BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARCELLA WOODY, Claimant, v. SENECA FOODS, Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	**IC 2010-012114** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** May 23, 2013

INTRODUCTION

Pursuant to Idaho Code § 72-506, the above-entitled matter was assigned to Referee Rinda Just, who conducted a hearing on May 10, 2012 in Twin Falls, Idaho. Claimant was present in person and represented by Dennis R. Petersen of Twin Falls. Employer (Seneca) and Surety (collectively referred to as Defendants) were represented by Alan K. Hull of Boise. Oral and documentary evidence was admitted, and post-hearing depositions were taken. Before the matter was fully briefed, Referee Just retired from the Commission; whereupon, the case was reassigned to Referee LaDawn Marsters. The briefing was completed and the matter came under advisement on April 22, 2013. The case is now ready for decision.

ISSUES

The parties seek adjudication of the following issues:

1. Whether Claimant's need for a right knee replacement was caused by the March 26, 2010 industrial accident;
2. Whether Claimant's condition is due in whole or in part to a preexisting or subsequent injury or condition;
3. Whether and to what extent Claimant is entitled to the following benefits:
    a. Medical care;
    b. Temporary partial and/or temporary total disability benefits;
    c. Permanent partial impairment;
    d. Disability in excess of impairment;
    e. Total permanent disability pursuant to the odd-lot doctrine.

Defendants argued that Claimant is not entitled to attorney fees pursuant to Idaho Code § 72-804 in their brief. Claimant did not address this issue, and it was not a noticed issue. Therefore, that issue will not be addressed in this decision.

CONTENTIONS OF THE PARTIES

Claimant contends she sustained an industrial meniscal tear to her previously asymptomatic right knee on March 26, 2010 when she stepped into a hole in the concrete at work, twisting her right leg. She further claims the meniscal tear permenantly aggravated her theretofore dormant right knee osteoarthritis, necessitating a right total knee arthroplasty (TKA). She claims entitlement to the above-noticed benefits.

Defendants counter that Claimant had suffered symptomatic bilateral knee osteoarthritis since at least 2008 and that, at most, her right knee condition was temporarily exacerbated by her industrial injury. They assert, among other things, that Claimant is not entitled to benefits related to her right TKA, nor to total permanent disability benefits.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The prehearing deposition testimony (including exhibits, where applicable) of:
    a. Claimant taken August 23, 2011; and
    b. Frederick Surbaugh, M.D., taken December 6, 2011;
2. Joint Exhibits numbered 1 through 31, admitted at the hearing;
3. The testimony of Claimant taken at the hearing; and
4. The post-hearing deposition testimony of:
    a. James Bates, M.D., taken June 19, 2012;
    b. Ron Tyler McKee, D.O., taken August 2, 2012;
    c. Roman Schwartsman, M.D., taken September 14, 2012; and
    d. Delyn Porter, M.A. and William C. Jordan, M.A., taken December 10, 2012.

OBJECTIONS

All pending objections are overruled.

FINDINGS OF FACT

1. **Claimant's Testimony: Vocational and Medical Background.** Claimant was two months shy of 65 at the time of the hearing and resided in Buhl, Idaho. She has lived most of her life in the Twin Falls area. Claimant finished the ninth grade, but left high school in the tenth grade. She does not possess a GED and did not pursue any additional formal education. Her hobbies include reading "thrillers", and she has enjoyed knitting in the past. Her life revolves mainly around her children and her siblings who live nearby.

2. Claimant got married when she was 16. She does not recall ever seeing a doctor before then. Specifically, she recalls no knee problems.

3. Claimant and Mr. Allred had eight children, all of whom still reside in the Twin Falls area. Claimant does not recall any of the physicians who delivered any of her children.

4. The family lived in Michigan during the years spanning, but not limited to, 1966 through 1969. Claimant was not regularly employed outside the home at that time. She had gall bladder surgery when she lived in Michigan. At some point, they returned to Twin Falls.

5. Claimant worked at Magic Valley Regional Medical Center, as a housekeeper, from approximately 1978 through 1979. Then, she worked at Green Giant for about seven years, until 1985, inspecting corn in a seasonal position. She stood and inspected cobbed corn, then put it on a conveyor belt. She suffered no workplace injuries in this position, and left because she became pregnant.

6. Claimant underwent a partial hysterectomy in approximately 1980. At some point she underwent a right carpal tunnel release and, later, a left carpal tunnel release. Following the procedure on the left side, Claimant returned to work, apparently without restrictions. Claimant has had no further carpal tunnel problems.

7. From 1986 through 1994 Claimant worked for Reed Grain & Bean in Twin Falls. She packaged beans in boxes in a full-time, year-round position. She also worked at other odd jobs during this period. Sometime in or around this timeframe, she also worked at a seasonal job at Seneca.

8. Claimant had two surgeries between approximately 1990 through 1996, including a right shoulder surgery and a right Achilles tendon surgery. She did not claim either injury as work-related. As for her Achilles tendon injury, Claimant recalled that it just started hurting,

from no apparent cause. She recovered fully from both procedures and missed no work for either one.

9. Sometime after 1996, Claimant was diagnosed with hypothyroidism. At some point, she was also diagnosed with a heart murmur and fibromyalgia. She does not recall when or by whom.

10. Claimant went to work full-time for Seneca in 2004. At first, she was a box handler. She injured her left shoulder when she reached up to a tall stack of boxes and it popped. Claimant obtained care from Seneca's designated physician, but she did not miss any work, and the injury apparently healed without significant treatment. Claimant soon became the Dyna-Pak machine operator. The Dyna-Pak machine packages boxes of corn into larger boxes. That job required no lifting related to the filled boxes, and Claimant testified that it could be done while seated on a stool; however, Seneca required her to stand. She only picked up flat box forms, opened them and placed them on the machine, which took care of the rest.

11. The Dyna-Pak machine was located on the second floor, approximately 15 steps up. Claimant testified that she had no trouble climbing up and down these stairs five or six times each day before her industrial injury.

12. Claimant's employment at Seneca was terminated on November 30, 2010. She testified that she loved the job, and had no problems doing it before her industrial injury on March 26, 2010.

13. Claimant began receiving Social Security Disability Insurance (SSDI) benefits in April 2011. She applied on her own, without the assistance of an attorney.

14. In her lifetime, Claimant does not recall ever being in a car accident, having a broken bone, or receiving stitches, other than during a surgery otherwise discussed herein. She

has taken Lorazepam every night to help her sleep since before she went to work full-time for Seneca. She smoked ¾ to a full pack of cigarettes per day for 48 years, but she testified at the hearing that she has reduced the amount that she smokes since her knee surgeries.

