Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: June 14, 2019

CLAIM NO. 201698536

ANGELA LUNDY PETITIONER

VS. **APPEAL FROM HON. CHRIS DAVIS, ADMINISTRATIVE LAW JUDGE**

OWENSBORO HEALTH REGIONAL HOSPITAL
and HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
VACATING IN PART & REMANDING

* * * * * *

BEFORE: ALVEY, Chairman, STIVERS and RECHTER, Members.

STIVERS, Member. Angela Lundy ("Lundy") appeals from the January 27, 2019, Opinion, Award, and Order and the February 7, 2019, Order overruling her petition for reconsideration of Hon. Chris Davis, Administrative Law Judge ("ALJ"). In the January 27, 2019, Opinion, Award, and Order, the ALJ awarded temporary total disability ("TTD") benefits, permanent partial disability ("PPD") benefits, and

medical benefits for a work-related left knee menisci injury and surgery.[1] The ALJ also determined the right knee replacement surgery Lundy underwent is non-compensable and she is not entitled to enhanced PPD benefits.

On appeal, Lundy asserts the ALJ erred in concluding her right knee replacement surgery is non-compensable. Lundy also asserts the ALJ erred by failing to award the three multiplier.

The Form 101 alleges Lundy sustained work-related injuries to her right knee and left elbow while in the employ of Owensboro Health Regional Hospital ("Owensboro Hospital") on January 12, 2016, in the following manner: "Walked into breakroom. Fell on wet, just mopped floor. No wet floor sign. Slid on right knee, hit corner of medal desk. Then fell back on left elbow."[2]

Lundy was deposed on January 26, 2017. She testified concerning her ability to return to work following her fall at work:

> Q: Between December 2006 and January 2016, you worked as an RN in surgery?
>
> A: Yes.
>
> Q: Then you fell at work in January 2016. You were off work for a period of time with treatment, correct?
>
> A: Yes.
>
> Q: Then you went back for a period of time and tried to do your job?

[1] As Lundy alleged sustaining a work-related injury to her right knee, in the February 7, 2019, Order, the ALJ deleted any reference to "left" knee and amended the order to reflect a right knee injury with "right."

[2] In her brief to the ALJ, Lundy only asserted entitlement to benefits for the alleged work-related injury to her right knee.

A: Yes.

Q: What period of time did you last work in Owensboro Health Regional Hospital?

A: One day.

Q: And that was in July of 2016?

A: No.

Q: When was it?

A: April.

Q: Why did you put your employment ended July 2016? Is that when you got notice that your employment ended?

A: Yes.

Q: Because you had restrictions that the hospital couldn't accommodate in that position or did you just resign?

A: No, I didn't. No.

Q: What happened?

A: I was terminated and I'm not exactly sure why.

Q: Could you do your job in RN surgery after January 2016?

A: No.

…

Q: Are there jobs at the hospital that you think you could currently perform that you know about?

A: Yes.

Q: Give me an example.

A: Surgery scheduling. Medical records. Surgical auditing or auditing in general.

> Q: So basically, as you understand it and your experience, there's a variety of jobs in the medical facility like a hospital that requires someone like you with medical knowledge and medical background, but doesn't require the physical duties of a full-blown nurse. Is that your understanding?
>
> A: Yes.

Lundy also testified at the November 28, 2018, hearing. She was released without restrictions by Dr. Philip Hurley in March 2017, and she has held two jobs since then. She explained why she is no longer able to work as a surgical nurse:

> Q: What are the – would you be able to go back to being a surgical nurse?
>
> A: No, I don't think I could do it.
>
> Q: Why? What problems are you having with your knee?
>
> A: You have the 12-hour shifts. You have bending, stopping. Sometimes you've got to crawl on the floor, get under the drapes, get down on your knees. A lot of the instruments are in cases from 30 to 50 pounds. And that type of work just causes pain and swelling in my knee.

Lundy filed the October 18, 2016, letter of Dr. Hurley. Dr. Hurley noted that, on March 21, 2016, Lundy underwent partial medial and lateral meniscectomies along with abrasion chondroplasty. The letter indicates that, on May 9, 2016, x-rays showed "a drastic difference in joint spacing and osteophyte formation." Dr. Hurley and Lundy decided to proceed with a total knee replacement. The letter continues as follows:

> On May 10, 2016 worker's compensation was again informed of the intent to perform surgery. This was denied on May 18, 2016 due to lack of relatedness to the claim. The reviewing provider explained that the abrasion

> arthroscopy caused the drastic deficit in joint spacing that was noted earlier. I think the majority of the decrease was due to the progression of the *pre-existing dormant arthritis being brought into debilitating reality by the injury on January 12, 2016*. (emphasis added).
>
> At this point, she should reach maximal medical improvement around July of 2017. This will place her one year past her operation which is the typical full return for a total knee replacement. She will most definitely have some impairment related to the events that have occurred in the last year.

