

TINA GUAJARDO, Employee/Appellant, v. LAMB WESTON/RDO FROZEN and EBI COS.,
Employer-Insurer.

WORKERS' COMPENSATION COURT OF APPEALS
JULY 19, 2001

No. [REDACTED SSN]

HEADNOTES

MEDICAL TREATMENT - REASONABLE & NECESSARY. Substantial evidence, including radiographic testing and well-founded expert medical opinion, supports the compensation judge's finding that proposed arthroscopic surgery for the treatment of the employee's right knee condition is not reasonable or necessary.

Affirmed.

Determined by Johnson, J., Rykken, J., and Wheeler, C.J.
Compensation Judge: Harold W. Schulz

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's determination that proposed knee surgery is not reasonable or necessary. We affirm.

BACKGROUND

The employee, Tina M. Guajardo, sustained an admitted personal injury on August 22, 1999 while working for the employer, Lamb Weston/RDO Frozen, as a member of its sanitation crew. The injury occurred when the employee inadvertently stepped backwards into a three-foot-deep open flume with her right leg. The employee, who is 5 feet, 2 inches tall, was unable to extricate herself from the flume.

After being assisted out of the flume the employee was temporarily unable to walk and was taken to the emergency room at St. Joseph's Hospital in Park Rapids, Minnesota. At St. Joseph's Hospital, the employee complained of right knee and calf pain. Examination showed moderate swelling of the right lower extremity. There was tenderness to deep palpation and around the anterior aspect of the knee. The employee reported some pain on full extension and flexion of the knee and some pain with lateral-medial stress. Sensor and motor function was intact in the right lower extremity and anterior and posterior Drawer's sign was negative. The employee was diagnosed with a sprain to the lower extremity and knee and advised to avoid weight bearing on the right lower extremity for two days and to return for a recheck three days later on August 25, 1999. (Exh. A.)

The employee returned to see Dr. John E. Fredell, M.D., at the Dakota Clinic in Park Rapids on August 25, 1999. The doctor noted that the employee was walking with crutches and that her right leg was visibly swollen around and below the knee. Range of motion of the knee on flexion and extension was somewhat limited but the joint was stable in all four directions. The employee was mildly tender in the medial joint space, but there was no obvious swelling within the joint, although there was swelling around the knee. Dr. Fredell reviewed an x-ray taken at the time of the employee's emergency room visit and characterized it as negative for bony injury. He diagnosed a right knee sprain and continued to restrict the employee to sedentary work. He provided the employee with a knee immobilizer. In order to rule out concerns over a possible internal derangement of the knee, Dr. Fredell referred the employee to an osteopath, Dr. Jeffrey Kalo. (Exh. B.)

Dr. Kalo saw the employee on September 1, 1999. His examination on that date showed a 2+ effusion of the employee's knee. Posterior Drawer and sag signs were "definitively negative." The employee exhibited significant guarding and Dr. Kalo was unable to perform McMurray's, straight Speed or Kellogg-Speed tests. The doctor's assessment was of a probable ACL sprain of the right knee with a large effusion. He also considered it possible that she had a bone bruise or microscopic fracture. Dr. Kalo prescribed six visits of physical therapy and advised the employee to return in two to three weeks. He hoped the physical therapy would improve her range of motion and that it would also make it possible to complete his examination and differentiate the cause of her continued knee pain. (Exhs. C, D.)

The physical therapy records note that the employee had complained of some periods of knee instability. The employee described this as "a - - feel like a rubber band type - - Your knee like springs back and forth . . . And then at times -- it depends - - like activities I'm doing, you know, it kind of gives on you." (Exh. D; T. 16-17.)

The employee returned to Dr. Kalo on September 27, 1999. Lachman's sign was 2+ with a trace positive pivot shift. The employee had difficulty with extension. Dr. Kalo kept the employee on light duty restrictions. He noted that the employee's situation was complicated by the fact that she was then two months pregnant and needed to be cautious about any anti-inflammatory use or any kind of surgery. He opined that surgery would be his preferred treatment option but that it would not be an option until after resolution of the pregnancy. (Exh. C.)

On November 15, 1999 the employee again returned to Dr. Kalo for reevaluation. Her range of motion in the right leg was from 0 to 125 degrees of flexion. Lachman's sign was 2+ and there was a 2+ pivot shift with significant medial joint line pain which the doctor noted to be consistent with a medial meniscus tear. Posterior Drawer and sag signs were negative. The employee was having some problems with her knee brace, although Dr. Kalo found it to fit nicely. He continued the employee on restrictions consisting of no lifting above 20 to 25 pounds and very limited climbing. He advised the employee to return in June 2000 after completion of her pregnancy and his treatment plan envisioned that the employee would then undergo knee reconstructive surgery. (Exh. C.)

