BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

DAVID JOYCE	)	
Claimant	)	
V.	)	
	)	
RED LINE INC.	)	AP-00-0493-797
Respondent	)	CS-00-0483-796
AND	)	
	)	
KS TRUCKERS RISK MGMT GROUP	)	
Insurance Carrier	)	

ORDER

The claimant, through Jeff K. Cooper, requested review of Administrative Law Judge (ALJ) Bruce E. Moore's Nunc Pro Tunc Award dated December 12, 2025. Todd E. Cowell appeared for the respondent and its insurance carrier (respondent). The Board heard oral argument on May 21, 2026.

RECORD AND STIPULATIONS

The Board adopted the same stipulations and considered the same record as the ALJ, consisting of the:

1. IME report of Brett Miller, M.D., dated September 19, 2024;
2. IME report of Lowry Jones, Jr., M.D., dated November 3, 2024;
3. Transcript of regular hearing, held August 8, 2025;
4. Deposition transcript of Brett A. Miller, M.D., taken September 16, 2025, with exhibits 1-4;
5. Deposition transcript of Lowry Jones, Jr., M.D., taken October 22, 2025, with exhibits 1-2; and
6. All documents of record filed with the Division, including the parties' briefs.

ISSUES

1. What is the nature and extent of the claimant's disability?

2. Is the claimant entitled to future medical treatment?

FINDINGS OF FACT

The claimant worked for the respondent as an over-the-road truck driver since 2020. On June 8, 2024, the claimant was taking a load to Georgia and stopped in Boonville, Missouri, to refuel. After refueling, the claimant put his left foot on the step and pushed up to get into the truck. He immediately heard a loud pop and felt a sharp pain in his left knee. He radioed dispatch, but was unable to reach them. He continued on his delivery route, albeit in pain.

After receiving some conservative treatment, the claimant was referred to Lowry Jones, Jr., M.D., a board-certified orthopedic surgeon, who became his treating physician. Dr. Jones diagnosed the claimant with a left knee complex medial meniscal tear, medial femoral condyle, and grade II chondromalacia of the patellofemoral joint. On September 13, 2024, the claimant underwent left knee surgery followed by physical therapy.

On September 19, 2024, the claimant saw Brett Miller, M.D., a board-certified orthopedic surgeon, at his attorney's request. The doctor diagnosed the claimant with postoperative left knee medial meniscus tear. Dr. Miller noted the claimant was not at maximum medical improvement and had recently undergone surgery.

On October 28, 2024, Dr. Jones released the claimant to return to work without restrictions. Dr. Jones testified the claimant had a "great recovery" postoperatively, based on the claimant not having pain and being able to do anything he wanted.[1]

Using the *Guides*, 6th edition, Dr. Jones assigned the claimant 9% impairment at the level fo the left knee and stated:

> It is more probable than not that future medical **WILL NOT** be necessary. As of his clinical examination on 10/28/2024 . . . there is no indication that [the claimant] will require additional medical or surgical treatment related to his injury date of 6/8/2024.
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> This evaluation and rating were derived by a review of all competent medical evidence, including a combination of the patient's subjective complaints, the clinical exam, objective findings, the physician's clinical judgment, a complete review of all the available records, imaging studies and AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. The rating is taken from Table 16-3, page509,510[sic].[2]

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[1] Jones Depo. at 10.

[2] *Id*., Ex. 2 at 1.

Dr. Jones' rating was based on the complexity of the claimant's medial meniscal tear and the damage to the claimant's medial femoral condyle. He testified his rating came "straight from the Sixth Edition."[3] He testified his opinions were all rendered within a reasonable degree of medical certainty.

Dr. Jones was unable to make a determination whether the claimant's current symptoms relate to patellofemoral pain or medial joint line pain, but testified, "the most common reason for people to have trouble with stairs is patellofemoral disease"[4] which would not be work related.

On cross-examination, Dr. Jones admitted his rating did not take into account the effect the injury had on the claimant's activities of daily living.

