BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DIANE M. McCROREY, Claimant, vs. BOISE PAVING & ASPHALT CO., Employer, and EXPLORER INSURANCE COMPANY, Surety, Defendants.	)	**IC No. 2000-025583** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** March 28, 2011

Pursuant to Idaho Code § 72-506, the above entitled matter was assigned to Referee LaDawn Marsters who conducted a hearing on August 4, 2010, in Boise, Idaho. Claimant was present in person and was represented by John F. Greenfield. Defendants, Employer and Surety, were represented by of Thomas V. Munson. Oral and documentary evidence was admitted, and post-hearing depositions were taken. The matter was briefed and came under advisement on January 25, 2011.

ISSUES

The parties stipulated at the hearing to the following issues to be decided:

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

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

    a. Medical care, including whether Claimant is entitled to knee replacement revision surgery; and

b. Temporary partial and/or temporary total disability benefits (TPD/TTD); and

3. Whether Claimant is entitled to attorney fees under Idaho Code § 72-804.

Claimant's Opening Brief did not address TPD/TTDs or attorney fees; however, Defendants' Post-Hearing Memorandum and Claimant's Reply Brief both did. Therefore, all of the issues the parties stipulated to at the hearing will be decided herein. All other issues are reserved.

CONTENTIONS OF THE PARTIES

Claimant contends she is entitled to another surgery because she has never recovered from her June 21, 2000 industrial injury to her left knee. She asserts that her 2003 left total knee arthroplasty (TKA) surgery and two subsequent TKA revision (TKAR) surgeries, in 2005 and 2008, among other procedures, all failed to alleviate her residual pain and significant loss of motion, and she is now entitled to a third TKAR. Claimant relies upon the medical opinion of Dr. Moore, her treating orthopedic surgeon, who opines that her femoral component is loosening. He further opines that this component, which contains nickel, should be replaced with one made of titanium. Based upon Claimant's history, including extremely excessive scar tissue formation, a blood test indicating she is highly sensitive to nickel, and the fact that her titanium tibial component is stable, he suspects the failure of her femur to properly heal since her TKA is due to an allergy to nickel. Dr. Moore believes replacing Claimant's femoral component with a titanium component is the only reasonable course.

In addition, Claimant seeks compensation and medical benefits from March 26, 2009, forward, because she is still not medically stable. Claimant argues she is entitled to an award of attorney fees because Defendants' cessation of her benefits on April 10, 2009 was unreasonable.

Defendants contend that a third TKAR is not a reasonable treatment for Claimant's residual symptoms. They rely upon Dr. Collins, who opines that surgery is contraindicated because

Claimant's knee is well-healed, there is inadequate evidence that her femoral component is loosening, and, further, there is an inadequate scientific basis from which to conclude that Claimant is allergic to nickel or that replacing her femoral component with a titanium component will achieve any end other than to further weaken her left knee joint. They assert that Claimant's smoking is the cause of her failure to properly heal and that the risks of a fourth knee replacement/revision surgery, including complications that could lead to amputation of her left leg above the knee, outweigh its potential benefits.

Defendants assert that Claimant has been medically stable since March 26, 2009, so they owe no additional TTDs. In addition, they argue that they did not unreasonably deny any benefits due to Claimant, so an award of attorney fees is unwarranted.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The Industrial Commission legal file;
2. The pre-hearing deposition testimony of Richard E. Moore, M.D., taken May 24, 2010;
3. Claimant's Exhibits 1 through 9 admitted at the hearing;
4. Defendants' Exhibits A and B admitted at the hearing;
5. The testimony of Claimant taken at the hearing;
6. The testimony of Twila Patten taken at the hearing; and
7. The post-hearing deposition testimony of Paul Collins, M.D., taken August 19, 2010 and September 30, 2010.

OBJECTIONS

All pending objections are overruled.

FINDINGS OF FACT

After considering 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.

Background

1. Claimant was 59 and residing in Fruitland at the time of the hearing. She was widowed in 2005 and has lived alone since then. She still smokes a half to a full pack of cigarettes per day, notwithstanding prior attempts to quit.

2. Claimant suffered an industrial injury to her left knee on June 21, 2000 while driving a Kenworth semi truck pulling an end-dump in a road surfacing operation. She is a five foot, three inch tall woman weighing in at approximately 118 pounds, and the truck, which she had operated before, had a particularly stiff clutch. She had to maintain constant pressure on it in order to control the speed of the vehicle so the road surfacing material could be evenly distributed. Claimant developed significant knee pain while operating the Kenworth clutch. Claimant reported her pain to Employer, who allowed her to select her own physician.

Past Medical Treatment

3. **Mark C. Meier, M.D.** Claimant was examined by Fred Fender, M.D., her family physician, who referred her to Robert N. Walker, M.D., an orthopedic surgeon. Subsequently Claimant, with Surety's permission, transferred her care to Dr. Meier, an orthopedic surgeon, who diagnosed a medial meniscal tear.

4. On October 19, 2000, Dr. Meier performed an arthroscopic partial medial and lateral meniscectomy. By June 20, 2001, Dr. Meier returned Claimant to work without restrictions. However, she still required a non-steroidal anti-inflammatory drug (NSAID) for pain and swelling. By August 24, 2001, Claimant was back at work driving big rigs, but she still had pain on clutching maneuvers. As of September 28, 2001 Claimant had again quit truck driving. By February 22,

2002, she was back at work again, but still experiencing pain along her medial left knee. Dr. Meier recommended an unloader brace, which helped but did not eliminate Claimant's pain. Other conservative courses were trialed, to no avail. Dr. Meier diagnosed degenerative arthritis, patellar chondromalacia and a medial meniscal tear.

5. On January 24, 2003, Dr. Meier performed another arthroscopic surgery on Claimant's left knee. He removed more of her medial meniscus, reshaped the patellar surface, and released the lateral retinaculum. He also identified bone hardening that he opined would likely necessitate a TKA in the future. Post-surgery, Claimant wore her unloader brace and took NSAIDS; however, she continued to have pain in the medial side and patellofemoral areas of her knee, along with popping. On July 23, 2003, Dr. Meier wrote a letter to Surety in which he opined that a TKA would be appropriate at such time that Claimant could not stand the pain any longer.

6. On November 4, 2003, after conservative therapies again failed, Claimant underwent a left knee TKA by Dr. Meier. He implanted a Zimmer NexGen total knee, including an All Poly Standard Patella, a Tivanium Precoat Stemmed Tibial Component, a Tivanium Posterior Stabilized LPS-Flex Taper Stem Plug, a Zimaloy Precoat Cruciate Retaining Femoral Component and a Prolong© Highly Crosslinked Polyethylene Cruciate Retaining Articular Surface. There is no dispute that Zimaloy is a cobalt chrome alloy containing approximately 4% nickel, that Tivanium is Zimmer's titanium metal product containing no measurable amount of nickel, and that, similarly, Zimmer's All Poly and Prolong© Highly Crosslinked Polyethylene products do not contain nickel. Therefore, the only component implanted in Claimant's left knee that contains nickel was the femoral component.

