BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MEGAN KELLY, Claimant, v. LIFE CARE CENTERS OF AMERICA, Employer, and OLD REPUBLIC INSURANCE CO., Surety, Defendants.	**IC 2008-035577** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** February 17, 2012

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee LaDawn Marsters, who conducted a hearing in Coeur d'Alene, Idaho on March 15, 2011. Claimant, Megan Kelly, was present in person and represented by Starr Kelso, of Coeur d'Alene. Defendant Employer, Life Care Centers of America, and Defendant Surety, Old Republic Insurance Company, were represented by Lora Rainey Breen, of Boise. The parties presented oral and documentary evidence. Post-hearing depositions were taken and briefs were later submitted. The matter came under advisement on December 13, 2011.

ISSUES

The issues to be decided by the Commission as the result of the hearing are:

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

2. Whether Claimant is medically stable and, if so, the date thereof;

3. Whether and to what extent Claimant is entitled to medical care; and

4. Whether and to what extent Claimant is entitled to attorney fees pursuant to Idaho Code § 72-804.

CONTENTIONS OF THE PARTIES

Claimant contends that she is entitled to surgery on her right knee to definitively diagnose and repair damage she sustained in a fall at work on October 28, 2008. She relies upon the surgical recommendation of Dr. King, one of her treating physicians. She also posits that Dr. King's later reversal of that recommendation is the result of a calculated effort on Defendants' part to frighten him or to otherwise unduly influence his medical opinion and, thus, his earlier opinion should be given more evidentiary weight.

Defendants counter that Claimant's long-standing history of significant right knee pathology, not her fall at work, is the root of her persistent symptomatology. They rely upon the medical opinions of Drs. King, McInnis (also a treating physician) and Provencher (an IME physician) to establish that Claimant's right knee symptoms related to her work accident were temporary in nature and have healed. They further assert that Claimant is not a credible witness and, thus, her reports and testimony should carry no evidentiary weight.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Joint Exhibits 1 through 26, admitted at the hearing;[1]

2. The testimony of Claimant, Philip Robinson and Linda Payne, taken at the hearing;

[1] Exhibit 16 consists of only a DVD recording without audio commentary. The accompanying report was removed from evidence at the hearing, by stipulation of the parties.

3. The post-hearing steno and video deposition testimony of Jonathan S. King, M.D., taken April 28, 2011, and July 14, 2011, respectively;

4. Exhibit 2 to Dr. King's video deposition, the post-hearing admission into evidence of which the parties stipulated at that deposition; and

5. The post-hearing deposition testimony of Stacey Davis, physical therapist, taken April 27, 2011.

OBJECTIONS

The objections of Defendants evidenced on pages 108, 109 and 140 of Dr. King's deposition are sustained. Further, Defendants' objection to the post-hearing admission into evidence of Exhibit 5 to Dr. King's deposition is sustained. All other pending objections are overruled.

After having considered the above evidence and the arguments of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

1. At the time of the hearing, Claimant was 27 years of age and a single mother of five. She is a former competitive soccer player, having played on a competitive travelling team based in California for several years, concluding in 2004.

2. From January 3, 2008, until approximately December 11, 2008, Claimant worked for Employer as a certified nursing assistant (CNA). That job required her to attend to and care for patients, which involved transferring them, for example, from bed to wheelchair. On September 29, 2008, she was commended in an employee review for compassionate care of her patients, her willingness to learn new things, take on more hours, and help others, among other things. She was also notified of areas that needed improvement, including attendance (she was

placed on a 90-day probation for excessive absences and tardiness on September 8, 2008), inability to leave her personal issues at home ("personal life overwhelms"), dependence on others ("do more by yourself") and team-building. JE 22, pp. 508, 511.

3. While on duty on October 28, 2008, Claimant tripped over a bed crank, injuring her right knee. She explained that the crank was approximately six to eight inches long and a little higher off the ground than her ankle-height. Claimant testified at the hearing that she fell directly onto her right knee, which she reported to Dr. King on November 20, 2008 (see below). However, Claimant's initial medical records only indicate that she fell and hyperextended her knee.

4. The pain from her fall brought tears to Claimant's eyes. She got up and immediately went to the nurse, where Claimant testified she first noted swelling. After completing her charting for the day, Claimant's mother drove her to Kootenai Medical Center for treatment. Claimant's related medical treatment, as well as her relevant prior medical history, are detailed below.

5. Claimant returned to light-duty work on November 11, 2008. Her last paycheck from Employer was issued on December 11, 2008, and Claimant has not been employed since then.