On December 20, 2024, Dr. Miller conducted an examination of the claimant via telemedicine. The claimant reported pain with prolonged standing and walking, but stated overall, he is "not bad."[5] Dr. Miller diagnosed the claimant with left knee medial meniscus tear. He opined the claimant had reached maximum medical improvement and it is more probably true than not the claimant will not require future medical treatment. Using the *Guides*, 6th edition, as a starting point, and based on all competent medical evidence, Dr. Miller assigned the claimant 26% impairment to the left knee within a reasonable degree of medical certainty. He testified:

> . . . If we look at Page 509, Table 16-3, and then we go down to the bottom column by row, it says "Ligament/Bone/Joint Meniscal injury". And then we go to Class 1 and 2. If we look at Class 1 we have three options. We have "Partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair." We have "Total meniscectomy (medial or lateral) or meniscal transplant (allograft)." We have "Partial (medial and lateral) meniscectomy." And then if we look at Class 2 column, we have "Total (medial and lateral) meniscectomy."
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> The issue I have with these two classes and the way they've been put in the table is that the - - there's more credit given to a total medial and lateral meniscectomy than a meniscal allograft transplant. And that's why I think this is erroneous in a number of ways. One is, any total meniscal resection leads to accelerated post-traumatic arthritis. An allograft meniscal transplant is literally a tertiary medical center, or KU Medical Center level open-extended procedure in which a cadaver graft is put in the knee secured with bone anchors and troughs. It's about a two-and-a-half, three-hour procedure versus a meniscectomy is 15 minutes. So they're giving less value to a meniscal transplant than they are to a

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[3] *Id*. at 12.

[4] *Id*. at 22.

[5] Miller Depo., Ex. 3 at 1.

> total meniscectomy. So I chose the Class 2 for a total meniscectomy of the medial compartment; and then added a percent for the additional pain and difficulty walking, walking long distances and the modification of his, quote, "I have to park in the back of the truck stop and my pain can go to eight to nine out of ten."[6]

Dr. Miller testified 6% of his rating is based on the claimant's subjective complaints. The doctor also changed his opinion on future medical after reviewing arthroscopy images, but without viewing Dr. Jones' operative report. Dr. Miller noted the images showed the claimant is missing a large chunk of the articular cartilage of the central aspect of the medial femoral condyle which was concerning for post-traumatic arthritis. Dr. Miller ultimately opined the claimant will more likely than not require future medical treatment, including corticosteroid injections, a brace, and potentially a partial or total knee replacement.

The ALJ observed Dr. Miller's report contained no descriptions of a physical examination and the doctor did not have Dr. Jones' operative report or photographs taken during and after surgery when Dr. Miller issued his rating opinion.

The claimant testified the surgery helped his knee some. The claimant continues to experience cramping after extended standing or walking, and his left knee feels like it is going to give out. He has difficulty with kneeling and squatting and has cramping after driving long distances. He denied these problems pre-injury. He currently works for himself doing RV transport.

The ALJ assigned the claimant 15% impairment to the left lower extremity at the level of the leg. The ALJ did not assign equal weight to the competing ratings. The ALJ stated:

> Dr. Jones had a greater opportunity to assess both the injury and the success of surgery. Dr. Miller rated a full meniscectomy rather than a partial meniscectomy and attributed ongoing complaints to the meniscus repair, rather than the preexisting degenerative patellofemoral joint.[7]

The ALJ further found the claimant failed to establish it is more probable than not he will require future medical treatment for the work injury to his left knee. The ALJ specifically found the "flip-flopping opinions" of Dr. Miller regarding future medical treatment did not outweigh the opinions of Dr. Jones.[8]

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[6] *Id*. at 15-16.

[7] ALJ Award at 7.

[8] *Id.* at 8.