MEDICAL RECORDS: PRE-INDUSTRIAL INJURY KNEE TREATMENT

15. On a few occasions, Claimant sought relief from her primary physician, Dan Nofziger, M.D., a general practitioner, and Dean Mayes, P.T. (Claimant's nephew), for knee pain. Chart notes indicate:

a. On July 23, 2008, Claimant sought treatment for swollen ankles and stabbing left knee pain and marked stiffness in the morning. Dr. Nofziger noted she had trouble moving ("waddles more than she walks") and that she had right knee swelling. JE-14. He obtained a left knee x-ray for "left knee pain and stiffness" with no known injury. JE-15. According to the reporting radiologist, the films demonstrated joint effusion and tricompartmental osteoarthritis. Dr. Nofziger, himself, did not diagnose any knee-specific condition. Instead, he diagnosed peripheral edema and suspected nephritic syndrome or hypothyroidism. Dr. Nofziger did not note any knee problems for her next three visits.

b. On September 23, 2008, Claimant's primary complaint was pain in her "knees." JE-17. "She has stiffness lasting 2 hours in the morning." *Id.* Noting that Claimant's recent x-ray demonstrated moderate osteoarthritis of the medial compartment of the left knee and some osteophyte scarring, and that the six Motrin she was taking daily was probably not enough, Dr. Nofziger diagnosed osteoarthritis of the left knee and referred her for physical therapy with Dean

Mayes. Claimant followed up with Mr. Mayes, who noted 5-6/10+ bilateral knee pain.

c. On September 26, 2008, Claimant had recently taken hydrocodone for bilateral knee pain, and she had an allergic reaction to the medication. Dr. Nofziger diagnosed bilateral knee osteoarthritis and prescribed darvocet. Claimant also saw Mr. Mayes, who again noted bilateral knee pain and weakness, this time more severe (7-8/10+).

d. By October 17, 2008, Claimant attended five more sessions with Mr. Mayes to treat her bilateral knee symptoms. On the last day, Mr. Mayes apparently provided Claimant with a home exercise regimen and planned to order two knee braces.

e. On January 30, 2009, Dr. Nofziger's notes state Claimant had pain and swelling in her left knee.

INDUSTRIAL RIGHT KNEE INJURY

16. On March 26, 2010, Claimant stepped into a hole in the cement while walking across the back lot to get to a meeting at Seneca, and she fell. Claimant testified that her knee hurt immediately and started swelling. During the next 44 days, Claimant continued to work.

17. **Initial care – Dr. Stagg.** On May 10, 2010, Claimant's knee was still painful and swollen, so she went to Douglas Stagg, M.D., an occupational medicine physician, for treatment. Dr. Stagg's chart note from the initial evaluation indicates that Claimant reported a right ankle twist and pain that developed into right knee pain and swelling over the first week or so following the accident. Although she still had some right ankle pain, her knee hurt worse than her ankle by the time she sought treatment. Dr. Stagg observed that Claimant walked with a

moderate limp favoring her right side. On exam, he could not detect an effusion in her knee, but he noted that it was fairly large, with mild diffuse tenderness. She had range of motion of 0 to 120 degrees. Dr. Stagg ordered x-rays, which identified degenerative changes (mild narrowing and osteophyte formation in the medial and patellofemoral compartments) and joint effusion in her right knee, but no fractures. He diagnosed a right knee sprain, lower leg strain, and a right ankle sprain. He recommended conservative care (ice, ibuprofen, exercises), no ladder-climbing, and limited walking.

18. On May 18, 2010, Claimant returned to Dr. Stagg. Claimant was still uncomfortable, with some popping and swelling in the back of the right knee, worse in the morning. Claimant did not recall at her deposition when the popping started. Claimant still walked with a moderate limp on the right, and her examination was unchanged from May 10. Dr. Stagg suspected a meniscal tear and ordered an MRI. He maintained her restrictions, adding no kneeling or squatting. He recommended two Aleve per day for discomfort and maintained his recommendation for icing and exercises.

19. Claimant underwent an MRI of her right knee on June 5, 2010. She did not recall Dr. Stagg discussing her MRI findings with her; however, they are well-documented in the record. The reporting radiologist noted:

> IMPRESSION: LARGE RADIAL TEAR, MEDIAL MENISCUS POSTERIOR HORN AND BODY.
>
> ADDITIONAL HORIZONTAL CLEAVAGE TEAR, POSTERIOR HORN OF MEDIAL MENISCUS.
>
> JOINT EFFUSION. LARGE COMPLEX BAKER'S CYST WITHOUT DEFINITE RUPTURE.
>
> MODERATE CHONDROMALACIA. SUBCHONDRAL MARROW EDEMA IN BOTH MEDIAL AND LATERAL FEMORAL CONDYLES. SMALL OSTEOCHONDRAL DEFECT PRESENT AT THE POSTEROLATERAL

ASPEC OF THE MEDIAL FEMORAL CONDYLE. THIS MEASURES APPROXIMATELY 5 MM IN DIAMETER. NEGATIVE FOR UNSTABLE FRAGMENT.

MILD SPRAIN OF THE MEDIAL COLLATERAL LIGAMENT.

TRICOMPARTMENTAL OSTEOARTHRITIS.

JE-171.

20. On June 7, 2010, Claimant was evaluated by Dr. Stagg for the final time. She still had pain, mostly medially but also laterally with a lot of catching and popping. She walked with a slight limp favoring her right knee. On exam, Dr. Stagg noted a small effusion, tenderness over both joint lines and a range of motion of 0 to 120 degrees. Dr. Stagg diagnosed a medial meniscal tear, continued Claimant's restrictions and medication recommendation, and referred her to Dr. McKee.

21. **Arthroscopy and medial meniscectomy – Dr. McKee.** R. Tyler McKee, D.O., an orthopedic surgeon, treated Claimant from June 17, 2010 until December 13, 2010. On June 17, she complained of persistent right knee pain, mostly medial, but also lateral. Dr. McKee noted that Claimant walked with a limp on her right leg and that her weight to height ratio placed her in the morbidly obese category. On examination, Claimant demonstrated two-plus effusion and tenderness over the medial joint line. Her knee was stable, and she had zero to 130 degrees of range of motion, which Dr. McKee opined was age-consistent. In addition to examining Claimant, Dr. McKee examined her MRI films.

22. Dr. McKee assessed degenerative joint disease (DJD) complicated by a meniscal tear in an "apparently asymptomatic" knee prior to her industrial injury. JE-178. "Number one she has degenerative changes of her knee…Number two she has a meniscal tear which was

aggravated by her degenerative changes." *Id.* He administered a cortisone injection to reduce inflammation and aspirated 20 cubic centimeters of excess fluid from Claimant's knee.

