Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

FINAL AWARD ALLOWING COMPENSATION
(Affirming Award and Decision of Administrative Law Judge
by Supplemental Opinion)

Injury No.: 08-013352

Employee: Ervin Hampton

Employer: R. C. Lonestar, Inc.

Insurer: Sentry Insurance Company

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the parties' briefs, and considered the whole record. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated June 10, 2011, with this supplemental opinion. The Commission adopts the findings, conclusions, decision, and award of the administrative law judge to the extent they are not inconsistent with the supplemental opinion set forth below.

Discussion

Employee argues the administrative law judge erred in failing to award his medical expenses related to his total knee replacement. We agree with the administrative law judge that employee is not entitled to these expenses because he failed to meet his burden of proof on the issue.

We note, however, that the administrative law judge incorrectly applied the law. Section 287.140.1 establishes employer's liability for medical treatment and provides (in relevant part), as follows:

> In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.

On page 13 of his award, the administrative law judge stated: "The employee has the burden to prove that the accident was the prevailing factor in causing the resulting total knee replacement." This is a misstatement of the law, because there is no "prevailing factor" standard under § 287.140.1 RSMo. *Tillotson v. St. Joseph Med. Ctr.*, 347 S.W.3d 511, 518 (Mo. App. 2011). Rather, the question where a particular medical treatment is disputed is whether employee has shown that the treatment in question is reasonably required to cure and relieve from the effects of the work injury. *Id.* The employee meets his burden if he shows that the need for the treatment "flows from the work injury." *Id*. at 519. We do not adopt the administrative law judge's findings, analysis, or conclusions applying a "prevailing factor" standard to the issue whether employee's need for a total knee replacement was reasonably required as a result of the work injury.

When we apply the appropriate test, we are not persuaded that the total knee replacement was reasonably required to cure and relieve from the effects of the work injury. We find Dr. Burke's opinion on the issue credible and persuasive. Dr. Burke opined the work injury had nothing to do with employee's need for a total knee replacement, and that employee would have required a knee replacement based on the arthritic changes in his knee alone. We find Dr. Burke credible. We conclude the need for the total knee replacement did not flow from the work injury and was not reasonably required to cure and relieve from the effects of the work injury.

Accordingly, employee's claim for the cost of his total knee replacement is denied.

Conclusion
The Commission supplements the award and decision of the administrative law judge with our own analysis herein.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten issued June 10, 2011, is affirmed and attached hereto and incorporated herein to the extent it is not inconsistent with this supplemental opinion.

We approve and affirm the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this ___16TH___ day of March 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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James Avery, Member

DISSENTING OPINION FILED
Curtis E. Chick, Jr., Member

Attest:

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Secretary

DISSENTING OPINION

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I disagree with the majority's choice to deny employee's claim for medical expenses related to his total knee replacement.

On February 21, 2008, employee was cleaning a plug chute when he slipped and fell to the floor, injuring his right knee. The key issue in this matter is the nature and extent of the injury that employee suffered as a result of this event. Employer tries to limit its liability in this matter by blaming the condition of employee's knee on degenerative arthritis. But employee had no problems with his right knee before the accident, and the evidence is uncontested that he thereafter suffered unrelenting pain and disability that was so bad he ultimately had to get a total knee replacement. Clearly, something changed on February 21, 2008, within employee's right knee that caused him to become symptomatic. The parties have provided competing expert medical opinions on the issue.

Employee presents Dr. Berkin, who believes employee sustained a strain of his right knee which caused a tear in his medial meniscus and also aggravated the underlying arthritis in his knee. Dr. Berkin opined employee needed the total knee replacement as a result of the February 2008 work injury, rated employee's permanent partial disability of the right knee at 65%, and opined employee will need future medical treatment for his right knee as a result of the work injury. Employer, on the other hand, presents Dr. Burke, who believes employee suffered only a medial meniscus tear as a result of the work injury, and that his other problems are totally unrelated to the work injury but instead the product of degenerative arthritis.

In my view, employer and Dr. Burke have set up a straw man argument here by characterizing Dr. Berkin's opinion as an anatomical impossibility because a medial meniscus tear doesn't cause Grade II or III arthritis. This is not what Dr. Berkin opined. Rather, Dr. Berkin believes the <u>accident</u> aggravated the arthritis and made it symptomatic. It appears both the administrative law judge and the majority failed to recognize this distinction, as the award affirmed by the majority basically restates employer's misleading theory as to why Dr. Berkin is not credible.

I find Dr. Berkin more credible than Dr. Burke. Dr. Burke asks us to believe a man with no knee problems whatsoever would have needed a total knee replacement in July 2008 even if he had not fallen down while working for employer in February 2008. To credit such an argument would require that we turn a blind eye to the medical treatment record, employee's history, and the undeniable reality that employee's problems started with the work injury and only progressed from there.

I find a total knee replacement was reasonably required as a result of the compensable injury employee sustained on February 21, 2008. I find that employee was temporarily totally disabled from July 30, 2008, until October 20, 2008. I find employee sustained a 50% permanent partial disability as a result of the work injury. I would modify the award

of the administrative law judge and enter an award granting additional permanent partial disability benefits, temporary total disability benefits, and the past and future medical benefits to which I believe employee is entitled.

Because the majority has determined otherwise, I respectfully dissent from the decision of the Commission.

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Curtis E. Chick, Jr., Member

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee:	Ervin Hampton	Injury No. 08-013352
Dependents:	N/A	
Employer:	R.C. Lonestar, Inc.	
Insurer:	Sentry Insurance Company	
Appearances:	Gary Matheny, attorney for employee. Mike Banahan, attorney for the employer-insurer.	
Hearing Date:	March 9, 2011	Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.

