BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

WILLIAM WATTS, Claimant, v. SCHWAN'S FOOD SERVICE, INC., Employer, and HARTFORD INSURANCE CO. OF THE MIDWEST, Surety, Defendants.	**IC 2016-005024** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed July 11, 2019**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael Powers, who conducted a hearing in Idaho Falls, Idaho, on May 25, 2018. Michael McBride of Idaho Falls represented Claimant. Susan Veltman of Boise represented Defendants. The parties produced oral and documentary evidence at the hearing and submitted post-hearing briefs. The matter came under advisement on February 8, 2019. After the matter came under advisement, but before Findings of Fact were prepared Referee Powers retired. The case was reassigned to Referee Brian Harper, who reviewed the record and prepared the following Findings of Fact and Recommendation. The undersigned Commissioners disagree with the treatment given to the cause of Claimant's pressure ulcer and issue these Findings of Fact, Conclusions of Law, and Order.

ISSUES

The issues for adjudication decided upon at hearing are:

1. Whether Claimant has complied with the notice limitations set forth in Idaho Code § 72-701 through 706, and whether these limitations are tolled pursuant to Idaho Code § 72-604;

2. Whether Claimant's injury or condition for which he seeks benefits was caused by an industrial accident arising out of and in the course of his employment.

At hearing, there was much discussion on the issues to be decided, and those to be reserved. Reserved issues include the extent of medical benefits for which Claimant will be entitled to if causation is established, the extent of Claimant's permanent partial impairment, and his disability in excess of impairment, if any. Claimant has no past temporary disability benefit claim, as he missed no work after the accident in question. Future TTD is not ripe for adjudication at this time. Attorney fees were also reserved for future hearing.

In briefing Defendants conceded Claimant timely reported his accident. As such, the sole remaining issue for determination at this time is causation.

CONTENTIONS OF THE PARTIES

Claimant sprained his right foot on or about November 20, 2015 while performing his regular duties for Employer. The accident caused a tear in Claimant's peroneal brevis tendon, leading to ankle laxity, which in turn forced Claimant's right foot to progressively turn inward, loading more of his weight to the outside of his foot. Because of Claimant's diabetes, this increasing pressure on the lateral aspect of Claimant's foot led to a pressure ulcer. Claimant has proven his peroneal tear and medical developments stemming therefrom, including his pressure ulcer, are causally related to his undisputed work accident.

Defendants argue that Claimant has not proven his peroneal tear and the development of a diabetic ulcer on the lateral side of his right foot were caused or aggravated by his industrial accident. Rather, Claimant's longstanding diabetes and congenital foot deformities are to blame for those conditions. His minor sprain resolved within six weeks with no impairment or permanent restrictions.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Herb Padigimus, and Linda Watts, taken at hearing;

2. Claimant's exhibits (CE) A through Z, and Z(a), through Z(c)[1], admitted at hearing;

3. Defendants' exhibits (DE) 1 through 7, admitted at hearing;

4. The post-hearing deposition transcripts of Tony Quinton, DPD, and Kylin Kovac, DPD, taken on July 16, 2018; and

5. The post-hearing deposition transcript of Brian Tallerico, DO, taken on August 30, 2018.

All objections preserved through the depositions are overruled.

FINDINGS OF FACT

1. At the time of his accident on Friday, November 20, 2015, Claimant was employed by Employer as a route home delivery driver. On that date, as he returned to Employer's parking area, he stepped onto a graveled slope and twisted his right ankle and/or

[1] Exhibit Z(c) was introduced during Claimant's testimony and was admitted only for illustrative purposes.

foot. He immediately felt popping and intense pain in the lateral, or outside, of his right foot up to his right knee. He e-mailed his supervisor that night to inform him of the incident.

2. Although Claimant testified his right foot had stiffened up and was painful, he was able to work delivering product on his route the following day. At one stop, Claimant stepped on what felt like to him "a rock in the arch of my [right] foot." Tr., p. 56. This incident further exacerbated Claimant's right foot pain.

3. Claimant called his manager and stated he could not continue the route. Claimant was advised to return to the lot. However, it was the Saturday before Thanksgiving and Claimant elected to finish delivering to his customers, albeit with difficulty.

4. At the time of these accidents, Claimant was wearing an "Unna" boot under his work boots to treat a sore above his right ankle. An Unna boot is a medicated wrapping (like an ACE bandage) which hardens once applied. Claimant had the wrapping from his toes up to his calf, and included his right ankle. Claimant testified the Unna boot provided added support for his ankle.

5. On Sunday, November 22, 2015, Claimant went to Eastern Idaho Regional Medical Center. X-rays of Claimant's right foot showed no fracture or dislocation or any acute findings. Claimant was diagnosed with a right foot sprain, or injury to the ligaments of his right foot. Claimant was given an ACE bandage to wear. He was advised to follow up with Robert Lee, M.D., an orthopedic surgeon.

6. Claimant did not see Dr. Lee. Instead, over the next few months, Claimant treated a few times with naturopath Gary Orchard, N.D., with whom Claimant had an ongoing "as-needed" patient relationship for a number of issues, including his right foot. Claimant continued

to work for Employer until his termination for reasons not associated with this accident, missing no days due to the accident in question.

