BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ROBERT GEISENDAFFER, Claimant, v. DAN WEIBOLD FORD, INC., Employer, and LIBERTY NORTHWEST INSURANCE COMPANY, Surety, Defendants.	)	**IC 2007-020154** **2009-007168** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** Filed February 8, 2011

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Boise, Idaho, on April 22, 2010. Richard S. Owen of Nampa represented Claimant. Kimberly A. Doyle of Boise represented Defendants. The parties submitted oral and documentary evidence. The record remained open for five post-hearing depositions, after which the parties submitted post-hearing briefs. The matter came under advisement on August 18, 2010 and is now ready for decision. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law and order

ISSUES

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

1. Whether the conditions for which Claimant seeks benefits were caused by the industrial accidents;

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

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

A. Permanent partial impairment;

B. Disability in excess of impairment, less than total;

4. Whether apportionment for pre-existing impairment is appropriate pursuant to Idaho Code § 72-406; and

5. Whether the Commission should retain jurisdiction beyond the statute of limitations.

CONTENTIONS OF THE PARTIES

Claimant asserts that his undisputed industrial injuries of June 9, 2007[1] and February 26, 2009, together with the surgeries necessitated by the injuries, both aggravated and accelerated pre-existing but asymptomatic degenerative arthritis in both of his knees. His doctors now believe that he will need bilateral knee arthroplasty in the future. Claimant contends that he is entitled to whole person permanent partial impairment of 1% for each knee (for a combined value of 2%) without apportionment for his asymptomatic pre-existing condition, and disability inclusive of his impairment of 35%. Because he anticipates the need for total bilateral knee arthroplasty in the future, Claimant asks this Commission to retain jurisdiction over this proceeding.

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[1] The Complaint states that the date of injury was June 8, 2007. However, the testimony and the medical records are consistent that the accident occurred on Saturday, June 9, 2007.

Defendants argue that the only knee injuries attributable to Claimant's industrial accidents were the meniscal tears treated at Defendants' expense. Therefore, Claimant's on-going knee complaints are purely the result of his pre-existing degenerative arthritis. Given the extent of the arthritic changes found in Claimant's knees during his arthroscopies, it is reasonable to apportion half of the combined 2% whole person PPI to Claimant's pre-existing condition. Claimant sustained no disability in excess of his impairment, because his treating surgeon imposed no permanent activity restrictions and released Claimant to return to his time-of-injury position. Finally, Defendants contend that any need Claimant may have in the future for bilateral knee arthroplasty will be because of his pre-existing degenerative condition and not compensable, so there is no need for the Commission to retain jurisdiction in this proceeding.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;

2. Claimant's exhibits 1 through 3, admitted at hearing;

3. Defendants' exhibits A through R, admitted at hearing;

4. The post-hearing depositions of Christian Gussner, M.D., taken April 29, 2010; Nancy J. Collins, Ph.D., taken May 4, 2010; David E. Hassinger, M.D., taken May 19, 2010; George A. Nicola, M.D., taken May 25, 2010; and Mary Barros-Bailey, Ph.D., taken May 28, 2010.

All objections tendered during the conduct of the post-hearing depositions are overruled.

FINDINGS OF FACT

1. Claimant was sixty years old at the time of the hearing. He lived in Nampa with his wife of thirty-seven years.

EDUCATION

2. Claimant moved with his family to Idaho when he was six years old. He attended public schools in Middleton, but left school in his junior year to join the Navy, where he earned his GED. Apart from his military specialties, Claimant received no additional formal education.

WORK HISTORY

3. Claimant's primary military occupation was in payroll finance. His service ended before the dawn of the digital age, and Claimant performed his payroll duties manually. Claimant's secondary military occupation was aviation firefighting instructor, which involved training sailors in the specialized skills needed to control aviation-related fires.

4. Claimant retired from the Navy with an honorable discharge after serving twenty-one years. After settling into a permanent home in Nampa, Claimant went to work for Pinkerton Security. Pinkerton initially hired Claimant as a security officer in 1990. After a short period, Pinkerton promoted him to night supervisor, then to manager of all of Pinkerton's Idaho offices. As Pinkerton's manager in Idaho, Claimant was responsible for all aspects of the Idaho operation, from hiring to firing and from drug testing to sales and customer service. Claimant left Pinkerton Security in 1998 when the company changed owners and pulled out of Idaho.

5. In October 1998, Claimant went to work for Employer as a shuttle driver. Claimant's primary job was to drive customers to their destination after they had dropped off a vehicle for repair, and to shuttle those customers back to the dealership at the end of the day to pick up their vehicles. Claimant also worked as a "porter"—moving vehicles from one place to another on the lot. On occasion, Employer sent Claimant on a parts run or to the bank. The job started as part-time--three days per week--but within a couple of weeks, Claimant was working five days a week, ten to twelve hours per day. The dealership moved to a new eleven-acre

facility near the Interstate in 2000, and Claimant's job became even busier because the new facility was both larger in area and some distance from the business district.

JUNE 2007 ACCIDENT

6. On June 9, 2007, Claimant moved a Ford Expedition to the service queue on the back lot. While stepping out of the Expedition, Claimant "jammed" his left knee. After pausing briefly, Claimant walked back to the front of the building, some four hundred feet. He described his knee as "tight," but not particularly painful. After grabbing a cup of coffee and another set of keys, Claimant headed out the door to move another vehicle. Just outside the door, Claimant's left knee "snapped" or "popped," and Claimant experienced severe pain in the left knee. He was unable to bear weight except on the tips of his toes.