2. Was the injury or occupational disease compensable under Chapter 287? Yes.

3. Was there an accident or incident of occupational disease under the Law? Yes.

4. Date of accident or onset of occupational disease? February 21, 2008.

5. State location where accident occurred or occupational disease contracted: Jefferson County Missouri.

6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.

7. Did employer receive proper notice? Yes.

8. Did accident or occupational disease arise out of and in the course of the employment? Yes.

9. Was claim for compensation filed within time required by law? Yes.

10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee slipped on material and injured his right knee.

12. Did accident or occupational disease cause death? No.

13. Parts of body injured by accident or occupational disease: Right knee.

14. Nature and extent of any permanent disability: 15% permanent partial disability of the right knee.

15. Compensation paid to date for temporary total disability: $11,251.90.

16. Value necessary medical aid paid to date by employer-insurer: $31,656.36.

17. Value necessary medical aid not furnished by employer-insurer: None.

18. Employee's average weekly wage: $930.61.

19. Weekly compensation rate: $620.41 for temporary total disability and $389.04 per week for permanent partial disability.

20. Method wages computation: By agreement.

21. Amount of compensation payable: $9,336.96.

22. Second Injury Fund liability: N/A.

23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: Gary Matheny.

FINDINGS OF FACT AND RULINGS OF LAW

On March 9, 2011, the employee, Ervin Hampton, appeared in person and with his attorney, Gary Matheny, for a hearing for a final award. The employer-insurer was represented at the hearing by it's' attorneys, Mike Banahan and Mary Ann Lindsey. Also present for the employer was Regional Human Resource Manager, Denise Menke. The Second Injury Fund was voluntarily dismissed without prejudice at the hearing. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. R.C. Lonestar, Inc. was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its' liability was fully insured by Sentry Insurance Company.
2. On February 21, 2008 Ervin Hampton was an employee of R.C. Lonestar, Inc. and was working under the Workers' Compensation Act.
3. On February 21, 2008, the employee sustained an accident arising out of and in the course of his employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was $930.61. The rate of compensation for temporary total disability is $620.41 per week and for permanent partial disability is $389.04 per week.
7. The employee's injury to the right medial meniscus and the March 10, 2008 surgery was medically causally related to the accident.
8. The employer-insurer paid $31,656.36 in medical aid.
9. The employer-insurer paid $11,251.90 in temporary disability benefits which represented 18 weeks of compensation from February 25, 2008 through July 3, 2008.

ISSUES

1. Medical causation as to the total right knee replacement performed on July 30, 2008.
2. Claim for previously incurred medical bills.
3. Claim for future medical aid.
4. Additional temporary total disability.
5. Nature and extent of permanent partial disability.

The following exhibits were offered and admitted into evidence:

<u>Employee's Exhibits</u>

A. Lost time slip from Dr. Dumontier.
B. Deposition of Dr. Berkin.

Employer-Insurer's Exhibits

1. Medical Records of Dr. Krewet.
2. Radiology reports.
3. ProRehab physical therapy records.
4. MidAmerica Rehab physical therapy records.
5. Missouri Baptist Medical Center records.
6. Dr. Dumontier records.
7. Deposition of Dr. Burke, containing his medical records.

Judicial Notice of the contents of the Division File was taken.

WITNESS: Ervin Hampton, the employee.

BRIEFS: The employee filed his brief on April 11, 2011. The employer-insurer filed its brief on April 13, 2011.

FINDINGS OF FACT

The employee was born in 1950 and is 60 years old. In February of 2008, he was employed as a material handler by R.C. Lonestar.

The employee testified that in January of 2005, the employee received treatment for his left knee including an MRI. The doctor prescribed a left knee brace due to instability issues.

In January of 2005, Dr. Dumontier ordered x-rays of the left knee which showed bi-compartmental degenerative arthritis with synovitis. Marginal osteophytes were seen in the patellofemoral compartment. A joint effusion distended the suprapatellar pouch. Joint space was slightly narrowed in the medial tibiofemoral compartment. A left knee MRI showed a posterior medial meniscus body and horn tear, without a displaced fragment, and secondary joint effusion. A moderately large joint effusion distended the suprapatellar pouch. There was mild subchondral edema in the medial posterior tibial plateau, adjacent to the meniscal tear.

The employee testified that prior to February 21, 2008 he had no problems with his right knee, had not had any treatment to his right knee, and had not experienced any problem performing his job duties due to his right knee. He was very active and ran a lot, walked a lot and played basketball and volleyball.

Around 3:00 a.m. on February 21, 2008, the employee was cleaning a plug chute. His leg slipped on material and his right knee popped. The employee reported the accident the next day and was sent to Dr. Krewet. The employee saw Dr. Krewet on January 25. The exam revealed slight laxity of the ACL and tenderness along the medial joint line; with a fair amount of swelling. X-rays were negative for fracture and showed minimal osteophyte formation involving the patellofemoral and medial femoral/tibial compartments; and minimal degenerative joint

disease with small associated knee joint effusion. Dr. Krewet diagnosed a right knee strain, rule out medial cartilage tear versus ACL tear; and ordered an MRI.

The February 28, 2008 MRI showed moderate joint effusion. The collateral and cruciate ligaments and patellar tendon were intact. The lateral meniscus was normal. The medial meniscus was abnormal with a horizontal tear of the posterior middle third of the meniscus. On February 29, Dr. Krewet diagnosed right knee strain with a tear of the posterior medial cartilage; and referred the employee to an orthopedic surgeon.