Several medical records of Dr. Hurley's were filed by Owensboro Hospital. Among the most relevant are the following:

- A record dated January 28, 2016, indicates Lundy was being seen for right knee and left elbow pain and was diagnosed with posttraumatic arthralgia of right knee and posttraumatic left cubital tunnel syndrome.

- Lundy had an MRI of her right knee on February 3, 2016.

- A record dated February 4, 2016, notes the right knee MRI shows tears in both the medial and lateral meniscus and partial and full-thickness articular cartilage loss in all three compartments.

- A record dated February 18, 2016, notes that Dr. Hurley feels arthroscopic surgery is necessary, workers' compensation has denied the surgery because of a lack of physical therapy, but Dr. Hurley is unaware of any studies documenting improvement of a torn meniscus with physical therapy. Dr. Hurley further states he is willing to do a "peer-to-peer" in order to get this resolved.

- A record dated March 21, 2016, indicates Lundy underwent an arthroscopic partial medial meniscectomy with abrasion chondroplasty and removal of chondral loose bodies.

- A record dated May 9, 2016, indicates Dr. Hurley's opinion that the only reasonable form of treatment for Lundy is a total knee replacement, and he restricted her to sedentary work.

Dr. Hurley was deposed on April 6, 2017. He testified Lundy first treated with his nurse practitioner for right knee pain on May 11, 2007. At that time, Lundy's right knee had been hurting for some time. Lundy did not return for another appointment until April 31, 2008, because her pain had increased. Dr. Hurley ordered an MRI and saw Lundy again on May 14, 2008, to review the results.

> Q: And what did it disclose to you?
>
> A: It did show an inferior surface tear of the posterior horn of the lateral meniscus. The reason that is significant is that, at her age and activity level, an inferior surface tear is actually a fairly common finding so it would not necessarily be considered abnormal or pathological. An inferior surface tear is another way of saying it's not a complete or through and through tear of the meniscus. That led us to believe at that point that her pain was coming mainly from the arthritis because the MRI did show some arthritis in the same side and area of the knee as the meniscus.

Dr. Hurley injected Lundy's right knee with cortisone.

Lundy did not return to see Dr. Hurley until June 17, 2009. He provided the following testimony regarding her status at that time:

> A: Stated that she had been on a trip to California, that she had played some volleyball in the sand, did a lot of walking, and that seemed to cause her symptoms to return and that's what led her to come back to the office and be re-examined. And at that point we felt it was pretty much the same thing all over again, so the recommendation was to go ahead and give her another shot of cortisone.
>
> Q: You're not really treating the meniscus at that point, are you?
>
> A: No, sir.
>
> Q: You're noting that it's there, but you're not suggesting that anything be done about it?

A: That is correct.

Regarding Lundy's subsequent appointments for additional cortisone injections, he testified as follows:

> Q: Right. Okay. Looks like she was able to get by without treatment for about six months and then showed up at your office again on December 30, 2009?
>
> A: Yes, sir.
>
> Q: And looks like the same complaints, same treatment?
>
> A: Yes, sir.
>
> Q: Against, about four months later she shows up, on April 14, 2010; same complaint, same treatment?
>
> A: Yes, sir.
>
> Q: Looks like another roughly six, seven months pass. She comes back to your office on January 3rd, 2011; same complaint, same treatment?
>
> A: Yes, sir.
>
> Q: Looks like another six months. July 12, 2011; same complaint, same treatment?
>
> A: Yes, sir.
>
> Q: And this is all due to osteoarthritis of the right knee?
>
> A: Yes, sir.
>
> Q: Is it accurate that this osteoarthritis of the right knee was not caused by any kind of work-related condition?
>
> A: At that point, no.
>
> Q: Okay. And looks like she stayed away from your office and cortisone injections until March 6, 2012?
>
> A: Yes, sir.

> Q: And same complaint, same treatment again?
>
> A: Yes, sir.
>
> Q: Another eight months pass and she comes back on November 12, 2012, with the same complaints, same treatment?
>
> A: Yes, sir.