6. From September 2008 through mid-February 2009, Claimant was the respondent in a legal action involving her children. She was required to appear in court in this action for 16 unconsecutive days throughout this period. She testified on approximately eight of those days. Her testimony in that case was witnessed by Phil Robinson, who testified at the hearing in this matter about some of his observations of Claimant following her industrial accident.

CLAIMANT'S PRIOR MEDICAL HISTORY

7. Claimant has a history of significant right knee pathology:

a. In July 1997, Claimant was treated for significant right knee pain and inability to straighten her knee. No swelling, bruising or effusion was noted, and x-rays were negative. A contusion was diagnosed and a knee splint was prescribed. (*See* JE 2, p. 9). Claimant testified that she sustained this injury by striking her right knee on a removable hardtop for a car, inside a garage, attempting to knee a soccer ball to her brother.

b. In November 1999 and July 2000, Claimant noted on medical intake sheets that she was under a physician's care for "knee dislocation" and "knee problems", respectively. (*See* JE 2, pp. 16, 18). She testified that, at the time, her knee felt like it was dislocating, but the physician said it had not dislocated.

c. In September 2002, a chart note by a California physician noted Claimant's right knee problems in the medical history section. "She has a very serious problem with her right knee with some ligament tears. She played soccer at a very high level and had recurrent knee injuries. This has been a chronic problem for her to the point where she has trouble walking and putting full weight on the right knee." (*See* JE 3, p. 19). He further noted that Claimant avoided weight-bearing on her right leg. "She can walk, but when she bears weight on her right leg she gets off it quickly because of her knee." (*Id.*, p. 20). Claimant testified that she does not recall this appointment and that she does not recall ever having trouble walking.

d. In June 2006, Bonner General Hospital notes state Claimant was diagnosed with internal derangement of the right knee after she heard/felt a "pop" and fell to the ground after descending stairs and bending down to pick up a child. She reported a history of right knee ACL tear. Claimant was released with a knee brace, crutches and medications. (*See* JE 4, pp. 82-84). Claimant does not remember the details of this incident clearly. She testified that she does not know the meaning of "internal derangement." Tr., p. 71.

e. In July 2006, Bonner General Hospital notes indicate Claimant has a past history of partial right knee ACL tear and chronic right knee pain worsened by climbing or descending stairs. (*See* JE 4, pp. 88-89). Claimant testified that she did not recall that stairs were an issue during this time period.

f. On February 9, 2008, Claimant was treated at Valley Hospital for a "[r]ight knee sprain with possible anterior cruciate ligament tear." She was unable to fully extend that knee, was placed in an Ace wrap and was prescribed medications. She reported her injury occurred when her right knee hyperextended while descending stairs, causing her to fall and twist her right ankle. Claimant was unable to fully extend her right knee or bear weight on her right leg, and she

reported right ankle pain. (*See* JE 7, p. 222). At the hearing, Claimant did not recall this incident.

g. Four days later, on February 13, 2008, Claimant again sought medical treatment for her right ankle. She reported to care providers at North Idaho Medical Care Center (NIMCC) that she rolled her right ankle when a patient fell on it. Claimant was diagnosed with a sprain and prescribed with an air splint, crutches, Vicodin and Motrin. There is no indication from the chart notes concerning Claimant's care for her sprained ankle, or that she ever reported the prior, non-industrial, right ankle twist on February 9. (*See* JE 9, pp. 247-253). Claimant did not recall this incident, or that she had obtained any follow-up treatment (records reflect follow-up on February 21, 2008). With respect to workers' compensation, she asked Defendants' counsel, who was questioning her at the hearing, "What is a work comp [*sic*] claim?" Tr., p. 74.

h. On September 28, 2008, Claimant was again treated for a right knee injury at NIMCC. According to the chart note, Claimant "[t]ripped on a mat & fell [illegible] forward with [right] knee hyper[-]extended against a bedrail…Now has pain [right] knee – mostly medially." The note also indicates Claimant tore her ACL in eighth grade but has had no surgery or resulting sequelae. She was diagnosed with a right knee strain. (*See* JE 9, pp. 258-259).

8. So, prior to her industrial accident, Claimant had a documented right knee history of ACL tear, chronic pain worsened by climbing and descending stairs, avoidance of weight-bearing, internal derangement, reliance on walking aids (crutches and braces), prescription medications, inability to fully extend the knee, dislocation, hyperextension and multiple falls.

9. Claimant also has a significant history of low back pathology with neuropathy symptoms and other medical conditions that are not relevant to the resolution of the claims to be decided herein.

