

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WALTER HARKINS,)
)
 Claimant,)
)
 v.)
)
 HARRIS MORAN SEED COMPANY,)
)
 Employer,)
)
 and)
)
 EMPLOYERS INSURANCE)
 COMPANY OF WAUSAU,)
)
 Surety,)
)
 Defendants.)
 _____)

IC 2008-001326

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND RECOMMENDATION**

FILED 09/26/2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Boise on March 24, 2011. Claimant was present and represented by Richard S. Owen. Kent W. Day represented Employer and Surety (“Defendants”). The parties presented oral and documentary evidence and two post-hearing depositions were taken. The parties then submitted post-hearing briefs and this matter came under advisement on July 20, 2011.

ISSUES

By agreement of the parties, the issues to be decided are:

1. Whether the condition for which Claimant seeks benefits was caused by the industrial accident;
2. Whether and to what extent Claimant is entitled to additional medical care; and
3. Whether and to what extent Claimant is entitled to temporary partial and/or temporary total disability benefits (TPD/TTD).

All other issues are reserved.

CONTENTIONS OF THE PARTIES

There is no dispute that Claimant suffered an industrial right ankle sprain when he slipped on a patch of ice and fell at Employer's on December 26, 2007. It is also undisputed that Claimant had no history of knee pain prior to his industrial accident.

Claimant contends that his ankle injury caused him to limp which, in turn, brought on persistent, debilitating pain in his right knee. He argues that his right knee pain constitutes an injury under the Compensatory Consequences Doctrine and, as such, Defendants are liable for his benefits. Further, conservative treatment has failed, so he now seeks a holding that right total knee replacement (TKR) surgery constitutes reasonable medical treatment. Claimant relies upon his treating medical care providers, the second opinion of Robert N. Walker, M.D., an orthopedic surgeon, and the Functional Capacity Evaluation (FCE) prepared by Rulin Hawks, P.T., to support his position.

Defendants counter that Claimant's post-accident right knee pain is solely due to the natural progression of his preexisting osteoarthritis and, therefore, they are not responsible for treatment of that condition. They additionally argue that Claimant is not an appropriate candidate, either clinically or radiographically, for a TKR. Defendants rely primarily upon the

independent medical evaluation (IME) opinion of Roman Schwartsman, M.D., an orthopedic surgeon.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The pre-hearing deposition of Claimant taken on August 3, 2010;
2. The testimony of Claimant taken at the hearing;
3. Claimant's Exhibits 1-15 admitted at the hearing;
4. Defendants' Exhibits A-J admitted at the hearing;
5. The post-hearing deposition of Robert N. Walker, M.D., taken by Claimant on April 13, 2011; and
6. The post-hearing deposition of George Nicola, M.D., taken by Claimant on April 21, 2011.

After considering all the above evidence and briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

BACKGROUND

1. Claimant was born on August 21, 1944. He was 66 years of age and resided in Nampa at the time of the hearing. He finished tenth grade, then went to work at an early age to help support his family. Claimant was first hired as an oil field laborer. Next, he worked as a tree trimmer for a number of companies, in Idaho and elsewhere. Then, from approximately 1980 through March 2008, Claimant held various jobs in Idaho feed and seed mills. Claimant has not worked since March 2009, when he agreed to take an early lay-off from Employer's

because he still was unable to do his full-duty job. He had worked as a seasonal employee for several years, and was routinely laid off from approximately April through July of each season before being hired back again.

2. Claimant's jobs in feed and seed mills required him to fill and load feed bags onto pallets, drive trucks, load trucks with hysters, and run mill equipment. His tree-trimming work was performed with the assistance of a utility bucket truck.

3. Prior to December 26, 2007, Claimant had no history of right ankle or knee difficulties, and these joints were all asymptomatic. He was overweight on the date of his industrial accident and he had a history of hypertension. Also, in 2006, Claimant underwent bilateral carpal tunnel repairs from which he fully recovered. Claimant has never smoked and he does not drink alcohol.

INDUSTRIAL ACCIDENT

4. On December 26, 2007, while working for Employer, Claimant slipped on a patch of ice and fell. He explained that he landed with his ankle going one way and his knee going the other. He was with three coworkers, who helped him up. Claimant recalled that they told him he also hit his head, but Claimant does not think so. Claimant reported the accident to his supervisor and he was sent to obtain medical care that same day.

MEDICAL TREATMENT

5. **Dr. Terry.** Claimant was examined by Ben Terry, M.D., a family practice physician at Saltzer Medical Group. Dr. Terry examined Claimant, ordered x-rays, and

diagnosed a right ankle strain.¹ He established restrictions limiting Claimant's climbing and any lifting, pushing or pulling of more than 30 pounds.

6. From January 10, 2008 through March 15, 2008, Claimant attended physical therapy for his right ankle. On his first visit, Claimant's therapist noted his antalgic gait pattern:

...antalgic gait pattern with less weight being born on the right foot. During ambulation the ankle does not go through is [sic] appropriate ROM and has poor push off...

CE 3, p. 11. Claimant experienced isolated moments of relief while he was in physical therapy, but no lasting improvement in either his gait or his pain level.

7. Claimant's ankle symptoms persisted and Dr. Terry diagnosed a sprain on January 17, 2008. A February 1, 2008 MRI revealed findings consistent with a fall on ice, including evidence of tenosynovitis, mild bone contusion with edema, and sprain or partial tear of the dorsal talonavicular ligament.

8. On February 6, 2008, Dr. Terry noted that Claimant reported right knee pain with numbness between his ankle and his knee. There is no evidence that Dr. Terry ever examined Claimant's right knee or otherwise addressed his right knee symptoms.

9. **Dr. Johnson.** On February 12, 2008, Claimant's right ankle was examined by Miers C. Johnson, M.D., an orthopedic surgeon. Dr. Johnson diagnosed a sprain and tenosynovitis. He prescribed a lace-up brace for work and a foot-drop (AFO) brace for home. He also took foot impressions for orthotics.

