BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DALE SHAW, Claimant, v. CALDWELL TRANSPORTATION CO., INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-012378** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** **Issued 11/30/18**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted a hearing in Boise, Idaho, on January 16, 2018. Claimant was represented by Jason Thompson, of Boise. Neil McFeeley, of Boise, represented Caldwell Transportation Company, Inc., ("Employer"), and State Insurance Fund, ("Surety"), Defendants at hearing. Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on August 30, 2018.

ISSUES

The noticed issues for resolution are:

1. Whether the condition for which Claimant seeks benefits was caused by the industrial accident;

2. Whether Claimant's condition is due in whole or in part to a pre-existing injury or condition;

3. Whether Claimant's condition is due in whole or in part to a subsequent injury, disease, or cause; and

4. Whether and to what extent Claimant is entitled to the following benefits:

a. Medical care;
b. Temporary disability benefits, partial or total (TPD/TTD); and
c. Attorney fees.

The first three listed issues are subsumed into the discussion and resolution of issue 4a., whether Claimant is entitled to the future medical care sought by him.

CONTENTIONS OF THE PARTIES

On May 1, 2014, Claimant injured his right knee (among other injuries which are not at issue) while in the course and scope of his employment. Claimant argues he needs a total right knee replacement surgery as a result of the subject accident. Defendants refuse to authorize the surgery. Claimant is entitled to attorney fees.

Defendants argue Claimant's need for surgery is in no way related to the industrial accident in question. Instead, the surgery is due to the natural progression of Claimant's longstanding arthritis following a prior knee surgery. Medical benefits and temporary disability claims for Claimant's proposed surgery should be denied. Attorney fees are not appropriate.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's testimony, taken at hearing;

2. Joint Exhibits (JE) 1 through 14, admitted at hearing;

3. Joint Exhibit (JE) 15, admitted post hearing by order of the undersigned Referee at hearing[1];

4. The post-hearing deposition transcript of Tom Faciszewski, M.D., taken on April 10, 2018; and

5. The post-hearing deposition transcript of Stanley Waters, M.D., taken on April 18, 2018.

The objection raised on page 24, line 1, of Dr. Faciszewski's deposition is sustained, and the response to the question is stricken. No other objections are sustained.

FINDINGS OF FACT

1. At the time of hearing Claimant was 58 years old. In 2011, he and his wife moved from Maryland to Nampa. Claimant took a job with Employer as a school bus driver and trainer for new drivers. He also worked in the shop and washed coach busses for extra money. At the time of hearing Claimant was employed full time by May Trucking as a long-haul driver.

Pre-Accident Medical History of Relevance

2. In 1983, Claimant injured his back in a motor vehicle accident. Claimant had back surgery in 1985. He had another surgical procedure on his back in 2005 after falling off a ladder. Claimant suffers chronic pain from his back injuries. Claimant acknowledged he had been on prescription pain medication since the 1983 accident.

3. Claimant had his first left knee meniscectomy surgery in or around 1996, and his second in 2003. Claimant had a right knee meniscectomy in 2002. The knee surgeries

[1] It was determined at hearing that Claimant had not produced his Social Security disability application paperwork and associated documentation, in spite of a discovery request which arguably would cover such production. The Referee determined such documents were material and relevant to the issues at hand, and ordered Claimant to produce the entirety of such documents. The record was held open for their inclusion. The documents were subsequently submitted, and labeled as "Joint Exhibit 15". The exhibit was admitted and considered herein.

were not the result of any specific incident. Claimant's treating physician noted Claimant's right knee surgery was due to "degenerative wear and tear". JE 12, p. 340.

4. When Claimant moved to Idaho, he became a patient of Rick Roberts, M.D., for management of his hypertension, hypercholesterolemia, and chronic pain. On his first visit, Claimant told Dr. Roberts that he had been on methadone and Percocet for "an extended time" while under the care of his prior pain management physician, and needed his medications refilled. JE 5, p. 148. Dr. Roberts assessed, among other things, chronic pain syndrome and osteoarthritis – multiple sites. Dr. Roberts refilled Claimant's pain medications for Claimant's chronic pain and osteoarthritis. Claimant saw Dr. Roberts on a regular basis thereafter.

5. In his office notes of April 8, 2014, Dr. Roberts, under the "history" heading noted:

> [O]steoarthritis of knees: Some years ago after sustaining [sic] an orthopedist, [Claimant] was told he would eventually need total knee replacements. He has had increasing pain over time. It is not too bothersome to the point that he would like to be referred back to see an orthopedist.

JE 5, p. 167. This statement has been the focus of much debate among the parties; its significance and limitations will be discussed hereinafter.

6. Claimant filed for Social Security Disability in November 2013. As part of the process, Claimant was seen by James Bates, M.D. Statements made by Claimant and Dr. Bates in the course of the application process will be examined subsequently.

Accident and Post-Accident History of Medical Treatment

7. On May 1, 2014, Claimant was struck from behind and knocked down by a playful German Shepard "guard dog" while in the course and scope of his employment

on Employer's property. Claimant reported the incident and resultant injuries to his right knee, left elbow and left wrist to the shop supervisor.