7. Claimant reported the incident to his supervisor, who fetched Claimant's vehicle for him and sent him home. Claimant drove home and packed the knee in ice. Icing the knee provided no relief, so Claimant sought medical care at the Nampa Urgent Care clinic operated by St. Alphonsus Medical Group later that same day.

Medical Care

8. On his initial visit to the urgent care clinic, he saw S. Daly, M.D., who diagnosed internal derangement and possible meniscus tear. Dr. Daly provided an immobilizer and crutches, and ordered no weight-bearing on the left extremity until the occupational medicine clinic could evaluate the knee on Monday.

9. Claimant followed up at the occupational medicine clinic on June 11. Charlie Frost, P.A., examined Claimant's knee and continued conservative treatment. Claimant returned for follow-up June 15 and June 22, 2007, and Mr. Frost continued to evaluate and offer conservative care. When Claimant returned to the clinic for his next appointment on July 2,

Mr. Frost ordered an MRI. The MRI showed a tear of the medial meniscus at the root posteriorly, as well as joint effusion and some costochondral defect along the posterior patella and medial femoral condyle. Mr. Frost referred Claimant to Dr. Nicola for a surgical consult.

Dr. Nicola

10. Claimant saw Dr. Nicola on July 10, 2007. Dr. Nicola noted that the MRI showed degeneration of the medial meniscus, tear of the root attachment of the medial meniscus, and some osteochondral contusion. He recommended arthroscopic surgery.

11. Dr. Nicola performed arthroscopic surgery on Claimant's left knee on July 25, 2007. Operative notes mention "significant grade III changes over most of the medial femoral condyle. I debrided as much of these as I could." Ex. F, p. 46. Dr. Nicola removed the torn portion of the medial meniscus. In a final check of the knee, Dr. Nicola observed grade III changes on the undersurface of the patella.

12. Claimant had an uneventful but slow recovery. In mid-August, Dr. Nicola ordered three weeks of physical therapy (three times per week). At the end of August, Claimant returned to the clinic for an unscheduled visit because of discomfort caused by swelling and fluid build-up in his knee. Claimant has an allergy to most local anesthetics, so declined the offer to have the knee drained without anesthesia.

13. Claimant continued receiving follow-up care through September, October, and November. He continued to complain of knee pain and swelling. During this three-month interval, Dr. Nicola ordered a TENS unit and performed a steroid injection, which provided only temporary relief. In late November 2007, Dr. Nicola began a series of Orthovisc injections. The Orthovisc injections were completed by mid-December, but did not provide noticeable improvement in Claimant's left knee symptoms. Dr. Nicola released Claimant to return to

full-duty work, without restrictions, beginning on December 28, 2007.

14. In response to a request from Surety, Dr. Nicola advised that he had rated Claimant at 1% whole person impairment as a result of his left knee injury, with no apportionment to his pre-existing asymptomatic degenerative knee condition. Dr. Nicola reaffirmed that Claimant had no work restrictions related to the industrial accident. Ex. H, p. 106. Dr. Nicola signed and dated the letter on January 23, 2008.

15. Claimant returned to Dr. Nicola on February 1, 2008 for "evaluation." The chart note for the visit released Claimant for full-duty work beginning February 1, 2008, and awarded 1% PPI. However, noting the "large amount of degenerative arthritis," he apportioned 50% of the PPI to Claimant's pre-existing degenerative condition. *Id,* at p. 107.

Dr. Hassinger

16. Claimant saw Dr. Hassinger on February 15, 2008, for a second opinion on his still-symptomatic left knee. Claimant told Dr. Hassinger that he had been doing well until his left knee popped on December 27, 2007. Since that time, Claimant had experienced mechanical symptoms and pain along the lateral aspect of his left knee. Although Dr. Hassinger could provide no anatomic explanation for Claimant's symptoms, he felt some additional investigation was appropriate and sent Claimant for a repeat MRI and an EMG study of the left lower extremity. The EMG was normal. The MRI showed post-surgical changes, as well as some arthrosis throughout the knee. Dr. Hassinger attributed Claimant's reported knee dysfunction to his degenerative arthritis. Dr. Hassinger had little to offer Claimant in the way of additional treatment other than cortisone injections or a total arthroplasty.

Return to Work

17. Claimant returned to work for Employer in October 2007 with restrictions. When

Dr. Nicola released Claimant to full duty, he did not resume all of his pre-injury duties. To some extent, he self-accommodated, and, to some extent, his co-workers accommodated him. For example, he did not climb the stairs to the second floor to pick up paperwork—his co-workers brought it down to him. He no longer filled the propane tanks on the hyster.

18. Prior to his June 2007 injury, Claimant worked ten to twelve hours per day. He did not earn over-time pay, but his wages were high as a result of the number of hours. In the four quarters before his June 2007 accident, Claimant earned $39,432.42. Claimant worked fewer hours after his left knee injury. In the four quarters preceding his February 2009 injury, he earned just $32,240.60.

FEBRUARY 2009 ACCIDENT

19. On February 26, 2009, Claimant was closing up the shop. As he walked across the service area to close and lock one of the bay doors, he tripped over an air hose stretched across the floor. Claimant fell, landing on both knees. It was near the end of the workday, and his supervisor sent him home. Both knees began to swell after the incident, and Claimant aggressively iced both. The left knee eventually returned to what constituted normal after his 2007 injury, but the right knee continued to swell, and cause an occasional twinge. Finally, on March 9, Claimant sought medical care at the St. Alphonsus Medical Group clinic in Nampa for his right knee.