The employee saw Dr. Burke, an orthopedic surgeon on March 7. It was noted that on February 21, the employee was clearing out a chute when his right foot slipped, and fell on material. The employee had a sudden onset of pain both medially and posteriorly in the right knee and denied any prior history of right knee problems. The MRI showed a horizontal tear of the posterior middle third of the medial meniscus. On examination, the employee had moderate knee joint effusion and joint line tenderness with a markedly positive McMurray's test. X-rays showed minimal arthritic changes within the knee. Dr. Burke reviewed the MRI and stated that it showed clear evidence of a horizontal tear involving the posterior middle third of the medial meniscus. The lateral meniscus, collateral ligaments, anterior cruciate ligament and posterior cruciate ligament looked good. Dr. Burke recommended a partial medial meniscectomy.

On March 10, Dr. Burke performed right knee surgery. The history showed a twisting injury at work with sudden onset of pain in the medial and posterior aspect of the knee. Dr. Burke's preoperative diagnosis was a torn medial meniscus. He performed a right knee arthroscopy with a partial medial meniscectomy; abrasion arthroplasty and drilling of the weight-bearing surface of the lateral femoral condyle; and debridement of Grade II chondromalacia of the patella and trochlea. An examination of the right knee during surgery revealed that the patellofemoral joint showed global Grade II chondromalacia on the undersurface of the patella, as well as in the trochlea. The medial compartment was examined and there was little, if any, chondromalacia on the medial femoral condyle or medial tibia plateau. There was clear evidence of a complex tear of the posterior horn of the medial meniscus. There was a significant longitudinal crack in the articular surface of the lateral femoral condyle that extended from the weight-bearing surface up to the patellofemoral joint and several loose areas of cartilage along the edge. Dr. Burke's post-operative diagnosis was an acute complex tear of the posterior horn of the medial meniscus; chronic Grade II chondromalacia patella and trochlea; and chronic Grade II with focal Grade III chondromalacia, lateral femoral condyle.

On March 17, Dr. Burke noted that the employee was doing very well with some soreness and achiness toward the end of the day. There was little, if any, swelling. Dr. Burke prescribed physical therapy.

The employee testified that after his meniscus surgery, he could not walk on his right knee and could not climb stairs. He had trouble putting weight on the knee, and had swelling.

On April 3, Dr. Burke noted that the employee still had knee pain, especially after sitting for a long period. Dr. Burke and administered a cortisone injection. On April 7, the employee

told the physical therapist that the cortisone injection resulted in no significant change in his right knee symptoms. He continued to have pain along the medial and anterior aspect of the knee but rarely had the intense, sharp pain he previously experienced.

The employee saw Dr. Burke on April 24, 2008. X-rays showed no changes in the joint space and the medial and lateral joint spaces were still nicely preserved with no evidence of significant patellar chondromalacia. Dr. Burke noted that the employee was doing well, but was slow to return to normal, due to arthritic changes in his right knee and quad atrophy. He prescribed a patellar tracking brace and continued therapy. The employee was released to limited work duty with restrictions of no squatting, climbing, kneeling, or lifting or carrying greater than 20 pounds.

On May 15, the employee had a lot of grinding and cracking in the knee. Dr. Burke stated that the employee had very severe arthritis of the right knee, both in the patellofemoral joint and laterally. The work-related injury was the torn medial meniscus which was taken care of. On exam, the employee had little, if any knee joint effusion; had full extension and flexion, and mild crepitation. Dr. Burke diagnosed status post knee scope and partial medial meniscectomy, with some persistent medial knee pain; and debridement and abrasion arthroplasty of the lateral femoral condyle and patellofemoral joint. Dr. Burke ordered work hardening; and returned the employee to limited work duty with the same restrictions.

On June 2, Dr. Burke noted that the notes from work hardening showed the recommendations did not meet claimant's reported requirements for full-time duty in his current job. On exam, the employee had mild right knee joint effusion and full flexion and extension. The x-rays showed moderate medial compartment narrowing and patellofemoral arthritis in the right knee and equal findings on the unaffected left side. Dr. Burke reviewed the March 10 operative note which showed an acute work-related medial meniscus tear, along with chronic arthritic changes in the lateral compartment and patellofemoral joint. It was Dr. Burke's opinion the employee had a temporary aggravation of his chronic arthritic changes due to surgery. He aspirated 25cc of clear, yellow fluid and injected Synvisc. The employee remained on limited work duty with the same restrictions.

On June 9, the employee told Dr. Burke that he may be a little better and a second Synvisc injection was performed. On June 16, the employee was doing better with no right knee swelling or limping; and no evidence of joint effusion. Dr. Burke performed a third Synvisc injection.

Due to persistent knee pain, Dr. Burke ordered an MRI which was performed on June 19. It showed the partial medial meniscectomy with no definite evidence of a recurrent tear. There was moderate, diffuse three-compartment chondrosis and more focal areas of involvement in the lateral femoral condyle and throughout the medial compartment. There was joint centered edema present, especially in the medial compartment, which was likely arthritic in nature.

On June 23, 2008 the employee reported to Dr. Burke that his right knee symptoms were worse since he tried to mow his grass, and experienced increasing pain and giving way. On

exam, there was no right knee joint effusion and there was reproducible tenderness over the medial joint line and medial femoral condyle. Dr. Burke reviewed the MRI which showed no evidence of any new meniscal pathology. Edema was seen in the medial femoral condyle and medial tibial plateau around some arthritic changes in the knee. There was some significant arthritis seen mainly in the medial compartment, and in the lateral femoral condyle. Dr. Burke diagnosed persistent complaints of right knee pain after partial meniscectomy and significant degenerative changes seen during arthroscopy. He ordered a functional capacity evaluation to determine employee's work limitations. The employee was returned to limited-duty work with restrictions of no squatting, climbing or kneeling.