23. Dr. McKee defined DJD as wear and tear on the joint, wearing away the cartilage. He confirmed that another term for this pathology is "osteoarthritis." McKee Dep., p. 14.

24. Claimant did well until June 21, 2010, when she was sent home from work due to knee pain and swelling. Dr. McKee examined her again on June 22, and found no change from her prior exam. He noted that Claimant was overdoing it at work, but he did not elaborate and did not remember the basis for this comment at the time of his deposition. Dr. McKee restricted Claimant to sedentary duty to allow time for the steroid injection he administered on June 17 to work.

25. By July 15, 2010, Claimant still had no relief from her right knee symptoms. Dr. McKee assessed no particular meaning to the lack of efficacy of the steroid injection. Claimant continued to walk with a limp and to exhibit knee effusion and medial joint line tenderness. On exam, he noted significant medial side joint pain with mechanical symptoms, which he described at his deposition as "catching" but not "locking." McKee Dep., p. 18. She had a positive Thessaly's test, indicating to Dr. McKee that Claimant's meniscus was generating her pain.

26. Dr. McKee recommended surgical intervention. At his deposition, he explained that Claimant had a 50/50 chance of improving following the procedure, and that the chance of improvement is directly related to the degeneration in the knee. Claimant initially agreed. However, upon consideration, she changed her mind. Dr. McKee recalled that she was afraid that the procedure may not relieve her symptoms because he had advised that it is difficult to know whether the pain is coming from the meniscus, or from the arthritis. Dr. McKee then

recommended physical therapy, which Claimant tried. As of August 26, 2010, Claimant had participated in physical therapy for four weeks without improvement. Dr. McKee again discussed surgery with Claimant, and she agreed. After a cardiac workup and a delay required by a bout of bronchitis, Claimant was cleared for surgery.

27. On September 13, 2010, Claimant underwent arthroscopic surgical repair of grade three chondral changes of the medial femoral condyle, grade two chondral changes of the medial tibial plateau, and a radial tear of the medial meniscus. Dr. McKee removed the torn portion of meniscus and smoothed it off, and shaved flaps of cartilage from the condyle surface that he opined may be symptomatic.

28. Of these conditions, Dr. McKee opined only the meniscal tear was directly related to Claimant's industrial accident and injury, though a fall could possibly cause cartilage to break away. Dr. McKee explained that the medial tibial plateau is the cartilage on the inside of the knee on the lower leg portion of the knee joint, where the medial femoral condyle connects. He opined that "life" activities are responsible for changes to this structure and that no research he knows of supports a genetic etiology for this condition. McKee Dep., p. 23.

29. Following surgery, Dr. McKee opined that the back of Claimant's meniscus was significantly weakened, increasing joint forces on that side of her knee:

> Q. Did that leave enough meniscus to provide her with sufficient shock absorbing - -
>
> A. In the back of the meniscus, no, not much.
>
> Q. Okay.
>
> A. Not much. Very little.
>
> Q. And how does that translate to any impact, if at all, upon the medial femoral condyle and medial tibial condyle?

> A. Well, we know, just from data recently, that any meniscectomy causes increased joint forces. So even if you lose a small amount of meniscus, you get increased joint forces on that side. So if you lose meniscus, you will most likely get some kind of degeneration. How much, I don't think we know yet.

McKee Dep., pp. 26-27.

30. Seven days post-operatively, on September 20, 2010, Claimant was having pain controlled by medication. Dr. McKee restricted her to sedentary work. On October 18, 2010, Claimant complained of shooting pain, throbbing and aching that Dr. McKee opined originated on the medial side and was non-neurogenic. Claimant did not remember having this kind of pain pre-surgery. Dr. McKee opined that she was not progressing very quickly, and he did not yet recommend physical therapy. By Claimant's deposition on August 23, 2011, the shooting, throbbing, aching pains had resolved, and she was having "pains like little needles sticking me in the knee." Cl. Dep., p. 60.

31. On November 15, 2010, Claimant again reported no improvement. Dr. McKee found Claimant's complaints consistent with the small subset of patients whose symptoms are actually worsened by surgical procedures like Claimant's. By December 13, 2010, Claimant had undergone injections, which helped somewhat. However, she was still having knee pain and was scheduled for a "second opinion" which was actually an independent medical evaluation by Dr. Schwartsman (see below). Dr. McKee had no additional recommendations other than a Synvisc (lubrication) injection or a partial knee replacement surgery, which Dr. McKee opined may not be compensable through workers' compensation because Claimant's arthritis preexisted her industrial accident.

32. Dr. McKee and Claimant both testified that Claimant never complained to him about her left knee.

33. By mid-January 2011, Dr. McKee had reviewed Dr. Schwartsman's December 2010 report and opinions. He agreed (in a check-box letter) that Claimant had reached medical stability from her industrial injury by December 16, 2010, but he did not specifically address Dr. Schwartsman's other opinions.

34. Although Dr. McKee's notes indicate Claimant had been diagnosed with peripheral artery disease, Claimant does not recall this. No physician in this case has opined that any of Claimant's knee conditions were caused or affected by peripheral artery disease.

35. At his deposition, Dr. McKee explained that Claimant's accident aggravated her preexisting DJD. "[P]atients who have arthritis often won't have symptoms until there's something that happens. So they twist their knee or kind of the straw that breaks the camel's back. And she twisted her knee stepping in that hole, aggravating, you know, this underlying problem….And I know she specifically told me she had not had knee problems or knee pain prior to that accident." McKee Dep., p. 13.

36. After learning of Claimant's 2008 knee pain treatment and bilateral osteoarthritis diagnosis, Dr. McKee confirmed that a traumatic accident can transform "a little knee pain" into a more symptomatic osteoarthritis and did not change his prior opinions. McKee Dep., p. 43.

37. With respect to the relationship between Claimant's industrial injury and her right TKA, Dr. McKee was hesitant. "With the knee replacement, we're getting into nebulous territory, meaning most of her arthritis changes were pre-existing in my opinion. Plan on getting Schwartsman's opinion and then make recommendations." DE-242.

38. **Independent medical evaluation – Dr. Schwartsman.** Roman Schwartsman, M.D. is an orthopedic surgeon who primarily treats shoulders, knees and hips. Approximately 40% of his practice is devoted to knees. He performed an IME regarding Claimant's right knee

on December 16, 2010. Claimant reported to him the details of her industrial knee twist in March 2010, and Dr. Schwartsman reviewed her medical records and performed an examination.