Initial Treatment and Physical Therapy

8. A week after the accident, on May 7, 2014, Claimant went to the "company doctor", Kevin Chicoine, M.D.

9. Dr. Chicoine ordered right knee x-rays, which showed no fracture or dislocation, and minimal marginal spurring in all three compartments with minimal joint space narrowing in Claimant's medial and lateral compartments, described as "early tricompartmental degenerative changes". Claimant had no visible soft tissue swelling. JE 2, p. 5. X-rays of Claimant's left hand and elbow were negative.[2] Physical therapy was prescribed.

10. On May 14, 2014, Claimant returned to Dr. Chicoine after starting physical therapy. Dr. Chicoine found Claimant's right knee was nontender, with no effusion, and no pain with walking. Dr. Chicoine diagnosed a knee strain and released Claimant to regular duty work with no restrictions. Ultimately, on June 20, 2014, Dr. Chicoine released Claimant from his further care, although by then Claimant had been referred to Stanley Waters, M.D., for his continuing left elbow and hand pain.

11. Claimant initially underwent physical therapy (P/T) from May 8, 2014 through September 17, 2014 at Caldwell Physical Therapy.

12. When Claimant first presented for P/T, he complained of right knee, left hand, and left elbow pain. His knee pain was rated at 4/10; Claimant was tender at his right medial joint line. The therapist diagnosed a right knee strain. Claimant was given

[2] Since Claimant's left elbow and hand injuries are not at issue herein, their inclusion is limited to instances where such conditions are in some way useful to the discussion of Claimant's contested right knee injury.

home exercises in addition to continued in-office P/T.

13. Less than a week after P/T commenced (May 13, 2014), Claimant presented with a bruise on his right calf, among other symptoms, stemming from a motorcycle mishap the previous day. JE 3, p. 22. Claimant's right knee pain was also temporarily exacerbated. However, soon thereafter Claimant's right knee pain diminished to 1 or 2/10, although his elbow continued to bother him. *See, e.g.,* JE 3,pp. 68, 70, 72 (no reference in P/T records of any pain in Claimant's right knee, with notation on August 21, 2014 that Claimant's right knee "hardly bothers him now".)

14. Physical therapy notes of September 17, 2014 indicate Claimant was ready for discharge with continuing home exercises. At that time Claimant's right knee "[was] doing very well" with Claimant "tolerating his work without problems". JE 3, p. 81.

Dr. Waters

15. As previously noted, Claimant came under the care of Dr. Waters on June 30, 2014. At that time, Claimant complained of left elbow and right knee pain. Dr. Waters' initial impression was right knee osteoarthritis. He treated Claimant's right knee with a Kenalog injection.

16. At his next appointment with Dr. Waters on August 14, 2014, Claimant indicated his right knee felt "much better" since the injection. JE 4, p. 125. His left elbow was still symptomatic. Dr. Waters suggested Claimant return as needed.

17. Claimant returned to Dr. Waters on December 22, 2014, complaining of knee and elbow pain. Claimant wanted repeat injections in both joints. Dr. Waters ordered a right knee MRI to determine if Claimant had a meniscus tear.

18. The MRI showed a complex tear of the medial meniscus and

tricompartmental degenerative changes.

19. After a second injection failed to provide significant relief, on March 18, 2015, Dr. Waters performed an arthroscopic surgery consisting of right knee partial medial meniscectomy, removal of a loose osteochondral fragment, and a microfracture chondroplasty procedure of the medial femoral condyle.

20. Intraoperative findings included grade 3 chondromalacia of the lateral patella facet and grade 3 chondromalacia changes in the area of Claimant's femur trochlear groove. The loose fragment identified above was noted, which appeared to Dr. Waters to have arisen from an "acute osteochondral injury from the medial femoral condyle". JE 6, p. 214. Also noted "were other degenerative changes consistent with grade 3 chondromalacia within the medial compartment" which Dr. Waters felt preexisted the work injury. *Id*

21. Post surgery, Dr. Waters referred Claimant back to physical therapy. Claimant began the therapy on April 1, 2015, at which time he complained of right knee pain, stiffness, and swelling. Claimant was taking Motrin, OxyContin, and Percocet for pain. He rated his pain at 4 or 5/10 and felt he was 30% improved since his recent knee surgery. Claimant intended to return to work with Employer on April 6.

22. Claimant gradually improved with P/T until early May 2015, at which time he claimed his knee had been "catching" for the past week. His pain level had increased from 2 or 3/10 to 6/10. Claimant denied any specific injurious event.

23. While in therapy Claimant would periodically return to Dr. Waters. On his May 11, 2015 visit, Claimant complained of intermittent stabbing pain below his right knee. Radiographic studies that day showed medial and patellofemoral joint space

narrowing "consistent with early osteoarthritis of the right knee". JE 4, p. 136. Claimant received a Kenalog injection.

24. After the injection, Claimant's P/T records show he was improving with lessening pain for a period of time. By mid-June 2015, Claimant's knee pain was 1/10, with occasional "popping" which would hurt for a bit and then subside. However, by early July Claimant's pain began creeping up again, with morning stiffness. On his last P/T visit of record (July 16, 2015), Claimant rated his pain at 4/10.