7. On April 8, 2016, just prior to seeing Dr. Kovac, Claimant was examined in a single visit by Brigham Redd, M.D., an orthopedic surgeon in Idaho Falls. Dr. Redd's notes discuss Claimant's swollen, purple legs from his knees down, as the result of longstanding venous insufficiency problems, which led to ulcers on Claimant's right lateral heel and medial mid leg. Dr. Redd also noted a very prominent callus over the lateral border of the fifth metatarsal head, which corresponded to the point where Claimant noted the most pain. Claimant's right foot was slightly inverted, and his ankle was stiff. Dr. Redd did not understand why Claimant walked on the outside of his right foot when that was the area which was most painful. Claimant indicated he was unable to walk on the flat underside of his foot. Dr. Redd did not treat Claimant, but instead made an immediate referral to Dr. Kovac.

8. Dr. Kovac described his practice as one that treats "all conditions as it relates to the foot and ankle, whether it's, you know, structurally with the bones and joints or tendons and muscles, skin, wounds, soft tissues. Anything basically, yeah, as it relates to the foot and ankle." Kovac Depo., p. 4. Claimant first saw Dr. Kovac in April 2016. At his initial visit, Claimant described ongoing lateral right foot pain since his industrial accident, made worse by walking and at the end of the day. Prior treatment modalities had not helped his condition.

9. Examination and x-rays taken that day demonstrated Claimant's "significant" cavus deformity (abnormally high arch), swelling, and osteoarthritis throughout Claimant's right ankle and foot. Dr. Kovac assessed chronic venous hypertension with ulcer and inflammation on Claimant's right lower extremity. (Claimant had a venous stasis wound on his right ankle, which pre-existed his industrial accident, and was related to his diabetes,

or as Claimant insisted "insulin resistance.") Dr. Kovac also diagnosed peroneal tendinitis based on Claimant's "significant pain" along the course of his peroneal tendons "both in the retromalleolar region and at its insertion into the base of the fifth metatarsal." CE J, p. 91.

10. Dr. Kovac felt Claimant's peroneal tendons may have been damaged in the industrial accident, and ordered an MRI to assess.

11. In late July 2016, Claimant returned to Dr. Kovac to review MRI findings and discuss treatment. Claimant had developed a stage 2 ulceration at the base of his fifth metatarsal, on the lateral aspect of his right foot. Claimant's primary source of pain continued to be in the area of his peroneal tendon posterior to the distal fibula. Dr. Kovac assessed Claimant's new foot ulcer as being related to his type 2 diabetes.

12. The MRI showed a partial tear of Claimant's peroneal brevis tendon. The treatment plan for this injury included physical therapy, bracing, foot immobilization, and orthotics. The possibility of corrective surgery was discussed if the conservative measures failed. Claimant was also given anti-inflammatory medication.

13. Dr. Kovac continued his treatment of Claimant's lower leg edema and weeping venous stasis sores. He also debrided Claimant's new ulceration at the fifth metatarsal (foot ulcer), and stressed the need for Claimant to make sure his orthotics were properly taking the load off of the ulceration so it could heal.

14. At Claimant's next visit, Dr. Kovac recommended an AFO (ankle foot orthosis) brace to stabilize Claimant's right ankle and continued physical therapy.

15. By early August 2016, Claimant indicated some improvement in his peroneal tendon pain but he was still walking on the lateral side of his foot. His foot ulcer was worse.

16. Dr. Kovac continued to treat Claimant's foot ulcer, and Claimant's ankle pain lessened by September 2016, although he took Tramadol for the pain. Claimant requested a work release "to submit to his employer to document his ability to continue working." CE J, p. 73.

17. By December 2016, Claimant developed significant swelling and a sore on his big left toe, which Dr. Kovac began treating.[2] Dr. Kovac recommended a knee scooter and a CAM boot for Claimant's right leg to keep pressure off his foot ulcer. Dr. Kovac also referred Claimant to a physician to evaluate his diabetes.

18. Dr. Kovac's notes reflect a shift in emphasis from Claimant's right foot to his left big toe by December 2016. Dr. Kovac referred Claimant to a surgical podiatrist, Tony Quinton, DPM, in mid-December, 2016, for continued care of Claimant's foot ulcer. Dr. Kovac's last medical records, dated February 16, 2017, dealt exclusively with Claimant's left toe treatment.

19. Dr. Quinton treated and resolved Claimant's foot ulcer by the time of hearing.

20. Surety hired Brian Tallerico, D.O., who evaluated Claimant on April 28, 2017. Dr. Tallerico examined medical records and Claimant. He wrote a report and answered specific questions from Defendants' attorney. Dr. Tallerico diagnosed a right foot/ankle sprain related to the November 20, 2015 industrial accident. He also diagnosed pre-existing diabetes/insulin resistance, chronic venous stasis in the bilateral lower extremities, predisposing Claimant to skin ulcers and non-healing wounds, as well as congenital right ankle/foot cavus deformity. Claimant also suffered from deformities of his toes bilaterally. Dr. Tallerico also noted Claimant's right foot ulcer, which he opined was unrelated to the work accident.