INDUSTRIAL ACCIDENT AND SUBSEQUENT MEDICAL EVENTS

10. On October 28, 2008, Claimant sought medical treatment for her right knee at Kootenai Medical Center (KMC). "[A]fter running into the crank of a bed, [she] hyperextended her knee, has distal crepitus of the knee and … pain with walking." JE 6, p. 184. Claimant reported no pain without movement, but 7-8/10 pain with movement. She reported "no other

injury or trauma that she knows of" and "that the knee does feel as if it is going to give way on her." *Id.* As for past medical history, Claimant only reported a partial torn ACL in her right knee and lumbar disc disease.

11. On examination, Claimant demonstrated full range of motion in her right knee, no ligament instability, minimal swelling, some tenderness both medially and laterally, and crepitus with normal tracking of the patella. X-ray imaging was normal.

12. The attending physician (Dr. Johnson) diagnosed a right knee sprain and provided a knee brace, hydrocodone and Motrin. He released Claimant to work without restrictions and recommended follow-up with her "Worker's Comp [*sic*] doctor and return if symptoms worsen." JE 6, p. 184.

13. Two days later, Claimant followed up at NIMCC, reporting that she had "tripped over crank on bed at work – hyperextended knee." JE 9, p. 266. She reported a past history of "partial [right] ACL tear in High School [*sic*]." *Id.* Dr. Johnson noted Claimant had swelling and walked with an antalgic gait. He continued her medications and splint, restricted her to limited walking with no kneeling or squatting and no patient transfers. He also noted that physical therapy and an MRI may be considered in the future.

14. Claimant again followed up at NIMCC (Dr. Hjeltness) on November 6, 2008 for "hyperextension" of her right knee. JE 9, p. 270. Again, the only prior history noted was Claimant's high school ACL tear. No swelling was observed, but Claimant walked with an antalgic gait, indicated ligament pain on medial stress, and reported that she was not getting better. Dr. Hjeltness revised Claimant's diagnosis to "[right] knee strain MCL patellar contusion", continued her medications, knee brace and restrictions, and scheduled her for a follow-up appointment twelve days later. JE 9, pp. 270-272.

15. On November 13, 2008, Claimant followed up at NIMCC, again with Dr. Hjeltness. She reported "[b]urning behind knee, if bends all the way gets stuck" after "knee locked [yesterday] [with] hyperflexion." JE 9, pp. 272-273. Claimant continued to walk with an antalgic gait, to demonstrate no observable swelling and to have ligament pain with medial stress. In addition, she now evidenced anterior ligament laxity, through a positive anterior drawer test. Dr. Hjeltness ordered an MRI to rule out a meniscal tear and continued Claimant's restrictions and medications.

16. On November 17, 2008, Claimant's knee locked when she got out of the shower and bent over. She sought emergent treatment at KMC because she could not straighten it out. Claimant reported to KMC staff that "[t]his had happened twice before, but she was able to straighten it on those previous occasions." JE 6, p. 188. She reported past medical history of lumbar disc disease and right ACL tear in high school, which healed. Right knee pain due to locked meniscus was assessed, medication was prescribed and restrictions were issued.

17. One final time, on November 18, 2008, Claimant followed up at NIMCC, apparently with Dr. Hjeltness. He noted that Claimant walked with an antalgic gait, that she had a positive anterior drawer test, and that she had ligament pain with medial stress. He further noted Claimant reported pain and a locking sensation with walking and that she was unable to bear weight on her right knee. Under past history, he simply circled "negative" on the preprinted form. *See* JE 9, p. 278. Dr. Hjeltness diagnosed internal derangement of the right knee, continued medications and restrictions, ordered an MRI and referred Claimant to Jonathan King, M.D., an orthopedic surgeon.

DR. KING

18. Dr. King first saw Claimant following her shower incident (see below), which occurred on November 17, 2008, nearly three weeks after her workplace accident. By then, Claimant's swelling from her industrial accident had long-since become unobservable to Dr. Hjeltness and she had developed new symptoms that documentation establishes were not present following the industrial accident, including locking of the knee, anterior laxity and instability.

19. Claimant's first examination by Dr. King occurred on November 20, 2008. He noted only lumbar disc disease in the past medical history section of his chart note. He observed that Claimant was limping and on crutches, and his exam was limited due to swelling and Claimant's inability to relax her knee (guarding). He was not able to evaluate her patellofemoral tracking. Nevertheless, he noted an abnormal range of motion, tenderness without laxity along Claimant's MCL, minimal pain with MCL stress and medial joint line tenderness.

20. Dr. King also reviewed Claimant's MRI report of November 18, 2008. It demonstrated chondromalacia of the patellar articular cartilage along Claimant's medial facet and did not exclude a full-thickness tear. It also identified "[m]inimal edema in Hoffa's fat pad…[that]…can be seen with acute or repetitive injury." JE 13, p. 321. The MRI also confirmed that Claimant's meniscus and ligaments were uninjured.