Medical Care

20. Claimant saw Mr. Frost, who ordered x-rays. The imaging showed some degeneration of the patella, but no obvious fractures. Mr. Frost diagnosed a right knee contusion, ordered physical therapy, and limited Claimant's porter work. Mr. Frost ordered a follow-up visit with his regular physician, Kevin Chicoine, M.D., in ten days.

21. Claimant returned to the clinic on March 11, complaining of increasing pain in his right knee. He reported that he was at work getting ready to go to physical therapy when he felt a pop in his knee and the onset of excruciating pain. He went to physical therapy, but the therapist was concerned that he was unable to weight-bear on his right lower extremity. The therapist had to locate a walker in order for Claimant to be able to ambulate at all. Mr. Frost took Claimant off work, and scheduled an MRI for the following day.

22. The MRI showed a tear of the root of the posterior horn of the medial meniscus, mild to moderate chondromalacia of the patella, joint effusion, and a tiny Baker's cyst with evidence of recent rupture. Mr. Frost referred Claimant to an orthopedic surgeon, but Surety requested that Claimant return to Dr. Nicola, which he did.

Dr. Nicola

23. Claimant saw Dr. Nicola on March 17, 2009. Dr. Nicola recommended arthroscopic surgery to repair the torn meniscus. Dr. Nicola performed the procedure on April 22, 2009. The operative report notes a successful resection of the medial meniscal flap tear. Examination of the knee with the arthroscope showed grade II degenerative changes in the medial compartment, the medial femoral condyle, and the tibial plateau. There were also grade II changes observed on the patellofemoral joint.

24. Employer filled Claimant's position after Mr. Frost took him off work on March 11, 2009.

25. On his first post-operative visit to Dr. Nicola on April 27, 2009, Claimant reported that the knee itself was doing well, but he was having pain across the front of the knee and in the medial joint line. Claimant consented to a steroid injection of his pre-patella bursa to see if that would help calm the knee down. Dr. Nicola directed Claimant to return in four weeks,

but Claimant presented on May 11, 2009, because of continuing pain in the right knee. Dr. Nicola ordered physical therapy.

26. Claimant was still reporting "quite a bit" of knee pain when he returned to see Dr. Nicola in late May 2009. Ex. H, p. 113. Dr. Nicola recommended aspirating the knee and injecting it with cortisone. On June 8, 2009, Claimant reported "significant" pain over the knee. The aspiration and cortisone injection provided only temporary (four days) relief. Dr. Nicola opined that he was quite pleased with Claimant's progress, noting that Claimant also healed slowly from his 2007 left knee procedure. Restrictions as of June 8 included no bending or stooping, no climbing, and occasional walking up to two hours per day. Dr. Nicola also noted that he was working with Don Thompson from the Industrial Commission Rehabilitation Division (ICRD) on a return-to-work strategy for Claimant.

27. On July 8, 2009, Claimant reported continued tenderness and increased warmth over the patella. Dr. Nicola believed these symptoms related to Claimant's degenerative arthritis. Other complaints of pain over the top of Claimant's right foot Dr. Nicola attributed to Claimant's diabetes, but ordered an EMG which confirmed the diagnosis of diabetic neuropathy. Dr. Nicola also met with Mr. Thompson from ICRD to discuss return-to-work. Restrictions included "no excessive walking, kneeling or squatting." Ex. H, p. 121.

28. On April 24, 2009, Dr. Nicola responded to a questionnaire from Surety. In response to Surety's specific questions, Dr. Nicola replied that Claimant's right knee was medically stable on August 24, 2009, and that he sustained one percent whole person PPI as a result of the torn medial meniscus on the right. Dr. Nicola answered a follow-up question about apportionment by responding that none of the PPI rating was assignable to pre-existing conditions. In September, Surety sent a second questionnaire inquiring about permanent

restrictions. Dr. Nicola advised Surety that he imposed *no* permanent restrictions on Claimant's activities as a result of the February 2009 accident.

INDEPENDENT MEDICAL EVALUATION

29. In late February 2010, Claimant's counsel arranged for an independent medical evaluation (IME) of Claimant by Dr. Gussner. Dr. Gussner's report, dated March 1, 2010, included a thorough review of relevant medical records, a patient history, results of an exam, and an evaluation of Claimant's responses to pain inventories. Dr. Gussner opined that Claimant was a good historian whose recounted history was consistent with the medical records. He found no evidence of symptom magnification on Claimant's part. His review of Claimant's answers on the Oswestry function test and Beck's depression questionnaire led Dr. Gussner to conclude that Claimant considered himself only moderately disabled as a result of his knee problems, and that there was no evidence of any mood disorder.

30. Dr. Gussner opined that each of the industrial injuries caused the respective meniscal tears, and that each injury exacerbated or aggravated Claimant's pre-existing degenerative changes. Dr. Gussner agreed with Dr. Nicola as to the dates that Claimant reached medical stability following each of his accidents, and Dr. Nicola's PPI rating of 1% whole person for each knee, which combines to provide a 2% whole person rating. Dr. Gussner did not believe that any of the PPI was apportionable to Claimant's pre-existing but asymptomatic degenerative arthritis.

31. Dr. Gussner disagreed with Dr. Nicola about work restriction. Dr. Nicola imposed no permanent restrictions on Claimant following his bilateral arthroscopic procedures. Dr. Gussner recommended the following restrictions:

- Avoid forceful repetitive movements involving the knees;

- Avoid continuous or frequent creeping, crawling, stair climbing, and ladders;
- Avoid impact activities to both lower extremities, *i.e.,* no jumping.