7. Dr. Meier's observations during the TKA confirmed his pre-surgical diagnosis of end-stage osteoarthritis, which he fully attributed to Claimant's 2000 industrial injury. Following

her TKA, Claimant received home health care and underwent physical therapy. Her recovery course was marked by swelling and pain, followed by progressive and worsening stiffness and slow improvement in ROM. By three months post-surgery, Claimant's left knee was still painful, swollen, stiff and warm to the touch. Her ROM was limited to a range of 10°-15° of extension through 80° of flexion.

8. By March 22, 2004, Claimant's ROM was reduced to 20°-80°, so Dr. Meier performed a manipulation of her left knee to break up scar tissue and relieve her postoperative stiffness. Afterward, Claimant passively achieved 15°-115°. She underwent another course of physical therapy and again continued to suffer pain and progressive stiffness. On August 11, 2004, Dr. Meier recommended that Claimant should obtain a second opinion and referred her to Dr. Moore.

9. Dr. Meier continued to treat Claimant for a few months before she transferred her care, with Surety's approval, to Dr. Moore. Dr. Meier and Dr. Moore agreed that Claimant's knee components, though well-fixed and well-positioned according to medical imaging, may nevertheless need to be revised to achieve a better anatomical fit.

Richard E. Moore, M.D. and Past IMEs

10. Following her left knee manipulation, Claimant continued to experience pain and left knee stiffness due to excessive scar tissue. She had been taking narcotic pain medication for a year, was having trouble sleeping and was becoming depressed from constant pain in her lateral medial and proximal knee, especially with movement, and was walking with a crutch. Claimant reported instability in her knee, and Dr. Moore noted side-to-side play at 2° in flexion each way.

11. To alleviate Claimant's instability, Dr. Moore performed the first of two TKARs on February 23, 2005. He removed dense scar tissue adhesions and reshaped the femoral component,

which appeared to have slipped post-surgery. He also converted to a posterior stabilized component and replaced the polyethylene articular surface. The record lacks any specific identification tags to identify the components Dr. Moore replaced, but there is no dispute that the only component in Claimant's knee that contained nickel at the time of the hearing is her femoral component.

12. Following her 2005 TKAR, Claimant underwent a course of physical therapy and continued to take narcotic pain medication. In spite of good effort on her part, Claimant nevertheless failed to improve. Pain, swelling and stiffness remained constant, and Claimant used a forearm cane to get around. One after another of Dr. Moore's predictions for when Claimant would reach maximum medical improvement (MMI) came and went. Claimant tapered off her narcotic pain medications onto 800 milligrams of Ibuprofen twice per day.

13. **IME.** Michael T. Phillips, M.D., an orthopedic surgeon, conducted an IME at Surety's request on October 24, 2005. According to his report, Dr. Phillips conducted two prior IMEs of Claimant, in September 2000 and May 2003. Those reports are not in evidence; however, Dr. Phillips notes in his 2005 report that he had not previously found Claimant to be at MMI. After a thorough examination, Dr. Phillips found Claimant still had not reached MMI following her first TKAR. He noted Claimant suffered chronic pain, limited motion in her left knee, atrophy of her left quadriceps and adhesive scar tissue. He recommended 3-4 more months of physical therapy with intensive home exercise.

14. By November 28, 2005, Claimant was frustrated that she was not improving. Her ROM measured 10°-95°. As of February 22, 2006, Claimant reported her pain had improved significantly, her physical therapy was progressing and she felt better overall. She walked with a limp but was no longer relying upon a cane or crutch. Dr. Moore ceased Claimant's Ibuprofen and started her on another NSAID.

15. **IME.** Dr. Phillips, along with Michael Weiss, M.D., a physiatrist specializing in occupational medicine, performed a panel IME at Surety's request on April 5, 2006. They opined that Claimant was now at MMI because she had not shown significant improvement despite ongoing therapy and her ROM had slightly worsened; therefore, she was not expected to improve with further time or treatment. Drs. Phillips and Weiss assessed a PPI rating of 30% of the whole person with no apportionment. Since her right knee evidenced no degeneration, they did not discount her PPI rating for the degeneration present in her left knee, attributing it all to her industrial injury. In addition, they predicted that Claimant would require at least one more revision surgery for her left knee over the course of her lifetime.

16. By May 2006, x-rays revealed soft tissue swelling over the medial aspect of Claimant's left knee, of unknown etiology, without evidence of loosening. Nevertheless, on December 18, 2006, Dr. Moore also deemed Claimant medically stable and referred her for a PPI rating.

17. Claimant's pain and sleeplessness persisted, however, and her ROM continued to shrink even though x-rays continued to show good fixation, position, alignment and space in her components. Claimant was again taking prescription Ibuprofen, 800 mg., twice per day. Her ROM ranged from 6°-95° by November 2007, and Claimant was again frustrated at her lack of improvement. Scar tissue was again growing excessively, creating adhesions and impeding her movement. Dr. Moore began to suspect an allergic reaction to metal[1]. No further surgery was recommended, however, due to the possibility of increasing Claimant's already abundant and debilitating scar tissue growth.

[1] Initial chart notes suspecting metal sensitivity were made by Dr. Moore's practice associate, Dr. Norris. Dr. Moore's testimony and subsequent notes confirm that he was personally concerned about metal sensitivity during this

18. Claimant's complaint continued to escalate. By the time of her April 21, 2008, visit with Dr. Moore, she was complaining of left knee pain with weight bearing activities, and exhibited a pronounced limp. However, x-rays continued to show a good fixation, position and spacing of all components. Dr. Moore began to explore with Claimant the feasibility of performing a left TKAR procedure to modify some of the components of the left knee prosthesis and to remove scar tissue. In connection with assessing Claimant's suitability for surgery, Dr. Moore ordered a three-phase bone scan, which was performed on April 24, 2008. That study was read as follows:

> PERFUSION PHASE: Slight hyperemia to the distal left femur and proximal left tibia.
>
> BLOOD POOL PHASE: Increased blood pool with the distal left femur and proximal left tibia.
>
> DELAYED PHASE: Significant focal tracer accumulation along the posterior and medial aspects of the tibial prosthesis/bone interface. There is also accumulation in the anterior proximal tibia as well as the associated with the medial and lateral femoral component. Mild activity posteromedial to the distal right femur.
>
> **IMPRESSION: Increased perfusion and blood pool as well as delayed activity involving the femoral and tibial components of the left total knee arthroplasty. This is greater than expected for physiologic activity and raises possibility of infection or loosening.**
>
> **Activity along the posteromedial aspect of the distal right femur is nonspecific and could be degenerative or traumatic.**
>
> Claimant's Exhibit 4 at p. 204.

Interestingly, although x-rays performed to that date failed to suggest a loosening of any components, the bone scan suggested the possibility of loosening with respect to both the femoral and tibial components. With the exception of the April 24, 2008 bone scan, none of the testing/evaluation performed to date has suggested that the Claimant's tibial component is thought to

---

period.

be problematic. Indeed, the fact that Claimant's titanium alloy tibial component has never shown any signs of loosening is offered by Dr. Moore as support for the hypothesis that Claimant's femoral component has caused problems with scar tissue formation and loosening because it was fabricated with 4% nickel.