25. On July 20, 2015, Claimant returned to Dr. Waters. Claimant described his pain as dull with symptoms exacerbated by exertion. Examination of Claimant's right lower extremity was normal. Dr. Waters determined Claimant was at MMI, and rated his permanent impairment at 1% whole person for his right knee injury and surgery with no apportionment. Claimant was released to full duty work with no restrictions.

26. On October 26, 2015, Claimant returned to Dr. Waters for right knee pain. Claimant was using a cane and indicated weight bearing increased his pain, with his symptoms dating back to the time of his May 1, 2014 industrial accident. Dr. Waters took x-rays which showed medial and patellofemoral joint space narrowing, as well as subchondral bone cysts and osteophytes; all findings were consistent with osteoarthritis of Claimant's right knee. Dr. Waters' notes stated that Claimant "wants to talk about having a RTKA [right total knee arthroplasty or knee replacement surgery] today". Under the heading "Impression" Dr. Waters noted traumatic arthropathy, right knee. JE 4, p. 142. Dr. Waters requested authorization from Surety to proceed with the proposed RTKA.

27. In response to Dr. Waters' request, Surety demanded Claimant submit to

an independent medical exam (IME) with Dennis Chong, M.D., a physical medicine and rehabilitation doctor supplied by Objective Medical Assessments (OMAC). The examination took place on May 12, 2016.[3]

28. Dr. Chong examined Claimant, reviewed medical records, and prepared a written report to Surety. Dr. Chong opined that Claimant would likely continue to have progressively increasing pain and disability over time without a TKA, but Claimant's current right knee complaints were not related to the industrial accident in question. If Claimant did undergo a TKA, it would be due to his longstanding and preexisting tricompartmental osteoarthritis, with no contribution from the industrial accident. Claimant's only industrial injury was an aggravation of his "historical posterior horn of the medial meniscus from a linear tear to a complex tear" which was addressed by his surgery with Dr. Waters in March 2015. Dr. Chong agreed with Dr. Waters' PPI rating and also felt that Claimant had no work restrictions once he had reached MMI from such surgery.

29. Surety sent a copy of Dr. Chong's report to Dr. Waters, who agreed with the report findings. In January 2018, Dr. Waters again affirmed that in his opinion Claimant's industrial injury did not cause the need for a TKA, nor did the work injury accelerate or hasten the need for a TKA. The doctor was subsequently deposed.

30. Claimant hired Tom Faciszewski, M.D., an orthopedic surgeon from the Boise area, to conduct an IME on his behalf. Dr. Faciszewski reviewed medical records, examined Claimant on November 22, 2017, and subsequently prepared a written report. He was deposed post hearing.

31. Dr. Faciszewski opined that Claimant suffered from acutely progressive

[3] Claimant asserts the extended delay between Dr. Waters' request and the subsequent IME was unreasonable and supports Claimant's claim for attorney fees. The issue of attorney fees is considered subsequently.

right knee arthritis secondary to medial femoral condyle cartilaginous injury, which resulted in chronic pain and was related to his industrial accident. A TKA would be a reasonable and necessary treatment for Claimant's industrial right knee injury. Dr. Faciszewski also felt Claimant was not at MMI but nevertheless imposed permanent restrictions on Claimant with regard to walking (100 yards), climbing, and lifting (35 pounds) due to increased pain in Claimant's right knee.

DISCUSSION AND FURTHER FINDINGS

32. Claimant has the burden of proving by a preponderance of the evidence all facts essential to recovery to his claims. He carries the burden of proving that the condition for which compensation is sought is causally related to an industrial accident. *Duncan v. Navajo Trucking,* 134 Idaho 202, 203, 998 P.2d 1115, 1116 (2000). The proof required is "a reasonable degree of medical probability" that Claimant's condition was caused by an industrial accident. *Anderson v. Harper's Inc.*, 143 Idaho 193, 196, 141 P.3d 1062, 1065 (2006). To prove that a causal relationship is medically probable requires Claimant to demonstrate that there is more medical evidence for the proposition than against it. *Jensen v. City of Pocatello,* 135 Idaho 406, 18 P.3d 211 (2000). In determining causation, it is the role of the Commission to determine the weight and credibility, and to resolve conflicting interpretations, of testimony.

33. Defendants do not dispute the fact that Claimant suffered a compensable accident on May 1, 2014, injuring his left arm and right knee. Defendants accepted Claimant's claim and resultant knee surgery, and paid benefits accordingly. However, they dispute the causal connection between Claimant's request for TKA surgery and his work accident.

Causation

34. Claimant argues he is entitled to right knee TKA surgery due to sequelae from the industrial accident. In support of his position, Claimant relies on the opinions of Dr. Faciszewski. Claimant also argues Dr. Waters' observations contained in his office notes (but not his deposition testimony) bolster the claim for medical benefits.