10. By April 8, 2008, Claimant had tried the orthotics prescribed by Dr. Johnson, but he ceased using them because they induced pain and numbness in his right leg. Concerned about

¹ Dr. Terry also diagnosed low back strain. Claimant's low back symptoms resolved, however, so no detailed findings concerning treatment for this condition are made in this decision.

his job, Claimant asked Dr. Johnson to return him to full duty even though he still had no relief from his ankle pain. Dr. Johnson complied, but he did not think Claimant's ankle issues were resolved:

...The patient is concerned that he is going to lose his job because he is not able to continue to work...he requested that I put him back to full duty. So this was done, [sic] I still don't believe that his problem is over, would recommend referral to a foot ankle [sic] specialist for evaluation...

CE 2, pp. 1-2.

11. **Dr. Kristensen.** Claimant saw Ronald M. Kristensen, M.D., an orthopedic surgeon specializing in foot and ankle pathology, on April 21, 2008. Based upon the MRI images, Dr. Kristensen suspected an injury to the dorsal talonavicular ligament and administered an injection into the talonavicular joint. Claimant again requested a release to full-duty work, which Dr. Kristensen provided.

12. Unfortunately, the injection only relieved Claimant's pain for a day or so. In May 2008, Dr. Kristensen discussed the possibility of surgical repair (a talonavicular fusion) with Claimant. However, by July 21, 2008, he no longer recommended this surgery, because Claimant's symptoms now appeared to originate in a different area. Dr. Kristensen concluded that Claimant had reached maximum medical improvement (MMI) with respect to his right ankle injury and assessed 0% permanent partial impairment (PPI). He explained that even though Claimant still had pain, his x-rays showed no changes to the cartilage at the talonavicular joint, so no PPI rating was warranted.

13. Claimant called Dr. Kristensen's office on August 12, 2008, very upset about his PPI conclusion. Claimant said that he could walk a significant distance before his accident, now he cannot due to significant pain.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION - 6

14. **Dr. Nicola/Dr. Shoemaker.** On October 20, 2008, Claimant sought treatment for his right knee symptoms from Dr. Nicola, an orthopedic surgeon. Dr. Nicola attributed Claimant's knee pain to his antalgic gait:

The patient is complaining of his knee and I do think that since the patient has been walking with an antalgic gait for many months, he has developed some knee pain.

CE 6, p. 27. Dr. Nicola took new x-rays and opined that they showed only minimal degenerative changes and no significant pathology. At his deposition, however, he related that he had suspected degenerative changes were present even though they were not obvious on Claimant's x-rays. He prescribed Voltaren gel, anticipated that surgery would not be required, and released Claimant without restrictions.

15. The Voltaren gel improved Claimant's ankle pain, but not his knee pain. Claimant was experiencing catching and popping over the medial joint line of his right knee. Dr. Nicola requested authorization for a right knee MRI. He also sought a right ankle MRI. He noted on November 17, 2008, that he believed Claimant's right ankle pain had previously distracted him from his right knee pain. "I think the patient had so much ankle pain, he did not notice his knee pain." CE 6, p. 26.

16. Claimant's condition did not improve. On January 20, 2009, he was evaluated by Howard W. Shoemaker, M.D., an occupational medicine specialist, for right knee pain and numbness and tingling in his right calf. Claimant was authorized to work full duty at the time, but Employer was accommodating Claimant's right leg condition by providing alternate work. Claimant reported that he had told all of his prior physicians about his knee pain, but the treatment focus at that time had been on his right ankle. On examination, Claimant exhibited

tenderness along the lateral joint line and peripatellar and retropatellar areas. He demonstrated full flexion and extension, and his ligaments appeared stable.

17. Dr. Shoemaker diagnosed a right knee sprain due to the industrial injury and administered an injection. Consistent with Dr. Nicola's opinion, Dr. Shoemaker explained that Claimant's knee injury arose from compensating for his industrial right ankle sprain:

The Patient is not medically stationary. This injury is medically reasonably work related "by history". Most consistent with compensatory knee strain as sx began and first recorded about one month after fall and limping on Rt ankle...Patient has remained limping on Rt ankle until just recently which is very consistent with compensatory PF dysfunction of rt knee.

CE 5, p. 14. (Reproduced as in original). Dr. Shoemaker also noted that he did not anticipate any permanent impairment or disability.

18. A few weeks passed, and the knee injection proved ineffective. Like Dr. Nicola, Dr. Shoemaker requested Surety's authorization for an MRI to help delineate a diagnosis. Authorization was denied on the basis that Claimant hadn't originally reported a knee injury.

19. On August 31, 2009, Claimant returned to Dr. Nicola because he was still having right ankle and knee pain. He had catching and popping over the medial joint line in his knee and catching and pain in his ankle. Dr. Nicola renewed his request for a right knee MRI and also requested a right ankle MRI. This time, Surety approved the MRI requests.

20. Claimant's MRIs were taken on September 9, 2009. The right knee MRI images revealed defects not discernible from prior x-rays. Specifically, they evidenced degenerative changes involving patellofemoral articulation, osteochondroma of the proximal tibia and small joint effusion. With respect to the degenerative changes, "There is thinning/loss of the articular

cartilage overlying the superior medial patellar facet near the apex with subchondral cystic changes...” CE 6, p. 20.

21. Claimant’s right ankle MRI demonstrated findings consistent with prior sprains and a possible partial tear of the cervical ligament from the talar attachment. Degenerative changes in the posterior subtalar articulation with chondromalacia and tenosynovitis of the flexor tendons was also identified.