19. **IME**. On June 17, 2008, Dr. Weiss again evaluated Claimant at Surety's request. Dr. Weiss noted Claimant's multiple prior surgeries and on-going complaints. Importantly, he noted the positive April 24, 2008, bone scan results, and opined that the evidence of loosening suggested by that study was sufficient to warrant yet another revision if Claimant could be persuaded to stop smoking. In this regard, Dr. Weiss stated,

> DISCUSSION: Diane McCrorey has had multiple surgeries of her left knee and now is post total knee arthroplasty and revision surgery. She has developed loosening of the prosthesis and revision surgery is medically appropriate. Since each surgery has increased risk of suboptimal result, she would be very strongly encouraged to discontinue smoking, at least 1 month before and 3 months afterwards, to improve the odds of a successful outcome.
>
> Claimant's Exhibit 7, page 336.

20. As a result of Dr. Weiss' recommendation, Surety approved the second TKAR, which was performed by Dr. Moore on September 10, 2008.

21. Although Surety clearly approved the surgery based on Dr. Weiss' belief that revision surgery was appropriate due to loosening of the femoral and tibial components, Dr. Moore's September 10, 2008 operative report failed to demonstrate that he confirmed loosening of any of Claimant's left knee components at the time of surgery. Indeed, aside from the extensive scar tissue debridement that he performed, the only work he did on Claimant's artificial components was to replace the tibial component articulating surface. It must be supposed that Dr. Moore found no evidence of a femoral component loosening at the time of surgery, because his subsequent notes, at

least until the May 20, 2010 left knee x-rays, reflect his belief that the femoral component was solidly anchored in the left femur.

22. Again, Claimant failed to improve post-surgery, exhibiting persistent pain, swelling and stiffness in her left knee. Although Claimant reported on January 29, 2009 that she was doing much better than pre-surgery, she was still taking narcotic pain medication daily, still having trouble sleeping due to pain and, apparently, also still dealing with inflammation because she was placed on a 10-day course of Prednisone. Claimant's ROM ranged from 3°-105°. She underwent another 10-day course of Prednisone in March 2009 for inflammation, yet continued to experience pain and decreased mobility.

IMEs of Dr. Collins and Current Controversy

23. Paul Collins, M.D. is an orthopedist and former orthopedic surgeon. He performed three IMEs at Surety's request, on March 26, 2009, March 9, 2010 and June 29, 2010. Before his first examination, Dr. Collins familiarized himself with Claimant's relevant medical records describing the onset of her left knee meniscal tears and consequent treatments and complications.

24. On March 26, 2009, approximately six and a half months following Claimant's second TKAR, Dr. Collins found Claimant to be at MMI and assessed a permanent partial impairment (PPI) rating of 27% of the whole person, attributing 30-50% of her impairment to the effect of smoking on her healing process. Dr. Collins did not dispute that Claimant was hampered by pain, excessive scar tissue and significant loss of motion. However, he concluded that Claimant's history of three replacement/revision surgeries with no improvement was a sufficient basis upon which to find Claimant's condition had stabilized. He did not believe any procedure was likely to improve her condition. In addition, Dr. Collins opined that Claimant's smoking diminishes her prognosis for a full and uncomplicated recovery.

25. As a result of Dr. Collins's opinion, Surety ceased Claimant's TTDs on April 10, 2009.

26. Dr. Moore, however, had not yet determined Claimant had reached MMI. On April 22, 2009, Dr. Moore wrote to Surety, seeking approval to order a metal reactivity blood test. He noted that Claimant was an extreme outlier with respect to the relevant population regarding scar tissue formation, so he wanted to rule out this possibility before opining Claimant to be at MMI. Surety denied approval, so Claimant paid for this test out-of-pocket.

27. The June 30, 2009 test report indicated Claimant was 13.1 times more reactive to nickel than the test control subject, placing her in the "high reactivity" category[2]. A disclaimer at the bottom of the report cautions that these results are not institutionally or governmentally approved for diagnostic purposes, that they must be carefully evaluated by a physician and that they do not necessarily indicate that an implant made of a material to which the patient has a measurable reaction will fail.

28. Dr. Moore investigated what role Claimant's metal sensitivity test results should play in his analysis of her distinctive scar tissue formation and repeated failures to heal. He wrote and called Joshua Jacobs, M.D., apparently an expert on the question, at Northwestern University in Chicago; however, Dr. Jacobs did not immediately respond[3]. By July 28, 2009, Dr. Moore was still unsure how to proceed, but responded to Claimant's questions by discussing with her the pros and cons of a revision to replace the nickel-containing femoral component. In August or September, Dr. Moore travelled to Chicago for meetings in which he was able to consult with colleagues about

[2] The metal reactivity test also indicated Claimant is mildly reactive to chromium and molybdenum. Claimant's femoral component contains chromium; the record does not address whether molybdenum is present in any of her components.

[3] Dr. Moore wrote in a letter to Claimant's attorney dated April 22, 2010 that Dr. Jacobs told him, personally,

Claimant's metal sensitivity. He determined that there was no consensus on how to treat a patient in Claimant's situation.

29. Based upon his observations of Claimant's rare and excessive growth of scar tissue and the metal sensitivity test results, Dr. Moore recommended to Claimant, on September 21, 2009, that Claimant's nickel-containing femoral component should be replaced with a titanium counterpart. He postulated that this is the only remaining treatment by which Claimant may achieve resolution of her left knee symptoms.

30. Regional Claims Services, through Twila Patten, is the third party claims adjustor for Surety. Dr. Moore faxed a request seeking approval for another TKAR due to a nickel allergy to Ms. Patten on September 23, 2009. However, Ms. Patten testified that she first learned of Dr. Moore's request two weeks later, on October 6, 2009, when she met with Claimant's attorney. At that meeting, Ms. Patten also first received Claimant's metal sensitivity test results. Ms. Patten provided the information to Dr. Collins and sought his expert opinion.

31. In an October 19, 2009 letter addressed "To Whom it May Concern", Dr. Moore explained:

> We have gone through an exhaustive process to try and understand as clearly as possible for the patient's best interest the option for change of the component she has which is chrome cobalt containing approximately 4% nickel to a titanium or oxinium component that does not contain nickel. Ms. McCrorey has shown, based on just recently available testing, to have a high reactivity to nickel. In trying to cover these bases I had a recent discussion with regard to all aspects of nickel containing metal that could be involved in the issue of surgery and as well the surgical instruments, which are stainless steel, all have nickel in them. Such a surgery would require a very specialized approach. I simply feel that this is the best chance to give her a fair option for recovery given her proven nickel sensitivity…It is the only reasonable approach left to try to improve her condition.

---

that it is uncertain whether replacing a component as proposed by Dr. Moore will produce a more favorable clinical outcome.

