI Contractors McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993); McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989).

The Commission is entitled to review the basis for a doctor's opinion in deciding the weight of the opinion. Further, a medical opinion based solely upon claimant's history and own subjective belief that a medical condition is related to a compensable injury is not a substitute for credible evidence. Brewer v. Paragould Housing Authority, Full Commission Opinion, January 22, 1996 (Claim No. E417617).

While I find that the opinions of each of the claimant's treating physicians vary with regard to the extent to which the claimant's injury of July, 2010, has affected the claimant's pre-existing pathology, I find that these opinions are consistent in that they each reflect that the claimant's current need for additional medical treatment in the form of right knee arthroplasty is resultant from his pre-existing arthritis, versus meniscal tears that have long since healed. In addition, I find that Dr. Stiles' opinion was motivated strictly from an objective viewpoint, whereas Dr. Mertz appears to have been biased in that his opinion reflects a misplaced belief that the respondent carrier is somehow liable for any and all of

the claimant's ongoing medical treatment or other services resultant from his pre-existing condition by mere virtue of the fact that he sustained a compensable knee injury on July 19, 2010. Therefore, I give more weight to the opinion of Dr. Stiles. Because I assign more weight to the opinion of Dr. Stiles, I find that the claimant has failed to prove by a preponderance of the evidence that his arthroplasty, or any medical treatment for the alleviation of symptoms arising from his pre-existing, right knee pathology, for that matter, is reasonably necessary for the treatment of his July 19, 2010, right knee injury, which was clearly meniscal tearing. Therefore, I find that the claimant has failed to prove that he is entitled to additional medical treatment as recommended by Dr. Mertz. Accordingly, I must respectfully dissent from the majority's opinion.

KAREN H. MCKINNEY, COMMISSIONER