

APPEAL NO. 110464
FILED JUNE 6, 2011

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on March 9, 2011. The hearing officer resolved the sole issue as amended by the parties by determining that the compensable injury of _____, extends to an injury to the right shoulder consisting of glenohumeral osteoarthritis and an injury to the right knee consisting of osteoarthritis of the patella. The appellant (self-insured) appealed the hearing officer's extent-of-injury determinations. The respondent (claimant) responded, urging affirmance.

DECISION

Affirmed in part and reversed and rendered in part.

The parties stipulated that the claimant sustained a compensable injury on _____. The claimant, a school bus driver, testified that he injured his right shoulder and right knee when he slipped and fell down bus steps at work. It was undisputed that the claimant's resulting injuries included a right shoulder rotator cuff tear and right knee meniscal tears.

Right Shoulder

The hearing officer's determination that the compensable injury of _____, extends to an injury to the right shoulder consisting of glenohumeral osteoarthritis is supported by sufficient evidence and is affirmed.

Right Knee

The claimant was initially treated by (Dr. H), who referred him for an MRI, and to (Dr. A), a board certified orthopedic surgeon, for his right knee. The MRI dated April 16, 2009, in evidence revealed findings of:

1. Horizontal cleavage tear involving all aspects of the medial meniscus with meniscal tissue extending along the anterior medial border of the tibia.
2. Tear of the posterior horn and anterior horns of the lateral meniscus.
3. Extensive degenerative change throughout the knee, worse at the patelofemoral articulation where there is bone on bone articulation, subchondral cyst like change, and early marginal osteophyte formation.

4. Medial joint space narrowing.
5. Joint effusion.

There is a medical report dated April 27, 2009, in evidence in which Dr. A states that he had reviewed the right knee MRI and diagnosed the claimant with internal derangement right knee-lateral meniscus tear, possible medial meniscus tear. Dr. A states that he recommends a right knee diagnostic arthroscopy with partial meniscectomy and treatment as indicated.

The claimant underwent right knee surgery on May 19, 2009. The operative report dated May 19, 2009, in evidence, reflects that Dr. A's post-operative diagnoses were: complex posterior horn medial meniscus tear; anterior horn and postero-central root lateral meniscus tears; anteromedial/anterolateral compartment synovitis and fat-pad hypertrophy; grade-4 patellofemoral chondromalacia without maltracking; and degenerative joint disease, medial and lateral compartments.

In evidence is a medical report dated August 31, 2009, in which Dr. A states that the claimant is doing very well after his right knee surgery. Dr. A further states that "[the claimant] has arthritis in the knee and this will no doubt have some occasional intermittent aching symptoms. As far as I am concerned, I can release him to full work activities regarding the right knee."

Almost a year later, there is a medical report dated July 26, 2010, in which Dr. A states that:

[The claimant] is here for a one-time visit on the work-related right knee injury. He had been doing very well up until about two months ago when he started having popping and catching in the right knee. He feels like it is anterior and it is always a giving way sensation where he feels like the knee just wants to buckle out from underneath him. He has noticed swelling in the knee

The right knee shows well-healed portals . . . quite a bit of patellofemoral crepitus with a positive grind and Trying to get the patella to sublux medially past the trochlea is fairly difficult

I reviewed his operative imagines (*sic*)-there is evidence of [degenerative joint disease].

If he is not substantially better in the next two months or so, then he may need to have a lateral release. As the knee arthritis worsens and as the patella collapses down into the trochlea, it lateralizes and the tissues become tight laterally

In a medical report dated September 20, 2010, Dr. A states that the claimant has deep aching pain in his right knee and wants to consider a total knee replacement. Dr. A in a medical report dated January 10, 2011, states that the claimant was evaluated in his office for the left knee. We note all the medical records prior to this date have concerned the right, not the left knee. Dr. A states in this report that the claimant “has an aggravation of his underlying internal derangement due to the severe osteoarthritis of his patella.”

Also in evidence is a peer review report dated February 1, 2011, from (Dr. M), who also testified at the CCH. Dr. M testified there is no objective evidence based medicine linking the right knee meniscal tears and resulting surgery with the right knee claimed extent-of-injury condition. In that same report, Dr. M states:

Interestingly the report obtained from [Dr. A] in support of his position states that [the claimant] has an aggravation of his underlying internal derangement due to the severe osteoarthritis of his *patella* as opposed to actual aggravation of the osteoarthritis at the areas of the meniscal tears where the injury occurred.

Dr. M attached scientific studies to his February 1, 2011, report as well as testified that the evidence-based literature does not support the claimant’s assertion that the right knee objectively worsened as a result of his knee meniscectomy.

In reviewing a “great weight” challenge, we must examine the entire record to determine if: (1) there is only “slight” evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. See Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The claimant had a successful meniscectomy and release to full-duty work in August of 2009 by Dr. A. It was not until July 2010 that Dr. A reported that the claimant had returned for follow-up complaining of popping in his right knee. At that time Dr. A noted that the claimant had problems with his pre-existing arthritis in the right knee and discussed the patella collapsing. However, under the specific facts of this case, there is not sufficient evidence explaining how the compensable injury or the treatment for the compensable injury resulted in an injury to the right knee consisting of osteoarthritis of the patella or an aggravation of the claimant’s pre-existing osteoarthritis of the patella. Accordingly, the hearing officer’s determination that the compensable injury of _____, extends to an injury to the right knee consisting of osteoarthritis of the patella is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

SUMMARY

We affirm the hearing officer’s determination that the compensable injury of _____, extends to an injury to the right shoulder consisting of glenohumeral osteoarthritis.

We reverse the hearing officer’s determination that the compensable injury of _____, extends to an injury to the right knee consisting of osteoarthritis of the patella and render a new decision that the compensable injury of _____, does not extend to an injury to the right knee consisting of osteoarthritis of the patella.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

**(SUPERINTENDENT)
(ADDRESS)
(CITY), TEXAS (ZIP CODE).**

Cynthia A. Brown
Appeals Judge

CONCUR:

Carisa Space-Beam
Appeals Judge

Margaret L. Turner
Appeals Judge