32. Dr. Gussner concluded his report with the following consultation note:

> [Claimant] is at increased risk for post-traumatic osteoarthritis due to his injury and subsequent surgery. He has three out of four risk factors for post-traumatic arthritis and this includes breech of the joint space, disruption of joint surface, and bleeding. There is no documentation of infection. I anticipate that [Claimant] will need total knee replacements in the future, related to degenerative arthritis, post-traumatic osteoarthritis, and obesity. The primary need for future joint replacements would be the pre-existing degenerative arthritis and obesity. The timeline for knee replacements is, on a more probable-than-not basis, shortened by the injury and subsequent surgery related to the 06/08/07 [sic] and 02/26/09 injuries.

Exhibit 1, p. 11.

VOCATIONAL EVIDENCE

33. Both parties retained vocational experts to address the issue of disability in excess of impairment. Claimant retained Nancy J. Collins, Ph.D. Dr. Collins appears regularly before the Commission, which recognizes her expertise in vocational rehabilitation. For that reason, the Commission will not discuss Dr. Collins' credentials in detail. Defendants retained Mary Barros-Bailey, Ph.D., as their vocational expert. The Commission is also well-acquainted with Dr. Barros-Bailey and her credentials as a vocational expert.

Dr. Collins

34. Dr. Collins reviewed relevant medical records and met with Claimant during the course of her evaluation. In assessing Claimant's loss of access to the job market, she relied on the restrictions that Dr. Nicola imposed on July 24, 2009, and those recommended by Dr. Gussner on March 1, 2010. Dr. Collins noted that Claimant's subjective complaints are consistent with objective medical findings, and nothing in the record suggests that Claimant is malingering or has secondary gain issues.

35. Dr. Collins noted that Claimant's prior work history in the Navy and for Pinkerton Security were both skilled positions, but were not a realistic snapshot of Claimant's transferrable skills, because neither required the use of computer hardware or software. She opined that, as an older worker with minimal computer skills, Claimant's opportunities for employment in skilled positions were limited before he went to work for Employer.

36. Dr. Collins found that all of Claimant's previous employment, including his work for Employer, was sedentary to light work. She concluded that Claimant would lose access to about 20% of the light work otherwise available as a result of the restrictions from Drs. Nicola and Gussner. If Claimant's limitation on walking precluded him from all light work, his loss of access to the labor market was probably closer to 50%.

37. Dr. Collins also addressed Claimant's potential loss of earning capacity. She observed that he could return to a shuttle driver position, but unless it was with his time-of-injury Employer, his hourly rate would probably be less than he was earning when Employer replaced him. In addition, Claimant's earnings while with Employer were quite high considering his $10.50 per hour wage. Claimant worked a lot of hours (all paid at straight-time rates) in order to earn more than $38,000 per year in the years prior to his June 2007 injury. Claimant's hours dropped somewhat after his first injury, but he still worked in excess of 3168 hours in 2008—almost 1100 hours more than is considered full-time. Dr. Collins concluded that Claimant would suffer a 24% loss of earning capacity based solely on his hourly rate, or closer to 50% if based on his annual earnings.

Dr. Barros-Bailey

38. Dr. Barros-Bailey met with Claimant to review his educational and work history. She also reviewed medical records and Claimant's earning history. Dr. Barros-Bailey determined

that Claimant had no permanent work restrictions as a result of either of his knee injuries, so there was no basis for estimating his disability.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

39. The burden of proof in an industrial accident case is on the claimant.

> The claimant carries the burden of proof that to a reasonable degree of medical probability the injury for which benefits are claimed is causally related to an accident occurring in the course of employment. Proof of a possible causal link is insufficient to satisfy the burden. The issue of causation must be proved by expert medical testimony.

Hart v. Kaman Bearing & Supply, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (internal citations omitted). "In this regard, 'probable' is defined as 'having more evidence for than against.'" *Soto v. Simplot*, 126 Idaho 536, 540, 887 P.2d 1043, 1047 (1994).

40. Here, there is no dispute that Claimant suffered a torn medial meniscus in each of his knees as the result of two industrial accidents, or that each injury resulted in a whole person 1% PPI rating (2% combined). The claims were accepted and Claimant received medical care and time loss benefits. Two primary issues remain in dispute:

- Whether all of Claimant's 2% whole person PPI was caused by the industrial accidents, or whether some percentage of that impairment is apportionable to the asymptomatic degenerative arthritis that pre-existed the acute knee injuries; and
- Whether, and to what extent, Claimant sustained disability in excess of his impairment as a result of the two accidents.

PPI

41. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of

the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

Dr. Nicola

42. Dr. Nicola was the physician and surgeon who treated Claimant for the acute knee injuries he sustained in each of the industrial accidents at issue in this proceeding. Dr. Nicola first rated Claimant's impairment for his left knee injury on a form provided by Surety. In response to specific questions, he rated the left knee injury at 1% whole person, with all of the impairment related to the industrial injury. February 1, 2008, just sixteen days after he filled out Surety's rating form, Dr. Nicola wrote the following chart note:

> The patient's impairment would be a 1% impairment for a torn medial meniscus. Unfortunately, the patient has a large amount of degenerative arthritis so apportioned 50% of that due to preexisting condition.

Ex. H, p. 106.

43. On August 24, 2009, Dr. Nicola filled out another rating form from Surety with regard to Claimant's second knee injury. In response to the question of whether Claimant had PPI assignable to the industrial accident, Dr. Nicola marked "Yes" and wrote 1% whole person. In response to the question of whether he would apportion any of that PPI to pre-existing conditions, Dr. Nicola marked "No."