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[2] Claimant's big left toe was eventually amputated. Claimant does not assert the left toe issue was related to his industrial accident, and it will not be discussed in detail herein.

21. While Dr. Tallerico did not review the MRI or the MRI report, he reviewed Dr. Kovac's narrative of the MRI report and felt it showed a degenerative or chronic peroneal tendon split tear, which Dr. Tallerico also felt was unrelated to the work accident. Prior lateral ankle ligament scarring shown in the film was due to Claimant's pre-existing conditions.

22. In October 2017, Dr. Kovac responded to a questionnaire from Claimant's attorney in which the doctor agreed that Claimant's right ankle tendon tear was caused by his industrial accident. When asked what evidence supported his opinion, Dr. Kovac noted subjectively Claimant reported pain in the region of the peroneal tendons, with swelling noted since the time of the accident, and tenderness on examination. Also, an MRI showed a longitudinal tear of Claimant's peroneal brevis tendon at the point of his maximum tenderness.

23. Dr. Kovac also indirectly attributed Claimant's right lateral foot ulcer to the work accident, as a consequence of the tear in Claimant's peroneal brevis tendon, which led to Claimant walking on the lateral aspect of his right foot due to instability of the supporting peroneal tendon, as more fully described below.

24. On March 6, 2017, Dr. Quinton wrote "The amount of time he may walk or stand is dependant on wound development/recurrence that may happen. He has decided against orthopedic referral to consider surgical correction." CE K, p. 125. Also in the fall of 2017, Dr. Quinton was asked by Claimant's attorney to opine on causation with authority for such opinions. Dr. Quinton also attributed Claimant's peroneal tendon tear and foot ulcer to his work accident. His rationale was fully explored in his deposition as discussed below.

25. On March 6, 2018, Dr. Steven Clinger authored a letter opining that upon his review of Claimant's medical records, Claimant's congenital high arch, diabetic neuropathy, and peroneal tendon injury "could have easily resulted in a blister and infection as well as

overloading of the outside of the foot, so the foot cannot stay flat without external forces." CE Y, p. 633. He concluded that "[t]his weakening of the support of the foot has resulted in the instability to walk flat without bracing and may require surgical fusion to keep it that way long term." *Id.*

DISCUSSION AND FURTHER FINDINGS

26. Claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident with evidence of medical opinion—by way of physician's testimony or written medical record—supporting the claim for compensation to a reasonable degree of medical probability. *Callantine v Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his contention. *Dean v. Dravo Corporation*, 95 Idaho 558, 560-61, 511 P.2d 1334, 1336-37 (1973). Probable is defined as "having more evidence for than against." *Jensen v. City of Pocatello*, 135 Idaho 406, 412, 18 P.3d 211, 217 (2000).

27. Claimant avers that his right peroneal brevis tendon tear, and resulting foot ulcer were caused by the uncontested industrial accident of November 20, 2015. Claimant acknowledges he had various conditions which could render him more susceptible to injury. However, a pre-existing disease or infirmity does not disqualify a workers' compensation claim. As noted in *Wynn v. J.R. Simplot Co.*, 105 Idaho 102, 104, 666 P.2d 629, 631 (1983), "our compensation law does not limit awards to workmen who, prior to injury, were in sound condition and perfect health. Rather, an employer takes an employee as he finds him."

28. Claimant relies upon the opinions of Drs. Kovac and Quinton to provide the needed medical opinions establishing the causal connection between

the November 20, 2015 accident and Claimant's current right ankle and foot condition. Both physicians treated Claimant and provided sworn testimony in post-hearing depositions.

Dr. Kovac's Deposition Testimony

29. In his deposition Dr. Kovac confirmed the opinions he made in his October 2017 letter to a reasonable degree of medical probability. He also testified the tear in Claimant's peroneal brevis tendon was in the retrofibular area, which is behind the "ankle bone," or end of the fibula, at a point where the tendon turns or curves from vertical to horizontal (from the ankle into the foot).[3] Dr. Kovac noted that is a common place for the peroneal brevis tendon to tear. He also described Claimant's "split tear" as noted on the MRI to be a vertical tear, "like a run in pantyhose." Kovac Depo., p. 15.

30. Dr. Kovac noted that the tendon is typically a tight circular structure, but when torn it can fray and flatten out. If severe enough, the split can actually tear the tendon such that one can "sometimes see straight through the tendon so literally the tendon almost is split in two sections." *Id.* Dr. Kovac further noted that in such cases, "the tendon can start to elongate and weaken and just lose its function."[4] Kovac Depo., p. 15.

31. Dr. Kovac acknowledged that individuals such as Claimant with a cavus foot type tend to naturally walk on the lateral or outside of their feet.

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[3] The MRI report did not describe the probable tear as being in the "retrofibular area" but rather it was in the "inframalleolar margin." CE N, p. 316. No one asked Dr. Kovac to explain the term inframalleolar margin, and how that MRI finding related to his testimony regarding the location of the tear.