Dr. Faciszewski Deposition

35. At his deposition, Dr. Faciszewski confirmed his original opinions as contained in his report. Elaborating on those opinions, the doctor pointed out that Claimant, in addition to the "routine" meniscectomy, also had an "acute" loose osteochondral fragment removed, with a microfracture chondroplasty procedure performed on the medial femoral condyle. The significance of the loose fragment is that it signified damage to the cartilage of the knee bone itself; the "cap" that is covering the end of the bone, as opposed to the meniscus, which is a "spacer" between the "two cartilaginous bony ends of the femur and tibia". Faciszewski Depo. p. 19. Damage to the femoral condyle "can have a worse prognosis" [than damage to meniscus]. *Id.*

36. Dr. Faciszewski's opinion was that Claimant had an acute injury with sudden onset of symptoms and "rapid progression because of the defect that is the osteochondral fracture that occurred during [Claimant's industrial accident], which has now led to a rapid progression of his degeneration of the medial femoral condyle". Faciszewski Depo. p. 21. The doctor's position relied heavily on his belief that Claimant was asymptomatic prior to the industrial accident.

37. Dr. Faciszewski supported his opinion with Dr. Waters' post-meniscectomy office notes of October 26, 2015, wherein he listed his impression as "traumatic arthropathy,

right knee". Ex. 4 to Faciszewski Depo; CE 4, p. 142. Dr. Faciszewski defined traumatic arthropathy as a forceful trauma or injury causing or leading to the destruction of a joint. He contrasted traumatic arthropathy, which is due to an acute injury, with degenerative arthritis, which happens over time with wear and tear. He felt the acute injury was the industrial accident.

38. Dr. Faciszewski was aware of Claimant's prior right knee meniscus repair, but felt that "from the standpoint of knee symptoms [the prior knee surgery was] irrelevant in his case because he was asymptomatic prior. Faciszewski Depo. p. 27.

39. On cross examination Dr. Faciszewski testified that Claimant having been asymptomatic prior to the industrial accident "made all the difference in the world" to his opinion on causation. Faciszewski Depo. p. 36. Pressed to elaborate, Dr. Faciszewski pointed out that patients frequently have degeneration on diagnostic films, but no subjective complaints. Here, because Claimant indicated he had no right knee symptoms prior to the work accident, Dr. Faciszewski felt Claimant's complaints sprang directly from "an osteochondral fracture of his knee joint, which caused the acute sudden onset progression… of his arthropathy". Faciszewski Depo. p. 38.

40. When asked if his opinion would change if Claimant's right knee had been symptomatic prior to his work accident, Dr. Faciszewski acknowledged that in such case he would have found no correlation between the work accident and Claimant's need for a knee replacement surgery. As Dr. Faciszewski put it, "[i]n that case, there's no causation. It's a completely different case." Faciszewski Depo. p. 39.

Dr. Waters Deposition

41. Dr. Waters, Claimant's treating surgeon, was deposed on April 18, 2018. He performs over 100 knee replacement surgeries per year.

42. Dr. Waters described his surgery on Claimant's right knee, including the partial meniscectomy, which he felt was related to the industrial accident. Dr. Waters also found a "fairly discrete area of damage to the medial femoral condyle" for which he performed a microfracture chondroplasty procedure, where he made holes in the bone to stimulate bleeding and promote healing of the defect. Waters Depo. p. 13. Dr. Waters testified he could not tell if the condyle damage was from the industrial accident or preexisting degenerative changes, although he did note the mechanism of injury was consistent with a meniscus injury, but not necessarily damage to the femoral condyle.

43. Dr. Waters recounted how, on October 26, 2015, Claimant returned to his office complaining of continuing right knee pain. Claimant brought up the prospect of knee replacement surgery.[4] X-rays taken that day continued to show osteoarthritis, including osteophytes and subchondral bones characteristic of arthritis, as had earlier films. *See* Waters Depo. pp. 15 – 19. Dr. Waters' opined at deposition that the osteoarthritis findings were in no way related to Claimant's industrial accident.

44. Dr. Waters recalled that is was Claimant who wanted to "try to go through workman's comp or someone to compensate for [the TKA]." Dr. Waters agreed that he requested authorization from Surety for the procedure for Claimant, and claimed it was

[4] Claimant testified at hearing that Dr. Waters had initially brought up the possibility of a TKA prior to the meniscectomy and Claimant was simply asking about the procedure first suggested by the doctor. The medical record does not support, or even hint at the notion that Dr. Waters was considering a TKA if the meniscectomy failed to eliminate Claimant's symptoms. Other medical records, and Claimant's testimony, discussed *infra*, make it clear that Claimant was aware of the procedure as a possible solution to entrenched knee pain well before he met Dr. Waters.

at Claimant's request that he did so. He testified that he simply was assisting his patient, and "made no judgment calls on anything". Waters Depo. p. 20 – 22.

45. Office notes from that same visit listed "traumatic arthropathy right knee." Dr. Waters was asked to clarify what he meant by the term "traumatic arthropathy". He explained his notation "as just something – you know, [Claimant has] worked hard and played hard, two arthroscopies on his left knee … two arthroscopies on his right knee, you know". Waters Depo. pp. 20, 21. When asked if the term traumatic was referring to the industrial accident, Dr. Waters answered "[a]ctually wasn't." Waters Depo. p. 21.