22. On September 10, 2009, Dr. Nicola went over the MRI results with Claimant and administered another injection into his right knee. In subsequent visits, Dr. Nicola recorded findings and opinions concerning the etiology of Claimant’s knee symptoms. “I think his foot/ankle is causing him to walk funny and irritate the patella.” CE 6, p. 15. “The patient has a small swelling over the medial side of his knee, which I think is just chronic irritation.” CE 6, p. 13. Dr. Nicola ordered new orthotics for Claimant which, like the earlier set, failed to improve his right knee symptoms.

23. From September 14, 2009 through October 30, 2009, Claimant participated in approximately 18 physical therapy sessions targeting his right knee and ankle. On September 16, the therapist noted, “Instability of ankle is causing knee pain. Would benefit from ankle stability and proprioception exercises to improve ability to ambulate.” CE 7, p. 18. On October 5, 2009, the therapist provided Dr. Nicola with a detailed analysis of why he believed Claimant’s right ankle injury was causing his right knee symptoms:

I feel Walter’s knee pain is secondary to his original R ankle injury. His knee pain adapted from poor ankle mechanics and changed load throughout his R LE as noted by the fact his lateral knee pain was abolished within 2-3 days of the ankle mobilizations [*sic*-immobilizations], we have had success in changing his lateral knee pain and some of his ankle pain...

CE 7, p. 11. Claimant improved for a time with ankle taping but, by the end of his sessions, he demonstrated decreased motion and increased pain.

24. Conservative treatment having failed, Dr. Nicola recommended arthroscopic surgery in early 2010. He thought Claimant may have a torn medial meniscus. On March 3, 2010, Claimant underwent right knee arthroscopic surgery. Dr. Nicola found Claimant's menisci and ligaments were intact, but he also observed significant patellofemoral degenerative changes tightening the patellofemoral compartment. He performed a lateral release with debridement.

25. Following surgery, Dr. Nicola's first few chart notes appear encouraging. However, on April 26, 2010, he restricted Claimant to sedentary work only. During the ensuing months, Claimant exhibited right knee pain and weakness, right quadriceps weakness and right ankle swelling and pain. On June 24, 2010, Dr. Nicola noted, "His ankle still is sore and he has difficulty with ambulation because of stiffness and soreness of the ankle." CE 6, p. 4. On August 19, 2010, he measured the circumference of Claimant's right quadriceps to be two centimeters smaller than his left. His ankle was still painful and his knee was also painful, especially when climbing. An electrical stimulation unit alleviated Claimant's pain for approximately 45 minutes following each use, but provided no lasting relief. Dr. Nicola ordered a functional capacity evaluation preparatory to issuing a PPI rating.

26. On August 25, 2010, Dr. Nicola found Claimant had achieved MMI. Relying upon the *AMA Guides, Sixth Edition (6th Edition)*, Claimant assessed 5% lower extremity PPI, apportioning 75% to preexisting conditions, and issued permanent restrictions. Dr. Nicola opined that none of these restrictions, however, were related to the industrial injury. In a September 1, 2010 addendum, he explained, "...His current capacity evaluation shows continued

pain, but I think what we are seeing now are degenerative symptoms, which pre-existed his December 2007 injury.” CE 6, p. 1.

27. Contrary to his opinion that Claimant had reached MMI, however, Dr. Nicola wrote to Surety,² and testified at his deposition, that Claimant’s right knee condition would probably qualify for further treatment, including a total knee replacement (TKR):

...Now, he’s got – we know he’s got two out of the three compartments in the knee affected, so he could have lubricant injections, he could have cortisone injections. He had one already...

Some patients do okay with an arthritis unloader-type brace. I’m not crazy about them, but there are some patients that like them. He is not really a candidate for bony procedures in the knee other than really, at this point, a knee replacement. No osteotomies will help. Most partial knee replacements won’t help him.

Nicola Dep., pp. 31-32.

28. He explained why a TKR is the “gold standard” treatment in cases like Claimant’s, even though there is one partial knee replacement product on the market that could possibly be considered:

Q. ...Are there partial/total knees?

A. Yes.

Q. Is – in your judgment, is that a good option for him?

A. There is one that would cover – one particular model out there that would cover the areas affected, but when you have a patient who’s 66 now, say, or so, 66, 67, partial knee replacements are not as reliable. The gold standard is a knee replacement. A standard knee replacement, we’ve been doing them in this country since 1968. They’re reliable, and they generally work very well.

...

A. ...partial knees generally are done on patients who are a little bit younger, for the simple reason that a lot of times the concept is you’re buying time with that partial. You would not want to do a partial knee replacement on a 67-year-old patient, say, and then a year or two later down the road start having

² On March 17, 2011, Dr. Nicola wrote to Surety that he disagreed with Dr. Schwartzman's assessment that Claimant does not meet TKR criteria (see below). He explained, "Pt. has grade III changes over medial femoral condyle which will probably result in total knee replacement." DE J, p. 80. He cited both grade III and grade IV changes during his deposition.

to have pain on the outside of the knee because you didn't replace that portion.

Nicola Dep., pp. 32-33.

29. **Dr. Walker.** On October 6, 2010, Claimant underwent a second opinion evaluation by Robert N. Walker, M.D., an orthopedic surgeon. Claimant's knee was more of a problem than his ankle on this date, with lateral and medial pain and some popping and catching. On exam, Dr. Walker found reduced range of motion in his right knee as compared with his left, tenderness to palpation over the medial and lateral joint lines of the patella, and mild quadriceps atrophy, among other things. Acknowledging that Claimant's x-rays (including those taken by him on the day of the evaluation) fail to identify any significant pathology, Dr. Walker nevertheless assessed advanced osteoarthritis in Claimant's right knee. He based his opinion on Dr. Nicola's findings during the March 2009 arthroscopy.