[4] No one asked Dr. Kovac, and he did not testify directly, that Claimant suffered a level of tear such that one could "see straight through the tendon" *i.e.* a full thickness tear. The MRI report likewise did not state whether the probable tear was partial or full thickness.

32. Dr. Kovac testified that when Claimant rolled his ankle in the work accident, it put additional pressure on the ligaments and tendons, including the peroneal brevis tendon, on the outside or lateral side of the ankle, and the pop that Claimant heard at that moment is a very common occurrence with people who either strain a ligament or tear the tendon in that area. It should be noted Claimant is a large man, standing 6'8" and weighing over 275 pounds.

33. When Dr. Kovac first saw Claimant in April 2016, he testified Claimant did not have any skin changes in the area where his foot ulcer eventually formed.[5] Dr. Kovac's notes of April 18, 2016 indicate that Claimant had a prominent fifth metatarsal base laterally and plantarly and pain with palpitation along the course of the peroneal tendons both in the retromalleolar region and at its insertion into the base of the fifth metatarsal. By July the pressure ulcer was present. This ulcer was due, in Dr. Kovac's opinion, to the fact that when Claimant's peroneal tendon tore, it lengthened and thus lost its ability to hold Claimant's foot stable. The foot began to tilt to the outside (roll inward) over time, which placed even more pressure on the outside of Claimant's right foot, leading to the pressure ulcer at the point where the peroneal tendon attaches to the fifth metatarsal bone, forming a bony prominence. Eventually with treatment that pressure sore healed, but Dr. Kovac felt the only way to permanently fix the issue is with an ankle fusion surgery to keep Claimant's foot from rolling inward.

34. Dr. Kovac noted that Claimant had a history of ulcers up and down his right lower leg, but those ulcers were due to venous stasis. Claimant's right foot ulcer was due to pressure on the area, a different mechanism of injury.

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[5] Dr. Redd's office notes of April 8, 2016 indicate he noticed a large callous in that same area of Claimant's right foot.

35. On cross examination Dr. Kovac acknowledged that by September 2016 Claimant had no further pain complaints in the area of his torn tendon. Dr. Kovac pointed out that Claimant also had diabetic neuropathy, and the doctor speculated that perhaps some of Claimant's lack of pain complaints could be due to his loss of feeling in his foot/ankle.

36. Dr. Kovac also felt Claimant had reached MMI by the end of October 2017, even though Claimant needed an ankle fusion surgery but could not pursue one due to his other health conditions. Without a structural repair, Dr. Kovac opined that there remains a chance for the ulcer to re-occur and that wound care would continue to be an ongoing issue for Claimant.

Dr. Quinton's Deposition Testimony

37. Claimant's other treating podiatrist, Dr. Quinton, was also deposed. As acknowledged in Dr. Kovac's deposition, Dr. Quinton was primarily responsible for treating Claimant's ulcers. Dr. Quinton testified that it is not uncommon for one podiatrist to refer a patient to another, and that his specialization in wound care means that he frequently receives referrals for more complicated wounds. Quinton Depo., p. 10. He felt Claimant was not at MMI, and was considering surgical treatment at the time of the deposition (July 16, 2018). Claimant was still treating with Dr. Quinton.

38. Dr. Quinton felt that while Claimant was congenitally predisposed to walk on the outside of his feet due to his varus foot structure, his right foot had been turning inward progressively since the accident, causing greater pressure on the outside of his right foot. The doctor attributed this development to peroneal weakness.

39. In Dr. Quinton's opinion, Claimant's right foot pressure ulcer was also the result of his work accident. As explained by the doctor, increased pressure from walking on the outside of his right foot, coupled with Claimant's lack of sensation due to his diabetic

neuropathy, led to the pressure ulcer. Claimant had not had such an ulcer in the past and developed it soon after the accident in conjunction with increased varus deformity after the accident, so that in the doctor's opinion, from a medical standpoint, it was more probable than not the ulcer was a sequela of the work accident.

40. Dr. Quinton suggested Claimant needed further ankle bracing for his condition, with the possibility of future surgery to correct his progressively inward turning right foot. At the time of his deposition, Dr. Quinton recalled Claimant's right foot ulcer had entirely closed.

41. Dr. Quinton drew marks on an illustration of a peroneal brevis tendon at a point where the tear occurred. His drawing lined up closely with the diagram drawings of Dr. Kovac. Dr. Quinton was not asked regarding the severity of Claimant's peroneal tendon tear.

Dr. Tallerico's Deposition Testimony

42. Dr. Tallerico was deposed on August 30, 2018. He is an orthopedic surgeon with a Fellowship in Knee Reconstruction and Arthroplasty, but treats injuries to the ankle as well. He acknowledged Claimant sustained a foot and ankle sprain/strain in the work accident in question. However he felt the peroneal tendon tear was not caused or aggravated by the accident. Instead, Dr. Tallerico believed the tendon tear was degenerative in nature. He testified that traumatic tears occur near the insertion site (origin of the tendon), and tear transversely, not longitudinally. Split tears, such as seen in Claimant's MRI, are "by definition" due to degenerative processes. He stated that when any major tendon fails traumatically and ruptures, it tears near the insertion site. As such, in the doctor's opinion, Claimant's split tear could not have occurred from trauma. He also testified it is very unusual to see a tendon tear with an ankle

sprain, which "almost always" sprain ligaments, rather than rupture tendons. Tallerico Depo. p. 14.