On June 30, 2008 the employee had a FCE which showed the primary deficits were decreased frequent load handling and difficulty with repetitive squatting, kneeling and walking on uneven ground. The quality of movement with squatting gradually worsened as the FCE progressed. Primary complaints of pain/popping appeared to be coming from the patellofemoral joint with repetitive squatting. The therapist concluded that the employee was capable of working in the very heavy physical demand level, with occasional lower level movements.

Dr. Burke, on July 3, diagnosed status post right knee scope and partial meniscectomy, articular shave and debridement of significant pre-existing arthritis within the right knee. Dr. Burke stated that the employee would likely benefit from a right knee replacement. Based on the operative findings showing clearly severe pre-existing arthritis within the knee; as well as the post-operative MRI suggesting no new meniscal pathology but degenerative changes within the knee; as well as the employee's persistent complaints of popping and pain in the areas where the degenerative changes were identified; and the FCE findings, it was Dr. Burke's opinion that the employee's symptoms at that point were completely related to his pre-existing degenerative changes, and not at all related to his torn medial meniscus.

On July 10, 2008 Dr. Burke issued a report and stated that during the right knee arthroscopy, he found a complex tear of the posterior horn of the medial meniscus that was acute, and Grade II and III chondromalacia of the lateral femoral condyle and patella and trochlea, which were clearly chronic in nature. The right knee arthroscopy for partial medial meniscectomy was related to the work injury. The abrasion arthroplasty and drilling of the lateral femoral condyle, was in a compartment away from the work injury. Post-operatively, claimant's medial knee pain resolved which was where his work related torn medial meniscus was. The employee had persistent anterolateral knee pain and sensations that his knee was going to give way, mainly anterior and anterolateral in nature, in the area of pre-existing arthritis. Dr. Burke performed exhaustive conservative care, including physical therapy, cortisone injections, and viscosupplementation. A repeat MRI scan did not reveal evidence of any new right knee pathology but showed significant arthritic changes. It was Dr. Burke's opinion that the employee had a 15% permanent partial disability of the knee of which 7.5% was due to the work related medial meniscus and 7.5% was due to severe pre-existing degenerative changes.

The employee underwent a total knee replacement for right knee arthritis by Dr. Burke on July 30, 2008. In the history, Dr. Burke stated that the employee had significant right knee

arthritis that had been unresponsive to all conservative care. Dr. Burke's pre- and post-operative diagnoses were degenerative joint disease of the right knee.

The employee saw Dr. Berkin on January 19, 2009 and Dr. Berkin's deposition was taken on July 15, 2010. Dr. Berkin stated that the employee injured his right knee in February 2008, when he stepped on some material while cleaning a chute and twisted his right leg. Dr. Berkin diagnosed a right knee strain which aggravated the employee's underlying degenerative arthritis; a tear of the medial meniscus of the right knee; status post arthroscopy of the right knee, with a partial medial meniscectomy and abrasion arthroplasty with drilling of the lateral femoral condyle and debridement of the patella and trochlea; and status post total right knee replacement.

It was Dr. Berkin's opinion that the February 21, 2008 accident was the prevailing factor in causing the employee's right knee strain, aggravating pre-existing arthritis, and causing the degenerative process to become symptomatic. The employee did not have any problems with his right knee prior to February 21, 2008 but did have pre-existing arthritis that was asymptomatic. It was Dr. Berkin's opinion that the injury caused the arthritis to be symptomatic, and the medial meniscus tear caused him to have an unstable knee which resulted in an acceleration of the natural progression of employee's pre-existing arthritis, necessitating his need for a total knee replacement.

It was Dr. Berkin's opinion that the February 21, 2008 accident was the prevailing factor in causing the tear of the medial meniscus in the employee's right knee and causing the need for arthroscopy of the right knee, with a partial medial meniscectomy, and other procedures. It was his opinion that the February 21, 2008 accident was the prevailing factor in causing the need for a total knee replacement that took place on July 30, 2008. It was his opinion that the employee was temporarily and totally disabled from July 30, 2008 until October 20, 2008.

Dr. Berkin believed the employee had a pre-existing arthritic condition in his right knee, which was not causing any symptoms. He also had the same disease process in his left knee, which was asymptomatic. After the right knee injury his condition became symptomatic, and the employee had an unstable knee. The knee instability promoted and caused progression of the arthritis to the point that employee had to have a knee replacement. Dr. Berkin stated that if the employee had not had the torn meniscus, he was not saying the employee would not have needed a knee replacement somewhere down the line but the need to have the knee replacement when he did was necessitated from the injury. It was his opinion that the employee's need for a total knee replacement was necessitated by his torn meniscus injury.

Part of his opinion that the accident led to an acceleration of the underlying arthritic condition was due to the instability created by the accident. Dr. Berkin agreed that Dr. Burke saw the employee on at least six occasions between the two surgical procedures. When asked if Dr. Burke did not find instability on any of those examinations if that would affect his opinion, Dr. Berkin stated that Dr. Burke not finding clinical instability does not alter the fact a knee with a torn meniscus can have subclinical instability that could cause a worsening of his arthritis over time. It was Dr. Berkin's opinion that the five months between the February 21, 2008 accident and the July 30, 2008 total knee replacement was a sufficient amount of time to cause the

acceleration of arthritis requiring the knee replacement. Dr. Berkin believed a person could develop arthritis in as little as three months.