46. Dr. Waters stood by his previous opinion that Claimant's industrial injury did not cause the need for a total knee replacement surgery, nor did it accelerate or hasten the need for the TKA. At deposition, Dr. Waters emphasized that it was his opinion, as a treating physician who was able to consider the "whole package of listening to [Claimant], having scoped [Claimant's] knee and really getting all the information on him" that Claimant's need for TKA surgery was due to "preexisting arthritis unrelated to his mechanism of injury". Waters Depo. p. 25.

47. On cross examination, it was pointed out that Dr. Waters had, as part of his preoperative diagnosis, listed right knee osteochondral injury – medial femoral condyle. When asked to explain what the doctor meant by that diagnosis, he responded that it was "difficult for [him] to determine at the time of surgery whether this had occurred as a result of the original date of injury or whether it could have been caused by some of the degenerative changes that were already occurring within the knee". Dr. Waters did acknowledge that any damage to the hyaline cartilage, including the damage diagnosed in Claimant's right knee, could lead to arthritis "down the road". Waters Depo. p. 31.

48. Dr. Waters disagreed with Dr. Faciszewski's conclusion that the osteochondral injury to Claimant's medial femoral condyle led to, or hastened the need for, Claimant's TKA surgery, because it was unclear to Dr. Waters whether the industrial accident had caused the osteochondral injury, or if it was a condition of Claimant's preexisting "significant changes within the medial compartment of [Claimant's right] knee" as noted in Claimant's original MRI. Waters Depo. p. 32.

49. Dr. Waters testified that he "truly in [his] heart believe[d] that Claimant was progressing toward knee replacement surgeries with both of his knees". While he admitted an injury involving the meniscus and femoral condyle can accelerate the need for TKA surgery, Dr. Waters did not believe such was the case with Claimant. As he explained, "[Claimant's] mechanism of injury was more consistent with a meniscus tear…. We later on confirmed it was a meniscal tear on top of the underlying preexisting osteoarthritis. We tried treating his meniscus tear, and he still had progression of the underlying osteoarthritis. That's different than did he have an acute exacerbation of underlying arthritis". Waters Depo. p. 33.

50. When confronted with the argument that Claimant was having left but not right knee issues prior to May 1, 2014, Dr. Waters flatly rejected the notion, stating:

> Sir, this gentleman (Claimant) was having both knee issues. He had his left knee scoped twice and his right knee scoped before I ever met him, before his work-related injury. And when you look at the preoperative MRI scan, this gentleman had significant tricompartment [sic; tricompartmental] arthritis of his knee. And it didn't occur – that degree of arthritis did not occur on that date of injury.

Waters Depo. p. 35.

Medical Testimony Analysis

51. Three medical experts have opined on the issue of causation; their positions must be analyzed and weighed. However, before that analysis is conducted, it is important to dispatch a statement made by Claimant which has taken root in certain medical analyses and the briefing submitted by the parties.

The Statement

52. In Dr. Roberts' office notes of April 8, 2014 (3 weeks before Claimant's work accident), under the heading "History of Present Illness", a new item appeared, the relevant portion of which is set out below:

> 3. osteoarthritis of the knees: Some years ago after sustaining [sic] an orthopedist, [Claimant] was told that he would eventually need total knee replacements. He has had increasing pain over time. It is not too bothersome to the point that he would like to be referred back to see an orthopedist.

JE 5, p. 167.

53. While the notation that Claimant has had increasing knee pain over time but that his complaints do not warrant physician care is relevant and material, several physicians have latched onto not only that portion of the history, but also the hearsay statement that some doctor somewhere at some point in time supposedly told Claimant that he would "eventually" need knee replacements to bolster their argument that Claimant's need for a right knee replacement in 2015 was inevitable, as allegedly foretold by a mystery physician at some remote time and place.

54. Claimant became so concerned about this statement that he discussed the history notation with Dr. Roberts in or around April 2017. After that conversation, Dr. Roberts authored a "to whom it may concern" letter wherein Dr. Roberts claimed that he misspoke in his history recitation of April 8, 2014, and that he specifically recalled Claimant stating that this unidentified

orthopedist said Claimant's *left* knee would need replacement surgery in the future. At the time, Dr. Roberts put misinformation in his office notes Claimant's *right* knee was "feeling well, and was being managed with simple non-steroidal anti-inflammatories". JE 7, p. 234.

55. Claimant's proclamation that he was told by some doctor in the past that he would need one or more knee replacement surgeries at some undefined future date is afforded no weight. It lacks foundation, is hearsay, and speculation. Furthermore, while it seems unlikely a physician would tell a patient that a single arthroscopic partial meniscectomy was going to lead to knee replacement surgery in the future, even if a doctor made such a prediction, it is still inadmissible under the facts of this case. The doctor did not make the statement on the record, if made at all, and there is no way to know the context in which the alleged statement was made.

56. The statement in Dr. Roberts' notes of April 8, 2013, that Claimant is having some mild but increasing knee complaints, is admissible for whatever weight it carries, as is Dr. Roberts' observation that before the work accident Claimant's right knee pain was being managed with NSAIDs.