Claimant's Exh. 4, p. 269. Neither Ms. Patten nor Dr. Collins received this letter until mid-December 2009. It appears that this letter was prepared and placed in Claimant's medical file, but was never delivered. In any event, Ms. Patten delivered the letter to Dr. Collins sometime during the last week in December. Neither she nor Dr. Collins were previously aware of this letter's existence.

32. On October 26, 2009, Dr. Collins responded to Surety's request for an assessment of Dr. Moore's request to perform another TKAR due to nickel sensitivity. He acknowledged Claimant's blood test results indicate she has a high sensitivity to nickel, but reiterates a point raised in the disclaimer printed on the report, that this finding is not diagnostic of an implant failure. He recommended additional diagnostic tests[4] to help identify whether infection or component loosening were present.

33. Dr. Collins went on to opine that *if* there was loosening, he still would not recommend another TKAR. He explained:

> The outlook for her is extremely poor given her past medical history, and moving ahead yet again with a significant operation with a high level of failure risk is not a good idea. A fusion is a very anatomically excellent procedure to give her pain free stability.

Defendant's Exh. A.

34. One month later, in a letter dated November 30, 2009, Ms. Patten conveyed Dr. Collins's request for testing to Dr. Moore. In the meantime, Surety did not investigate the matter further or pay any TTD benefits.

35. On December 3, 2009, Dr. Moore clarified his opinion in a letter to Dr. Collins. He stated that loosening was not an issue, that Claimant's nickel sensitivity could be responsible for her scar tissue overgrowth regardless of what sed rate and C-reactive protein test results may show, and that a CT scan would not add any new relevant information. He also disagreed that fusion surgery

was a desirable option because it would increase Claimant's disability. Dr. Moore explained:

> The current issue revolves around an unknown area that has only recently come to light with regard to the particular sensitivity, and in Diane's case, to nickel, which is at approximately a 4% content level with the chrome cobalt components in the past. The only issue in my mind raised by recent findings is whether to convert her to a non-nickel continuing femoral component with debridement of the scar tissue. Admittedly, I do not know that this will change her course considerably, but she has had an unusual course with regard to her scar tissue response, not with the bone's acceptance of the component or maintaining issues of fixation.

Claimant's Exh. 4, p. 274.

36. In a letter dated January 5, 2010, Dr. Collins again wrote to Surety. He reiterated that the metal sensitivity test is not diagnostic and that he is concerned another TKAR would produce an "extremely negative" outcome. Defendant's Exh. A. He added that Claimant's smoking increases her risk for a bad outcome and that her prior knee replacement and revision surgeries have only worsened her condition. While Dr. Collins acknowledges that Claimant has a potential reaction to metal, he explains that removing the offending part would not necessarily alleviate her symptoms because there is a significant amount of microscopic nickel already in her knee.

37. Again, Dr. Collins opines that *if* a procedure is indicated, he recommends a knee fusion:

> This would result in essentially no motion at the knee, however, as we know, for each procedure she has had on the knee she has lost motion. The outcome from a 4th procedure given this trend would probably end up with an almost fused knee in any event.

Defendant's Exh. A. He also reiterates that Claimant is at a high risk of infection from another TKAR and that an infection could lead to an above knee amputation, explaining:

> For that reason, I think that the way best to maintain this patient's lower extremity and her function (given that she has almost no motion in the knee functionally now) would be to have a removal of all of the potentially inflammatory material and [have

[4] Dr. Collins recommended a sedimentation rate ("sed rate") test, a C-reactive protein test and a CT scan.

> a knee fusion]. Again, I am not saying that she does not need a procedure, however, my intent is to make the outcome as potentially positive as possible.

Id. He goes on to recommend that he should reexamine Claimant.

38. One month later, on February 9, 2010, Ms. Patten wrote to Dr. Collins thanking him for agreeing to examine Claimant again and asking him to address several questions, none of which elicited relevant information that Dr. Collins had not already provided since October 26, 2009. The letter closes with an open invitation to provide any information regarding Claimant's condition.

39. On March 9, 2010, Dr. Collins performed a follow-up IME. Claimant continued to have pain in her knee; however, she was not using her brace because it had become too big for her, and was not using a cane. She was receiving no treatment and no physical therapy, but his report is unclear as to whether she was taking any medications for pain or other conditions. She continued to smoke "on a significant level". Defendants' Exh. A. Dr. Collins testified at his deposition that half a pack or more per day is significant. On examination, Dr. Collins found left knee ROM of 24˚-85˚, indicating some loss of motion since his prior exam. He found no evident enlargement or swelling, no remarkable heat change, no indication of looseness on gentle rocking and no specific area of discomfort. Claimant's lower extremity pulses were equal bilaterally, though weakened, and her surgical wound was well-healed.

40. Dr. Collins reaffirmed his prior opinion that no additional procedure is indicated. His analysis of the question, this time, included whether or not to perform a fusion surgery. Like before, Dr. Collins opined that another TKAR carried the risk of infection that could lead to above knee amputation and was not likely to be successful. Unlike before, he discussed fusion surgery, both in his report and with Claimant, and then ruled it out because Claimant was fairly functional in her present condition and because Claimant was not interested in having her left knee fused.

41. Dr. Moore does not believe a fusion surgery is a reasonable alternative because it would create additional functional problems, such as significant difficulties with simple activities like riding in a car or sitting in a movie theater. It would also increase the risks of back and hip problems, among other detrimental effects.

42. On May 20, 2010, Dr. Moore obtained x-ray images that he opined demonstrated a radiolucent line around the nickel-based femoral component indicating it is loosening. No such evidence of loosening was identified around the tibial component, which is made of titanium. On this date, Dr. Moore also examined Claimant. She presented with restricted ROM, a thickened joint capsule, sensitivity, lateral and medial pain, and sensitivity and warmth over her knee. Dr. Moore's prehearing deposition was conducted on May 24, 2010. In the course of his testimony he stated that notwithstanding the issue of whether or not Claimant's nickel bearing femoral component should be replaced in a effort to ameliorate the formation of scar tissue, it was clear that the femoral component would have to be replaced in any event, due to the fact that the May 20, 2010 x-ray studies demonstrated loosening of the component. Faced with this new information, Surety again arranged for Claimant to be evaluated by Dr. Collins. Dr. Collins ordered a sed rate test and new x-rays. The sed rate test was read as "normal," i.e. demonstrating no evidence of inflammation. The x-ray studies were performed at Idaho Medical Imaging, and read by radiologist, Neil Davey, M.D. Dr. Davey compared the studies of June 29, 2010, to earlier studies performed in October 2008, also performed at IMI. Comparing the June 29, 2010 study to earlier films, Dr. Davey stated, inter alia:

> BONES: The patient has undergone total knee replacement. No plain film features of the prosthetic using. Prostheses and surround bone are unchanged in appearance since the prior examination October 2008.
>
> . . . .
>
> CONCLUSION: No change in imaging findings since the prior examination in this patient is undergone left total knee replacement. No plain film features of loosening.

Claimant's Exhibit 5, page 304.