Lundy was seen several more times by Dr. Hurley for cortisone injections in her right knee. Dr. Hurley discussed the benefits of cortisone injections for pain relief. He also testified to the rationale behind avoiding knee replacement surgery in individuals as young as Lundy:

> A: …Another mitigating circumstance for her is her age. We do not like doing total joints on very young people because when you do a total joint replacement it's going to wear out eventually. We would prefer that the person be old enough that the joint will probably last longer than they will because, even though total joints can be redone, every time you redo a total joint the results are poorer and poorer and poorer. And that's why, if you remember, when she first started with us she was 39, and that is way too young to start talking about knee replacement surgery unless there are very unusual circumstances.
>
> Q: I understand.
>
> So given all that, it was your judgement that it was best not to consider surgery at such a young age and to address her symptoms with periodic cortisone injections?
>
> A: That is correct.

In January 14, 2015, Lundy's arthritis began to worsen. Dr. Hurley testified as follows:

> Q: Okay. Then you see her on January 14, 2015. Looks like her arthritis may be getting worse; at least that's what's reflected in the history?

A: Yes, sir.

Q: By that you mean more symptomatic?

A: At that point we were referring to the x-rays.

Q: Okay. I see. So she's basically losing the cushioning effect in her knee?

A: Yes, sir.

Q: But still, at her age, you're trying to delay any kind of partial or total knee replacement and just trying to get her through with treating her symptoms?

A: Yes, sir.

Dr. Hurley acknowledged Lundy was seeking treatment more frequently towards the end of 2015.

Following the work injury, Dr. Hurley was initially concerned Lundy fractured her right knee. An MRI revealed tears in both menisci which he began treating. Eventually arthroscopic surgery was performed.

Q: The arthroscopic surgery involved both some sort of excision of the partial medial and lateral meniscus. What do you do with the meniscus arthroscopically? Are you just taking out meniscus?

A: Let me just refresh my memory. Yes. What I did was I took out the torn portion of both the medial and lateral meniscus in her right knee.

In addition to removing the torn portions of the meniscus, he also performed an abrasion chondroplasty:

A: Chondroplasty means you're just basically going in and smoothing out rough areas.

Q: Rough osteoarthritic bone areas?

A: Chondroplasty refers to the fact that the lining of the bone, the articular cartilage has been damaged. So when

you do a chondroplasty, that means you're just simply smoothing off the rough areas.

The difference between it and arthroplasty mean you're actually drilling holes in the bone to try and get new tissue to grow in. But her arthritis was not such that she would have likely responded to that, so that's why all I did was the chondroplasty.

Dr. Hurley acknowledged that the need for the chondroplasty was not a result of the fall at work:

Q: ….The need for the chondroplasty, which is to clean up degenerative material in the knee, that degenerative material didn't develop between the time of the fall and the surgery a month later?

A: Correct.

However, he opined the fall exacerbated Lundy's pre-existing arthritis:

A: As I stated earlier, it's my opinion that the fall exacerbated the arthritis.

Q: I understand. I don't dispute that at all, Doctor. But it basically caused the arthritis to again become a problem or become symptomatic?

A: Correct.

Q: But that arthritis had been symptomatic for ten years, including a month or six weeks before, in December of 2015?

A: That is correct.

Q: You would certainly expect that any significant trauma to her right knee, in addition to maybe creating a new issue with the meniscus, was going to exacerbate pre-existing conditions, the degenerative disc disease?

A: You said disc.

Q: Degenerative arthritis.

A: Correct.

…

> Q: She was losing cushioning for the last ten years. Isn't that what osteoarthritis is?
>
> A: She was losing articular cartilage. That is what arthritis is. Arthritis does not involve the meniscus. So like I said, she lost parts of both the medial and lateral meniscus as a result of the injury, which therefore made the arthritis become worse both in degree and in rapidity of deterioration.

Dr. Hurley expounded on how the work injury exacerbated Lundy's pre-existing arthritis:

> Q: Now, what I'm trying to understand is, what do you mean by dormant? I mean, this lady was getting active treatment and was actively symptomatic for a period of ten years before this fall at work. In fact, six weeks before she fell at work she's complaining of right knee pain associated with osteoarthritis and getting cortisone injections. So would you agree that her pre-existing osteoarthritis was not dormant but was actually in an active, was actively symptomatic?
>
> A: Yes.
>
> Q: So to be accurate – and we're trying to be accurate obviously – you would modify your statement in this October letter to Mr. Caslin, that she had pre-existing actively symptomatic arthritis that was exacerbated by the fall of January 12, 2016?
>
> A: I'm going to qualify my answer by saying that based on – and again, please forgive me. I'm not trying to be condescending. But based on my 30-plus years experience in doing depositions, the one thing I've learned is that the legal definition of a word is often different than the layman's definition.
>
> …
>
> Q: When you say dormant or active or exacerbation, I'm interested in knowing what's going through your mind when you say that.