Dr. Chong Analysis

57. Of significance in Dr. Chong's report is his recitation of a radiology report from St. Luke's Health System dated January 21, 2015, which noted "[t]ricompartmental osteoarthritis, severe within the medial compartment where there is a full-thickness chondrosis". JE 13, pp. 444, 445. This finding is consistent with Dr. Waters' intraoperative observations.

58. Other points of interest include the fact that Claimant wanted it noted in the report that work and personal sports injuries were not relevant, and therefore were not going to be disclosed by Claimant, since in his opinion such injuries were not related to his right

knee condition. Claimant did reiterate that his remote knee surgeries were due to wear and tear, and no specific incident.

59. Dr. Chong diagnosed preexisting bilateral knee osteoarthritis, unrelated to the industrial accident. In support of his diagnosis, the doctor noted Claimant had been on chronic opiate therapy since at least 2012, and had previously undergone right arthroscopic surgery in 2002. He also listed the office note from Dr. Roberts that Claimant had been previously told he was destined for total knee replacements. Additionally, he highlighted the MRI findings of tricompartmental osteoarthritis, severe within the medial compartment, where there was full-thickness chondrosis. Dr. Chong related this finding to accelerated cartilage degeneration secondary to Claimant's 2002 medial meniscectomy. Finally, Dr. Chong opined the loose osteochondral fragment found and removed by Dr. Waters was unrelated to Claimant's work injury. The only related finding was Claimant's surgically-treated medial meniscus tear.

60. When asked specific questions on diagnosis/prognosis, Dr. Chong wrote that Claimant "had been destined for bilateral total knee arthroplasty since April 2014, one month predating the industrial event of May 2014." JE 13, p. 450. He repeated this same inaccurate statement later in his report.

61. Claimant argues Dr. Chong's report should be given little weight since he appears to rely heavily on Dr. Roberts' "erroneous" note concerning Claimant's statement on the eventual need for bilateral TKA surgeries, and does not discuss the "acute" osteochondral injury. Dr. Chong does emphasize Dr. Roberts' office note as if it proves a fact, and furthermore seems to attribute the comment to Dr. Roberts, placing the "diagnosis" in April 2014. Dr. Chong merely mentioned the osteochondral fragment as being unrelated

without further elaboration. However, there are a few points in Dr. Chong's report which bear consideration.

62. The most significant observation from Dr. Chong is the fact that in January 2015 an MRI showed severe, full-thickness chondrosis in Claimant's medial compartment, with osteoarthritis in all three compartments. Further, Claimant had osteoarthritis since at least 2012, leading Dr. Chong to the conclusion that Claimant had been progressing to the point where he was complaining of right knee pain and disability by 2015, which complaints will continue to increase unless and until he has a TKA surgery.

63. Claimant acknowledges preexisting right knee osteoarthritis, and does not dispute the MRI findings relied upon by Dr. Chong. He argues he was asymptomatic prior to his work accident despite his osteoarthritis, and therefore had no need for TKA or any other knee surgery on the date of the accident. The accident accelerated his need for TKA surgery, and therefore Surety is responsible for providing such procedure.

64. Dr. Chong's May 12, 2016 report does not address Claimant's contention that the accident accelerated Claimant's osteoarthritis, thus requiring a TKA at this time. Dr. Chong appears to believe the TKA was indicated before the work injury, based on the statement in Dr. Roberts' office notes. Stripped of the validity of such note, Dr. Chong provides only conclusions with no supporting explanations. As such, his report of May 12, 2016 is afforded little weight.

65. Dr. Roberts' "retraction/correction" letter (JE 7) was provided to Dr. Chong. Nothing in the letter caused Dr. Chong to change his opinions. Instead, he mocked Dr. Roberts' purported recall ability, and suggested collusion. He also pointed out that there were no medical records showing Claimant had ever complained about his left knee in the recent past

(or subsequent to Dr. Roberts' April 8, 2013 office note for that matter), which makes the doctor's explanation questionable. Finally, there are records going back to 2012 which list Claimant's "osteoarthritis at multiple sites", which Dr. Chong felt would include Claimant's right knee unless excluded. None of these arguments are particularly weighty, although the fact that Claimant was complaining of knee pain at least as of April 2014 is worth noting, and will be discussed in further detail hereinafter.

Dr. Faciszewski Analysis

66. Dr. Faciszewski summarized his opinion thusly:

> [Claimant] suffered an acute injury to his knee, with the subsequent meniscal tear in concert with his osteochondral fracture which led to, as Dr. Waters pointed out, and I agree, [Claimant's] acute traumatic arthropathy.

Faciszewski Depo. p. 27. Dr. Faciszewski felt the above scenario was the only medically-logical explanation for Claimant's condition. Unfortunately, in reaching his conclusion Dr. Faciszewski relies heavily on his belief that Claimant was asymptomatic prior to his industrial accident. In fact, his opinion hinges on this belief to the point that the doctor testified that if Claimant had not been asymptomatic prior to the accident, then Claimant's knee replacement surgery would not be causally related to his May 1, 2014 accident. As shown below, the weight of the evidence supports the proposition that Claimant was not asymptomatic prior to his work accident.