For his part, Dr. Collins was willing to concede that the May 20, 2010 x-rays ordered by Dr. Moore could be interpreted as providing some evidence for femoral component loosening. Not surprisingly, following his May 24, 2010 deposition, Dr. Moore was asked to review the x-ray studies ordered by Dr. Collins on June 29, 2010. Concerning these x-rays, Dr. Moore has stated that to his eye, the June 29, 2010 studies confirm the femoral component loosening first noted on the May 10, 2010 x-ray he ordered. (*See* July 9, 2010, Moore letter, Claimant's Exhibit 4 at 287). Accordingly, there appears to be a real conflict between the opinions of Drs. Collins, Davey and Moore on whether or not femoral component loosening is demonstrated by the June 29, 2010 studies.

43. Based on his belief that the May 20, 2010 study supported the proposition of femoral component loosening, Dr. Moore testified at his deposition that the part could fail within one year, depending upon usage:

> It's usually a geometric progression. It is not a linear progression. So from the standpoint of this I think it would be within a year. And I think, again, it depends on the issue of use. But what I have noticed in particular on this that I did not see before is the issue of a contiguous radial lucent [sic] line from the anterior flange all the way to this area (indicating). So it appears to me that it is loosening.

Moore Dep., pp. 46-47.

44. He also explained how the evidence of loosening around the femoral component supports the proposition that Claimant's nickel sensitivity is impeding her recovery:

> The femur, the end of the thigh bone, has a three dimensional shape on both sides. So as a consequence it has more inherent stability than the tibia. But it is also noteworthy that on the tibial side I see zero evidence of loosening. Same attachment. It is a difference of titanium component.

Moore Dep., pp. 47.

45. Dr. Moore further opined that the standard treatment for a loose component, even

where multiple revisions have already been done, is to revise the component and achieve better fixation. He acknowledged at his deposition the detrimental effects of smoking, noting that he has recommended that Claimant quit. He does not believe Claimant's smoking is the cause of her extreme scar tissue growth.

46. As noted, Dr. Collins again examined Claimant on June 29, 2010. In a letter to Surety prepared the same day, Dr. Collins wrote that Claimant's condition was essentially unchanged. He found ROM of 0-162 degrees in Claimant's right knee, but only 15-86 degrees in her left knee, noting that she had difficulty with walking and balance while observing her ambulating freely in and out of the office. He found no obvious swelling, inflammation or infection in Claimant's left knee, intact but weakened pulses in both lower extremities, intact medial and lateral collateral ligaments in both knees and equal ROM in both hips. Her surgical wound was well-healed. Claimant was pleasant even though she was clearly frustrated with her poor ROM and what he characterized as "generalized discomfort". Defendants' Exh. A. Claimant's medications included hydrocodone and Wellbutrin.

47. Based on his examination and testing, Dr. Collins opined that there was inadequate evidence of loosening or infection. He maintained his position that another TKAR is unwarranted.

48. Surety has continued to deny all benefits since it received Dr. Collins's first IME report in April 2009.

Claimant's Credibility

49. A claimant's credibility is generally at issue in a workers' compensation proceeding. Here, the record demonstrates that Claimant's testimony at the hearing was clear, direct and unaffected. Claimant's medical records indicate she has devoted sufficient effort to her recovery, notwithstanding the fact that she has been unable to permanently quit smoking. No secondary gain

issues have been identified. Observation of Claimant at the hearing confirmed that her gait was consistent with the descriptions in the record. Moreover, Defendants do not assert that any of Claimant's testimony should be discredited. The Referee finds Claimant is a credible witness.

DISCUSSION AND FURTHER FINDINGS

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

Reasonable Medical Care

Claimant carries the burden of proving, to a reasonable degree of medical probability, that the injury for which benefits are claimed is causally related to an accident arising out of and in the course of employment. *Wichterman v. J.H. Kelly, Inc.,* 144 Idaho 138, 158 P.3d 301 (2007). It is clear that in order to recover medical benefits, the injured worker must prove both that the need for medical care is causally related to the accident and that the medical care is "reasonable." See *Henderson v. McCain Foods, Inc.,* 142 Idaho 559, 130 P.3d 1097 (2006).

Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by 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 is reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

The Idaho Supreme Court has held that medical treatment is reasonable when three

circumstances exist: 1) the claimant made gradual improvement from the treatment received; 2) the treatment was required by the claimant's physician; and 3) the treatment received was within the physician's standard of practice, and the charges were fair, reasonable and similar to charges in the same profession. *Id.* However, the *Sprague* standard anticipates a situation in which treatment has already been rendered, and the *Sprague* analysis is not readily applicable to care, like that at issue in the instant matter, that is prospective in nature. *See*, Richan v. Arlo G. Lott Trucking, Inc., IC 2007-027185 (Feb. 2011); Ferguson v. CDA Computune, Inc., et. al., consolidated cases numbers IC 2001-005778, IC 2001-021764, IC 2004-504577 and IC 2004-000161 (filed Feb. 2011).

To determine whether the care required by Dr. Moore is "reasonable," the Commission must ascertain whether the required care is likely to be efficacious. In other words, if, from the medical evidence adduced by Claimant, it appears that it is more probable than not that the care required by Dr. Moore will improve Claimant's condition, then the care is "reasonable."

50. There is no dispute that Claimant suffers from osteoarthritis in her left knee as a result of her industrial injury or that she continues to suffer pain and significantly reduced ROM. Claimant's case is complicated by her unexplained over-abundant scar tissue growth in response to her past surgeries leading to inflammation, pain and loss of mobility. There is also the ever-present risk of surgical and post-surgical complications.

51. During the course of this case, the factual medical care issue evolved as new medical evidence emerged. What began as a question of whether Claimant is entitled to another TKAR to replace an undisputedly stable component morphed into an inquiry as to whether Claimant is entitled to another TKAR to replace a component that Dr. Moore opines is loosening, but Dr. Collins opines is stable. Both questions must be resolved in order to address all of the currently pending legal issues.

52. Claimant argues that another TKAR is reasonable because it is required by Dr. Moore to stabilize her left knee and to ameliorate the suspected effects of the nickel in her femoral implant, and also because more conservative treatment has failed to alleviate Claimant's pain and loss of mobility in her left knee.

53. Both parties assert that the nickel sensitivity diagnosis is multi-factorial. Dr. Moore primarily relies upon x-ray evidence of loosening (first evident on May 20, 2010 x-rays) around Claimant's nickel-containing femoral component with concurrent evidence of a stable titanium tibial component, the blood test evidencing high reactivity to nickel, and Claimant's previously unexplained extreme scar tissue growth to conclude that surgery is reasonable. Defendants argue that Claimant's clinical presentation and her test and imaging results, together, are insufficient to establish loosening or biological incompatibility with her nickel-containing femoral component or that another TKAR is reasonable.

54. Defendants also posit that Claimant's smoking could be the cause of her scar tissue response. While Dr. Moore acknowledges smoking is a problem, he does not view it as the cause of Claimant's scar tissue response or an obstacle to surgery.