30. Relying upon Claimant's historical reports, he further opined that Claimant's preexisting degenerative right knee condition was exacerbated by his gait alteration due to his persistent ankle pain. "...It does not appear that his knee pain is a direct result of his industrial injury, but is most likely an exacerbation of preexisting osteoarthritis, due to gait alteration following his ankle injury." CE 9, p. 1. Dr. Walker's testimony is consistent with his documentation:

...I believe that, from what I know from Mr. Harkins – and unfortunately this is based upon a one-time visit with him – that the pain that he is describing in his knee is consistent with the history that he provided to me, that is consistent with the injury and the exacerbation from gait alteration. Unfortunately, there's no way to know with certainty, but on a more probable than not basis there is a connection there.

Walker Dep., p. 25.

31. Dr. Walker opined that Claimant has three treatment choices. First, he can learn to adapt to his pain limitations. Second, he can undergo periodic viscosupplementation injections. Or, third, he can undergo a TKR, the only choice offering a permanent solution.

32. At his deposition, Dr. Walker explained why a TKR is reasonable in Claimant's case:

...Mr. Harkins has relatively localized areas of severe cartilage loss, rather than real global cartilage loss. It's much easier to make the decision to proceed with knee replacement with more global cartilage loss; for instance, severe, longstanding arthritis involving all three compartments of the joint.

In other words, just resurfacing, for instance, the patellofemoral joint alone. However, at his age most joint surgeons, to my understanding, would elect to do the complete replacement, because frequently the partial replacements eventually then need to be revised later to a complete replacement as the knee ages. And so past a certain age, more commonly they'll do the complete replacement rather than just these partials.

So there are some – you know, I think that one could present a range of options as far as replacements, but likely the one that makes the most sense would be a complete replacement.

CE 9, pp. 23-24. Dr. Walker used to perform TKRs, but he no longer does so. He practices with physicians who perform this procedure.

INDEPENDENT MEDICAL EVALUATION

33. **Dr. Schwartzman.** At Defendants' request, Dr. Schwartzman conducted an IME on November 18, 2010. He interviewed Claimant, reviewed his medical records, conducted an examination, and prepared a report.

34. Claimant's presentation on exam was consistent with his prior medical records: he had right knee pain and generalized right ankle discomfort. Dr. Schwartzman noted that Claimant did not exhibit any pain magnification behaviors.³

35. Dr. Schwartzman observed Claimant's antalgic gait pattern. He characterized it as exhibiting a quadriceps avoidance component in which Claimant was reluctant to flex his right knee and preferentially shifted his weight to the left leg. Based upon his observation, Dr. Schwartzman concluded that Claimant's gait pattern would cause problems in his left knee, not his right. Therefore, he opined, the industrial right ankle injury was noncontributory to Claimant's right knee symptoms.

36. Dr. Schwartzman diagnosed patellofemoral degenerative joint disease and osteochondroma of the right knee, all due to Claimant's preexisting condition. Without elaborating, and somewhat contrary to his opinion that the industrial accident was altogether unrelated, he opined that any aggravation or exacerbation would have been temporary in nature. He relied on his understanding, from Claimant's medical records, that Claimant did not report right knee pain until October 2008 when, in fact, Dr. Terry's records reflect that he reported right knee pain at least as early as February 6, 2008.

37. With respect to medical stability, Dr. Schwartzman opined that Claimant had reached MMI from his industrial accident injury. As indicated, above, Dr. Schwartzman does not consider Claimant's right knee injury to be related to that event. He deferred to

³ In his cover letter to Surety, Dr. Schwartzman inconsistently stated that Claimant "...did manifest evidence of pain magnification behavior during the examination...". DE G, p. 44. Given the weight of evidence in the record and the context of the statement in the letter, the Referee finds it most likely that the letter contained an inaccurate restatement of the information contained in Dr. Schwartzman's IME report.

Dr. Kristensen with respect to when Claimant's right ankle reached MMI, thereby opining that Claimant reached MMI from his industrial injury on July 21, 2008.

38. Dr. Schwartzman further opined that Claimant is not a candidate for TKR. He reasoned that Claimant has well-preserved joint spaces and patellofemoral arthritis that is isolated, so he meets neither the clinical nor the radiographic criteria for a TKR. Instead, Dr. Schwartzman opined that the best treatments for Claimant would include physical therapy, viscosupplementation, and anti-inflammatory medication. He did not explain why he believed these approaches may offer relief even though they have repeatedly proven unsuccessful for Claimant in the past. Dr. Schwartzman also recommended a repeat MRI to objectively assess whether Claimant's knee condition had progressed.

FUNCTIONAL/VOCATIONAL EVIDENCE

39. **ICRD.** From April 28, 2010 until approximately February 11, 2011, Claimant was assisted by Teresa Ballard, consultant with the Idaho Industrial Commission Rehabilitation Division (ICRD). Ms. Ballard's records indicate that Claimant worked for Employer until March 2009, when he was laid off. Ms. Ballard initiated a Job Site Evaluation (JSE), but in spite of many, many requests to Dr. Nicola to review the JSE and opine as to whether Claimant could return to his pre-accident position, there is no evidence in the record that Dr. Nicola ever responded.

40. **Mr. Hawks.** On October 25, 2010, at Dr. Nicola's request, Claimant underwent an FCE by Rulin Hawks, P.T., a physical therapist. Following an interview with Claimant, Mr. Hawks administered a number of tests to assess Claimant's functionality and work-readiness, then provided the test results, along with his opinions, in a comprehensive report.

41. Mr. Hawks reported that Claimant participated with maximum effort during the entire evaluation process. Claimant registered high pain ratings, which Mr. Hawks noted were consistent. Similarly, he observed Claimant's gait pattern was invariably antalgic and that Claimant uniformly favored his right leg, even when sitting. Mr. Hawks opined, "Due to his right knee and ankle dysfunction, he is unable to perform lifting activities that require squatting, pushing, pulling or carrying." CE 12, p. 8. Specifically, Mr. Hawks opined that Claimant's right leg conditions relegate him to sedentary activities, because he cannot stand for more than ten minutes, cannot walk at a normal gait velocity, and cannot walk more than five minutes, in any event.