39. Dr. Schwartsman deemed Claimant medically stable from her industrial injury and assessed 2% lower extremity PPI (1% whole person) to Claimant's meniscal tear in the event it is deemed industrially related. He assessed no PPI in relation to Claimant's right knee osteoarthritis because he deemed any permanent impairment related to this condition to be unrelated to the industrial injury.

40. At his deposition, Dr. Schwartsman acknowledged Claimant's July 23, 2008 left knee x-ray report, which identified tricompartmental arthritis, as well as a chart note of the same date by Dr. Nofziger indicating Claimant was seeking treatment for pain and stiffness in her "knees" lasting two hours in the morning. Dr. Schwartsman opined that these complaints are consistent with degenerative arthritis and that she was taking six Motrin daily, which he presumed was probably not enough to control her symptoms.

41. Dr. Schwartsman opined that Claimant's May 10, 2010 right knee x-ray films identified significant joint space narrowing, sclerosis (hardening of the underlying bone) suggesting extensive or complete loss of cartilage, and osteophyte formation (bone spurs) along the margins of the joint suggesting loss of stability likely caused by either loss of meniscus or loss of cartilage over time (years). He summarized his findings at his deposition as "moderate to moderately severe osteoarthritis in that joint." Schwartsman Dep., p. 9. "And that is my opinion to a reasonable degree of medical certainty that the x-rays were most reflective of a chronic arthritic process that took years and years to evolved [*sic*]." Schwartsman Dep., p. 9.

42. Regarding Claimant's June 5, 2010 right knee MRI studies, Dr. Schwartsman generally agreed with the reporting radiologist's findings. More specifically, he opined that the

MRI demonstrated cartilage loss of 75-100% of the cross-sectional thickness from Claimant's patellofemoral compartment, which he attributed to normal aging:

> This is arthritic wear and tear caused by normal aging, in this case. It can also be caused by trauma such as falling directly onto the knee.
>
> But in this case, with no intervening history of trauma and with the fairly progressive pattern of cartilage loss, the conclusion that would be drawn, to a reasonable degree of certainty, is that this is normal arthritic change consistent with the appearance of a 63-year-old knee.

Schwartsman Dep., p. 12.

43. Dr. Schwartsman opined that Claimant's May 2010 right knee x-rays and her June 2010 right knee MRI images were consistent. "In this case both showed extensive arthritic change at the patella femoral [*sic*] joint and extensive change in the medial compartment of the knee." Schwartsman Dep., p. 12.

44. Regarding the meniscal tear, Dr. Schwartsman opined the MRI evidence did not support an acute etiology. He observed that the MRI showed a frayed degenerative medial meniscus; however, "what we see in an acute meniscal tear is typically a distinct meniscus with a sharp margin." Schwartsman Dep., p. 13.

> In this case I did not see any sharp margins. I saw an indistinct irregular mass consistent with a macerated tear, not consistent with a fresh recent acute tear but rather consistent with a macerated tear, which would be the result of the meniscus drying out and wearing out and fraying out as part of the normal aging process that a meniscus undergoes.

Id. Dr. Schwartsman further opined that the presence of a Baker's cyst is consistent with his view that Claimant's meniscus just wore out:

> Baker's cysts are frequently seen in association with meniscal tears. The fluid, over time, will leak through the meniscal tear outside of the joint capsule and form a cyst in the popliteal space, which is the area in the back of the knee.

Id. at pp. 13-14.

45. Dr. Schwartsman opined that interoperative photographs taken during Claimant's meniscal debridement[1] surgery on September 13, 2010 confirmed the absence of evidence of an acute etiology:

> The medial meniscal tear was visualized on these photographs prior to any debridement, prior to any treatment being rendered, and the tear has a macerated degenerative appearance.
>
> It looks frayed, sort of like a pant leg that hasn't been properly cuffed and has been walked on under a shoe. It has that frayed mop-end looking appearance, which is characteristic of a degenerative tear, and that's exactly what was seen on these photographs.
>
> That involved a mid-body and posterior horn, so approximately 2/3 of the meniscus had that macerated degenerative appearance. There was nothing in there to show a previously healthy meniscus with an acute sharp margin and recent tear.

Schwartsman Dep., p. 16. Dr. Schwartsman also opined that those photographs confirmed his findings with respect to Claimant's right knee arthritis:

> The appearance of the cartilage change and the transition between grade 3 and grade 4 tells me that this was a chronic change. This is not an acute cartilage flap that had been chipped off or flaked off. This was a chronic tear that had gone - - I'm sorry, this was chronic wear pattern that had gone from 75 percent worn and transitioning smoothly to full-thickness cartilage loss in the center.

Id. at p. 17. Dr. Schwartsman opined that only the surgeon at the time of the procedure has a better view of the pathology than the interoperative photos show.

46. On exam, Dr. Schwartsman noted varus alignment in both knees (bow-leggedness). He also took bilateral x-rays which identified medial and patellofemoral degeneration, but well-preserved lateral compartments. He opined bow-leggedness was the "sole and major contributing factor" to Claimant's medial compartment arthritis. Schwartsman Dep., p. 18.

[1] Dr. Schwartsman would not characterize the procedure as a repair surgery, since Claimant's meniscus was irreparable.

47. Dr. Schwartsman diagnosed severe bilateral knee arthritis and recommended bilateral TKAs. However, he opined there was no causal connection between Claimant's industrial accident and her persisting right knee condition. Rather, he opined that the accident only temporarily exacerbated her preexisting arthritis. Claimant had increased pain, so she sought treatment and was coincidentally diagnosed with a meniscal tear. "…[T]he finding of the meniscal tear, in my opinion, is incidental in this case. This is a macerated tear, this is not a flap that's going to flip up and cause her knee to lock. This is a simple macerated tear." Schwartsman Dep., p. 19. "I don't think her pain was ever coming from the meniscus. I think the meniscus had worn itself out over time. I think the pain was probably coming from the subchondral edema, which we see on the MRI." *Id.* "Basically, in stepping awkwardly this patient bruised her bone." *Id.* at pp. 19-20.

48. In addition, Dr. Schwartsman opined that Claimant was morbidly obese and that morbid obesity is a "known and accepted cause of progressive degenerative joint disease in the knees." Schwartsman Dep., p. 31. This particular view is unrebutted. Dr. Schwartsman was unaware of any research studies that established a genetic predisposition to osteoarthritis, though he suspected such a connection.

49. Dr. Schwartsman also opined that Claimant's knees would have been painful before the date of her industrial accident, and he questioned the accuracy of her testimony in these proceedings indicating she had never experienced right knee pain before the industrial accident.