67. At hearing, and to several doctors, Claimant averred that between the time he recovered from his meniscus surgery in 2002 and his fall on May 1, 2014, he "never had any problems" with his right knee; "none at all". *E.g.,* Tr. p. 45. While it is true there are no medical records in evidence wherein Claimant sought medical treatment for right knee issues in that time frame, and was able to perform jobs involving kneeling and lifting, there are

several records in evidence in which Claimant mentions pain and problems with his bilateral knees.

68. First, Dr. Roberts' in April 8, 2014 notes, for the first time in nearly a year and a half of treatment, Claimant complaining of increasing pain due to osteoarthritis in his knees. While Claimant and Dr. Roberts disavow the statement that Claimant was told he would need bilateral knee replacements, there is nothing in the record to suggest that Claimant did not complain of increasing bilateral knee pain (albeit "not too bothersome" at that time) to Dr. Roberts in April 2014. In fact, Dr. Robert's letter of April 13, 2017 supports his understanding that Claimant had at least some issues with his right knee prior to the accident. Dr. Roberts, who saw Claimant on a regular basis over an extended time frame, and prescribed Claimant his medications, including opioids, mentioned that Claimant's right knee problems were "managed with simple non-steroidal anti-inflammatories." JE 7, p. 234. One does not "manage" an asymptomatic joint or condition with non-steroidal anti-inflammatories.

69. In late 2013, Claimant applied for Social Security Disability benefits. Claimant did not list knee problems as a factor for his disability. Nevertheless, during the process of filling out documents for the Social Security Administration to consider when analyzing Claimant's eligibility for benefits, Claimant hand wrote and signed the following on November 21, 2013:

> … I feel like I went from a vibrant and strong firefighter with a lot of vitality to a weak old man over a short period of time. *** Now however I've broken my back, suffer with chronic severe pain, have knee problems bilaterally, ankle and foot pain.

JE 15, p. 645.

70. In December 2013, it appears the Idaho DOL sent Claimant to James Bates, M.D., for an orthopedic examination and report. In that report, Dr. Bates listed Claimant's

chief complaints as, "[s]houlder and back, throughout the neck, through the back and knee pain." Expanding on the knee complaints, Dr. Bates wrote "[Claimant] has pain in the bilateral knees. He had arthroscopic surgery in the past. He has had knee pain since the mid 90s." JE 15, p. 669. Dr. Bates also noted Claimant's "reported tolerance of activity is standing about 45 minutes, limited by knees and feet. *** He can walk about 100 yards. He reports hip, knee, and foot pain. *** Currently he takes methadone 15mg three times per day, oxycodone 10mg three per day, Tramadol 50mg every four hours during waking hours." JE 15, p. 670.

71. Claimant's testimony that he never had any problems with his right knee after 2002 is against the weight of the evidence, and is rejected.

72. At his deposition, Dr. Faciszewski testified he had reviewed Claimant's Social Security Administration documents submitted in conjunction with his application for disability benefits (including Dr. Bates' report) and Dr. Roberts' correction letter from 2017. In spite of that, he held fast to the notion that Claimant was asymptomatic before the industrial accident. Perhaps Dr. Faciszewski was using the term "asymptomatic" in some way other than its commonly-understood definition of "without symptoms", but if so he was not given the opportunity to explain himself. No one questioned the apparent contradiction between Dr. Faciszewski's assertion that Claimant had no prior symptoms with his right knee and the SSDI document statements made by Claimant, or the history Claimant gave to Dr. Bates, or Dr. Roberts' assertion that Claimant managed his right knee with NSAIDs.

73. Taken literally, Dr. Faciszewski's deposition testimony can be read to endorse the fact that there was not a causal connection between Claimant's need for a TKA and his industrial accident. After all, Dr. Faciszewski testified that if Claimant was symptomatic prior to the day of the work accident, then he would argue there was no causal link between

the accident and Claimant's current right knee condition. While it does not appear Claimant's right knee was severely symptomatic prior to the accident, the record supports some level of symptomatology.

74. Dr. Faciszewski's otherwise-plausible opinion on causation is greatly weakened by his reliance on an invalid proposition (asymptomatic knee) which formed the cornerstone for his viewpoint.

Dr. Waters Analysis

75. Dr. Waters found Claimant's industrial injury did not cause the need for a total knee replacement surgery, nor did it accelerate or hasten the need for the TKA. He disagreed with Dr. Faciszewski's assertion that the osteochondral injury to Claimant's medial femoral condyle and the hyaline cartilage fragment found at the time of surgery were necessarily the result of Claimant's work accident. Instead, Dr. Waters felt it was "difficult" to make such determination.[5]

76. While Dr. Waters' conclusion was articulated well enough, the rationale for his conclusion was weak. Carefully scrutinized, much of his deposition testimony is not truly responsive to the question asked, and often fails to address the issues. By the end of the deposition questioning, it was clear Dr. Waters felt that since Claimant had previous knee surgeries and some arthritis, he was progressing toward knee replacement surgeries. Such an observation fails to address the exact question of whether the preexisting arthritis was progressing at such a rate that Claimant would have been in need of a right TKA by late 2015 even if he had not had the work accident in question, and if so, what evidence supported that exact timeframe as compared to any other timeframe.