42. **Dr. Barros-Bailey.** At Defendants' request, Mary Barros-Bailey, Ph.D., a vocational consultant, prepared a Disability Evaluation. She interviewed Claimant, reviewed his medical records and FCE, then developed a report. Dr. Barros-Bailey opined that Claimant's work tolerance is limited to sedentary and a partial range of light-duty work; however, he has few skills transferrable to these work categories. She opined that Claimant's limitations are not work-related, because they are due to preexisting degenerative processes. Her opinion on this point is based upon the medical evidence in the record, which is in dispute, and further which she is not qualified to evaluate. As such, Dr. Barros-Bailey's opinion on this point lacks credibility and carries no weight.

43. Claimant underwent another right knee MRI on November 30, 2010. It showed a small oblique tear in the posterior horn lateral meniscus near the posterior root insertion along with degenerative fraying, among other findings.

CLAIMANT'S CREDIBILITY

44. Claimant's medical records uniformly confirm that Claimant asserted full effort on testing and in treatment, and at all times exhibited a sincere desire to recover. Similarly, there is no evidence in the record that Claimant has ever demonstrated any pain magnification behaviors. On the other hand, there is evidence that Claimant, both before and after his industrial accident, prompted his medical care providers to return him to work when they otherwise may have delayed a full release. The Referee is persuaded that Claimant's pain experiences are as he describes them and that he would return to work if he could.

45. Along these lines, Claimant testified that after onset of his right knee pain approximately six weeks post-accident, it steadily increased, prompting him to take an early lay-off from work in March 2009. The Referee finds Claimant's testimony in this regard is consistent with the weight of evidence in the record and is credible.

46. Claimant did, however, exhibit some understandable confusion as to some of the medical details and dates of some of his relevant treatment. To the extent that his testimony is inconsistent with otherwise reliable and contemporaneously-made documentation in the record, the Referee finds the information in the documentation more credible than Claimant's testimony.

DISCUSSION AND FURTHER FINDINGS

The provisions of the Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). However, the Commission is

not required to construe facts liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

MEDICAL CAUSATION/UNDERLYING DEGENERATIVE CONDITION

The Idaho Worker's Compensation law defines accident to mean "an unexpected, undesigned, and unlooked for mishap, or untoward event, connected with the industry in which it occurs, and which can be reasonably located as to time when and place where it occurred, causing an injury." An injury is "construed to include only an injury caused by an accident, which results in violence to the physical structure of the body." See I.C. § 72 – 102(18); *Perez v. J.R. Simplot Company*, 120 Idaho 435, 816 P.2d 992 (1991); *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 901 P.2d 511 (1995).

A claimant must prove not only that he or she suffered an injury, but also that the injury was the result of an accident arising out of and in the course of employment. *Seamans v. Maaco Auto Painting*, 128 Idaho 747, 751, 918 P.2d 1192, 1196 (1996). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 785, 890 P.2d 732, 736 (1995). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). Proof of a possible causal link is not sufficient to satisfy this burden. *Beardsley v. Idaho Forest Industries*, 127 Idaho 404, 406, 901 P.2d 511, 513 (1995).

The employer is not responsible for medical treatment that is not related to the industrial accident. *Williamson v. Whitman Corp./Pet, Inc.*, 130 Idaho 602, 944 P.2d 1365 (1997). The fact that a claimant suffers a covered injury to a particular part of his or her body does not make

the employer liable for all future medical care to that part of the employee's body, even if the medical care is reasonable. *Henderson v. McCain Foods, Inc.*, 142 Idaho 559, 563, 130 P.3d 1097, 1101 (2006). However, secondary medical consequences resulting from a compensable industrial injury are compensable. 1 Larson, *The Law of Workman's Compensation*, 13.11 (1985).

The permanent aggravation of a pre-existing condition is compensable. *Bowman v. Twin Falls Construction Company, Inc.*, 99 Idaho 312, 581 P.2d 770 (1978). "The fact that [claimant's] spine may have been weak and predisposed him to a ruptured disc does not prevent an award since our compensation law does not limit awards to workmen [or women] who, prior to injury, were in sound condition and perfect health. Rather, an employer takes an employee as he [or she] finds him [or her]. *Wynn v. J.R. Simplot Company*, 105 Idaho 102, 104, 666 P.2d 629, 631 (1983).

47. In his opening brief, Claimant cites the Industrial Commission's decision in *Quentin v. American Interstate Ins. Co.*, 2003 IIC 0237, for the proposition that a preexisting condition aggravated by a limp from an industrial injury is compensable under Idaho Workers' Compensation Law. In *Quentin*, the Commission held the claimant's resultant deep vein thrombosis (DVT) in his left leg was a compensable consequence of the limp he developed after sustaining an industrial injury to his right leg. Even though the claimant had a blood clotting disorder at the time of his industrial injury, medical expert testimony established that his difficulty standing and walking, due to the industrial injury, likely caused his DVT. The Referee agrees that *Quentin* embodies an appropriate application of the relevant law.

48. Claimant's testimony regarding the occurrence of an industrial accident on December 26, 2007, causing persistent right ankle pain, is credible and is not contested by Defendants. However, Defendants argue that Claimant's industrial injury to his right ankle is stable and that neither the industrial accident nor the ankle injury caused his right knee pain. Defendants contend that Claimant's right knee pain is wholly due to preexisting arthritis and other degenerative changes, and that he would have required the same treatment even in the absence of the industrial injury. As developed below, the real issue in this case is not whether Claimant had developed knee pain starting in approximately early February 2008, but, rather, whether that knee pain is the manifestation of an acceleration or exacerbation of Claimant's right knee arthritis related to gait alteration associated with the right ankle injury.