It was Dr. Berkin's opinion that a problem in the medial compartment could accelerate degenerative arthritis in the patellofemoral and lateral compartments of the knee. Dr. Berkin did not agree with Dr. Burke's opinion that a meniscus tear could in no way affect the degenerative changes in the lateral or patellofemoral joint, and had no effect on employee's need for a total knee replacement. Dr. Berkin stated that the findings in the femoral and patellar compartment during the March 10, 2008 surgery were pre-existing arthritic changes. The February 21, 2008 accident did not cause the arthritis but could have aggravated that condition. By aggravation, Dr. Berkin meant it would trigger the condition to become symptomatic. Dr. Berkin stated that the accident did not cause the arthritic pathology but resulted in the employee's symptoms that required further treatment. The knee replacement surgery was performed to address the arthritic condition in employee's right knee. During the knee replacement surgery, there was nothing surgically done to remedy any residual symptoms from the torn meniscus.

It was Dr. Berkin's opinion that the employee sustained a 65% permanent partial disability of the right lower extremity at the level of the knee as a result of the February 21, 2008 injury and took into account his subjective complaints, physical findings, the knee replacement, and the likelihood of the requirement of another knee replacement in ten years. The rating was for everything that occurred to the employee including the aggravation of his underlying pre-existing arthritis and two surgical procedures. Dr. Berkin was unable to apportion the 65% disability between the medial meniscal tear, the drilling of the lateral femoral condyle with debridement of the patella and trochlea, and the total knee replacement.

Based on the nature of the work injury and right knee pathology, Dr. Berkin stated that the employee would require additional treatment for his right knee condition. This treatment included the use of non steroidal medication, home exercise program, and an additional right knee replacement. The employee would require care for exacerbation of his knee symptoms. There would be times over-the-counter medications would not give him the relief required, and he would need treatment from a physician for prescription strength medications. The February 21, 2008 accident was the prevailing factor in causing Dr. Berkin to make these treatment recommendations. Dr. Berkin recommended the employee avoid activities such as squatting, kneeling, stooping, turning, twisting and climbing. The employee should avoid climbing ladders and working at a height above ground level. If the employee was required to perform exertional activities for an extended period of time, he should be permitted frequent breaks to avoid exacerbation of his symptoms or further injury to the right knee.

On August 31, 2009, Dr. Burke, after reviewing the report of Dr. Berkin who stated that a twisting injury to employee's right knee was the prevailing factor in causing a right knee strain, aggravating the underlying degenerative arthritis and causing a tear of the meniscus, issued a supplemental report. Dr. Burke stated that the employee had a horizontal tear of the posterior horn of the medial meniscus, which was taken care of at the time of arthroscopy. The significant area of arthritis was in the lateral compartment which was already down to the bone and required drilling at the lateral femoral condyle. There were degenerative changes in the patellofemoral

joint. Dr. Burke stated that the degenerative changes in employee's right knee were in completely different compartments of the knee from the torn medial meniscus. The tear of the posterior horn of the medial meniscus was traumatic in origin and related to the February 21, 2008 injury. The medial meniscus tear could in no way positively or negatively affect degenerative changes in the lateral or patellofemoral joint, and therefore had absolutely no effect on the need for a total knee replacement. It was anatomically impossible for the medial meniscus tear to affect or accelerate degenerative changes in a separate compartment from where it was located. The need for a total knee replacement was based on the degenerative changes seen at the time of arthroscopy, and was in no way related to the work injury of the torn medial meniscus.

The employee testified that he treated with Dr. Dumontier in October 2009 for right knee pain and swelling. Dr. Dumontier took him off work from October 5, 2009 through October 28, 2009.

The employee saw Dr. Dumontier on October 5, 2009, for constant right knee pain with popping and cracking. The employee was having difficulty performing his physical job. X-rays showed the total knee replacement, no bony abnormalities and a small suprapatellar joint effusion. Dr. Dumontier diagnosed right knee pain, status post total knee replacement. There was an off work slip from Dr. Dumontier from October 5, 2009 through October 27, 2009.

Dr. Burke's deposition was taken on December 6, 2010. He is a board certified orthopedic surgeon, who specializes in knee and shoulder surgery, and routinely performs arthroscopic knee surgery. Dr. Burke first saw the employee March 7, 2008, and thought the employee had a symptomatic torn medial meniscus and recommended arthroscopy. In was his opinion that as a result of the February 21, 2008 accident, the employee sustained a torn medial meniscus. Dr. Burke performed arthroscopic surgery on March 10. During surgery, Dr. Burke diagnosed a complex tear of the posterior horn of the medial meniscus, as well as Grade II chondromalacia of the patellofemoral joint and Grade II and III chondromalacia of the lateral femoral condyle. Dr. Burke stated that the employee's medial meniscus tear was related to a recent traumatic twisting type injury, and was consistent with the work accident. The employee's arthritic changes, or chondromalacia, were quite advanced. It was impossible to have developed these advanced arthritic changes in the two and a half weeks between the time of the injury and the arthroscopy. The chondromalacia was Grade II in the patellofemoral joint and Grade II and III on the weight-bearing surface on the lateral femoral condyle. Having viewed employee's knee during surgery, Dr. Burke stated that the complex tear of the medial meniscus was a recent injury, and the chondromalacia in the patellofemoral joint and lateral femoral condyle predated the injury by many months, if not years. The drilling of the lateral femoral condyle was done to address the arthritis which in his opinion was pre-existing.