21. According to his chart note, Dr. King discussed with Claimant possible surgical interventions *if* she had a full-thickness articular cartilage tear:

> I discussed with the patient that with a possible full thickness cartilage injury, she may not improve unless she has an arthroscopy with debridement of the chondral injury. Debridements of patellar cartilage injuries are often successful. However, if this fails, she may require a 2nd surgery which would be an OATS procedure or ACI. We discussed all of her options, [*sic*] the only non-surgical option I can offer her today is a cortisone injection which may or may not improve her symptoms but it may at least help us examine her better today since it will be mixed with

> lidocaine and marcaine. She understands all the risks and benefits and would like to try a cortisone injection today.

JE 14, 325.

22. Dr. King administered a cortisone injection. Afterward, he noted a broader range of motion in Claimant's right knee, still restricted by pain. He recommended physical therapy, desk work and medication for one month, after which he surmised, "if she is still symptomatic at that time, the next step would be right knee arthroscopy, chondroplasty patella." JE 14, p. 325.

23. Dr. King examined Claimant again on December 18, 2008. Claimant reported that an emergency room physician told her that she may have dislocated her patella laterally; however, there is no indication of a timeframe for this communication, and none of Claimant's post-October 28, 2008, medical records reflect such an assessment. Claimant described pain in her right knee with popping and catching and limited range of motion with both flexion and extension. She also reported that her pain improved with taping by her physical therapist. Dr. King, again, was unable to perform a full examination. "Patient is guarding excessively and I am not able to evaluate patellar stability or laxity." JE 14, p. 326. He assessed a right knee patellar chondral injury with a possible medial patellofemoral ligament sprain and lateral instability.

24. Dr. King recommended more physical therapy and discussed appropriate surgical procedures in the event it turned out she required surgical intervention. Due to her pain symptoms, Dr. King recommended no weight-bearing on Claimant's right lower extremity and, accordingly, no driving. He added, "She can certainly weight bear [*sic*] as tolerated as her symptoms allow but at this point, she is too symptomatic." JE 14, p. 326.

25. On January 20, 2009, Claimant still reported significant pain, crepitus and feelings of instability, so, during a telephone conversation, Dr. King recommended arthroscopic

surgery to repair Claimant's right knee articular cartilage, to evaluate her patellar tracking and, *possibly*, to perform other procedures in the event additional pathology was identified. In a letter to Claimant's attorney at the time, Dr. King confirmed his surgical plans and that he had sought Surety's approval.

26. On February 3, 2009, Dr. King again examined Claimant. Although this examination, like the others, was limited due to Claimant's guarding, he was able to ascertain more information than he could in prior exams. As a result, Dr. King limited his assessment, now doubting that Claimant's knee was unstable. He scaled back the scope of what he expected to encounter at surgery, but his basic plan did not change; he still recommended surgery to repair Claimant's patellar articular cartilage and to observe whether any other pathology existed.

27. Dr. King explained at his deposition that he recommended surgery based on minimal objective findings combined with Claimant's consistent complaints of significant pain and related inability to perform activities of daily living. Since conservative treatment had failed, he opined that surgery was the appropriate next step in identifying and repairing her injury. He sought Surety's approval because he (erroneously) believed that all of Claimant's right knee symptomatology began after her October 28, 2008. work accident. However, after learning that she had a history of significant right knee pathology, he opined that he would need to review all of Claimant's relevant medical records before he could provide an opinion as to whether the subject accident had any causal relationship to Claimant's current symptoms.

28. On February 10, 2009, Dr. King decided not to treat Claimant any longer. He had received a telephone call from an individual he could not identify at his deposition. The caller advised that Claimant was observed walking and driving without apparent difficulty. In a letter

"To Whom It May Concern", Dr. King detailed the call and his decision to discontinue treating Claimant:

> I have recently learned that there is question to whether Ms. Kelly may be participating in more activities of daily living than she is admitting to and there may even be evidence that she has been driving without difficulty as well as walking and again, participating in activities of daily living without difficulty.
>
> This inconsistency in her history is quite concerning, especially due to the fact that her objective medical findings, which is a chondral injury to the patella, are quite minor compared to the subjective pain and limited activity that the patient complains of when I do see her in my office. I am quite concerned that if I perform surgery on this patient, this may not eliminate her symptoms and again, due to the discrepancy of the pain out of proportion to objective medical findings and the fact that there is evolving evidence suggesting that the patient may be much more active than she admits in my office, at this point I would decline to perform any surgery on this patient and respectfully recommend that she find another orthopaedic surgeon to treat her and assume all care at this point.