A: Thank you. What is going through my mind is the fact that, yes, this woman was having problems with her knee; however, she was still responding to conservative – the definition of conservative for a surgeon being nonoperative.

Q: Right.

A: So her condition was showing signs of progression in, as you pointed out earlier, the decreasing time between treatments, but she still was not at the point where we were trying to be – the old Boy Scout motto – be prepared, recognizing the fact that sooner or later this woman was going to require a knee replacement. So we were trying to do things to help her to modify her lifestyle. Unfortunately, obese people tend to have a propensity to increase their obesity. And so, again, she was not morbidly obese or anything at that point, but I didn't want to let her get that way. So that's why the notes frequently referred to the fact that she was obese. We were trying to get her to do everything she could to help herself.

So like I said, the condition was being treated actively. Yes, she was coming in on fairly regular intervals and getting treatment, but she was still responding to those treatments and so I was not telling her, 'Angela, you're going to be having a knee replacement in six months.' After the fall, it was in my opinion the straw that broke the camel's back. I had to go in and relieve the pain being caused by the torn menisci. And unfortunately, by doing that, it did affect the arthritis and make it worse.

Q: How did it make it worse? How did it make the arthritis worse? I understand that the spacing, the joint spacing decreased post surgery.

A: Okay. Again, I'm a big fan of analogies and so I always like to talk to the people I'm treating in terms of analogies to try and make it as simple for them to understand.

If you consider arthritis the same as an automobile tire where the tread is going thin, you may be aware of the fact that those tires are wearing out but they're not yet worn out and I don't need to replace them now, but I do need to keep the front end in alignment and I do need to

> keep the tires and wheels balanced because if I do that then they will last as long as possible.
>
> Because of the fact that she had the torn menisci as a result of the fall, we were no longer able to do things to try and prevent things from getting worse. In other words, we went in and did the meniscus removal to try and take care of the mechanical symptoms and pain she had from that; but as is often the case, because of the fact you relieve that cushioning, therefore the joint space, the collapse will accelerate.
>
> Q: How did you determine that the injury caused the space to accelerate and not your procedure where you trimmed back the degenerative material?
>
> A: The x-ray showed me that.
>
> …
>
> Q: But it's your opinion that the fall of January 12, 2016 exacerbated that pre-existing active condition and I guess accelerated the need for the performance of a total knee replacement that she was going to have eventually anyway?
>
> A: Your statement is correct.

Concerning when he believed Lundy would have needed knee replacement surgery prior to the fall, Dr. Hurley testified:

> Q: Could you anticipate prior to her fall when she would've needed a knee replacement in the future? Could she have gone another ten years?
>
> A: Again, I like to use phrases. M.D. does not equal G-o-d. So, I'm sorry. The answer to your question is, I really don't feel comfortable in putting a specific year or number on it. There's no doubt in my mind that at some point she was going to need to have a knee replacement. Like I said, she is still – for somebody who has had a knee replacement, I'm not happy that I had to do it on a 49-year-old, but unfortunately she had no choice. She was either going to have to have the knee replacement or spend the next several years taking narcotic pain

> medicine, and everybody knows what that can lead to in Kentucky.
>
> There's no question a knee replacement was coming. She's an OR nurse. She has worked with me for many years. She knows that I'm very conservative when it comes to surgery in this situation, but we both acknowledge that at this point she had no choice. But as far as your question is, we were going to try and get every bit of function out of her right knee as we could before we did surgery. And I think I feel comfortable in telling you it would have probably been at least a few more years. I think you said ten years. I don't think that was – I don't think that she would've lasted that long; but again, I don't know for sure. That's speculation.

Lundy also filed the January 11, 2018, Independent Medical Examination ("IME") report of Dr. James Carothers. After performing a physical examination and medical records review, Dr. Carothers set forth the following diagnoses:

> 1. Status post workplace injury to right knee on 01/12/2016.
>
> 2. Severe direct blow to hyperflexed right knee, with resultant meniscal tears, articular cartilage damage and subsequent regional/panarticular chondrolysis. (With severe pain uncontrolled without total joint arthroplasty).
>
> 3. Right total knee arthroplasty on 07/12/2016, secondary to sequelae of #1 and #2.
>
> 4. Anesthesia/dysesthesias weight bearing anterior surface (kneeling) right knee secondary to necessary iatrogenic transection of superior inferior geniculate sensory nerves.