49. Claimant credibly and persuasively testified that he had no known history of right knee pain or pathology prior to his 2007 industrial accident, that he began having right knee pain about six weeks after the industrial accident, and that this pain intensified over time, prompting him to take an early lay-off in March 2009.

50. Further, Claimant does not dispute that his right knee was not injured immediately following the December 26, 2007, accident. Rather, based on Claimant's history of onset of right knee discomfort approximately six weeks following the subject accident, Claimant posits that the onset of that discomfort is a compensable "secondary effect" caused by the subject accident.

51. Claimant bears the burden of demonstrating that it is more likely than not that his right knee symptomatology is the result of violence to the physical structure of his body caused by the gait alteration, and not something else. The timing of the onset of Claimant's right knee

discomfort is consistent with the proposition that his pre-existing right knee arthritis was exacerbated by the gait alteration he experienced as a consequence of the original ankle injury. There is no temporal objection to Claimant's theory; however, the timing of onset alone is inadequate to meet Claimant's burden.

52. There is no question that Claimant suffered from long-standing, bilateral degenerative knee arthritis predating the industrial accident. Indeed, Dr. Schwartzman testified that Claimant's left knee osteoarthritis is, in some respects, more severe than the degenerative condition that plagued his right knee. Yet, only the right knee is symptomatic. Drs. Nicola and Walker opined that mechanical changes in the right knee due to altered gait are consistent with Claimant's pain. These opinions account for why Claimant's right knee is painful and his left knee is not. Overall, evidence of Claimant's left knee arthritis is not inconsistent with Claimant's position.

53. As well, the medical testimony uniformly fails to establish that there is any objective medical evidence that Claimant suffered a worsening of his right knee arthritis, in terms of joint space narrowing due to cartilage loss or other measures, between the date of accident and the date of hearing. Although Claimant underwent a number of post-accident radiological studies, including x-rays in 2008, and MRIs in 2009 and 2010, neither Dr. Nicola nor Dr. Walker felt that the evidence was sufficient to support a conclusion that Claimant experienced any progression of his right knee arthritis following the subject accident because they had no prior studies for comparison. This evidence does not necessarily rule out an exacerbation of a preexisting condition as contemplated under Idaho Worker's Compensation Law. So long as Claimant establishes, through other evidence, that his right knee pain was

caused by an injury due to violence to the physical structure of his body, he is entitled to benefits.

54. Dr. Walker persuasively testified that Claimant's pain reports, if credible, are consistent with the effects of mechanical changes from gait alteration on his arthritic right knee:

Q. I guess what I'm getting at here, Dr. Walker, and you're probably seeing this coming is: Your opinion is that this accident and the gait disturbance has aggravated his arthritis, and I'm wondering: Do these tests and the progress of the degenerative changes that the tests show support that?

A. You know, I think that the aggravation of the preexisting arthritic problem is not so much a conclusion that one draws from diagnostic imaging, but more a conclusion that one draws from the clinical setting.

And the diagnostic imaging is consistent with the findings that Dr. Nicola had at the time of his operative procedure; that he had cartilage loss in the patellofemoral joint. Diagnostic imaging suggests that there was cartilage loss in the patellofemoral joint, so those things are consistent.

And to me the cystic changes on the MRI scan are also consistent with this being longstanding. So having established that then the question that I would have to ask is: Why is his knee more painful now than it was previously?

And in that we have to rely upon his history. What are the inciting factors to that? One of those inciting factors he provides is an injury in 2007 which then injured his ankle and has caused him to walk abnormally.

But me coming into this late, I have to rely upon him to tell me, you know, what then are the—what is the time relationship to that injury, when did the knee start becoming more painful, and how might that relate to his knee pain? Based upon that, it seems consistent that his knee pain is more likely than not related to his ankle injury.

Q. Let me ask you this question, Dr. Walker: Are the test results that we just went through, are those consistent with Mr. Harkins' claim that this—the gait disturbance has accelerated the degenerative change in his knee?

A. I don't know that we can say that based upon the objective data that we have.

Q. And why is that?

A. We don't have data that images his articular cartilage prior to his injury, so we don't know what his status was at that time. We have an x-ray that was obtained at some point after the injury that we cannot use as definitive proof of what his cartilage status was. It doesn't show a lot of arthritis, but it doesn't—but you can't depend on it telling you that he doesn't have arthritis.

Q. Doesn't rule it out either?

A. Correct. We do have MRI scans, two of which were done a year apart, that are really consistent with each other. They both show relatively advanced arthritis—you know, cartilage wear of his patellofemoral joint.

And to my read, one's not necessarily worse than the other one, but they're both two points down the road from his injury. We have no data points prior to his injury for comparison to draw that conclusion.

Q. All right.

A. Now, symptomatically it might be worse, and that is what the patient feels. And the patient can feel the symptoms but can't really, you know—doesn't really have data to tell us is it objectively worsening, or not, but symptomatically it might be worsening, yes.

....

Q. Dr. Walker, I asked you previously about the objective evidence in his file. Based on what Mr. Harkins tells you about his symptoms and the objective evidence, if we factor all of that in together, do you have an opinion as to whether or not this accident has aggravated and accelerated Mr. Harkins' knee arthritis?

A. No. I believe that, from what I know from Mr. Harkins—and unfortunately this is based upon a one-time visit with him—that the pain that he is describing in his knee is consistent with the history that he provided to me, that is consistent with the injury and the exacerbation from gait alteration. Unfortunately, there's no way to know with certainty, but on a more probably than not basis there is a connection there.

....

Q. You indicated to Mr. Day that when you get degenerative arthritis, it was pretty well a certainty that at some point it's going to get worse, and there's a lot of variables. When you see people like Mr. Harkins with a demonstrated limp, is that one of the things that you have seen make arthritis worse faster than normal?