44. Taken at face value, it appears that Dr. Nicola would rate Claimant's PPI at 2% whole person, but would apportion .5% of that rating to Claimant's pre-existing degenerative

condition in his left knee. Dr. Nicola testified that, in all relevant respects, the February 2009 injury (right knee) is basically the same as Claimant previously suffered to his left knee:

- Both involved a torn medial meniscus;
- Both required the same surgery;
- Both knees showed degeneration in the same locations and to a similar degree; and
- The PPI calculation and rating is the same for both knees.

Dr. Nicola's records raise more questions than they provide answers. Is the February 2008 chart note an aberration? Did Dr. Nicola forget that he had already rated the left knee, specifically declining to apportion impairment? If Dr. Nicola believed that apportionment was appropriate for the left knee, why not apportion the right knee? Neither party addressed the confusion about the impairment rating during Dr. Nicola's deposition.

Dr. Gussner

45. Dr. Gussner performed an IME for Claimant and addressed the issue of impairment. Dr. Gussner agreed with Dr. Nicola's impairment rating in all respects except for Dr. Nicola's apportionment of .5% of the PPI on the left knee to a pre-existing condition. Dr. Gussner explained his thinking about the apportionment issue in his deposition:

> Q. [By Ms. Doyle] All right. When you say in your report that you agree with the 1 percent impairment rating for each of his knees, would you apportion any of that out? It doesn't look like from your report that you would apportion –
> A. No, I wouldn't. I was really thinking of the meniscal tear and the resulting partial meniscectomy, that was the industrial injury.
> And 1 percent is as low as you can get for an impairment. If I would have included all the degenerative changes in the knee and the cartilage changes, the impairment would have been much higher. Then I would have apportioned it out.
> I just felt it was much cleaner to just look at the meniscus, and that's what Dr. Nicola did, and that's what Dr. Hassinger did, so I felt that was a reasonable way to look at the impairment.

Deposition of Dr. Gussner, pp. 38-39.

Dr. Hassinger

46. Claimant saw Dr. Hassinger for a second opinion about his left knee after Dr. Nicola had released him from care. Dr. Hassinger agreed that 1% whole person PPI was the correct measure of Claimant's impairment, noting, "I mean, George [Nicola] rated him based on the meniscus, and so, yeah. I mean, that's spot-on with a meniscus rating." Deposition of Dr. Hassinger, p. 29. Dr. Hassinger did not weigh in on the matter of apportionment of impairment.

Finding on PPI

47. Dr. Nicola was inexplicably inconsistent in his handling of Claimant's PPI rating. Two other physicians, Dr. Gussner, a board-certified physiatrist, and Dr. Hassinger, a board-certified orthopedist, both agreed that the appropriate rating for a torn meniscus was 1% whole person for each knee. Dr. Gussner explained that because the rating Dr. Nicola gave was limited to impairment that arose as a result of the torn meniscus, none of the PPI should be attributed to Claimant's pre-existing degenerative condition. Dr. Hassinger did not explicitly discuss apportioning the PPI rating between the industrial injuries and the degenerative condition. But his comment that Dr. Nicola's rating was "spot-on" for a meniscal tear supports the view that the industrial injuries were separate from the pre-existing arthritis. There is nothing in the record to suggest that the pre-existing degenerative arthritic condition contributed in any way to the meniscal tears caused by the industrial accidents. The Commission finds that all of the 2% whole person impairment awarded Claimant relates to Claimant's industrial meniscus injuries.

DISABILITY

48. Under the Idaho Worker's Compensation Law, a "disability" is defined as "a

decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors." Idaho Code § 72-102(11). A claimant's permanent disability rating is determined by appraising the combined effect of those medical and nonmedical factors on the "injured employee's present and probable future ability to engage in gainful activity." Idaho Code § 72-425.

49. The issue of Claimant's PPI rating was relatively straightforward, but the matter of disability is more complicated. Physician-imposed work restrictions are the starting point in evaluating disability, because they set the stage for a discussion about access to the labor market and earning capacity.

Dr. Nicola

50. Dr. Nicola did not dispute that Claimant's knees restricted his activities. In his deposition, he agreed that Claimant was limited in walking, running, climbing stairs, and standing. But Dr. Nicola opined that these restrictions were the result of Claimant's degenerative arthritis, not his industrial injury. Dr. Nicola did not impose prescriptive restrictions regarding Claimant's degenerative arthritis, because he believed that Claimant's arthritis was self-limiting, *i.e.*, Claimant could do whatever he could do without causing undue discomfort.

Dr. Hassinger

51. Dr. Hassinger agreed that Claimant had functional limitations as a result of his degenerative knee condition. He discussed his general philosophy about restrictions in a case like Claimant's, but noted that he did not discuss the subject of restrictions with Claimant. Dr. Hassinger testified regarding his ambivalence about restrictions:

> Q. [By Mr. Owen] . . . I'm wondering if you feel that it would have been appropriate to put restrictions on [Claimant] for walking, standing, activities of that sort?

> A. That's—you know, that's hard to say. What I'll often do with somebody with knee arthritis—and, you know, this is outside of the comp setting—but I'll tell people, "You can do whatever you feel like doing."
>
> Because from an objective orthopedic standpoint the horse is out of the barn. If your knee is gone, your knee is gone. And if you go out and run a marathon, it's not going to be more gone. At some point you're going to need a knee replacement or some kind of intervention.
>
> From a functional standpoint, though, those people are going to be limited. It's just hard to put—and I'm always leery of putting objective, you know, restrictions on somebody when it's such a subjective problem.
>
> Some people with terrible knee arthritis can go out and run marathons and other people can't walk out to get the mail, so it makes it—I didn't talk to him specifically about it.