During the remainder of the employee's pregnancy she did not seek any medical attention for her right knee condition. (T. 33.)

The employee's child was born on May 18, 2000 and the employee returned to see Dr. Kalo within a month or two after that. She testified that she was still experiencing some symptoms of her knee buckling and giving way as well as audible snapping sounds in the knee. Dr. Kalo sent the employee for an MRI scan. (T. 24-25.)

The employee underwent an MRI scan of the right knee on July 17, 2000. The scan was interpreted by Dr. Donald G. Douglas, M.D., a radiologist. Osseous alignment was well-maintained with no evidence of occult fracture or bone contusion. No significant effusion was identified. Dr. Douglas reported that there was a slight focal increase in signal along the anterior portion of the anterior cruciate ligament where it attached to the intercondylar eminence. However, he noted that the ligament was otherwise normal in caliber and course and opined that the increased signal most likely represented a Type I - Type II strain. There was no evidence of a meniscal tear. (Exh. E: 7/18/00 MRI report.)

The employee did not return to Dr. Kalo after the MRI scan through the date of the hearing below on December 22, 2000. However, on July 21, 2000 Dr. Kalo wrote a letter giving his opinion following his review of the MRI scan. He opined that the MRI scan showed fluid in the employee's knee, and noted that he could see no evidence of any cause for the presence of fluid. He opined that, in his view, the likely cause would be a partial tear of the anterior cruciate ligament. Dr. Kalo further opined that, if the employee's knee had evidence of instability, she should consider undergoing arthroscopic surgery. (Exh. E.)

The employee filed a medical request on September 1, 2000 seeking authorization for arthroscopic evaluation of a partial tear of the anterior cruciate ligament and surgical repair of the tear. The employer and insurer filed a medical response denying payment for the proposed surgery on the basis of the radiologist's MRI report. (Judgment Roll.)

On December 1, 2000 the employee was examined by Dr. Peter Strand, M.D., on behalf of the employer and insurer. Dr. Strand noted that the employee did not describe any locking or giving out of the knee, and that she did not have any swelling in the knee. His examination of the employee's knee revealed a normal knee configuration without effusion and with good alignment. The pivot-shift test was negative and manipulation of the knee caused no discomfort. Collateral ligaments appeared to be intact and strong. While the employee had a Grade I to II drawer and Lachman's sign on the right, this was also true of the other knee. Dr. Strand diagnosed a sprain of the right knee. He noted that the MRI failed to show any disruption of the anterior cruciate ligament, and considered the employee's symptomology minimal. In his opinion, the employee had reached maximum medical improvement from the August 22, 1999 work injury, needed no further treatment for her knee and was not a candidate for an acromioclavicular reconstruction. (Exh. 1.)

A hearing was held on the employee's medical request on December 22, 1999. Following the hearing, the compensation judge found that the proposed surgery was not reasonable and necessary. The employee appeals.

STANDARD OF REVIEW

On appeal, this court must determine whether the compensation judge's findings and order are "clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1(3) (1992). Substantial evidence supports the findings if, in the context of the record as a whole, they "are supported by evidence that a reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where the evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings must be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, "[f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Factfindings may not be disturbed, even though this court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Id.

DECISION

The employee argues on appeal that the compensation judge's finding regarding the reasonableness and necessity of the proposed knee surgery is clearly erroneous and unsupported by substantial evidence. Specifically, the employee maintains that the compensation judge's view, expressed in his memorandum, that the employee "appears to be doing relatively well," is contrary to the employee's testimony, in which she noted that she still experienced occasional right knee instability and buckling, particularly after extended periods of standing or stair climbing. The employee argues that the compensation judge should have given more weight to the employee's testimony regarding these knee symptoms, and to Dr. Kalo's opinion that knee surgery was appropriate, in light of such symptoms.

We note that the compensation judge made specific findings summarizing the employee's testimony about her continuing symptoms, and accordingly it cannot be said that the judge misunderstood or was unaware of this evidence. Determining the weight to be given to the employee's testimony about her occasional knee symptoms, as compared to the remainder of the evidence in the case, is a matter committed to the compensation judge, and this court will not reverse in the absence of clear error.

The compensation judge's memorandum reveals that the result in this case was based in significant part on the judge's acceptance of the reading of the MRI scan as interpreted by Dr. Douglas, the radiologist, over the interpretation offered by the employee's treating osteopath, Dr. Kalo. Dr. Douglas failed to find radiographic evidence of any tearing in the ligaments of the right knee. The expert opinion of Dr. Strand, who examined the employee on December 1, 2000, also supported this conclusion. This court will affirm a compensation judge's

choice between the opinions of the medical experts, unless the opinion relied upon is without adequate foundation. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985); Minn. Stat. § 176.421, subd. 1(3) (1992). We therefore affirm.