PRINCIPLES OF LAW AND ANALYSIS

The claimant argues he is entitled to 26% impairment to the left knee. The claimant asserts Dr. Miller's impairment rating is more credible because it takes into consideration the effect the injury had on his activities of daily living, consistent with *Garcia*.[9] Additionally, the claimant argues future medical should be left open. The claimant continues to have pain and problems in his left knee which is in direct contradiction to Dr. Jones' assertion he had a "great recovery." The respondent maintains the Award should be affirmed.

K.S.A. 44-501b(c) states the claimant carries the burden of proof to establish the right to an award of compensation and to prove the various conditions on which the claimant's right depends. Under K.S.A. 44-508(h), the trier of fact shall consider the whole record. The burden of proving an affirmative defense is on the employer.[10]

The Board possesses authority to review *de novo* all decisions, findings, orders and awards of compensation issued by administrative law judges.[11] A de novo hearing is a decision of the matter anew, giving no deference to findings and conclusions previously made by the administrative law judge.[12]

1. The claimant is entitled to permanent partial disability benefits based on a 17.5% impairment, a split of the expert opinions.

The extent of permanent partial general disability shall be the percentage of functional impairment by the employee sustained on account of the injury as established by competent medical evidence and based on the 6th Edition of the AMA *Guides*.[13] In *Johnson v. U.S. Food Service,*[14] the Kansas Supreme Court held, in rating whole body impairments, the ratings calculations should begin with the AMA *Guides* as a starting point and consider competent medical evidence to modify or confirm the rating. This conclusion also applies to scheduled injuries: "So for scheduled injuries as well as for non-scheduled

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[9] See *Garcia v. Tyson Fresh Meats, Inc.*, 61 Kan. App. 2d 520, 506 P.3d 283 (2022).

[10] See *Hanson v. Logan U.S.D. 326*, 28 Kan. App. 2d 92, 96, 11 P.3d 1184 (2000), *rev. denied* 270 Kan. 898 (2001); *Foos v. Terminix*, 277 Kan. 687, 693, 89 P.3d 546 (2004).

[11] K.S.A. 44-555c(a).

[12] See *Rivera v. Beef Products, Inc.,* No. 1,062,361, 2017 WL 2991555 (Kan. WCAB June 22, 2017).

[13] K.S.A. 44-510e(a)(2)(B).

[14] *See Johnson v. U.S. Food Service*, 312 Kan 597, 478 P.3d 776 (2021).

injuries, the key fact – the percentage of functional impairment – must always be proved by competent medical evidence."[15]

Garcia states a rating physician must start with the AMA *Guides* and consider the competent medical evidence pertaining to a worker's capacity to function in work by incorporating whatever exams, patient reports, tests or research the physician's training or experience directs them to use.[16] *Garcia* states,"[S]ubjective work-related elements should be an integral part of the calculus if the ideology of the Act is to be preserved – to compensate the injured worker for the actual loss they have experienced."[17] An impairment rating must be formulated following a "comprehensive review of the worker's condition."[18] Further, each individual case of impairment is "not dictated by strict adherence to the Guides in isolation, but through careful consideration of competent medical evidence in conjunction with the Guides."[19] The case says the physician should not simply follow the steps in the *Guides*, but incorporate exams, patient reports, tests, research, training and experience to arrive at a "fair and comprehensive result."[20]

Garcia further notes while the *Guides* may be sufficient in some cases, the *Guides* may be insufficient at assessing impairment in other circumstances.[21] The case says a physician may opine the *Guides* provide "too narrow a view" or "understated" functional impairment, and may rely on competent medical evidence to yield a more accurate result.[22]

In *Weaver*, the Court of Appeals indicated a physician bases a rating for a scheduled injury on competent medical evidence if the physician incorporates exams, patient reports, tests or research the physician's training and experience directs the physician to use to formulate a fair and comprehensive result.[23]

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[15] *Weaver v. Unified Gov't of Wyandotte Cnty.*, 63 Kan. App. 2d 773, 785, 539 P.3d 617 (2023)

[16] See *Garcia v. Tyson Fresh Meats, Inc.*, 61 Kan. App. 2d 520, 532, 506 P.3d 283 (2022).