50. According to Dr. Schwartsman, the industrial accident did not hasten Claimant's need for her right knee replacement. "She had an end-state preexisting need for a right-knee replacement." Schwartsman Dep., p. 23. However, he conceded that knee replacement surgery

is elective, so in addition to objective findings supporting a need for the procedure, "[t]he patient has to sign up for it." *Id.* at p. 46. He further conceded that "[p]ain is the overriding reason" why a patient will elect to undergo knee replacement surgery and that such surgery will only relieve pain related to worn out cartilage. *Id.* at p. 47. According to Dr. Schwartsman, "the signing up is when they've reconciled their perception of pain with their aversion to surgery." *Id.* at p. 45.

51. As to simultaneously performing bilateral knee replacements, Dr. Schwartsman opined that he does not do them because it places too much stress on the patient during the procedure, itself. Added blood loss, increased marrow fat circulating in the bloodstream (which increases risk for pulmonary complications), and increased anesthesia risks are some of the reasons he cited. He did not have an opinion regarding increased risks of a poor outcome due to recovery complexities.

52. **Bilateral total knee arthroplasties (TKAs) – Dr. Surbaugh.** Frederick Lee Surbaugh, M.D., an orthopedic surgeon, treated Claimant from January 26, 2011 through January 24, 2012 for her post-meniscectomy right knee pain. Claimant was referred by her sister. Dr. Surbaugh performed Claimant's bilateral TKAs on March 9, 2011.

53. At Claimant's initial consultation, Dr. Surbaugh noted she complained of pain in her right knee and reported that she had smoked ¾ to a pack of cigarettes per day for 48 years. On exam, Dr. Surbaugh reported that both knees were stable to varus and valgus stress and that Claimant had mild effusions in both knees. He observed that her walking gait was halting, favoring either side. At his deposition, Dr. Surbaugh opined that Claimant's knee symptoms were consistent with severe wear.

54. Dr. Surbaugh did not order an MRI of Claimant's left knee before proceeding with bilateral TKAs. Because of the high cost ($3,000), he never orders a contralateral MRI. He recommended a left knee TKA on the basis of her instability, and that the standing alignment of her knees was abnormal. "She was in slight varus, which means that she's getting bow-legged. So she was developing a similar deformity pattern in both knees." Surbaugh Dep., p. 25. In addition, left knee x-rays[2] from March 2, 2011 indicated mild narrowing in the medial compartment and osteophytes in the medial, lateral and patellofemoral compartments, with no evidence of fracture, in the left knee. The reporting radiologist assessed bilateral knee osteoarthritis based upon these and Claimant's right knee x-rays. In comparison with right knee x-rays taken on the same day, Dr. Surbaugh opined that the right knee demonstrated greater medial compartment narrowing, but the left knee bone spurring was more significant. Overall, he opined that Claimant's osteoarthritis, by x-ray, was more advanced in her left knee. However, Claimant's symptoms observed through imaging were fairly symmetrical. "…[T]hat's a typical pattern that you see with degenerative arthritis. It tends to be fairly symmetric in probably 80 percent of the patients. 20 percent will just have one knee that's severely or moderately severely involved, and the other knee that doesn't look too bad." Surbaugh Dep., p. 27. He went on to posit that Claimant's bilateral knee osteoarthritis was the result of genetic predisposition, plus her weight.

55. Dr. Surbaugh confirmed that he recommended that she undergo both knee replacements at once for the substantial cost savings – approximately one-third based upon Medicare reimbursement tables. He estimated that Claimant would have required the left knee replacement within one to five years, had she not undergone the procedure at the same time she had her right knee done.

[2] Dr. Surbaugh always orders contralateral x-rays.

56. In his surgical report, Dr. Surbaugh noted that Claimant had synovitis (inflammation of the joint lining), more severe in the right knee. "…[W]hen the knees start to degenerate and you get all these bone particles and cartilage particles floating around in the joint, the body tries to absorb them. And the synovial lining is the structure that does that. And it gets pretty angry when there's a lot of particles. So it's just an indicator of the ongoing wear process." Surbaugh Dep., pp. 31-32. Dr. Surbaugh also noted Claimant's knees were both[3] "soft", or somewhat osteoporotic. *Id*. However, osteoporosis would not affect her arthritis or degeneration of chondral surfaces.

57. On November 22, 2011, Dr. Surbaugh evaluated Claimant for the last time before his deposition. He thought she was doing pretty well, although he did diagnose her with gout in the bursa over the front of her right knee. He opined that it was possible that her knee replacement surgery ignited the gout. "Acute gout does occur after surgery. We don't know why. And I hate to take the blame for it. She's the only one I've ever seen, interestingly, that got it in the knee in the prepatellar bursa after surgery." Surbaugh Dep., p. 42. He did not believe, on a more-probable-than-not basis, that the surgery was the cause. Dr. Surbaugh prescribed Allopurinol, to which Claimant had a bad reaction, then he recommended cherry juice. At his deposition, he opined that Claimant's gout was controlled with Uloric.[4]

58. On exam, Claimant had 120 degrees of flexion in her right knee, with just a little swelling. She had more pain in her left knee, and she was walking better and more quickly,

[3] Although he did not specifically state both knees in his report, Dr. Surbaugh explained that, had one knee been softer than the other, he would have noted that fact.

[4] Questioned about Claimant's gout diagnosis, her Uloric regimen, and her lower-than-normal results from a uric acid c-reactive protein test administered by Dr. Howar on January 24, 2010, Dr. McKee also opined that Claimant's gout was under control. Along those lines, he further opined that Claimant's knee pain on January 24, 2010, and during any period in which her gout was controlled, was most likely not attributable to gout. He also opined that the serum test was not as sensitive as the gold standard method for diagnosing gout, which requires microscopic observation of fluid aspirated from a joint to confirm the presence or absence of uric acid crystals. "Gout" and "gouty arthritis" are the same condition to Dr. McKee.

without any assistive devices. She was taking colchicine and Uloric for gout, flurazepam for postoperative depression and tramadol for pain. Dr. Surbaugh expected that she would only need the tramadol for a couple more months; however, he expected she would continue with her other medications. He was aware that she had taken anti-depressants before, and had no opinion as to the reasons for that.

59. Dr. Surbaugh opined that Claimant had probably reached MMI on December 6, 2011, the date of his deposition. He assessed permanent restrictions based upon her exercise tolerance. "We just tell the patients pain and swelling and [*sic*] your guidance to level of activity. And if you have too much pain and too much swelling, you need to take anti-inflammatories and slow down." Surbaugh Dep., p. 44. Dr. Surbaugh released Claimant for sedentary work and specifically opined that she could probably work on a sorting line if she could remain seated on a stool. He believed that she would not be able to carry more than 30-40 pounds. Dr. Surbaugh opined that Claimant's frame of mind was the key factor to determining when she would return to work:

> It's just a matter of - - I think psychologically she has to feel like she can do it. She had a significant problem with depression. And Dr. Nofziger got her started on antidepressants. I don't know what she's taking now in that regard. She did seem a lot happier at that last visit. I hardly ever - - I don't think I ever saw her smile until she came in on that visit.