43. Dr. Tallerico also was skeptical of the idea that Claimant's torn tendon would cause his foot to turn inward, leading to additional pressure on the outside of his foot. The doctor felt one would need to completely rupture both peroneal tendons (brevis and longus) to see the type of foot inversion (turning inward) described in this case.

44. While Dr. Tallerico felt that Claimant's tear was not related to his work accident, he testified that even if it was, he would still opine that Claimant's right foot pressure ulcer was not caused or in any way related to such tear. Instead, he testified the pressure ulcer was due to Claimant's diabetic hardening of the arteries in his feet, which led to decreased sensation, which, coupled with Claimant's foot deformities (which tend to load the pressure to the outside of his feet), resulted in the ulcer in question. In support of this proposition, Dr. Tallerico noted Claimant "has a history of lower extremity wounds and diabetic foot ulcers even before the industrial injury." Tallerico Depo., pp. 8, 19.

45. On cross examination Dr. Tallerico acknowledged he did not personally review the MRI film of Claimant's right ankle, nor did he have the radiologist's report when preparing his report on April 28, 2017. Instead, he reviewed Dr. Kovac's reading of the radiologist's report.[6]

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[6] Dr. Tallerico testified that his understanding of the MRI findings comes from Dr. Kovac's "verbatim review" of the radiologist's interpretation. Tallerico Depo., p. 24. However, Dr. Kovac's chart notes are telegraphic, at best, in describing the MRI findings, and what is there is not entirely consistent with the radiologist's report:

> I discussed with the patient the results of his MRI reviewing a partial split tear of the peroneal tendon and lateral ankle ligament scaring from old injuries.

46. Dr. Tallerico opined that Claimant's foot turning in with time is due to his "anatomic alignment" and has nothing to do with his industrial accident. *Id.* at 42. Likewise, Claimant's right foot pressure ulcer's development several months after the accident was a coincidence only; Claimant was anatomically predisposed to the development of such ulcers.

47. When asked if the medical literature supported his opinion that longitudinal tears are not caused by acute trauma, Dr. Tallerico stated his opinion was based on his education and training as an orthopedic surgeon; he further reiterated that "this type" of a longitudinal split tear was unlikely to be caused by trauma. Dr. Tallerico speculated that perhaps a large longitudinal tear could occur from "severe trauma." Tallerico Depo., p. 49.

Medical Testimony Analysis

48. While a temporal relationship is always required to support a finding of causation between an accident and the injury, the existence of a temporal relationship alone, in the absence of substantive medical evidence establishing causation, is insufficient to satisfy Claimant's burden of proof. *Swain v. Data Dispatch, Inc.* IIC 2005-528388 (February 24, 2012). The Industrial Commission, as the fact finder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000). It is the also the role of the Industrial Commission to resolve conflicting interpretations of testimony. *Lopez v. ISIF*, 136 Idaho 174, 178, 30 P.3d 952, 956 (2001). The Commission is not bound to accept the opinion of the treating physician over that of a physician who merely examined the claimant for pending litigation. *Gooby v. Lake Shore Management, Co.*, 136 Idaho

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CE J, p. 88. However, Dr. Tallerico's testimony makes it clear that he was conversant with certain aspects of the MRI report not found in Dr. Kovac's records. At page 24 of his deposition, he referred to a 1.5 cm split tear of the peroneal tendon, the same finding made by the radiologist who interpreted the study. The record leaves the Commission unable to say where Dr. Tallerico learned about the MRI findings.

79, 86, 29 P.3d 390, 397 (2001). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries,* 136 Idaho 733, 737, 40 P.3d 91, 95 (2002). Claimant's burden of proof requires a reasonable degree of medical probability that the condition for which he seeks benefits was caused by an industrial accident. *Anderson v. Harper's Inc.,* 143 Idaho 193, 196, 141 P.3d 1062, 1065 (2006).

Peroneal Tendon Causation Analysis

49. In this case the medical experts have reached different conclusions on the cause of Claimant's peroneal tendon tear. Drs. Kovac and Quinton both feel that Claimant suffered a longitudinal split tear of his peroneal tendon in the accident, and that such an injury is common in "rolled ankle" accidents. Dr. Tallerico argued such a tear by definition could not be due to Claimant's rolled ankle, but had to be degenerative in nature.

50. All physicians agree Claimant was predisposed to tearing his peroneal tendon by his varus/cavus anatomical condition. However, that fact does not shed light on whether the tear occurred before, or as a result of, Claimant's work accident. Dr. Kovac testified that the "pop" Claimant heard at the time of injury is consistent with either a ligament strain or a tendon tear. Kovac Depo., p. 17. Dr. Tallerico asserted that the type of longitudinal tendon tear suffered by Claimant is almost always degenerative in nature. Notwithstanding Dr. Kovac's acknowledgement that the "pop" heard by Claimant is consistent with a strain, both Drs. Kovac and Quinton clearly believe that Claimant suffered a discrete tear at the time of injury. Both thought it important that Claimant had no pain in the area of the peroneal tendon tear until after the work accident.