JE 14, p. 332.

29. Dr. King did not investigate the caller's claims or notify Claimant of his decision to discontinue treating her. Claimant attempts to establish that Dr. King's decision was not medically motivated, but instead was the result of coercion by Defendants. Along those lines, she asserts that Dr. King had a telephone conversation with Defendants' attorney, likely just before he authored his letter. Dr. King testified that he could not remember the conversation, and his records do not reflect it.

30. At his video deposition, Dr. King demonstrated by his demeanor in the face of approximately three hours of aggressive questioning by Claimant's attorney, as well as by the substance of his testimony, that the information conveyed by the caller would not have altered his view of Claimant's case, had she demonstrated adequate objective evidence in the absence of her subjective complaints to support a surgical recommendation. Moreover, his medical

determination not to perform surgery is strongly supported by the opinions of Dr. McInnis and Dr. Provencher, below.

31. Dr. King did not ever see Claimant for himself outside his office and did not investigate the caller's claims before discontinuing his treatment relationship with Claimant. As a result, his records and testimony lack foundation and are unpersuasive to establish that Claimant actually performed functions in excess of what she represented to him she could do.

32. Moreover, Dr. King's testimony is inadequate to establish that Claimant's right knee symptoms on and after November 20, 2008, were caused by her industrial accident of October 28, 2009. He explained at his video deposition what is obvious; that he would need to review all of Claimant's prior medical records related to treatment of her right knee in order to determine the most likely cause of her current symptoms. Since Dr. King was not aware of any prior right knee history, except perhaps a healed ACL tear from Claimant's high school years, he clearly lacked the proper foundational knowledge to provide a causation opinion.

33. Presuming that Claimant's symptoms portrayed to Dr. King were bona fide, there is, nevertheless, no statement in Dr. King's records or post-hearing testimony relating them to the October 28, 2008, accident, rather than to her long history of right knee pathology or to her subsequent shower incident. Dr. King's request for Surety's approval for surgical treatment is inadequate on its own to prove what he did or did not opine regarding the etiology of her condition. Even if it were sufficient, such an opinion would lack foundation, as discussed, above.

DRS. McINNIS AND PROVENCHER

34. Claimant began treating with Dr. McInnis on March 11, 2009. He notes no prior right knee history and relies on Claimant's report that "onset of the symptoms occurred gradually

after an injury or accident. The injury occurred at work." JE 17, p. 368. He also noted Claimant's history and circumstances of her discharge from care by Dr. King. On exam of her right knee, Dr. McInnis noted "no deformity, ecchymosis or swelling. Symmetric hypotrophic bilateral [vastus medialis oblique]." JE 17, p. 369. There was no evidence of crepitus or effusion, and he noted "exaggerated peripatellar tenderness." *Id.* Claimant had full range of motion with evidence of pain on the right, and strength testing was limited by pain. "She does have grossly evident patellar instability, although she does exhibit patellar apprehension." *Id.*

35. Dr. McInnis discussed with Claimant the accusations of malingering communicated to him by Dr. King. She apparently denied them, and Dr. McInnis apparently felt she was being untruthful in her denial. His belief may have colored his opinion at that time that surgical intervention would not be appropriate for her; however, such a bias is not clear because he also explained that he did not believe patellofemoral reconstruction to be a good option because it is unpredictable. Dr. McInnis recommended a functional capacity evaluation (FCE) and a repeat MRI. Upon review of these, he predicted he would recommend an independent medical evaluation (IME).

36. On June 24, 2009, Dr. McInnis again examined Claimant. Her complaints had not changed, and neither had her exam findings. Claimant's new MRI was also basically unchanged, with the exception that the minimal edema in Hoffa's fat pad was no longer noted in this report. Specifically, this MRI demonstrated no evidence of any tears to the meniscus or ligaments, but identified "a focal lesion of articular cartilage of the patellar medial facet without subchondral edema or unstable cartilage fragmentation." JE p. 372.

37. Dr. McInnis interpreted Claimant's FCE results to establish that, even though she had exerted maximal effort on testing, Claimant was unable to complete the tasks required of her

CNA job. Summarizing his opinion that Claimant had reached maximum medical improvement (MMI), was not a surgical candidate, and was unable to return to work as a CNA, Dr. McInnis wrote:

> …Her MRI is unchanged from the previous one and reveals a chondral injury of the medial patella without strong indications for surgery. Surgery (to included [*sic*] cartilage transplantation [OATS or carticel] and possible unloading of the patella via tibial tubercle osteotomy or extensor mechanism realignment) would offer some hope of improvement but would be fairly unpredictable and certainly no guarantee of success. At this time I therefore continue to agree with Dr. King that this is not strongly indicated.
>
> In summary, I conclude that based on her FCE she is unable to perform her job as a CNA and has no strong indications for surgery. She is therefore at maximal medical improvement following months of PT and bracing. I recommend that she be referred for an independent medical evaluation for the purpose of permanent partial impairment rating. She is likely also to benefit from job retraining. I will see her back prn.