Dr. Burke stated that the knee is divided into three compartments: the medial side, the lateral side, and the front side, which is the patella. The medial meniscus tear was in the medial compartment. The arthritic changes were in the lateral compartment and in the patellofemoral joint. The meniscal tear was in a completely separate, self-contained compartment from the arthritic changes. The tear was on the medial side, but the arthritis was on the lateral and anterior side of the knee. During his examinations in March and April of 2008, Dr. Burke did not find

any evidence of instability in the right knee. On June 2, 2008, Dr. Burke stated that the employee had a temporary aggravation of his chronic arthritic changes, due to surgery. There is a difference between a temporary aggravation and a permanent acceleration of arthritis. It was Dr. Burke's opinion that the meniscus did not accelerate the arthritic process because they were in two separate compartments. During surgery, he went in to fix the meniscus and address what other things needed to be done including doing something about the pre-existing arthritis. Dr. Burke did not see any evidence of instability in the right knee.

Dr. Burke ordered another right knee MRI which was done on June 19 and showed no new meniscal tears and the acute injury appeared to have been treated and rectified. Dr. Burke found significant arthritis, mainly in the medial compartment and the lateral femoral condyle; and diagnosed persistent right knee pain due to his arthritis and significant degenerative changes seen on arthroscopy. On July 3, Dr. Burke released the employee from his care with the restrictions of limited work duty, no squatting, climbing, kneeling, and no uneven surfaces which were solely related to the employee's arthritic changes and had no relation to the meniscal tear, or the February 21, 2008 accident and injury. Dr. Burke thought he had reached maximum medical benefits from his therapy from the meniscus. Dr. Burke performed a total knee replacement on July 30, 2008, which was treated under his group health insurance.

It was Dr. Burke's opinion that the February 21, 2008 accident had nothing to do with the need for a total knee replacement. There is no orthopedic study, suggesting any significant progression of arthritis related to meniscectomy within the knee. There was one study that the arthritic changes can progress maybe one grade at most but the vast majority of studies showed absolutely no correlation between meniscectomy and progression of arthritic changes. Based on this medical literature, Dr. Burke stated that the medial meniscus tear had nothing to do with his need for a total knee replacement.

During the March 10, 2008 surgery, Dr. Burke visualized the arthritis which was Grade II and III, was pre-existing, and unrelated to the February 21, 2008 accident. Dr. Burke disagreed with Dr. Berkin's opinion that claimant had instability of the right knee due to the medial meniscus tear, which resulted in an acceleration of the natural progression of claimant's arthritis, necessitating his need for a total knee replacement. This conclusion was contradictory to the medical literature and orthopedic knowledge. Dr. Burke stated that the meniscus is only a secondary stabilizer within the knee, and did not function as an active stabilizer in the presence of an intact anterior cruciate ligament. The employee had an ACL that was completely intact and the meniscus tear had nothing to do with instability. Dr. Burke found no evidence of instability in employee's right knee, either before or subsequent to the arthroscopic surgery. A medial meniscus tear would not cause Grade II or III arthritis in a stable knee. The vast majority of total knee replacements are done for lack of cartilage on the bone and for bone-on-bone arthritic changes; and are performed on ligamentously stable knees and included the employee's right knee.

The need for the total knee replacement due to arthritis was clearly supported by the medical literature. The employee's meniscus tear was in a completely different compartment from the severe arthritic changes. The severity of the arthritic changes found during the time of

the March 10, 2008 which was performed within three weeks of the injury, was so profound and advanced that those changes greatly predated the injury by months, if not years. It was Dr. Burke's opinion that the vast prevailing factor in the employee's need for joint replacement surgery was clearly without question his pre-existing arthritis and had nothing to do with his meniscal tear.

When asked but for the alleged accident of February 21, 2008 whether he could give an opinion as to whether the employee would have gotten a total knee replacement in July of 2008, Dr. Burke stated he cannot give an opinion as to when he would have gotten it, but based on the severity of the degenerative changes he found during the March 10 surgery it is quite clear he would have required a knee replacement. When asked since he did not have any right knee complaints prior to February 21, 2008, even in light of the pre-existing arthritic condition, wouldn't the prevailing factor for the total knee replacement be the February 21, 2008 accident, Dr. Burke testified "absolutely not".

It was Dr. Burke's opinion that the treatment the employee received from the date of the total knee replacement forward were related to the total knee replacement, and the time off work due to the total knee replacement was not in any way related to the February 21, 2008 accident.

The employee testified that after his July 30, 2008 knee replacement, he had therapy and was released by Dr. Burke. The employee returned to work for the employer on full work duties, without restriction. The employee testified that prior to the accident he did not have any pain. He did not improve after the meniscus surgery but got worse. He did not improve after the knee replacement but did not get worse. The employee's current right knee complaints include swelling, aching, trouble climbing stairs and constant pain. He no longer exercises or does sports or hobbies or leisure activities. He does not walk except for work. It is hard to separate the complaints from the meniscus tear with the complaints from the knee replacement. The last time he saw a physician for his right knee was when he treated by Dr. Dumontier in October 2009. The employee is not taking any prescription medication but does take Aleve or Tylenol for right knee pain. When working, he usually takes one Tylenol or Aleve per shift, and sometimes twice a shift. He takes pain medication even when he is not working. Dr. Burke prescribed a right knee brace which he wears approximately once every two weeks at work, depending on how strenuous his job activities are and if there is swelling and instability. Generally his pain is about a three out of ten but will sometimes go up to a four. The employee is claiming $265.80 in previously incurred medical bills which are attached as exhibits to Dr. Berkin's deposition. Those bills were incurred for the employee's right knee replacement and are unpaid.

RULINGS OF LAW:

Issue 1. Medical causation as to the total right knee replacement performed on July 30, 2008.

The employer-insurer is disputing that the need for the total knee replacement on July 30, 2008 was medically causally related to the accident.