[17] *Id.* at 530-31.

[18] *Id.* at 531.

[19] *Id*.

[20] *Id.* at 532.

[21] *Id*.

[22] *Id.* at 533.

[23] See *Weaver*, 63 Kan. App. 2d at 627-28 (citing *Garcia v. Tyson Fresh Meats, Inc.*, 61 Kan. App. 2d 520, 531-32, 506 P.3d 283 (2022)).

The ALJ afforded more weight to the opinion of the treating doctor and surgeon, Dr. Jones, who had the opportunity to actually see inside the claimant's left knee. While these considerations provide support for Dr. Jones' opinion, the Board sees no reason to afford greater weight to the opinion of Dr. Jones. While Dr. Jones' report states he considered competent medical evidence, as required by *Weaver*, his testimony was his rating opinion came straight from the AMA *Guides*, 6th Edition. The doctor's testimony is contrary to the *Weaver* requirement for a rating to be based on the 6th Edition of the *Guides*, but more importantly, competent medical evidence. Dr. Jones also opined the claimant had a great surgical result, but this information is inconsistent with the claimant's generalized complaints about pain and physical limitations.

Dr. Miller's opinion is more consistent with the dictates of *Weaver* and, to a lesser degree, *Garcia*. Dr. Miller considered the *Guides*, 6th Edition, as a starting point, but deviated from a strict reading of the *Guides* by supplementing his opinion based on competent medical evidence. Dr. Miller did not believe the *Guides* alone adequately addressed the claimant's impairment. However, Dr. Miller's rating report contained no physical examination findings, such as loss of range of motion or loss of strength. It is difficult to determine the precise basis for Dr. Miller's opinion, other than his testimony that he used the *Guides*, 6th Edition, and the more important competent medical evidence. The doctor also never reviewed the operative report.

The two medical opinions are imperfect. Based on the facts of this specific case, the Board sees no reason to not simply award a split of the impairment ratings. As such, the Board finds the claimant is entitled to permanent partial disability benefits based on a 17.5% impairment.

2. The claimant did not prove he will more probably than not require future medical treatment.

K.S.A. 44-510h(e) states:

> (1) It is presumed that the employer's obligation to provide [medical benefits] shall terminate upon the employee reaching maximum medical improvement.
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> (2) If the employee has undergone an invasive or surgical procedure or an authorized treating healthcare provider recommends that the employee will need an invasive or surgical procedure in the future, the presumption in subsection (e)(1) as to termination of the right to medical treatment may be overcome with evidence that it is more probably true than not that future medical treatment will be needed after the employee reaches maximum medical improvement.
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> (3) In all other cases, such presumption to terminate the right to medical treatment provided by the employer may be overcome only with clear and convincing evidence of the need for future medical treatment.

> (4) As used in this subsection, "medical treatment" means only that treatment provided or prescribed by a licensed healthcare provider and shall not include home exercise programs or over-the-counter medications.

The Board agrees with the ALJ on this issue. Simply as a matter of sustaining the burden of proof, the claimant did not succeed. Dr. Miller's original opinion was the claimant would more probably not need future medical treatment. The doctor's belated and contrary opinion is in stark contrast to the original written opinion. Such opinion is rejected. The Board finds Dr. Jones' opinion to be more credible.

AWARD

WHEREFORE, the Board affirms in part, and modifies in part, the Award. The denial of future medical treatment is affirmed. The award of permanent partial disability benefits is increased based on a finding the claimant sustained a 17.5% impairment to the left leg.

Accordingly, the claimant is entitled to temporary total disability benefits at the rate of $753.79 per week or $12,814.43, followed by 32.03 weeks of permanent partial compensation at the rate of $753.79 per week or $24,143.89, for a 17.5% functional impairment to the left leg, making a total award of $36,958.32, which is ordered paid in one lump sum less amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of June, 2026.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: (via OSCAR)
Jeff K. Cooper
Todd E. Cowell
Hon. Bruce E. Moore