55. In their risk-benefit analysis, Defendants figure heavily the potential that another TKAR could lead to an above knee amputation, while Dr. Moore places a lower emphasis on this possibility.

56. Since her 2000 accident, Claimant has seen primarily two physicians. She has portrayed an optimistic attitude to her health care providers at times when her medical findings showed no improvement. Other than her smoking addiction, Claimant has portrayed a model patient for ten years.

57. Claimant does not use her condition as an excuse to avoid her life's responsibilities or

to participate in social activities. She is able to drive her stick shift vehicle, to do her own shopping and to complete the light-duty cleaning of her house. She gardens by sitting on the edge of her raised plant beds. She goes to lunch with her friends. However, Claimant has suffered considerable reductions in her abilities to perform many functions. For example, she is no longer able to play tennis, which she used to enjoy, or to participate in any activities that require her to ambulate quickly or to exercise good balance. She must hire a cleaning lady to help her with her heavy house cleaning chores. And, of course, she is unable to return to her former profession of truck driving. In addition, Claimant's activities are limited by chronic knee pain.

Reasonableness of Proposed TKAR: Dr. Moore vs. Dr. Collins

58. Dr. Moore is an orthopedic surgeon who specializes in hip replacements and TKAs. He has been practicing for 21 years and he estimates he has performed 5,000-6,000 TKAs. He has been Claimant's treating orthopedic surgeon since 2004. Dr. Collins is an orthopedist and former orthopedic surgeon. As of the hearing date, he had not performed a knee surgery for 15 years. In his lifetime, he has performed 300-500 knee surgeries, hundreds of them consisting of knee fusion surgeries, including many performed on Australian aboriginals during the year he spent working on that continent. He examined Claimant three times between March 26, 2009 and June 29, 2010.

59. **Nickel sensitivity.** The initial question is whether Claimant is entitled to another TKAR to revise her fixed and stable femoral component because nickel sensitivity may be responsible for her extremely overabundant scar tissue growth.

60. After the 2008 TKAR, Claimant's recovery course began to mimic her previous courses, so Dr. Moore began to investigate the metal sensitivity diagnosis in earnest. He could identify no other possible reason for her symptoms.

61. Dr. Moore acknowledged that identifying implant failures due to metal sensitivity is a

new science. He agrees with Dr. Collins that positive metal sensitivity test results do not necessarily coincide with implant failure. He also does not know if replacing a toxic part will alleviate the adverse physiological responses previously triggered by it.

62. Dr. Moore ultimately concluded that there is no consensus as to how to treat a patient with a stable component who is experiencing an abnormal, debilitating tissue response, and who has an established sensitivity to an implanted metal. In his experience and given his knowledge of metal sensitivity and Claimant's case, Dr. Moore concluded that another TKAR to replace Claimant's femoral component was the only available course that might possibly lead to a better outcome. He believes Claimant's nickel reactivity could account for her scar tissue growth, which is so excessive as to render her an extreme outlier when compared to the amount generated by the rest of the relevant population. He did not, however, opine that replacing Claimant's stable femoral component with a titanium component was likely to improve her condition. He was very cautious and very specific in his position that he could not speculate as to what her outcome would be.

63. Dr. Collins is unconvinced that nickel sensitivity plays any role in Claimant's symptomatology and has consistently opposed another TKAR.

64. The Referee finds that the metal reactivity blood test Dr. Moore ordered constitutes reasonable medical care. While the test, on its own, is inadequate to diagnose implant failure due to nickel sensitivity, there is no dispute that it provided relevant diagnostic information about Claimant's condition.

65. The Referee further finds that the totality of evidence, particularly Dr. Moore's testimony, fails to establish that nickel reactivity is causing Claimant's implant complications, or that any procedure was likely to improve Claimant's condition while her femoral component was stable. Therefore, a TKAR did not constitute reasonable medical care through May 20, 2010, when

evidence of loosening was arguably identified.

66. **Loosening.** The second question is whether Claimant is entitled to another TKAR to replace her femoral component because it is loosening, regardless of whether nickel sensitivity plays a part in her symptomatology.

67. On December 3, 2009, Dr. Moore wrote a letter to Dr. Collins in which he stated that loosening of Claimant's knee components was not an issue. At his deposition, however, he explained that Claimant's May 20, 2010 x-rays demonstrate radiolucency between the nickel-based femoral component and her femur, indicating that the part is pulling away from the bone. During his testimony, Dr. Moore marked the referenced area of radiolucency on a photocopy of the x-ray, which was admitted as Exhibit 3 to his deposition. Dr. Moore predicted that Claimant's knee could fail within one year, depending upon how the loosening progresses. He disagreed with Dr. Collins and the radiologist who interpreted claimant's follow-up x-rays and subsequently opined that they did not demonstrate loosening.

68. Dr. Collins agrees that surgical intervention would be warranted if the component were loosening, but he disagrees that it is. Dr. Collins testified that Claimant did not demonstrate swelling, localized pain or effusion consistent with loosening of a component. He also ultimately opined that the follow-up images he ordered in June (because he was unsure what the May x-rays showed) did not establish any component instability.

69. Dr. Moore opined that the standard treatment for a loose component, even in cases where multiple revisions have been performed, is to replace the component to achieve better fixation. Similarly, Dr. Moore opined that Claimant's second TKAR (in 2008) was necessary due to femoral component loosening, and Surety approved the surgery. In that case, IME physician Dr. Weiss agreed with both Dr. Moore's diagnosis of an unstable component and his plan to resolve the

condition with another TKAR. However, the femoral component was not replaced at the time of the September 2008 surgery, apparently because femoral component loosening could not be verified.

70. The Referee finds that both Dr. Moore and Dr. Collins have offered credible testimony on the issue of femoral component loosening. For his part, Dr. Collins was willing to acknowledge that the May 20, 2010 x-rays ordered by Dr. Moore were suspicious for femoral component loosening. This prompted Dr. Collins to order additional films, taken on June 29, 2010 and read by IMI radiologist, Neil Davey, M.D. The record is unclear whether Dr. Collins had the opportunity to review the actual June 29, 2010 films. However, the radiologist who interpreted the studies reported that the films did not show evidence of femoral component loosening. Dr. Moore was provided with the June 29, 2010 films, and reviewed the same. In his July 9, 2010, letter, he stated that the lateral study performed on June 29, 2010 still confirms the existence of a radio-lucency that is the hallmark of femoral component loosening. Though the question is a close one, and turns almost entirely on how the June 29, 2010 films are read, the Commission finds that the testimony of Dr. Moore is more persuasive. Dr. Moore has a history with Claimant starting in October 2004, and is intimately familiar with her long and tortured course. That he was evidently cautious enough not to disturb the femoral component at the time of the September 2008 surgery, in spite of a bone scan which suggested that the component was loose, suggests that his decision to recommend revision of the femoral component at this juncture is not lightly made. Dr. Moore had the opportunity to review the actual films of May 20, 2010 and June 29, 2010, and his interpretation of the June 29, 2010 study is persuasive.