JE 17, p. 373.

38. On August 25, 2009, Matthew Provencher, M.D., an orthopedic surgeon, performed an IME examination. Dr. Provencher's *curriculum vitae* (CV) lists awards, publications, and accomplishments that favorably distinguish him as an accomplished practicing orthopedic surgeon. Dr. King confirmed in his deposition that he knows Dr. Provencher as a lecturer/teacher, and considers him to be a national expert in orthopedics. Similarly, Dr. McInnis wrote in a letter to Defendants' attorney on March 2, 2011, that, according to his CV, "Dr. Provencher would appear eminently qualified to make this opinion." JE 24, p. 576.

39. In preparing to render his opinion, Dr. Provencher reviewed Claimant's medical records related to her right knee from both before and after her industrial accident. He also conducted an interview with Claimant and performed an examination.

40. Dr. Provencher's findings on exam were similar to those of Drs. King and McInnis. No joint effusion, erythema, warmth or signs of infection. Significant guarding preventing a full examination. Superficial tenderness in the patellofemoral joint and medial to the patella. No subluxation, no patellofemoral crepitus. Stable ACL. Dr. Provencher also noted symptom magnification. "I think her subjective complaints far outweigh the level of pathology that is present in her knee, both [*sic*] objectively on the MRI scan from November 2008, which is consistent with my examination today." JE 19, p. 429.

41. Dr. Provencher opined that Claimant's industrial accident temporarily exacerbated her knee symptoms, but that she had returned to baseline. Noting that he has an active cartilage replacement practice, Dr. Provencher also recommended no further treatment for her symptoms and no restrictions regarding the October 2008 injury. He did not believe that any surgical intervention would improve Claimant's symptoms, given her level of verifiable pathology.

42. In late October 2009, Dr. McInnis responded to a "fill-in-the-blank" letter composed by Claimant's attorney. The letter sets forth more than three pages of Claimant's medical history, beginning on October 28, 2008, the date of her industrial accident. It does not state her prior medical history and there is no evidence that Dr. McInnis was ever provided with this information before he prepared his response. Given his limited knowledge, Dr. McInnis agreed that Claimant's industrial accident likely aggravated her right knee condition, but disagreed that Claimant needed surgery.

43. Later, Defendants provided Dr. McInnis with Claimant's prior medical records, and he reversed his opinion. Dr. McInnis noted that his prior opinion was entirely based upon Claimant's subjective complaints, and opined that her prior records demonstrate she had

preexisting right knee pathology involving her patellofemoral joint at the time of her industrial accident. Although he vaguely asserted that Claimant's right knee complaints appeared to increase following her industrial accident, he nevertheless recanted his earlier opinion:

> As such, while I do believe that subjectively her symptoms seem to have been worsened following that injury compared to what they were before, I do not believe that there is sufficient objective documentary or radiographic evidence to offer the opinion that there has been an objective and permanent worsening of her condition as a result of that injury.

JE 17, p. 381.

44. Dr. McInnis continued to treat Claimant on two later dates. On June 3, 2010, Claimant's exam findings were essentially unchanged, including Dr. McInnis' opinion that she evidenced exaggerated patellar facet tenderness. She had full range of motion with anterior knee pain and crepitance with deep squatting and marked patellar crepitance on palpation. She had no swelling, ecchymosis or deformity. She also demonstrated focal medial joint line tenderness, the only new finding.

45. As a result, Dr. McInnis recommended a new MRI, which Defendants questioned, given his previous opinion in which he declined to opine that her right knee condition is related to her industrial accident. Without changing his causation opinion, Dr. McInnis apparently convinced Defendants to authorize the imaging, which Dr. McInnis discussed in his chart note related to his final examination of Claimant, on December 15, 2010. He opined the new study demonstrated "evolution of her prior patellar osteochondral injury, with some new subchondral edema." JE 17, p. 385. However, he still did not recommend surgery:

> I re-iterated [*sic*] to her that not every bone or joint problem has an advisable surgical solution. I informed her that her degree of disability and pain has always been in excess of what would by [*sic*] objectively expected. While there are surgical options that could be considered, I personally do not believe she would derive sufficient benefit from surgery to make it worth the risk.

JE 17, p. 386.