Surbaugh Dep., p. 46.

60. Dr. Surbaugh acknowledged that Claimant had a hard recovery from her bilateral knee replacements, which is not unusual. "It's definitely harder on you." Surbaugh Dep., p. 48. Dr. Surbaugh explained that the procedure sends a lot of bone marrow fat into the blood stream, which makes some patients very sick. He also noted that medical research has established,

through psychometric testing, that major surgery such as total knee replacement surgery is correlated with a significant drop in I.Q. for six months post-surgically.

61. As to causation, Dr. Surbaugh opined that Claimant's industrial injury accelerated her need for knee replacement surgery:

> I think it did. I think it accelerated the process. I don't - - I can't really say it was inevitable. But the fact that she had this fairly dramatic meniscal tear would indicate that that was acute and traumatic. And so I think there were probably two processes going on.

Surbaugh Dep., pp. 37-38. He explained that a large radial meniscal tear, such as Claimant's, is likely to flap back and forth, leading to significant wear of the chondral surface within a matter of weeks in a woman of Claimant's age. Eventually, the flap may break off, as it appears to have done in Claimant's case. Activity and weight on the knee play a part in this process, too.

62. **Independent medical evaluation – Dr. Bates.** James Bates, M.D., a physiatrist, conducted an IME at Claimant's request on March 7, 2012. Preparatory to authoring his report, he interviewed and examined Claimant, and reviewed her medical records. He was aware that Claimant had undergone arthroscopic surgery on her right knee, as well as bilateral total knee replacements.

63. Claimant told Dr. Bates the details of her industrial accident and that, prior to then, she had no knee problems. Dr. Bates found this consistent with Claimant's medical records in his possession. Claimant's chief complaint was constant right knee pain and swelling, worse with standing and walking. She reported that her left knee was doing well.

64. Dr. Bates examined Claimant's gait walking normally and on her toes. He also observed her standing on one leg and checked her bilaterally for range of motion, tenderness to touch and knee stability. His comparative findings indicated more limited range of motion on the right in both flexion and extension, as well as increased tenderness on the right.

65. Dr. Bates opined that Claimant's industrial injury caused her preexisting degenerative changes in her right knee to become symptomatic. "I believe that a trauma to the right knee could accelerate the process[5] and the need for surgery." Bates Dep., p. 18.

66. Finding Claimant had reached medical stability,[6] Dr. Bates calculated her permanent partial impairment. Pursuant to the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*, Dr. Bates assessed 1% whole person PPI to Claimant's meniscal tear and 12% to her right TKA. He considered Claimant's residual range of motion deficits (lacking 55 degrees of flexion and 10 degrees of extension) and leg instability (as determined by his detection of laxity on stress) in calculating her permanent impairment. He assessed permanent restrictions including no bending, stooping, kneeling, or squatting; climbing (stairs or ladders) limited to five or six times per day; frequent position changes (alternating between sit, walk, stand and stand/walk every half hour, with sitting limited to an hour at a time); lifting/carrying limited to 20 pounds to reduce wear and tear on her knee; and use of a cane or assistive device when walking, especially on uneven ground, to stabilize her gait.

67. On April 4, 2012, Dr. Bates responded to a letter from Claimant's counsel seeking additional information about the restrictions he would assess to Claimant's meniscal tear, alone. He opined that, post-meniscectomy, Claimant's knee condition remained stable for six months, so he would not expect it to improve significantly thereafter. Given her symptoms during that period, Dr. Bates opined that Claimant's permanent restrictions would be the same as those he assessed on March 7. At his deposition, Dr. Bates explained that ordinarily, a surgically repaired partial meniscal tear would not warrant any significant restrictions. However, in addition to her

[5] By process, Dr. Bates meant degeneration, which he described as, "The breakdown of the knee, the cartilage of the knee, the forming of bone spurs." Bates Dep, p. 18.

[6] Dr. Bates concurred in Dr. Surbaugh's opinion that Claimant reached medical stability from her TKA on December 6, 2011.

large radial meniscal tear, Claimant also had advanced degenerative changes, chondromalacia and subchondral marrow edema. Therefore, after her industrial injury but prior to her TKA, Claimant's knee was significantly different than a simple post-meniscectomy knee:

> I believe this represents more than a temporary exacerbation of knee pain. Six months of the knee pain being symptomatic, and therefore the limitations that Ms. Woody reports would be an appropriate guide or basis for restrictions. Due to the fact that they were fairly consistent over six months, they are similar to the restrictions of a recurrent postoperative state.

JE-354.

68. Regarding Claimant's pre-injury right knee condition, Dr. Bates testified that he had never rated an asymptomatic limb. Although impairment from degenerative changes in a joint space can be rated by x-ray evidence, "[w]ith no complaint of pain, most likely there would not be a cause for obtaining her rating." Bates Dep., 19. He recommended that the *Guides* be consulted with respect to this issue.

69. Dr. Bates recommended continuing physical therapy as long as Claimant's functioning continued to improve, but he did not anticipate that her right knee would improve significantly in the future and believed that she was "getting close to the maximum benefit from the therapy" at the time of his evaluation. Bates Dep., p. 23. He recalled that Claimant reported only a little improvement from physical therapy and had not reviewed the physical therapy notes himself. He acknowledged that Claimant could do her physical therapy exercises at home.

70. Dr. Bates was aware of Dr. McKee's and Dr. Schwartsman's opinions regarding the etiology of Claimant's knee condition requiring total knee replacement. He was unaware of Claimant's medical records documenting knee problems prior to her industrial injury. Dr. Bates' opinion lacks foundation to render any credible comparative opinions regarding Claimant's pre-

and post-industrial injury knee. Dr. Bates' opinions with respect to physical limitations, medical restrictions and PPI assessment are credible.

CLAIMANT'S CREDIBILITY

71. Claimant testified, both at her deposition and at the hearing, that she never had any knee problems before her March 2010 injury at Seneca. However, contemporaneous treatment records compiled by Dr. Nofziger and Mr. Mayes establish that Claimant obtained treatment for bilateral knee pain from bilateral osteoarthritis (DJD), on several occasions between July and October 2008. Also, Mr. Mayes gave Claimant a home exercise plan and a recommendation for bilateral knee braces at the end of her physical therapy sessions in October 2008, suggesting that he believed her knee problems were on-going.