A. I don't believe the limp itself will cause—well, let me back up here. Generally a limp won't cause arthritis to worsen. And, again, I'm speaking from the

physician side, meaning it would cause it to wear faster, because usually a person's limping because of their arthritis pain, if that makes sense?

We're dealing with a little bit different situation here. If we have someone who just has, for instance, arthritis of their knee, and they're limping because of that, then it usually doesn't, in my opinion, make their arthritis pain—or their arthritis in their knee worsen and wear faster because of that limp. In fact, it probably would make it wear less because they're not putting as much weight on that side.

Now, on the other hand, we're dealing with a more complex environment in this particular patient's setting, because is he limping, you know, because of his knee arthritis? Is he limping because of his ankle problem? And what effect is that causing—what effect does one cause to the other?

And I don't know that you can say definitively or even with a high degree of probability, what the answer to that question is, but, you know, the limp from a ankle could reasonably cause some other joint in his body to become more symptomatic—weight-bearing joint, just because of his alteration in gait.

Walker Dep., pp. 19–21; 24–25; 38–39. Ultimately, accepting Claimant's history of onset to be accurate, Dr. Walker felt that it was reasonable to conclude that Claimant's gait alteration exacerbated his underlying right knee arthritis.

55. There is evidence in the record which appears to challenge this conclusion. For example, both Dr. Nicola and Dr. Walker testified that Claimant responded poorly to inter-articular injections and a right shoe insert, both modalities which would be expected to improve his symptomology, if his symptoms were indeed related to right knee arthritis. Nevertheless, Claimant's poor response to conservative treatment did not prevent either physician from opining that his knee pain is related to the interaction between his arthritis and his gait alteration. Further, Dr. Schwartzman did not address this in his opposing opinion.

56. Although Dr. Nicola opined that gait alteration caused Claimant's knee pain, he declined to opine that a TKR to relieve that pain should be attributable to the workplace injury:

...

Q. Dr. Nicola, we have in evidence a response to a questionnaire from the Liberty claims people. It's marked Defendant's Exhibit 80 and 81. Counsel has asked you some questions about the second question, but he didn't ask you anything about the first question. The first question states, "Do you concur with Dr. Schwartsman's assessment that a total knee orthoplasty for the right knee is not reasonably required on an industrial basis?" And you marked "yes." Is that correct?

A. Correct.

Q. Okay. And is there any—anything about any of the representations that Mr. Owen has made to you today or anything else, any of the questions or representations he's made to you, that would change your opinion in that regard?

A. No.

Nicola Dep., p. 35. Dr. Nicola's conclusion as to the compensability of Claimant's claim (that a TKR is not reasonably required on an industrial basis) is a legal conclusion that carries no weight. It is clear that Dr. Nicola is rendering a compensability opinion, as opposed to a medical opinion, because he opines elsewhere that Claimant will likely require a TKR. Further, his conclusion in this regard opposes his medical opinions, which mitigate toward the conclusion that Claimant's right knee symptomatology resulted from his industrial accident. Recall, Dr. Nicola opined that Claimant's right knee pain resulted from his altered gait.

57. Taking into consideration the medical testimony as a whole and, in particular, the testimony of Dr. Walker, the Referee finds that Claimant has met his burden of proving that it is more probable than not that his right knee arthritis was exacerbated or accelerated as a result of the gait alteration associated with the subject accident. In reaching this conclusion, it is again worth noting that the Referee finds Claimant to be a credible witness, and that Dr. Walker's reliance on Claimant's testimony is well-placed. The mechanical changes from gait alteration caused by Claimant's industrial injury, persuasively described by Drs. Walker and Nicola,

constitute violence to the physical structure of his body that exacerbated his preexisting but asymptomatic right knee arthritis, such as to establish a compensable injury under Idaho Code § 72-102(18)(c).

MEDICAL CARE

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special Indemnity Fund*, 126 Idaho 781, 890 P.2d 732 (1995). “Probable” is defined as “having more evidence for than against.” *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974).

In *Sprague*, the following factors were found to be relevant to the determination of whether the particular care at issue in that case was reasonable: (1) a claimant should benefit from gradual improvement from the treatment rendered, (2) the treatment was required by a claimant’s treating physician, and (3) the treatment was within the physician’s standard of practice and the charges were fair and reasonable. However, the *Sprague* standard anticipates a situation in which treatment has already been rendered, and the *Sprague* analysis is not readily applicable to care that is prospective in nature, like that at issue in this case. *See, Richan v. Arlo G. Lott Trucking, Inc.*, IC 2007-027185 (filed Feb. 2011); *Ferguson v. CDA Computune, Inc.*,

et. al., consolidated cases numbers IC 2001-005778, IC 2001-021764, IC 2004-504577 and IC 2004-000161 (filed Feb. 2011).

58. To determine whether the care proposed by Dr. Walker is “reasonable,” the Commission must ascertain whether it is likely to be efficacious. In other words, if, from the medical evidence adduced by Claimant, it appears that it is more probable than not that a TKR will improve Claimant’s condition, then the care is “reasonable.”

59. **Reasonableness of a TKR.** Drs. Walker and Nicola both opined that a total knee replacement is the optimal permanent solution for Claimant’s arthritic knee pain. Although partial knee replacement products and procedures are also available, both physicians opined that a TKR is the best surgical choice in Claimant’s case due to his condition and his advancing age. Each physician also recommended, as alternatives, non-permanent solutions. However, Claimant has tried conservative treatment, to no avail.

60. Dr. Nicola's opinion is complicated by the fact that, at the end of his deposition testimony, he opined, “[Claimant] will need a knee replacement. Maybe not right now, but [sic] will need lubricant and/or a knee replacement at some point in the future.” Nicola Dep., p. 34. His testimony as to Claimant’s need for a TKR up until that last sentence all indicate that Dr. Nicola believed Claimant was a present TKR candidate. Dr. Nicola did not explain his apparent change of heart, which was inconsistent with the rest of his deposition testimony on this point. Indeed, he explained that he had previously written to Surety confirming that Claimant’s grade III and grade IV changes warrant treatment. (*See*, fn. 2).