Dr. Carothers assessed a 16% whole person impairment rating, and opined the knee replacement surgery was due to "the injury that she sustained at work, pure and simple."

Owensboro Hospital filed several medical reports of Dr. Bart Goldman. After performing a medical records review, in a record dated May 12, 2016, Dr. Goldman opined as follows regarding the work-relatedness of the knee replacement surgery:

> The reason that the joint space was decreased is because chondroplasty was performed on that joint thereby taking away more cartilage and decreasing the joint space. Total knee replacement may be this lady's only option but this would be secondary to her pre-existing degenerative arthritis which was accelerated by the chondroplasty performed for that previous testing degenerative arthritis and not by the torn meniscus that may have been caused by her work-related injury.
>
> It is, therefore, recommended that total knee arthroplasty, while likely reasonable, be denied for lack of relatedness to the injury in question.

The April 18, 2017, Benefit Review Conference Order lists the following contested issues: benefits per KRS 342.730, work-relatedness/causation, unpaid or contested medical expenses, injury as defined by the Act, and TTD.

In the January 27, 2019, Opinion, Award, and Order, the ALJ determined as follows regarding the compensability of Lundy's right knee replacement surgery:

> **I. Work-relatedness/causation and Injury as Defined by the Act**
>
> While I understand the parties could not come to an agreement, the ALJ considers it clear and evident that the torn menisci are work-related and compensable and the total knee replacement and arthritis are not work-related and not compensable.
>
> **A. Total Knee Replacement**

> The Plaintiff's history of a symptomatic right knee arthritis dates back ten years prior to the work injury. She received regular treatment for it. Dr. Hurley, well prior to the date of injury, predicted the Plaintiff would need a total knee replacement. At one point his treatment for the right knee, prior to the work accident, was to delay the inevitable need for a total knee replacement.
>
> Even Dr. Hurley's opinions on this matter are, at best equivocal. He testifies that the work injury, with the torn menisci, accelerated the condition but he does not deny that the underlying, pre-existing active condition, would have led to a total knee replacement.
>
> Because the Plaintiff's right knee condition was clearly pre-existing and symptomatic with treatment less than two years prior to the injury and because prior to the injury a total knee replacement was considered and considered inevitable I conclude that, the total knee replacement is not work-related.
>
> **B. Torn Menisci**
>
> There is no debate that the torn menisci are work-related. Medical and TTD benefits have been paid for them. They are work –related and compensable.
>
> **II. Temporary Total Disability Benefits**
>
> No additional TTD benefits beyond those paid for the torn menisci are owed.
>
> **III. Unpaid or Contested Medical Benefits**
>
> No medical benefits beyond those paid for the torn menisci are owed.

The ALJ subsequently set forth the following analysis regarding the applicability of the multipliers contained in KRS 342.730(1):

> The evidence is in agreement that for the torn menisci, i.e. excluding the total knee replacement, the correct impairment rating is 5%. The issue is the multiplier.
>
> I do not believe that the torn menisci alone is the reason that Lundy cannot return to work as an OR nurse. The

> much more serious injury to her knee is the arthritis with total knee replacement. I do not believe there is any serious medical evidence to the effect that the torn menisci alone, having been repaired there is nothing from the work injury that precludes her returning to the type of work done on the date of injury.
>
> Following the injury she never returned to work at equal or greater wages.
>
> No multipliers are being awarded.

Both parties filed petitions for reconsideration. Lundy requested additional findings from the ALJ concerning the determination her right knee replacement surgery is non-compensable. Lundy also requested the ALJ to reconsider his decision not to award the three multiplier.

The ALJ overruled Lundy's petition for reconsideration in the February 22, 2019, Order.

Lundy first contends the ALJ erred by determining her knee replacement surgery is non-compensable, as "[h]er knee would not have needed replacement for years were it not for the work injury." We vacate the ALJ's finding that the knee replacement surgery is non-compensable and remand for additional findings.