72. In addition, Claimant was an excessively poor historian in terms of dates and identification of care providers at her deposition in August 2011. It is unusual that she did not remember, for instance, who diagnosed her with fibromyalgia or a heart murmur, who delivered any of her children, or whether she had previously undergone an MRI. At the hearing, her recall seemed substantially better, but a close review of the transcript reveals that this impression may be due, in large part, to her concurrence in leading questions. Claimant, herself, admitted that her "mind is very bad," and that her memory is better when she tries to recall more recent events. Tr., p. 66.

73. The Referee finds Claimant's medical records from 2008 regarding her diagnosis of bilateral knee osteoarthritis and related treatment are more credible than her testimony. On this point, Claimant's testimony is rebutted, and the Referee finds that she had symptomatic bilateral osteoarthritis prior to March 26, 2010. The Referee also finds that where Claimant's testimony conflicts with evidence in the record that is otherwise credible, including but not

limited to her contemporaneously created medical records, Claimant's testimony will carry less weight.

DISCUSSION AND FURTHER FINDINGS

74. 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).

CAUSATION

75. 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).

76. 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. Dravo Corporation*, 95 Idaho 958, 560-61, 511 P.2d 1334, 1336-37 (1973). See also *Callantine*, *Id*.

77. 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).

78. The Industrial Commission, as the factfinder, is free to determine the weight to be given to the testimony of a medical expert. *Rivas v. K.C. Logging*, 134 Idaho 603, 7 P.3d 212 (2000). The Commission can accept or reject the opinion of a physician regarding impairment. *Clark v. City of Lewiston*, 133 Idaho 723, 992 P.2d 172 (1999). The Commission's conclusions as to the weight and credibility of expert testimony will not be disturbed unless such conclusions are clearly erroneous. *Reiher v. American Fine Foods*, 126 Idaho 58, 878 P.2d 757 (1994). "When deciding the weight to be given an expert opinion, the Commission can certainly consider whether the expert's reasoning and methodology has been sufficiently disclosed and whether or not the opinion takes into consideration all relevant facts." *Eacret v. Clearwater Forest Industries*, 136 Idaho 733, 40 P.3d 91 (2002). Unless a decision to render no weight to a medical expert opinion was clearly erroneous, it will be affirmed. *Id.*

79. Defendants do not dispute that Claimant suffered an industrial accident when she twisted her leg on March 26, 2010. They do argue, however, that Claimant did not suffer a meniscal tear, or any injury as a result of that event that remained symptomatic as of December 16, 2010. They also argue that Claimant's industrial injury had no significant effect on her preexisting DJD.

80. It is well-settled that the permanent aggravation of a preexisting condition is compensable. See, for example, *Bowman v. Twin Falls Construction Company, Inc.*, 99 Idaho

312, 581 P.2d 770 (1978). "The fact that [claimant's] spine may have been weak and predisposed him to a ruptured disc does not prevent an award since our compensation law does not limit awards to workmen [or women] who, prior to injury, were in sound condition and perfect health. Rather, an employer takes an employee as he [or she] finds him [or her]. *Wynn v. J.R. Simplot Company*, 105 Idaho 102, 104, 666 P.2d 629, 631 (1983). Regardless of Claimant's preexisting degenerative condition, Defendants will be liable for at least a portion of Claimant's benefits if her industrial injury aggravated her DJD.

81. **Nature of industrial injury.** An MRI taken a little more than two months after the industrial accident identified a medial meniscal tear and a large Baker's cyst. Dr. Stagg referred Claimant to Dr. McKee, who diagnosed two separate problems on her first visit: 1) a medial meniscal tear as a result of Claimant's workplace injury, 2) that was aggravating her preexisting DJD. He noted Claimant's DJD was "apparently asymptomatic prior to her injury." JE-178. Even after learning of Claimant's medical records demonstrating her prior right knee DJD diagnosis and treatment, however, Dr. McKee maintained his opinion that Claimant's industrial injury worsened her preexisting DJD by igniting increased symptoms, including pain. Dr. Surbaugh concurred in the opinion that Claimant's industrial injury (the meniscal tear) likely accelerated her right knee condition and hastened her need for TKA.

82. Dr. Schwartsman, however, opined on December 16, 2010 that Claimant's meniscal tear was most likely not caused by her industrial knee twist. He based his opinion on the appearance of Claimant's medial meniscus as he observed it through preoperative diagnostic imaging and interoperative photos, as well as the presence of a large Baker's cyst. The absence of clearly defined edges and the frayed (macerated) appearance of Claimant's medial meniscus, Dr. Schwartsman posited, evidenced a chronic etiology.

83. Dr. Surbaugh offered an explanation in his deposition on December 6, 2011 that could reconcile Claimant's macerated meniscus on September 13, 2010[7] with an acute injury on March 26, 2010. He opined that upon tearing, Claimant's meniscus likely had one or more loose flaps that wore against the chondral surface and broke off. This theory is consistent with Dr. McKee's operative report, in which he described finding a displaced meniscal fragment in the posterior portion of Claimant's knee. Dr. Schwartsman's explanation of the causal relationship between Claimant's Baker's cyst and the chronic drying out of her medial meniscus, however, remains unrebutted.

84. Of the three opining physicians, only Dr. McKee observed the unrepaired meniscus firsthand. In addition, he appropriately considered the evidence regarding the extent of Claimant's preexisting DJD. Further, Dr. Surbaugh's concurrence in Dr. McKee's opinion after treating Claimant, himself, and his medical reasoning reconciling the appearance of the meniscus with an acute etiology, bolster their shared opinion. Dr. Schwartsman's observations regarding the Baker's cyst, however, are also persuasive. It does not appear from the record that Dr. McKee ever addressed the etiology of Claimant's Baker's cyst.

85. The Referee finds the evidence in the record supports the proposition that Claimant already suffered from chronic degeneration of her medial meniscus at the time of her industrial accident. However, Dr. Schwartsman's opinion is insufficient to overcome the opinions of Drs. McKee and Surbaugh that she also incurred an additional meniscal injury due to her workplace accident.

[7] Dr. Schwartsman found no evidence of acute injury on Claimant's June 10, 2010 MRI, either; however, he placed greater weight on the interoperative photos because those views are second only to observing the meniscus firsthand during surgery. Dr. Surbaugh's explanation also reconciles Dr. Schwartsman's observation that the MRI demonstrated no sharp edges in Claimant's meniscal tear with an acute etiology because he opined that, in a patient Claimant's age, a flap created by an acute tear could wear off within a few weeks.