He further suggested, based on her representation that she was better when she was in physical therapy, that she may consider paying out-of-pocket to attend more physical therapy or just do it at home on her own. He also recommended that Claimant see a physician who specializes in patellofemoral surgery to possibly obtain a more optimistic opinion about her prognosis.

46. On February 28, 2011, Dr. Provencher supplemented his earlier report after Defendants provided him with additional information concerning Claimant's medical care and her claims in this case. Dr. Provencher set forth his credentials as a patellofemoral surgery specialist, opining that he is qualified to provide the opinion requested by Dr. McInnis. Dr. Provencher detailed the intricacies of patellofemoral cartilage surgery, including the very real possibility that Claimant's condition could be significantly worsened with a failed surgery. With that, he confirmed his earlier opinion that Claimant is not a candidate for such surgery and, in any event, no surgical intervention would be related to her October 2008 injury, which was temporary in nature and has fully healed.

47. In March 2011, Dr. McInnis reviewed Dr. Provencher's report and concurred in his opinion, "…which more or less mirrors my own opinion." JE 24, p. 576.

FUNCTIONAL CAPACITY EVALUATION

48. Claimant underwent an FCE on May 12 and 13, 2009, with Stacy Davis, PT. As reported by Dr. McInnis, above, Ms. Davis opined that Claimant participated with maximum

effort and, nevertheless, she was unable to perform all of the functions required of her job as a CNA.

49. Following the FCE, for a few months in summer 2009, Claimant attended physical therapy sessions with Ms. Davis. Ms. Davis noted that Claimant's prior level of function included playing soccer, running and jumping. She failed to note any prior right knee problems. At her deposition, Ms. Davis, likewise, knew of none of Claimant's preexisting knee problems. Apparently, Claimant did not report any.

DISCUSSION AND FURTHER FINDINGS

The provisions of the Idaho Workers' Compensation Law are to be liberally construed in favor of the employee. *Haldiman v. American Fine Foods*, 117 Idaho 955, 956, 793 P.2d 187, 188 (1990). The humane purposes which it serves leave no room for narrow, technical construction. *Ogden v. Thompson*, 128 Idaho 87, 88, 910 P.2d 759, 760 (1996). Facts, however, need not be construed liberally in favor of the worker when evidence is conflicting. *Aldrich v. Lamb-Weston, Inc.*, 122 Idaho 361, 363, 834 P.2d 878, 880 (1992).

CLAIMANT'S CREDIBILITY

50. A claimant's credibility is always a factor considered in workers' compensation proceedings. Here, the scrutiny is heightened because Claimant's medical records demonstrate that she consistently failed to report her extensive history of right knee pathology when obtaining treatment related to her industrial right knee injury. In addition, Phil Robinson testified, among other things, that Claimant has a reputation for untruthfulness within his professional prosecutorial community and that he observed her walking, both with and without difficulty during the relevant period. Also, Drs. King, McInnis and Provencher all noted subjective complaints in excess of objective findings on exam. Further, a surveillance video arguably

shows Claimant walked and drove with less difficulty than should have been expected, given her presentation to Dr. King during that period.

51. Because this case turns upon the medical evidence, as discussed below, and in preservation of the humane purposes served by the Workers' Compensation Law, the Referee declines to make an invasive and detailed examination regarding Claimant's credibility. It is sufficient to conclude, based upon significant evidence in the record, that Claimant is a poor historian/reporter of her medical history and that her subjective complaints are unreliable indicators of her objectively verifiable right knee pathology. Where otherwise credible evidence contradicts her testimony regarding her medical history or the medical conclusions to be drawn based upon her subjective complaints, that evidence will be afforded more weight.

CAUSATION

The Idaho Workers' Compensation Act places an emphasis on the element of causation in determining whether a worker is entitled to compensation. In order to obtain workers' compensation benefits, a claimant's disability must result from an injury, which was caused by an accident arising out of and in the course of employment. *Green v. Columbia Foods, Inc.*, 104 Idaho 204, 657 P.2d 1072 (1983); *Tipton v. Jannson*, 91 Idaho 904, 435 P.2d 244 (1967).

The claimant has the burden of proving the condition for which compensation is sought is causally related to an industrial accident. *Callantine v.Blue Ribbon Supply*, 103 Idaho 734, 653 P.2d 455 (1982). Further, there must be medical testimony supporting the claim for compensation to a reasonable degree of medical probability. A claimant is required to establish a probable, not merely a possible, connection between cause and effect to support his or her contention. *Dean v. Drapo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine*, *Id*..