71. The Referee finds both Dr. Moore's and Dr. Collins's opinions are credible. In a general way, their recommendations represent opposite sides of the same coin: Dr. Moore seeks to

improve Claimant's condition, while Dr. Collins seeks to guard it from further deterioration. Ultimately, however, Dr. Moore's opinions are more persuasive. His experience and knowledge with knee surgery and Claimant's course are superior to Dr. Collins's. In addition, Dr. Moore has demonstrated caution and restraint in his approach to Claimant's treatment through the years, so there is inadequate evidence from which to conclude that he is now overreaching.

72. Both Dr. Moore and Dr. Collins are qualified in assessing x-rays; however, Dr. Moore's sworn deposition testimony combined with the x-ray images and Claimant's medical records establish, by a preponderance, that Claimant's femoral component is again loosening. Neither Dr. Collins, nor any radiologist who reported on Claimant's x-rays, had an alternate explanation sufficient to rebut Dr. Moore's opinion for why radiolucency was present around Claimant's femur, but not around her tibia. Further, Claimant's treatment records establish that she has consistently battled localized knee pain and inflammation, although, at times, her inflammation symptoms did subside.

73. Further, Dr. Moore's recommendation for another TKAR in the event of loosening is generally supported by Dr. Weiss's 2008 IME opinion, and his reasons for rejecting fusion surgery are sound.

74. Defendants argue that Dr. Moore is not *currently* recommending surgery to correct Claimant's loosening femoral component. Indeed, he testified at his deposition:

> …
> A: I think it will become necessary. It's not necessary now. That is my opinion.
> Q: Why isn't it necessary now?
> A: Well, from the standpoint of the issue of the last finding, the issue of loosening, she still has some stability, but the process appears to be progressive. So based on the issue of the bone you could make the case that it is not immediately necessary.

Moore Dep., pp. 21-22. Although Dr. Moore acknowledges Claimant is not in need of an emergency

replacement here, he also testified that Claimant's knee could completely fail, meaning the component could completely separate from her femur, within one year without treatment. In addition, he noted that the evidence of failure is isolated to Claimant's femoral component, while her tibial component, made of titanium, demonstrates no evidence of failure. Dr. Moore's testimony and the evidence in the record establish a visual benchmark by which the Referee can compare the appearance of an allegedly well-seated component with an allegedly unstable one, and this evidence has not been rebutted. There is also ample evidence in the record that Dr. Moore has wished to perform another TKAR since 2009.

75. It is unnecessary to establish that Claimant's left knee has failed in order to find that another TKAR is reasonable. Indeed, evidence of loosening was enough, even for Defendants, in 2008.

76. The Referee finds that Claimant has proven her femoral component is loosening and that another TKAR to replace her femoral component would likely improve her condition by restoring stability. Therefore, the proposed surgery constitutes reasonable medical treatment. Further, the evidence establishes that deploying a titanium component replacement during the proposed TKAR also constitutes reasonable treatment.

77. Claimant is also eligible for reimbursement of past unpaid medical expenses related to her reasonably required medical care. Claimant's Exhibit 8 itemizes expenses from February 15, 2006 through June 29, 2010, specifically including mileage and the costs associated with her metal reactivity test. Defendants did not scrutinize Claimant's itemization or argue that she is not entitled to the amounts she seeks. Claimant is entitled to reimbursement for these amounts.

78. The Referee finds, pursuant to Idaho Code § 72-432, Claimant is entitled to additional reasonable and necessary medical care; specifically, another TKAR to treat her left knee

component loosening and to replace her existing nickel-containing femoral component with a titanium counterpart, as well as reimbursement for her past medical expenses itemized on Claimant's Exhibit 8.

Temporary Total Disability (TTD)

79. Idaho Code §§ 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled. Here, there is no dispute that Claimant has been unable to return to her truck driving job, due to her industrial injury, since she made her last attempt in 2003. Rather, the issue is whether, as Dr. Collins opined, Claimant reached MMI as of March 26, 2009. Claimant argues that she has not yet reached MMI following her 2008 TKAR and, therefore, Surety owes TTD benefits from that date forward.

80. Claimant seeks a determination that the loosening of her femoral component is just another step in the progression of her alleged nickel allergy, so she has never reached MMI. Toward that end, Dr. Moore has never opined Claimant is medically stable. However, he did write, on April 22, 2009, that he believed she would be at MMI if he could rule out nickel sensitivity. In that same letter to Surety, he sought approval for a metal sensitivity blood test.

81. Surety denied Dr. Moore's request without consulting a physician, even though Dr. Collins had not addressed the issue of nickel sensitivity in his IME report. Claimant paid for the test herself. It returned results, on June 30, 2009, showing she is highly reactive to nickel. Dr. Moore discussed these results with Claimant on September 21, 2009. Based upon the test results and his examinations, he concluded that another TKAR was the most reasonable course, but he could not say that it was likely to improve her condition. Neither Dr. Moore's opinion nor Claimant's diagnosis changed until May 20, 2010.

82. The Referee found, above, that the metal reactivity blood test was a relevant piece in

puzzling out the cause of Claimant's abnormal scar tissue growth. When Dr. Moore ordered the test, Claimant was still having more trouble than usual with inflammation and had recently completed two 10-day courses of Prednisone. It made sense to order the blood test and observe Claimant's symptoms to determine if he could get her inflammation stabilized, if not her scar tissue growth. By the time he received the blood test results, on June 30, 2009, Claimant's inflammation was manageable without steroids.

83. Although two more months passed before Dr. Moore made his recommendation for surgery, he did not receive any new information relevant to that determination after June 30, 2009. At this point, he had exhausted all of his treatment avenues and could not recommend any treatment that was likely to improve Claimant's condition. Although the loosening of Claimant's component may very well be related to a nickel allergy, the evidence in the record is insufficient to establish this fact. The Referee finds Claimant reached MMI as of June 30, 2009, the date on which Dr. Moore received the last piece of information relevant to the inquiry he posited on April 22.

84. The Referee finds Claimant was medically stable from June 30, 2009 until her component instability was identified on May 20, 2010.

85. The record does not reflect whether Claimant's ability to work was additionally impacted by the loosening of her femoral component. However, as noted above, the Commission has found that Claimant became medically unstable with the diagnosis of femoral loosening made on or about May 20, 2010. Under *Malueg v. Pierson Enterprises*, 111 Idaho 789, 727 P.2d 1217 (1986), once a claimant establishes by medical evidence that she is within a period of recovery from the industrial accident, she is entitled to TTD benefits unless and until evidence is presented that she has been medically released for light work and (1) that an employer has made a reasonable and legitimate offer of suitable employment to her or that (2) there is employment available in the

general labor market which claimant has a reasonable opportunity of securing, and employment which is consistent with her physical abilities. Therefore, having shown that she was within the period of recovery from the industrial accident as of May 20, 2010, the burden shifts to Defendants to adduce the proof required to curtail the obligation to pay TTD benefits. Here, no such proof has been presented, and the default case is that Claimant is entitled to time loss benefits effective May 20, 2010, through the date of medical stability, unless and until, Defendants can meet their burden of proof.