61. Dr. Schwartsman opined that a TKR does not constitute reasonable medical treatment because Claimant has well-preserved joint spaces and patellofemoral arthritis that is isolated. He opined that Claimant meets neither clinical nor radiographic criteria for a TKR.

Dr. Schwartzman did not cite authority for his opinion or further delineate the clinical and radiographic criteria on which he relied. Drs. Nicola and Walker agreed that a TKR would be an easier call in a patient with arthritis affecting all three compartments of the knee. However, noting Claimant's age and his arthritis affecting two compartments, Dr. Nicola opined that a TKR is reasonable in Claimant's case. Likewise, Dr. Walker acknowledged Dr. Schwartzman's opinion, but nevertheless confirmed that a TKR is reasonable, considering Claimant's age and condition.

62. Claimant's right knee pain was determined, above, to be the result of permanent exacerbation of his preexisting osteoarthritis. He has tried conservative treatments without success. The opinions of Drs. Nicola and Walker establish that a TKR will, more likely than not, relieve Claimant's right knee arthritis pain. The Referee finds Claimant has proven a right knee TKR constitutes reasonable medical treatment for his right knee condition.

TEMPORARY TOTAL DISABILITY

63. Idaho Code Sections 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled until such time that he is no longer in a period of recovery. Neither party specifically addressed TTD benefits in his or its briefing. However, the record establishes that Claimant reached MMI following his right ankle injury on July 21, 2008. Concerning his right knee condition, Claimant reported right knee pain to Dr. Terry on February 6, 2008, but no treatment was rendered until October 20, 2008 (by Dr. Nicola). Claimant's pain persisted so, in a mutual agreement with Employer, he ceased working as of March 2009.

64. Under *Maleug v. Pierson Enterprises*, 111 Idaho 789 (1986), once a claimant establishes by medical evidence that he is within the period of recovery from the industrial

accident, he is entitled to total temporary disability benefits unless and until evidence is presented that he has been medically released for light work and that (1) his former employer has made a reasonable and legitimate offer of employment to him which he is capable of performing under the terms of his light work release and which employment is likely to continue throughout his period of recovery, or that (2) there is employment available in the general labor market which Claimant has reasonable opportunity of securing and which employment is consistent with the terms of his light-duty work release.

65. Claimant worked with limitations for more than a year after his industrial injury, but he ceased working in March 2009 due to his industrial right ankle and knee injuries. Conservative treatment failed, as did arthroscopic surgery on March 3, 2010. Claimant's right knee condition did not improve post-surgically and he did not return to work.

66. Nevertheless, on September 1, 2010, Dr. Nicola found Claimant had reached MMI from his *industrial injury*, because he attributed Claimant's post-surgical unresolved right knee pain to his osteoarthritis, which Dr. Nicola attributed wholly to Claimant's preexisting degenerative condition. As determined above, Claimant's osteoarthritis was permanently exacerbated by his industrial injury, so Dr. Nicola's conclusion that Claimant had reached MMI even though he still had significant arthritis pain for which reasonable medical treatment was available, is contrary to Idaho Worker's Compensation Law.

67. The evidence establishes that Claimant remains in a period of recovery for his right knee condition. Further, Defendants have failed to establish that Employer has made an appropriate offer of employment since Claimant was laid off in March 2009 or that there is other appropriate employment available to him. Claimant is entitled to TTD benefits from the date

following his last day of work in March 2009, until such time that he reaches MMI following reasonable medical treatment for his right knee condition.

CONCLUSIONS OF LAW

1. Claimant has proven that his right knee injury is due, at least in part, to the 2007 industrial accident.

2. Claimant has proven his entitlement to past and future medical benefits for reasonable treatment of his right knee condition, including but not limited to a total knee replacement.

3. Claimant has proven his entitlement to temporary total disability benefits, beginning on the day following his last day of work for Employer in March 2009 and extending through the date on which he reaches MMI from his right knee injury. Defendants are entitled to credit for TTD payments, if any, already rendered during this period.

4. All other issues are reserved.

RECOMMENDATION

Based upon the foregoing Findings of Fact, Conclusions of Law, and Recommendation, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this 29th day of August, 2011.

INDUSTRIAL COMMISSION

_____/s/_____
LaDawn Marsters, Referee

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of September, 2011, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

RICHARD S. OWEN
206 TWELFTH AVENUE ROAD
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NAMPA, ID 83653

KENT W DAY
PO BOX 6358
BOISE ID 83707-6358

srn

_____/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WALTER HARKINS,)
)
 Claimant,)
)
 v.)
)
 HARRIS MORAN SEED COMPANY,)
)
 Employer,)
)
 and)
)
 EMPLOYERS INSURANCE)
 COMPANY OF WAUSAU,)
)
 Surety,)
)
 Defendants.)
 _____)

IC 2008-001326

ORDER

FILED 09/26/2011

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has proven that his right knee injury is due, at least in part, to the 2007 industrial accident.
2. Claimant has proven his entitlement to past and future medical benefits for reasonable treatment of his right knee condition, including but not limited to a total knee replacement.

3. Claimant has proven his entitlement to temporary total disability benefits, beginning on the day following his last day of work for Employer in March 2009 and extending through the date on which he reaches MMI from his right knee injury. Defendants are entitled to credit for TTD payments, if any, already rendered during this period.

4. All other issues are reserved.

5. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this 26th day of September, 2011.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas E. Limbaugh, Chairman

_____/s/_____
Thomas P. Baskin, Commissioner

_____/s/_____
R.D. Maynard, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of September, 2011, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS**, and **ORDER** were served by regular United States Mail upon each of the following persons:

RICHARD S. OWEN
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_____/s/_____