The Idaho Supreme Court has held that no special formula is necessary when medical opinion evidence plainly and unequivocally conveys a doctor's conviction that the events of an industrial accident and injury are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 591 P.2d 143 (1979); *Roberts v. Kit Manufacturing Company, Inc.*, 124 Idaho 946, 866 P.2d 969 (1993).

52. Two physicians have opined on the issue of whether Claimant's persistent right knee condition afflicting her at the time of the hearing is a result of her industrial accident.[2] Neither concluded that it is. Drs. McInnis and Provencher both opined, after reviewing all of Claimant's relevant medical records, that the October 2008 injury did nothing more than temporarily exacerbate her preexisting condition. These opinions are consistent and unrebutted.

53. Claimant has adduced sufficient medical evidence to prove that she sustained a temporary exacerbation of her preexisting right knee condition as a result of her October 28, 2008, industrial accident.

MAXIMUM MEDICAL IMPROVEMENT (MMI) AND MEDICAL CARE

54. Dr. McInnis determined that Claimant reached maximum medical improvement (MMI) on June 24, 2009. Although he suggested in December 2010 that additional physical therapy may be desirable, he also suggested that she should consider paying "out-of-pocket" for it. Thus, it is clear that he did not intend to link her subsequent need for physical therapy to her industrial injury. Similarly, Dr. Provencher opined in August 2009 that Claimant had, by then, reached MMI. Both physicians opined that Claimant's industrial injury had healed and that she warranted no restrictions or further treatment (specifically no surgery) related to that injury.

55. The Referee finds Claimant reached MMI following her October 28, 2008,

[2] As discussed, above, Dr. King was unaware of Claimant's prior right knee history until his video deposition. Thus, he lacked proper foundation to provide a credible opinion on the subject because he knew nothing of Claimant's significant prior right knee history.

industrial injury on June 24, 2009. She is entitled to the reasonable and necessary medical care related to her temporary right knee injury she received through that date in addition to the diagnostic care she received from Dr. McInnis through the end of 2010.

MEDICAL CARE

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

56. There is no dispute that the care for Claimant's industrial right knee injury through June 24, 2009, was reasonable. However, Dr. McInnis continued to treat Claimant on two separate occasions following that date (in June and December 2010), and he ordered a new MRI in June 2010. It appears that Surety paid for this MRI and these appointments, and Defendants have not argued that this care was unreasonable. However, Defendants do argue that Claimant is not entitled to further medical care related to her industrial injury. The Referee agrees.

57. The Referee finds Claimant is entitled to the reasonable and necessary medical care related to her industrial right knee injury that she received through June 24, 2009, in addition to the diagnostic care she received from Dr. McInnis through the end of 2010.

ATTORNEY FEES

58. Idaho Code § 72-804 provides that if the Commission determines that the employer contested a claim for compensation made by an injured employee without reasonable ground or the employer neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee the compensation provided by law or without reasonable ground discontinued compensation as provided by law, the employer shall pay reasonable attorney fees in addition to the compensation provided by law.

59. The evidence presented does not establish that Defendants acted unreasonably. There is no basis for an award of attorney fees in this case.

CONCLUSIONS OF LAW

1. Claimant has proven that she sustained a temporary exacerbation of her preexisting right knee condition as a result of her fall at work on October 28, 2008.

2. Claimant has proven that she is entitled to reasonable and necessary medical care through June 24, 2009, the date she reached MMI.

3. Claimant has failed to prove that she is entitled to an award of attorney fees for unreasonable denial of her claim pursuant to Idaho Code § 72-804.

RECOMMENDATION

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

DATED this _6th__ day of ___February_____, 2012.

INDUSTRIAL COMMISSION

/s/_____
LaDawn Marsters, Referee

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _17th_ day of ___February_____, 2012, 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:

STARR KELSO
STARR KELSO LAW FIRM, CHTD
PO BOX 1312
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LORA RAINEY BREEN
GARDNER AND BREEN
PO BOX 2528
BOISE ID 83701

sjw /s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MEGAN KELLY, Claimant, v. LIFE CARE CENTERS OF AMERICA, Employer, and OLD REPUBLIC INSURANCE CO., Surety, Defendants.	)	**IC 2008-035577** **ORDER** February 17, 2012

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters submitted the record in the above-entitled matter, together with her 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 proven that she sustained a temporary exacerbation of her preexisting right knee condition as a result of her fall at work on October 28, 2008.

2. Claimant has proven that she is entitled to reasonable and necessary medical care through June 24, 2009, the date she reached MMI.

3. Claimant has failed to prove that she is entitled to an award of attorney fees for unreasonable denial of her claim pursuant to Idaho Code § 72-804.

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

DATED this 17th day of February, 2012.

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 17th day of February, 2012, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

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