Deposition of Dr. Hassinger, pp 15-16. Dr. Hassinger also noted that he did not like to restrict physical activity in patients, because he viewed cardiovascular fitness to be a higher priority than making an arthritic joint last a few more years, noting, " . . . you could be dead with a good knee. . . . You might live a long time with a bad knee . . ."

Dr. Gussner

52. Dr. Gussner disagreed with both Drs. Nicola and Hassinger on the need for permanent restrictions. He also recognized that Claimant's degenerative condition was self-limiting in some respects. He accepted at face value (as did Drs. Nicola and Hassinger) Claimant's statements that his knees limited his ability to walk distances, climb stairs and ladders, and to sit or stand for extended periods. Dr. Gussner explained his thinking in the course of his deposition:

> In my practice if somebody has significant degenerative arthritis, if they've had surgery and they're still symptomatic, I always give restrictions. Because I feel that there is an increased risk for tissue damage, increased risk for degenerative arthritis and posttraumatic arthritis.

Deposition of Dr. Gussner, p. 28. Dr. Gussner was particularly concerned about Claimant's increased risk of post-traumatic arthritis because of the knee injuries and surgeries. Dr. Gussner opined that Claimant's industrial injuries were responsible for lighting up his asymptomatic

degenerative arthritis, and that the meniscal tears would permanently aggravate the pre-existing degeneration.

Finding on Restrictions

53. After carefully reviewing the chart notes and deposition testimony of the three physicians, the Commission concludes that Claimant does have work restrictions as a result of the industrial accidents. The Commission finds Dr. Gussner's opinions convincing, particularly with regard to effect of the industrial trauma superimposed on the pre-existing degenerative condition. Dr. Nicola's assertion that the torn menisci and invasive surgery played no part in Claimant's on-going knee pathology does not persuade the Commission.

Evaluating Claimant's Disability

Dr. Barros-Bailey

54. Dr. Barros-Bailey determined that Claimant sustained no disability in excess of his impairment based on the fact that Dr. Nicola imposed no permanent restrictions. When asked during her deposition to consider disability in light of Dr. Gussner's limitations, she maintained that Claimant suffered no disability in excess of impairment. Her explanation—that Claimant did not engage in the prohibited activities in his time-of-injury position, so they did not restrict his access to the job market—is faulty where there is no time-of-injury job for Claimant to return to. Because Dr. Barros-Bailey concluded Claimant had no restrictions and no disability, she offered no analysis that aids in evaluating Claimant's disability.

55. Dr. Collins performed a more comprehensive disability analysis, although as noted during her deposition, she mistakenly relied on temporary restrictions imposed by Dr. Nicola in reaching some of her conclusions. Dr. Collins recognized that Claimant's disability included both the industrially-related restrictions imposed by Dr. Gussner, and the

functional restrictions discussed by Drs. Nicola, Hassinger, and Gussner that related to Claimant's degenerative knee condition. In addition, Dr. Collins accounted for Claimant's age, his lack of marketable skills, and his relative lack of competitiveness in a difficult labor market.

56. Dr. Collins opined that if Claimant could find work utilizing his current skills, he would likely earn between $8.00 and $9.00 per hour compared to his time-of-injury wage of $10.50. Expressed as a percentage, the reduction in hourly wage represents a 24% loss (based on $8.00 per hour and 3708 hours—the number of hours worked in the year prior to his first injury). Alternatively, Dr. Collins calculated the percentage earnings loss if he were only able to work a standard number of hours (2080), and concluded that could result in a 50% reduction in his earning capacity.

57. Dr. Collins also addressed Claimant's loss of access to the labor market caused by his industrial injuries. Dr. Collins determined that, pre-injury, Claimant was able to perform both light and sedentary work. In her deposition, Dr. Collins testified that light and sedentary jobs make up about 60% of the labor market. She noted that because of Claimant's limited skills, he would not have had access to all the light and sedentary work available even before his injuries. Dr. Collins calculated that Dr. Nicola's restrictions would eliminate about half of the light jobs Claimant was qualified for pre-injury—an overall 20% loss of access to the labor market. When made aware of her error in using Dr. Nicola's temporary restrictions, she conceded that Claimant's loss of access might be slightly less using Dr. Gussner's restrictions.

Findings on Loss of Earning Capacity and Market Access

58. The Commission finds that Dr. Collins' more conservative estimate of 24% loss of earnings is the best measure of Claimant's actual earnings loss. Claimant is not restricted in the number of hours he can work, only in some of the activities he can perform. Based on his

work history, if Claimant were able to find a suitable job, there is no reason to believe that he would choose to limit his hours, so the loss of hourly wage represents the best measure of Claimant's loss of earning capacity.

59. Dr. Collins estimated a 20% loss of labor market access based on Dr. Nicola's temporary restrictions. While Dr. Collins may have misunderstood the temporary nature of Dr. Nicola's restrictions, it was not inappropriate for her to consider Claimant's permanent *functional* limitations (upon which all three physicians agree) as one of the relevant factors affecting Claimant's future ability "to engage in gainful activity." Idaho Code § 72-102(11). Dr. Collins concluded that, if she considered Claimant's functional limitations in walking, standing, or sitting for prolonged periods, he would be limited to sedentary jobs, which constitute about 22% of the jobs in the Boise labor market. Collins deposition, p. 11. She calculated that sedentary work only would result in a 50% loss of labor market access.