The burden of proof is on the employee to prove all material elements of his claim. See Marcus v. Steel Constructors, Inc., 434 S.W.2d 475 (Mo. 1968) and Walsh v. Treasurer of the State of Missouri, 953 S.W.2d 632,637 (Mo. App. 1997). The employee has the burden to prove that his injuries arose out of and in the course of employment. See Smith v. Donco Construction, 182 S.W.3d 693, 699 (Mo. App. 2006).

Under Section 287.020.3 (1) and (2) RSMo, "injury" is defined to be an injury which has arisen out of and in the course of employment. An injury shall be deemed to arise out of and in the course of employment only if it is reasonably apparent upon consideration of all the circumstances that the accident is the prevailing factor in causing the injury. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.

Black's Law Dictionary 621 (Abridged Fifth Edition 1983) defines primary as "First; principal; chief, leading." Webster's College Dictionary 1071 (1991) defines primary as "First in rank or importance; chief;"

The employee has the burden to prove that the accident was the prevailing factor in causing the resulting total knee replacement.

Dr. Berkin believed that prior to February 21, 2008, the employee had a pre-existing arthritic condition in his knee which was not causing any symptoms. It was Dr. Berkin's opinion that the February 21, 2008 accident was the prevailing factor in causing the strain of the right knee and the tear of the medial meniscus; the need for arthroscopy of the right knee, with a partial medial meniscectomy, and other procedures; aggravating his asymptomatic pre-existing right knee arthritis; and causing the degenerative process in the right knee to become symptomatic. It was his opinion that the employee developed right knee instability due to the medial meniscus tear and surgery, which promoted and caused an acceleration of the natural progression of the pre-existing arthritis to the point that it necessitated the need for a total knee replacement. It was his opinion that the February 21, 2008 accident was the prevailing factor in causing the need for the July 30, 2008 total knee replacement. Dr. Berkin stated that if the employee had not had the torn meniscus, the employee would have needed a knee replacement somewhere down the line but the need for a total knee replacement was necessitated by his torn meniscus injury.

Dr. Berkin stated that the findings during the March 10, 2008 surgery were pre-existing arthritic changes in the femoral and patellar compartment. The February 21, 2008 accident did not cause the arthritis but could have aggravated that condition, which meant it triggered the condition to become symptomatic. It was Dr. Berkin's opinion that a problem in the medial compartment could accelerate degenerative arthritis in the patellofemoral and lateral compartments of the knee. Dr. Berkin did not agree with Dr. Burke that a meniscus tear could not affect degenerative changes in the lateral or patellofemoral joint, and had no effect on the need for a total knee replacement.

Dr. Burke examined the inside of the employee's knee during the March 10, 2008 surgery. The patellofemoral joint had global Grade II chondromalacia on the undersurface of the patella, as well as in the trochlea. In the medial compartment, there was little, if any, chondromalacia on the medial femoral condyle or medial tibial plateau but there was a complex tear of the posterior horn of the medial meniscus. There was a significant longitudinal crack in the articular surface of the lateral femoral condyle that extended to the patellofemoral joint. It was Dr. Burke's opinion that the employee had very significant arthritis of the right knee, both in the patellofemoral joint and laterally. The severity of the chondromalacia in the patellofemoral joint and lateral femoral condyle was so profound and advanced that it predated the injury by many months, if not years.

Dr. Burke stated that the partial medial meniscectomy was related to the work injury. The significant area of arthritis was in the lateral compartment which was already down to the bone and required drilling at the lateral femoral condyle to address the pre-existing arthritis. There were degenerative changes in the patellofemoral joint. Post-operatively, the medial knee pain resolved but the employee had persistent anterolateral knee pain and a giveaway sensation mainly anterior and anterolateral in the area of the pre-existing arthritis.

Dr. Burke disagreed with Dr. Berkin's opinion that claimant had instability of the right knee due to the medial meniscus tear, which resulted in an acceleration of the natural progression of the arthritis, necessitating his need for a total knee replacement. Dr. Burke stated that the arthritic changes were in the lateral compartment and in the patellofemoral joint which are in completely different compartments of the knee from the torn medial meniscus. It was Dr. Burke's opinion that it was anatomically impossible for the medial meniscus tear to affect or accelerate degenerative changes in the lateral or patellofemoral joint because they were in separate compartments and had absolutely no effect on the need for a total knee replacement. It was Dr. Burke's opinion that the need for a total knee replacement was based on the degenerative changes seen at the time of arthroscopy, and was in no way related to the torn medial meniscus.

It was Dr. Burke's opinion that the vast prevailing factor in the employee's need for joint replacement surgery was his pre-existing arthritis and had nothing to do with his meniscal tear. It was clear that the employee would have required a knee replacement based on the arthritic changes in his knee. It was Dr. Burke's opinion that the February 21, 2008 accident had nothing to do with the need for a total knee replacement.

Based on a thorough review of the evidence, I find that the opinion of Dr. Burke is very persuasive and credible and is more credible and persuasive than the opinion of Dr. Berkin on the issue of medical causation. I find that the employee's work accident was not the prevailing factor in causing the need for the July 30, 2008 total knee replacement. I find that the employee failed to satisfy his burden of proof on the issue of medical causation for the knee replacement. I further find that the need for the total knee replacement is not medically causally related to the accident.

Issue 2. Claim for previously incurred medical bills.

The employee is claiming $265.80 in medical expenses. The bills requested are from Dr. Burke and Ballas Anesthesia with a date of service of July 30, 2008 which are for the total knee replacement. The employer-insurer is disputing the authorization and causal relationship of those bills. The employer-insurer is not disputing the reasonableness or necessity of those bills.

Based on my ruling on medical causation with regard to the knee replacement, I find that these bills are not medically causally related to the accident. The employee's claim for previously incurred medical bills is denied.

Issue 3. Claim for future medical aid.