51. Without some supporting authority for his "definitional" proposition, Dr. Tallerico's testimony is afforded less weight than the testimony of Claimant's two treating physicians who testified to seeing split tear injuries to peroneal tendons resulting from twisted ankles as a common part of their practices. The Referee found, and the undersigned Commissioners agree, that it is unlikely that two treating physicians in their office notes and in sworn testimony would each independently overlook such an obvious "fact" (that Claimant's split tear had to be degenerative) in assessing and treating Claimant. It is more likely that split tears may result from ankle trauma, notwithstanding Dr. Tallerico's assertion to the contrary.

52. Claimant has proven his peroneal tendon split tear was caused by his work accident of November 20, 2015. He has thus satisfied the first element of this ulcer claim. Next he must establish the tear caused his ankle instability to a point where his right foot began to turn inward resulting in a right foot ulcer. Again, the physicians disagree on the likelihood of this scenario.

Right Foot Ulcer Causation Analysis

53. Claimant's claim for compensability of his right foot diabetic pressure ulcer is a multi-step analysis. His theory is that because of the longitudinal tear in the peroneal tendon, the tendon lost its ability to provide lateral support to the ankle, thus accelerating the lateral foot loading already being caused by Claimant's varus/cavus foot deformity. The accelerated loading of the lateral side of the right foot eventually led to the pressure ulcer at Claimant's fifth metatarsal bone, which Claimant was unable to appreciate due to his diabetic neuropathy. Without the tendon tear, Claimant argues that the pressure ulcer would not have formed when and where it did.

54. Idaho recognizes the "compensable consequences" doctrine, which provides that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to the claimant's own intentional conduct. Lex K. Larson, Larson Workers' Compensation § 10.01 (Matthew Bender, Rev. Ed.) The Industrial Commission has recognized the compensable consequences doctrine in prior cases. *Castaneda v. Idaho Home Health, Inc.*, 1999 IIC 0538 (July 1999); *Martinez v. Minidoka Memorial Hospital*, 1999 IIC 0262 (February 1999); *Offer v. Clearwater Forest Industries*, 2000 IIC 0956 (October 2000).

55. Drs. Kovac and Quinton both testified that the peroneal tendon tear advanced Claimant's pre-existing right foot cavus/varus deformity. Dr. Kovac testified to having seen other patients with peroneal tendon tears similar to Claimant's causing the foot to tilt sideways:

> [A]s that tendon loses its pull, the foot tends to roll inward more and more because that tendon has less ability to turn or to work and pull. So as his foot slowly began to tilt and roll over the next several months, because the tendon weakness he started to develop that pressure sore which is right on a bony prominence in that area.

Kovac Depo., p. 19.

56. Dr. Quinton acknowledged the possibility that the peroneal tendon tear might have nothing to do with the development of Claimant's foot ulcer. Quinton Depo., pp. 15-16; 17-18. Even so, he ultimately concluded that Claimant's peroneal tendon injury aggravated Claimant's congenital tendency to weight the lateral side of his foot. *Id.* However, it might be argued that Dr. Quinton's ultimate opinion is based on an unproven assumption concerning the severity of Claimant's tendon injury:

> Q: [By Ms. Veltman] I just need to clarify. I understood earlier that the varus deformity is what was congenital?

A: Right. So the fixed - - the deformity that creates the wound is the worsening of that deformity caused by the tendon injury, and that's what we're talking about here.

Q: Okay. But the actual tendon injury, my understand is that the varus deformity was the congenital thing with - - they have a high arch?

A: Correct.

Q: And it would lend toward pressure on the outer foot; is that correct?

A: In varying degrees that's correct. Made increasingly worse with no peroneal tendon function. So without your peroneal tendon and muscle, you pull your muscle outward. They counteract a varus foot. And so without them your varus foot deformity becomes progressively worse inevitably, and that's what's happened to Mr. Watts.

Quinton Depo., pp. 29-30. Therefore, with "no peroneal tendon function" lateral support for the ankle is obviously absent, thus contributing to Claimant's foot deformity. However, the evidence fails to support a complete absence of peroneal tendon function: Claimant has an intact peroneal brevis tendon with a 1.5 cm longitudinal "probable focal split tear," without evidence that the tear is a full thickness tear. Kovac Depo., pp. 12-16. Moreover, as Dr. Tallerico pointed out, the peroneal brevis tendon is but one of two tendons which provide lateral support to the ankle. Claimant's peroneus longus tendon demonstrated some thickening on the MRI evaluation, but was intact. However, the testimony of Drs. Kovac and Quinton nevertheless supports some diminishment of peroneal tendon function as a result of the tendon tear. Dr. Quinton's poor choice of words does not denigrate the thrust of his testimony; Claimant's tendon injury was sufficient to accelerate his varus/cavus deformity.