60. The Commission finds 50% to be a reasonable estimation of Claimant's actual loss of labor market access. Claimant's functional limitations on walking and standing, and his need for frequent changes from sitting to standing, limit him to sedentary work. If Claimant were qualified for all sedentary jobs, which he is not, the percentage loss of access would exceed 63%. Since Dr. Collins calculated only a 50% loss of market access, she clearly considered only those sedentary positions for which Claimant was qualified. Claimant's functional restrictions may not be industrial, but it is appropriate to consider all relevant factors in evaluating Claimant's permanent disability.

61. Dr. Collins averaged the figures for loss of earnings and loss of access, and opined that Claimant's disability ranged from 22% to 35%, depending on whether she used wages or earnings to calculate the percentage loss of earning capacity. Using Dr. Collins'

methodology of averaging Claimant's loss of earning capacity (24%), and his loss of access to the labor market (50%), results in a disability rating of 37%, inclusive of impairment.

62. Averaging loss of market access and earning capacity is a "quick and dirty" method for calculating disability, but it is not the only method. Averaging gives earning capacity equal weight with all of the other factors that affect employability—age, skills, education, physical limitations, presentation, language fluency, etc. Averaging can inflate the relative impact of earning capacity when it is but one factor to consider in the Commission's disability calculation. In the case at bar, however, averaging actually paints the most accurate picture of Claimant's permanent disability—his loss of earning capacity is relatively small when figured on an hourly basis, while his loss of access to the labor market is substantial because of the number of impediments that contribute to the figure. The Commission finds that Claimant's permanent disability rating is 37%, inclusive of impairment.

APPORTIONMENT

Idaho Code § 72-406 provides:

> **72-406 – Deductions for preexisting injuries and infirmities.**
> (1) In cases of permanent disability less than total, if the degree or duration of disability resulting from an industrial injury or occupational disease is increased or prolonged because of a preexisting physical impairment, the employer shall be liable only for the additional disability from the industrial injury or occupational disease.
> (2) Any income benefits previously paid an injured workman for permanent disability to any member or part of his body shall be deducted from the amount of income benefits provided for the permanent disability to the same member or part of his body caused by a change in his physical condition or by a subsequent injury or occupational disease.

Pursuant to the specific language of the statute, a prerequisite to apportionment of disability is the existence of a "pre-existing physical impairment." Here, the medical record establishes that Claimant suffered from a bilateral degenerative arthritis of the knees which

clearly pre-dated the earliest of the subject accidents. Moreover, it is clear that these degenerative changes, standing alone, were of the type that would have qualified Claimant for an impairment rating, at least as of the date of Dr. Gussner's examination of Claimant.

> Q. All right. When you say in your report that you agree with the 1 percent impairment rating for each of his knees, would you apportion any of that out? It doesn't look like from your report that you would apportion - -
>
> A. No, I wouldn't. I was really thinking of the meniscal tear and the resulting partial meniscectomy, that was the industrial injury.
>
> And 1 percent is as low as you can get for an impairment. If I would have included all the degenerative changes in the knee and the cartilage changes, the impairment would have been much higher. Then I would have apportioned it out.
>
> I just felt it was much cleaner to just look at the meniscus, and that's what Dr. Nicola did, and that's what Dr. Hassinger did, so I felt that was a reasonable way to look at the impairment.

It is less clear whether Claimant's degenerative arthritis would have entitled him to an impairment rating had his condition been rated prior to the subject accidents. The evidence established, after all, that although the degenerative conditions were extant prior to the subject accidents, Claimant was altogether asymptomatic prior to the first accident. However, review of the relevant sections of the *AMA Guides to the Evaluation of Permanent Impairment* (6th ed.) suggests that Claimant would qualify for an impairment rating for his bilateral knee arthritis prior to the first accident, even though he was asymptomatic. See *AMA Guides to the Evaluation of Permanent Impairment* (6th ed. 2008) at ch. 16. Even so, testimony necessary to quantify or calculate that rating was never adduced from any of the treating or evaluating experts. Notwithstanding this failure, evaluation of the issue of apportionment will proceed on the basis that the evidence is sufficient to establish the existence of a pre-existing physical impairment of some type, such that consideration of I.C. § 72-406 is appropriate. Therefore, the question before the Commission is whether the extent or degree of Claimant's disability was increased by virtue of his pre-existing degenerative arthritis.

It is important to note that although Claimant does have evidence of significant pre-existing degenerative knee arthritis, the record fails to disclose that Claimant had any symptoms from his bilateral knee condition prior to the first of the subject accidents. As of the date of hearing, however, Claimant did have significant limitations/restrictions as a result of his bilateral knee injuries, as discussed above. Claimant's current limitations/restrictions derive not only from the work-related meniscal injuries, but also from the severe underlying degenerative changes in his knees. Per Dr. Gussner, Claimant's current limitations/restrictions are half related to the meniscal injuries, and half related to the underlying degenerative arthritis. However, a closer examination of the relevant medical opinions demonstrates that the subject accidents are responsible for creating the limitations that currently apply as a result of Claimant's underlying degenerative changes. First, there was substantial medical testimony establishing that the underlying degenerative changes noted in Claimant's knees bilaterally, were of a type that sometimes cause significant symptoms. Absent the occurrence of the subject accidents, however, and neither Dr. Nicola, Dr. Gussner, nor Dr. Hassinger, could say, without speculating, when, or if, Claimant's underlying degenerative knee condition would have become symptomatic. What we do know, however, is that at the present time Claimant does have symptomotology which is referable, at least in part, to his underlying degenerative knee condition. The question that arises is whether these symptoms arose coincidentally, or as a result of something that the subject accidents did to light up or aggravate Claimant's underlying degenerative condition. Dr. Gussner has clearly articulated his opinion that the subject accidents did permanently aggravate Claimant's underlying degenerative problems, causing them to become symptomatic, and resulting in the need to impose significant permanent limitations/restrictions (Gussner deposition 10/22-11/22; 39/22-40/14; 41/3-41/15). Dr.