The employee must establish, through competent medical evidence, that the medical care requested, "flows from the accident" before the employer-insurer is responsible. See Crowell v. Hawkins, 68 S.W.3d 432 (Mo. App. 2001), Landers v. Chrysler Corporation, 963 S.W.2d 275 (Mo. App. 1997); Modlin v. Sunmark, Inc., 699 S.W.2d 5, 7 (Mo. App. 1995); and Sifferman v. Sears, Roebuck and Company, 906 S.W.2d 823 (Mo. App. 1995). Where future medical benefits are to be awarded the medical care must of necessity flow from the accident, via evidence of a medical causal relationship between the injury from the condition and the compensable injury before the employer-insurer is to be held responsible. See Mickey v. City Wide Maintenance, 996 S.W. 2d 144 (Mo. App. 1999). The employee has the burden of proof to show that any future medical care flows from the compensable work accident. There must be sufficient medical evidence showing that the employee needs future treatment for his compensable work related torn meniscus that "flows" from the accident and not from his pre-existing arthritic condition or knee replacement.

At the time of the hearing, the employee was not treating with any doctor for his right knee. The last time he sought treatment was with Dr. Dumontier in October 2009. The employee is not taking any prescription medication but is taking Aleve and Tylenol for right knee pain.

It was Dr. Berkin's opinion that the employee required additional treatment for his right knee condition including the non steroidal medication, home exercise program, and additional right knee replacement. The employee would require care for exacerbation of his knee symptoms and at times over-the-counter medications would not give him the relief required, and he would need to have treatment from a physician for prescription strength medications.

I find that Dr. Berkin's opinion does not meet the required burden of proof of sufficient competent medical evidence. Dr. Berkin did not separate out what medical care including medication was required due to the work related meniscus tear compared to what was needed due to the non worked related arthritic condition and knee replacement. I find that his opinion did not provide the proper basis to show that the employee needs future treatment for his compensable work related medial meniscus condition that "flows" from the accident and not from his non work related arthritis and knee replacement.

It was Dr. Burke's opinion that the employee had reached maximum medical benefit from his therapy for the meniscus and released him from care.

Based on a review of the evidence and my ruling on medical causation, I find that the opinion of Dr. Burke is more credible and persuasive than the opinion of Dr. Berkin regarding future medical treatment.

I find that there is not sufficient medical evidence that any future medical treatment is a result of and flows from the compensable work accident. I find that the employee failed to satisfy his burden of proof that any future medical treatment flows from the work accident and is medically causally related to conditions caused by the work accident. The employee's claim for future medical aid is denied.

Issue 4. Additional Temporary Total Disability.

The employee is claiming additional temporary total disability from July 30, 2008 through October 20, 2008; and from October 5, 2009 through October 28, 2009. The parties stipulated that the employer is entitled to a credit for any short-term disability benefits paid to the employee during the two alleged additional periods of temporary total disability. The employer paid $4,053.30 in short-term disability benefits from July 28 through October 19, 2008, and paid $1,146.70 in short-term disability benefits from October 8 through November 1, 2009.

From July 30, 2008 through October 20, 2008, the employee was recovering from his total knee replacement that took place on July 30. It was Dr. Berkin's opinion that the employee was temporarily and totally disabled from July 30, 2008 until October 20, 2008. It was Dr. Burke's opinion that the treatment from the date of the knee replacement forward was related to the knee replacement, and the time off work due to the knee replacement was not related to the February 21, 2008 accident. Based on my ruling on medical causation, I find that Dr. Burke's opinion is more credible and persuasive than Dr. Berkin's opinion. The employee's claim for temporary total disability from July 30, 2008 through October 20, 2008 is denied.

The employee is claiming temporary total disability based on Dr. Dumontier taking him off from work from October 5 through October 27 of 2009. On October 5, Dr. Dumontier saw the employee for right knee pain with difficulty performing his physical job. Dr. Dumontier diagnosed right knee pain, status post total knee replacement. There is no medical opinion addressing whether the employee's need to be off work was for the work related meniscus tear or the non work related arthritis and knee replacement. Based on the lack of any medical opinion that the need to be off work was connected to the February 21, 2008 accident, I find that the employee has failed to meet his burden of proof on the issue of temporary total disability from October 5, 2009 through October 28, 2009. The employee's claim for temporary total disability for that period is therefore denied.

Issue 5. Nature and extent of permanent partial disability.

It was Dr. Berkin's opinion that the employee sustained a 65% permanent partial disability of the right lower extremity at the level of the knee as a result of the February 21, 2008 injury. Dr. Berkin's rating took into account the aggravation of his underlying pre-existing arthritis, the two surgical procedures including the knee replacement and the likelihood of another knee replacement in the future. Dr. Berkin did not apportion the 65% disability between the medial meniscal tear, the drilling of the lateral femoral condyle with debridement of the patella and trochlea, and the total knee replacement.

It was Dr. Burke's opinion that the employee had a 15% permanent partial disability of the knee of which 7.5% was due to the work related medial meniscus and 7.5% was due to severe pre-existing degenerative changes.

Based upon the evidence, I find that as a direct result of the medial meniscus tear caused by the February 21, 2008 accident, the employee sustained a permanent partial disability of 15% permanent partial disability to the right knee. The employer insurer is therefore ordered to pay to the employee 24 weeks of compensation at the rate of $389.04 per week for a total award of permanent partial disability of $9,336.96.

ATTORNEY'S FEE: Gary Matheney, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

INTEREST: Interest on all sums awarded hereunder shall be paid as provided by law.

Date:_____ Made by:

_____
Lawrence C. Kasten
Chief Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

_____
Naomi Person
Division of Workers' Compensation