86. Claimant has proven that she is entitled to time loss benefits related to her industrial accident through June 30, 2009. Her left knee condition was not medically stable until then, and the record demonstrates by a preponderance that this condition prevented her from working.

Attorney Fees

Idaho Code § 72-804 provides that if the Commission determines that the employer contests 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.

87. Claimant seeks attorney fees because the defense tendered by Surety and its medical expert was unreasonable. Specifically, she seeks attorney fees related to procurement of Dr. Moore's recommended surgery, TTD benefits, past unpaid medical expenses and past unpaid medical mileage.

88. In general, the opinions of Dr. Moore were found to be more persuasive than those of Dr. Collins. However, that is not to say that Surety's reliance on the opinions of Dr. Collins was

necessarily unreasonable. Given the determinations, above, the inquiries are divided by relevant time period, below.

89. **April 10, 2009 through June 30, 2009.** Claimant was found eligible for compensation benefits and further medical treatment during this period, including treatment related to diagnosing her nickel sensitivity. Surety refused (or continued to refuse) to pay these benefits without first consulting a medical expert. Later, Surety's expert tacitly agreed that the metal sensitivity test provided relevant diagnostic information even though it is only one point in a constellation of facts that must be considered. By October 26, 2009, Surety knew, or could have known, had it asked Dr. Collins, that he did not dispute that the metal reactivity test results were relevant to Claimant's diagnosis. Nevertheless, it continued to deny payment for either compensation benefits or medical expenses.

90. Surety must have adequate grounds for denial at the time a request for benefits is refused. Failure to investigate a claim in a "timely and reasonably thorough manner constitutes an unreasonable denial of compensation, for which claimant is entitled to attorney fees," Matter of Burke, 85 IWCD 70 (1985). The practice of denying medical benefits without reasonable grounds, and then six months later seeking to develop a reasonable basis to support the denial is wholly contrary to one of "the primary duties of an employer to an injured workman (which) is to furnish him reasonable medical, surgical or other treatment necessary to rehabilitate him and as far as possible restore his health, usefulness, and earning capacity." *Steinebach v. Hoff Lumber Company*, 98 Idaho 428 (1977); quoting *Clevenger v. Potlatch Forests, Inc.*, 85 Idaho 193 (1963).

91. Surety denied benefits without properly investigating Claimant's eligibility for continued TTDs and medical treatment related to resolving her nickel sensitivity question. It continued to deny benefits even after information in its possession established that such treatment

was reasonable. As a result, its denial of these benefits was unreasonable.

92. **July 1, 2009 through May 19, 2010.** Claimant was found ineligible for compensation benefits or further treatment during this period. Further, although she was found eligible for medical benefits following this period, that eligibility was based upon new information about her condition, so Defendants' denials during this period are irrelevant to that finding of compensability. Therefore, the Referee finds insufficient grounds to assess attorney fees based upon events occurring from July 1, 2009 through May 19, 2010.

93. **May 20, 2010 forward.** Claimant was found eligible for another TKAR based upon the May 20, 2010 x-ray evidence of loosening. Although Dr. Collins did not agree with Dr. Moore's finding, it is well within his expertise to assess this feature and there is no evidence of fraud or uncorrected mistake. Likewise, Dr. Collins's fusion surgery recommendation, though ultimately rejected, was based upon relevant medical principles. As a result, the Referee finds that Surety did not unreasonably rely upon Dr. Collins's opinions in continuing to decline Claimant's requests for benefits.

94. Further, Claimant was found eligible for reimbursement of her past unpaid medical expenses related to her reasonable required medical care. However, the record does not establish that these expenses were presented to Surety for payment, with the exception of the metal sensitivity test expenses which are generally addressed above, before Claimant produced her Rule 10 exhibits. Therefore, Claimant has failed to prove that reimbursement for these expenses was unreasonably denied.

93. The Referee finds that Defendants failed to properly investigate the claim to determine whether they were liable for continued coverage for medical treatment and compensation

benefits through June 30, 2009. The evidence presented establishes that Defendants acted unreasonably.

CONCLUSIONS OF LAW

1. Claimant has proven that she was not medically stable until June 30, 2009.

2. Claimant has proven that she is entitled to reasonable and necessary medical care for her left knee symptoms, including another TKAR to restore stability in which a titanium femoral component is used.

3. Claimant has proven that she is entitled to reimbursement for the medical expenses itemized on Claimant's Exhibit 8.

4. Claimant has proven that she is entitled to TTD benefits through June 30, 2009, and from May 20, 2010 until medically stable, or until Defendants adduce proof sufficient to meet their burden under Malueg.

5. Claimant has proven that she is entitled to attorney fees under Idaho Code § 72-804. Defendants unreasonably denied TTD and medical benefits between April 10, 2009 and June 30, 2009.

6. All other issues are reserved.

RECOMMENDATION

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

DATED in Boise, Idaho, on ___24_____ day of ___February_____, 2011.

INDUSTRIAL COMMISSION

_/s/_____
LaDawn Marsters, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

DIANE M. McCROREY, Claimant, v. BOISE PAVING & ASPHALT CO., Employer, EXPLORER INSURANCE COMPANY, Surety, Defendants.	)	**IC 2000-025583** **ORDER** March 28, 2011

Pursuant to Idaho Code § 72-717, Referee LaDawn Marsters submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusions of law to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the 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 was not medically stable until June 30, 2009.

2. Claimant has proven that she is entitled to reasonable and necessary medical care for her left knee symptoms, including another TKAR to restore stability in which a titanium femoral component is used.

3. Claimant has proven that she is entitled to reimbursement for the medical expenses itemized on Claimant's Exhibit 8.

4. Claimant has proven that she is entitled to TTD benefits through June 30, 2009, and from May 20, 2010 until medical stability, or until Defendants adduce proof sufficient to meet their burden under Malueg.

5. Claimant has proven that she is entitled to attorney fees under Idaho Code § 72-804. Defendants unreasonably denied TTD and medical benefits between April 10, 2009 and June 30, 2009.

6. All other issues are reserved.

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

If the parties are unable to agree regarding the amount of attorney fees, Claimant's counsel shall, within 21 days of entry of the Commission's order, file with the Commission a memorandum requesting attorney fees incurred in counsel's representation of Claimant and an affidavit in support thereof. Defendants shall have 14 days within which to respond. Claimant's counsel shall reply no later than 7 days thereafter. The parties are instructed to address the factors set forth in Hogaboom v. Economy Mattress, 107 Idaho 13, 684 P.2d 990 (1984). The Commission shall then review the pleadings and issue an order determining reasonable attorney fees.

DATED this _28____ day of _March_____, 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 __28___ day of _March_____, 2011, a true and correct copy of the foregoing **Order** was served by regular United States Mail upon each of the following persons:

JOHN F GREENFIELD
THE HUNTLEY LAW FIRM PLLP
P O BOX 854
BOISE ID 83701-0854

THOMAS V MUNSON
P O BOX 7426
BOISE ID 83707-7426

jkc _/s/_____