Unclear from the wording of the January 27, 2019, Opinion, Award, and Order is the specific medical evidence upon which the ALJ relied in determining Lundy's knee replacement surgery is not related to the work injury. However, the implication in the ALJ's analysis is that he relied upon Dr. Hurley's medical opinions to reach his conclusion. Implication is insufficient. Parties are entitled to findings sufficient to inform them of the basis for the ALJ's decision to allow for meaningful review. Kentland Elkhorn Coal Corp. v. Yates, 743 S.W.2d 47 (Ky. App. 1988);

Shields v. Pittsburgh and Midway Coal Mining Co., 634 S.W.2d 440 (Ky. App. 1982). While an ALJ is not required to engage in a detailed discussion of the facts or set forth the minute details of his reasoning in reaching a particular result, he is required to adequately set forth the basic facts upon which the ultimate conclusion was drawn so the parties are reasonably apprised of the basis of the decision. Big Sandy Community Action Program v. Chafins, 502 S.W.2d 526 (Ky. 1973). This is particularly pertinent in the case *sub judice* since Lundy requested additional findings in her petition for reconsideration on this issue, and the ALJ failed to provide any such findings in the February 22, 2019, Order.

Additionally, Dr. Hurley's opinions cannot constitute substantial evidence supporting the ALJ's ultimate conclusion regarding the knee replacement surgery. In his deposition, Dr. Hurley opined the work-related fall exacerbated Lundy's arthritis which ultimately accelerated the need for the knee replacement surgery. This is clearly illustrated by the following portion of Dr. Hurley's deposition testimony:

> A: If we go to algebra, if A equals B and B equals C, then A equals C. So if I have to do surgery to remove the torn meniscus, okay, and removing the torn meniscus can cause the arthritis to progress, then it's not the surgery that caused the progression. It's the injury.
>
> Q: Okay. Just so I'm clear and the record is clear, you don't contend as we sit here today that the osteoarthritis, the pre-existing osteoarthritis that was in Ms. Lundy's right knee was dormant prior to this injury. It was causing her symptoms; is that accurate?
>
> A: Yes, sir.
>
> Q: It was requiring treatment of an increased frequency over time?

A: Yes, sir.

Q: But it's your opinion that the fall of January 12, 2016 exacerbated that pre-existing active condition and I guess accelerated the need for the performance of a total knee replacement that she was going to have eventually anyway?

A: Your statement is correct.

While the ALJ has described Dr. Hurley's opinions on this issue to be "equivocal," there is simply no other conclusion that can be derived from his testimony other than the knee replacement surgery is, at least in part, work-related. On remand, should the ALJ continue to rely upon Dr. Hurley's opinions in resolving the issue of the compensability of the knee replacement surgery, the ALJ cannot find the knee replacement surgery non-compensable. That said, this Board acknowledges the existence of other medical testimony in the record which supports a finding the knee replacement surgery is not work-related. Therefore, on remand, before the ALJ can once again determine the knee replacement surgery is non-compensable, he must first identify the medical evidence in the record supporting such a determination.

Lundy's second argument is that, should Lundy's knee replacement surgery be found compensable, the issue of the three multiplier should be considered again. We agree and vacate and remand for additional findings.

In the January 27, 2019, Opinion, Award, and Order, the ALJ determined the torn menisci *alone* is not the reason Lundy is unable to return to the type of work she was performing at the time of the injury, as "[t]he much more serious injury to her knee is the arthritis with total knee replacement." However, since we are vacating the ALJ's determination the knee replacement surgery is not compensable

and remanding for additional findings, out of an abundance of caution, we must also vacate the ALJ's conclusion the three multiplier is not applicable. On remand, should the ALJ choose to rely upon Dr. Hurley when resolving the issue of the compensability of the knee replacement surgery and, consequently, determine the knee replacement surgery is work-related, he must re-examine applicability of the three multiplier in light of those new findings. Conversely, should the ALJ, on remand, determine the knee replacement surgery is neither work-related nor compensable after citing the supportive medical evidence in the record, he can indeed reject the applicability of the three multiplier once again, as the ALJ's determination the torn menisci alone does not preclude Lundy from returning to her pre-injury work is supported by substantial evidence in the record. We express no opinion on the outcome on remand.

Accordingly, the ALJ's determination the knee replacement surgery is not work-related and the finding the three multiplier is not applicable as set forth in the January 27, 2019, Opinion, Award, and Order and the February 7, 2019, Order are **VACATED**. This claim is **REMANDED** to the ALJ for additional findings and an amended decision consistent with the views expressed herein.

ALVEY, CHAIRMAN, CONCURS.

RECHTER, MEMBER, DISSENTS WITHOUT SEPARATE OPINION.

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