[5] Ironically, Dr. Faciszewski reached that conclusion by reading Dr. Waters' postoperative diagnosis of "right knee acute osteochondral injury medial femoral condyle". JE 6, p. 213.

77. Dr. Waters' contemporaneous notes while treating Claimant used terms such as "acute" and "traumatic", suggesting the injuries, including the osteochondral injury to Claimant's medial femoral condyle, were the result of a discreet incident, not a degenerative process. The doctor's attempt to walk back those labels during his deposition seemed a bit disingenuous.

78. Dr. Waters' opinions carry some weight due to the fact he was the treating doctor, and, as he put it, was able to consider the "whole package of listening to [Claimant], having scoped [Claimant's] knee and really getting all the information on him". Waters Depo. p. 25. However, his opinions were steeped in subjective feeling, and short on authoritative evidence. Additionally, his apparent waffling between his office notes and his deposition testimony further weakens his opinions.

Weighing the Medical Evidence

79. The undersigned is left with the difficult task of sorting through three seriously flawed opinions to assign weight on a pivotal issue.

80. At the outset, Dr. Chong's opinion is discarded as conclusory and relying upon unfounded hearsay lacking in foundation.

81. Dr. Faciszewski's opinions are not inherently improbable and could explain how Claimant got to the point where he is contemplating a TKA due to the industrial accident. However, Dr. Faciszewski's theory would be given more weight if Claimant truly had been asymptomatic prior to the work accident. Alternatively, if Dr. Faciszewski had elaborated on what he meant by "asymptomatic", perhaps by noting he meant "not under a doctor's active care for ongoing disabling pain or functional limitation", or maybe by noting that he did not consider transient aches and pains, or mild discomfort which did not reduce Claimant's day-to-day

activities when considering the term “asymptomatic”, or some other qualifier to the term, then perhaps his opinion would have been given more weight. However, as his opinion and deposition testimony now stands, he severely compromised his position by stating that it made all the difference in the world whether Claimant was or was not asymptomatic at the time of his work injury. He put all his eggs in a basket with a hole in the bottom.

82. Dr. Waters’ opinion was also less than satisfying. Examination of his deposition testimony left the undersigned with as many questions as it did answers. Dr. Waters’ statement that Claimant was progressing toward bilateral knee surgeries does little to answer the question before the Commission.

83. Though tempted to declare the evidence in equipoise, as this is such a close call, and the medical evidence is so conflicted and non-persuasive, it does appear, by the slightest of margins, that the testimony of Dr. Waters, lacking though it is, carries the most weight for the following reasons. First, Dr. Waters was the surgeon who had the opportunity to view Claimant’s knee joint first hand. He saw the damage to Claimant’s femoral condyle, and could not say it was acute. He did have the opportunity to meet with Claimant multiple times, and get to see and discuss issues with the Claimant which led the doctor to feel strongly that Claimant’s current desire for a knee replacement surgery was not in any way the causal result of the work accident. Finally, Dr. Waters’ testimony that the twisting mechanics of the injury supported a torn meniscus, but not necessarily other damage, such as to Claimant’s femoral condyle, was persuasive. (Dr. Waters was not asked if Claimant falling on his right knee could account for the femoral condyle injury found at surgery.)

84. When examining the record as a whole, the Referee finds the opinions of Dr. Waters carry the greater weight.

85. Claimant has failed to prove to a reasonable medical probability that he is entitled to additional medical treatment for his industrial injury.

86. Because Claimant's request for temporary disability was contingent upon an award of future medical benefits in the form of a TKA surgery, and attorney fees cannot be awarded if the right to additional compensation is not proven, *Salinas v. Bridgeview Estates,* 162 Idaho 91, 394 P.3d 793 (2017), those issues are moot.

CONCLUSIONS OF LAW

1. Claimant has failed to prove he is entitled to additional medical treatment.

2. The issues of temporary disability benefits and attorney fees are moot.

RECOMMENDATION

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

DATED this 20th day of November, 2018.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of November, 2018, 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:

JASON THOMPSON
350 N 9TH ST, STE 500
BOISE ID 83702

NEIL MCFEELEY
PO BOX 1368
BOISE ID 83701

/s/

jsk

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DALE SHAW, Claimant, v. CALDWELL TRANSPORTATION CO., INC., Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-012378** **ORDER** **Filed 11/30/18**

Pursuant to Idaho Code § 72-717, Referee Brian Harper submitted the record in the above-entitled matter, together with his recommended 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 recommendations of the Referee. The Commission concurs with these recommendations.

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 failed to prove he is entitled to additional medical treatment.
2. The issues of temporary disability benefits and attorney fees are moot.
3. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to

all matters adjudicated.

DATED this 30th day of November, 2018.

INDUSTRIAL COMMISSION

/s/
Thomas E. Limbaugh, Chairman

/s/
Thomas P. Baskin, Commissioner

/s/
Aaron White, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of November, 2018, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

JASON THOMPSON
350 N 9TH ST, STE 500
BOISE ID 83702

NEIL MCFEELEY
PO BOX 1368
BOISE ID 83701

/s/

jsk