57. While Dr. Kovac testified that the tendon tear accelerated Claimant's foot deformity, he also testified that repairing the tendon will not address the root cause of Claimant's problems:

Q: [By Mr. McBride] Other than just staying off the foot, which appears to be protocol, was there anything else that you could do to assist with the underlying condition which is the tear of the tendon?

A: So the fix for this condition, the cause of the condition is the gradual rotation of the foot and the peroneal tendon tear, and so the only way to fix that in his case was either to go in and fix the tendon which in most cases is not enough. A lot of cases you need some kind of bone work as well, like a joint fusion which - - to just lock those joints in place so the foot can't keep rolling in.

Q. So as I take it you were trying to avoid that more major surgery like a bone fusion?

A. We were. And I talked to him about it from the very beginning just saying that this –"you may need some kind of surgery with this."

He has a lot of other medical problems and he's not a great surgical candidate for those bigger surgeries. So we were trying to do as much as we could conservatively, you know, nonsurgically to heal the ulcer first and then try to do a bigger surgery if we needed to.

In that time, too, he also was getting other opinions from other doctors around to see what surgical intervention he would need, and they kind of all agreed, too, that he would need some kind of fusion.

Q: [By Mr. McBride] Eventually, you know, work on the bone structure?

A: Uh-huh. Yeah.

Q: Is that a yes?

A: Solve the source of the problem, yeah.

Q. Okay. Where do we stand today with him as far as you know?

A. Yeah, and again, I haven't seen him since March –yea, March of this year. But as far as I know he has been planning on doing that fusion surgery for him, but they've run into—again, a lot of his other medical conditions have kind of prohibited them from doing that big of a surgery. So they're kind of in a waiting pattern for him to. . .

Q: So without the fusion, then, the likelihood, as I take it, is that he's still going to have that drifting or that rolling of the foot --

A: Uh-huh

Q: - - laterally - -

A: Yeah, I have - -

Q: Is that right?

A: Yes, that's right.

Kovac Depo., pp. 22-24. Assuming that Claimant's peroneal brevis tendon could be returned to its pre-injury state by surgery, but accepting that such a repair, by itself, will not prevent the recurrence of diabetic foot ulcers, it could be argued that the tendon injury is not implicated in the genesis of Claimant's foot ulcer. However, there was no testimony on whether Claimant's tendon could be fully repaired.

58. Neither Dr. Kovac nor Quinton were challenged on their apparent conviction that a 1.5 cm "probable focal point tear" of one of two supporting tendons lying adjacent to one another can destabilize Claimant's ankle to the point where it detrimentally affects his gait. Further explanation on this point would have been helpful.

59. Dr. Tallerico confidently testified that a small tear in one of two tandem tendons which are, as he put it, "not a main stabilizer of the ankle"[7] would not destabilize Claimant's ankle to the point of leading to his pressure ulcer:

> Q: [By Ms. Veltman] Okay. I'm going to switch gears a little and ask about - - if you have a peroneal tendon tear, does that impact how someone's foot loads?
>
> A: Well, if you have a true traumatic tear, it could contribute to how someone loads on their foot. Typically, that is not the case. It's a dynamic structure. If you had a chronic complete rupture, then perhaps you would lose the ability to evert or bring your foot and ankle outwards - - but again, like I said, we have two of those tendons for a reason. So, technically you probably have to rupture both of those peroneal tendons to have a loss of function on eversion - - or bringing foot and ankle out - - which would then result in perhaps abnormal loading pressure.

[7] Dr. Tallerico described the peroneal tendons as a "secondary dynamic stabilizer." Tallerico Depo., p. 45.

…

Q: [By Ms. Veltman] Okay. In the second paragraph of Dr. Kovac's answer to Question No. 4, he addresses your opinion and discusses the differences of the two types of ulcers. Have you reviewed that paragraph?

A: I have.

Q: Okay. Do you agree or disagree with the comments provided by Dr. Kovac?

A: Disagree.

Q: Okay. Please explain your disagreement.

A: Well, if one would read my report, I never said they were the same thing - - that being venous stasis ulcers and diabetic pressure ulcers. That's in the second paragraph. As far as the first paragraph is concerned, a small - - and I do mean small - - longitudinal tear of one of the peroneal tendons is not going to cause - - there's no orthopedic, or physiologic, or anatomic way that that sort of tear is going to cause any significant weakness of that tendon and, therefore, contribute to lack of eversion accentuating his cavus foot. Like I said several times before - - and my opinion won't change - - but in essence, "the horse is already out of the barn" with this unfortunate gentleman, given his disease and anatomic alignment of his feet. So I say small - - I believe 1.5 centimeter long longitudinal tear - - significantly impacts his ability to evert and, therefore, loading more on the foot than normal is just - - it doesn't make sense.

…

Q: [By Mr. McBride] So if you have a strain or sprain injury that further weakens the ankle, that then can cause pressure to the outside of the foot; correct?