Hassinger, too, felt that the subject accidents exacerbated Claimant's underlying condition by causing an "inflammatory cascade" that resulted in the previously asymptomatic underlying condition suddenly becoming symptomatic. (Hassinger deposition 13/21-15/10). Only Dr. Nicola refused to acknowledge the possibility that the subject accident aggravated Claimant's underlying arthritis. However, even Dr. Nicola acknowledged that Claimant is entitled to limitations/restrictions as a result of his underlying arthritis, and even Dr. Nicola acknowledged that it is impossible to know whether Claimant would have these limitations/restrictions if the subject accidents had not occurred.

The Commission finds the views of Dr. Gussner to be more persuasive and better reasoned than those of Dr. Nicola. The Commission finds that the subject accident did aggravate or light up Claimant's underlying degenerative arthritis, causing that previously asymptomatic condition to become symptomatic, and require the imposition of permanent restrictions. Therefore, those current limitations/restrictions that are, in some sense, referable to the underlying degenerative process, are actually part and parcel of the Claimant's accident produced limitations/restrictions, since it was the accident that caused the Claimant to require restrictions related to his underlying degenerative arthritis.

Based on the foregoing, the Commission finds that Claimant has met his burden of persuasion on the issue of whether he has suffered disability referable to the subject accident. Defendants, in turn, have failed to adduce evidence that a portion of Claimant's disability is, in fact, referable to a pre-existing physical impairment. Neither the degree of pre-existing permanent physical impairment has been proven, nor the fact that some part of Claimant's disability is referable to that pre-existing permanent physical impairment. In short, Defendants have failed to prove that Claimant was entitled to limitations/restrictions on the pre-injury basis

which might have impacted his ability to access the labor market, and earn a competitive wage. To the contrary, the best medical evidence tends to establish that Claimant's current limitations/restrictions, and hence his disability, are entirely referable to the accidents which damaged his menisci bilaterally, and permanently aggravated his underlying degenerative arthritis. The Commission finds that the entire 37% disability rating is referable to the subject accidents.

RETENTION OF JUDISCTION

Claimant has requested that the Industrial Commission retain jurisdiction over this matter to consider whether Claimant is entitled to additional indemnity benefits in the future following the anticipated need for bilateral total knee arthroplasties. Defendants have pointed out that Claimant's entitlement to future medical treatment is not among the noticed issues, and, accordingly, request of the Commission that it deny the request to retain jurisdiction. Although Defendants correctly note that Claimant's entitlement to future medical care is not a noticed issue, Claimant's entitlement to indemnity benefits is. A casual perusal of the *AMA Guides to the Evaluation of Permanent Impairment* compels recognition that even successful total knee arthropasties may result in additional impairment and disability owed to Claimant. The Commission has found Dr. Gussner's opinion on causation to be more persuasive than the views expressed by Dr. Nicola. Dr. Gussner has concluded that the subject accidents did aggravate Claimant's underlying degenerative arthritis. Dr. Gussner has also concluded that Claimant will likely require bilateral total knee arthroplasties, and that the need for such procedures has been accelerated as a result of the subject accidents. Of course, whether Claimant is entitled to this treatment as a result of the subject accidents is unknown, since no physician has recommended that Claimant is a current candidate for knee replacement surgery. Moreover, if, and when,

Claimant does become a candidate for total knee replacement surgery, it may be as a result of the subject accidents, or, some type of intervening event that may supersede the impact of the subject accidents. Claimant's entitlement to total knee replacement surgery under the subject claims, must await future determination. However, because the facts before the Commission do admit a scenario that would leave Claimant entitled to future indemnity benefits following total knee replacement surgery, we believe it appropriate to retain jurisdiction of this matter since Claimant's impairment may indeed be progressive, thus entitling him to additional impairment and disability benefits. (See *Brooks v. Duncan*, 96 Idaho 579, 532 P.2d 921 (1975); *Horton v. Garrett Freight Lines, Inc.,* 106 Idaho 895, 684 P.2d 297 (1984). In the event that a future hearing results in a finding that Claimant is entitled to knee replacement surgery related to the subject accidents, it would be unfair to deny Claimant the opportunity to pursue a claim for additional indemnity benefits referable to such a procedure or procedures.

CONCLUSIONS OF LAW

1. Claimant is entitled to Permanent Partial Impairment of 1% whole person for each knee, for a total PPI of 2%, all attributable to the industrial injuries;
2. Claimant is entitled to Disability, inclusive of impairment, of 37% of the whole person;
3. None of Claimant's disability is apportionable to a pre-existing physical impairment;
4. The Commission retains jurisdiction to consider a claim for additional impairment and disability, which may be progressive

DATED this __8th____ day of February, 2011.

INDUSTRIAL COMMISSION

_/s/_____
THOMAS E. LIMBAUGH, Chairman

_/s/_____
THOMAS P. BASKIN, Commissioner

_/s/_____
R.D. MAYNARD, Commissioner

ATTEST:

_/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _8th__ day of February, 2011, 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:

RICHARD S. OWEN
PO BOX 278
NAMPA ID 83653-0278

KIMBERLY DOYLE
PO BOX 6358
BOISE ID 83707-6358

amw _/s/_____