A: Counselor, not in this case. I know we can go around and around about it, but my firm opinion that would be unchanging is the tear that has been described whether or not I read the actual report or looked at the actual images - - I know what the tendon has been described as and diagnosed as. If I were handed the MRI report right now or had the images in front [sic-of] me, it wouldn't change my opinion. It would basically support my opinion.

Q: I understand - -

A: Okay. I mean, I'm just trying to be clear.

Q: Go ahead.

> A: The morphology of his tear and the location anatomically will not appreciably increase any - - I guess inability to evert the foot, will not increase any propensity towards an ulcer on the lateral side of the foot. Again, unfortunately, Mr. Watts had very - - a few strikes against him when it comes to developing these ulcers. Just because the one developed following this strain/sprain - - which has been documented and which I never disagreed occurred - - is coincidental. He developed it because "the horse was already out of the barn" for a long time. He had similar problems on both feet, from what I understand - - maybe not in the exact same spot - - however, the right foot already had significant malignement - - much like the left foot - - identical cavovarus alignment - - thus, in conjunction with his Diabetes and his peripheral neuropathy and peroneal vascular disease because of those, he developed the ulcer - - not because of a small tear along the peroneal tendon - - one of the two peroneal tendons - - which is not a main stabilizer of the ankle. It's a secondary dynamic stabilizer. If you've ever sprained your ankle in sports, you know you injured the ligaments on the outside of your ankle - - not the tendons along the leg. That's about as clear and thorough as I can be.

Tallerico Depo., pp. 17-18, 23-24, 44-45. Therefore, according to Dr. Tallerico, the type of injury suffered by Claimant to one of two lateral ankle stabilizers cannot reasonably have contributed to the development of his lateral foot ulcer.

60. Dr. Tallerico's opinions come with a few difficulties, however. As noted, he did not review the radiology report of the July 9, 2016 MRI. More problematic is the following testimony from Dr. Tallerico's deposition:

> Q: [By Ms. Veltman] Okay. And on the page we were talking about, page 11 of your report, which is Defendants' Exhibit 3, page 14, you addressed that "The diabetic ulcers were neither caused nor aggravated by the industrial injury." How did you come to that conclusion?
>
> A: I came to that conclusion, given the fact that he has history of lower extremity wounds and diabetic foot ulcers even before the industrial injury.

Tallerico Depo., pp. 7-8. From this it appears that, in forming his opinion, it was of central importance to Dr. Tallerico that Claimant suffered from diabetic pressure ulcers both before and after the subject accident. However, even after being apprised of the fact that the record does not reveal a history of pressure ulcers prior to the subject accident, Dr. Tallerico did not revise any of

the opinions referenced above.[8] Instead, he explained that it is purely coincidental that Claimant's first experience with a diabetic pressure ulcer post dated the subject accident. Tallerico Depo., p. 43.

61. All of the opinions elicited on the causal relationship between the tendon tear and the foot ulcer can be criticized in one way or another. However, even though Drs. Quinton and Kovac were not cross-examined in any detail on the biomechanical impact of a 1.5 centimeter longitudinal tear of the peroneal brevis tendon, both doctors are clearly of the view that Claimant's tendon tear did something to accelerate the abnormal foot loading caused by his varus/cavus deformity, leading to the right foot ulcer. Dr. Kovac did explain that such a tear can cause the tendon to elongate, weaken, and lose its function. Dr. Tallerico initially testified that he came to the conclusion that Claimant's foot ulcer was unrelated to the tendon tear because Claimant's history was of suffering from pressure ulcers both before and after the tendon tear. Obviously, such a history would be important to the question at hand. However, when faced with the actual facts, he somewhat disingenuously explained that it was simply a coincidence that Claimant developed a foot ulcer post-accident. On balance, we find the opinions of Drs. Kovac and Quinton more persuasive.

62. Claimant has proven his diabetic right foot pressure diabetic ulcer was a compensable consequence of his industrial accident of November 20, 2015.

63. All other issues are reserved.

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[8] In a letter dated June 5, 2017, Dr. Orchard, Claimant's naturopath, stated his clinic treated Claimant "for a diabetic ulcer" prior to the subject accident. CE T, p. 412. Dr. Orchard's contemporaneous chart notes reflect he referred Claimant to Cameron French, PA-C, of Alpine Dermatology on November 12, 2015; PA French's notes dated that same day reflect he treated a "stasis ulcer." CE I, p. 57; CE O, p 319. Dr. Tallerico's misunderstanding regarding Claimant's medical history may be premised on this erroneous letter.

CONCLUSIONS OF LAW AND ORDER

1. Claimant has proven his right peroneal brevis split tear is causally related to his industrial accident of November 20, 2015.

2. Claimant has proven his diabetic right foot pressure ulcer was a compensable consequence of his industrial accident of November 20, 2015.

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

DATED this __11th__ day of **___July____** 2019.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas P. Baskin, Chairman

_____/s/_____
Aaron White, Commissioner

_____/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _11th_ day of __July___, 2019, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

MICHAEL MCBRIDE
1495 E 17TH ST
IDAHO FALLS ID 83404

SUSAN VELTMAN
1703 W HILL RD
BOISE ID 83702