86. **Claimant's industrial meniscal tear permanently aggravated her preexisting DJD.** At his deposition, Dr. McKee affirmed his opinion that Claimant's industrial injury aggravated her preexisting DJD. Dr. Schwartsman, on the other hand, opined that, at most, Claimant's knee twist only temporarily exacerbated her DJD. By December 16, 2010, according to Dr. Schwartsman, Claimant had recovered to her pre-injury status. "The amount of pain that the patient is experiencing in her knee is consistent with what would be expected with this degree of arthritis, regardless of the presence of a fall." JE-277.

87. In order to accept Dr. Schwartsman's view, the record would have to demonstrate sufficient evidence that either Claimant was experiencing the same symptoms in mid-March 2010 as she was experiencing in December 2010, or that Claimant's symptoms would have progressed as they did, even in the absence of the industrial knee twist. However, the evidence of record establishes neither.

88. In December 2010, according to Dr. McKee's notes, Claimant was still having significant pain and difficulty with standing and stair-climbing, and she walked with a limp on her right leg.[8] In addition, her physical therapy notes confirm pain, weakness and dysfunction. Following her surgery, Claimant worked in a sedentary position until November 30, 2010, when she was laid off. By contrast, in the weeks before the accident in March 2010, Claimant was working full-time in a job that required her to stand for long periods of time and to climb a flight of 15 stairs several times during the day, and Dr. Nofziger's records indicate she was trying to slim down, working out several times per week. Although Claimant's medical records establish that she likely experienced periodic knee stiffness and pain before her industrial accident, there is

[8] Dr. Schwartsman characterized Claimant's gait as symmetrical and antalgic later in December 2010, as did Dr. Surbaugh in January 2011. Dr. McKee's opinion, shared by Dr. Stagg, is more persuasive on this point with respect to the initial months following the industrial accident because he had more opportunities on which to observe Claimant's gait and his notes consistently record a limp on the right.

insufficient evidence to prove she was experiencing pain comparable to those that she reported, and physicians observed, in December 2010. There is insufficient evidence to establish whether and what type of functional difficulties related to her right knee that Claimant may have experienced prior to her accident. The record fails to support the proposition that Claimant's knee condition had returned to its March 2010 baseline by December 2010.

89. There is, likewise, insufficient evidence of the rate of progression of Claimant's preexisting DJD from which to conclude that her right knee was likely to deteriorate to its December 2010 condition in the absence of her industrial injury. Along those lines, Drs. McKee and Surbaugh, as well as Claimant, all testified that Claimant did not complain of left knee symptoms through the time of her bilateral TKAs. This evidence tends to rebut Dr. Schwartsman's testimony regarding the likely progression of Claimant's right knee DJD, particularly in light of Dr. Surbaugh's opinion that, anatomically, Claimant's DJD was more advanced in her left knee than in her right knee at the time of those procedures.

90. In addition, Drs. Surbaugh and Bates both opined that Claimant's right knee was weakened and made more susceptible to arthritic changes by her meniscectomy.

91. It must be acknowledged that Dr. McKee hesitated when asked whether the industrial injury contributed to Claimant's need for a right TKA and deferred to Dr. Schwartsman's opinion on this point. It is apparent from the record that Dr. McKee's hesitation was rooted in his belief that a TKA may not be compensable, not because he had second thoughts about whether the industrial injury aggravated Claimant's DJD. Dr. McKee's hesitation and deferral, such as they were, were based upon a legal determination, which he was unqualified to make.[9] Compensability and causation determinations go hand-in-hand, but they are not the same. Under the Idaho Workers' Compensation Law, medical opinions must

[9] Dr. Schwartsman was similarly unqualified to determine the compensability of the claim.

determine causal relationships between accidents and injuries (and related symptoms). However, it is the Commission's charge to determine whether the causal relationships established by medical testimony are sufficient to prove that the defendants are liable for a claimant's workers' compensation benefits. Dr. McKee's deferral regarding the compensability of the claim does not alter the weight of his relevant medical opinions, which clearly opposed those of Dr. Schwartsman with respect to the etiology of Claimant's meniscal tear and its contribution to her right knee symptomatology following her industrial accident.

92. The Referee finds Dr. Schwartsman's opinion that Claimant's right knee condition, by December 2010, was unrelated to her industrial knee twist, is less persuasive than the view shared by Drs. McKee, Surbaugh and Bates. The Referee finds Claimant's knee condition in December 2010 was the result of the permanent aggravation of her preexisting DJD by her industrial injury.

93. **Natural consequences of the industrial injury are also causally related.** When the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury likewise arises out of employment, unless it is the result of an independent intervening cause attributable to the claimant's own intentional conduct. *Larsons, The Law of Worker's Compensation,* § 13. Claimant underwent the meniscectomy due, in part, to her industrial injury. Defendants do not argue that Claimant engaged in any intentional conduct that would constitute a supervening cause. To the extent the meniscectomy contributed to Claimant's need for a right TKA, by weakening her knee or increasing her pain or other symptoms, that contribution is directly related to her industrial accident and is, thus, compensable.

94. Claimant's subsequent knee injury (while toileting) sustained while she was in recovery for her TKA was a natural result of her industrial injury and any treatment related to this event is also compensable.

95. No physician opined to a reasonable medical certainty that Claimant's gout developed post-TKA was related to her surgery or her industrial injury. Defendants are not liable for Claimant's gout treatment.

MAXIMUM MEDICAL IMPROVEMENT (MMI) AND MEDICAL CARE

96. Dr. Surbaugh opined Claimant had "turned the corner" by November 22, 2011, and agreed with counsel's suggestion that she had probably reached medical stability by that date. Surbaugh Dep., p. 47. He also opined that Claimant reached MMI on December 6, 2011. No other physician offered a post-TKA medical stability opinion. The Referee finds Claimant reached MMI following her March 26, 2010, industrial injury on December 6, 2011. She is entitled to the reasonable and necessary medical care related to her industrial right knee injury she received through that date.

MEDICAL CARE

97. 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).

98. In *Sprague*, the following factors were found relevant to the determination of whether the particular care at issue in that case was reasonable: (1) the claimant should benefit from gradual improvement from the treatment rendered; (2) the treatment was required by a claimant's treating physician; (3) the treatment was within the physician's standard of practice and the charges were fair and reasonable.

99. Here, the record clearly establishes the second and third *Sprague* prongs. Although Claimant obtained less than optimal results from both her meniscectomy and her TKA, Defendants do not argue that this surgery was not medically reasonable. As Dr. McKee noted prior to Claimant's meniscectomy, her industrial injury placed her "in a tough spot" in terms of her prognosis due to its interaction with her preexisting DJD. JE-178. Claimant's hesitation to undergo meniscectomy signals her concern about a bad outcome, but she did not see any improvement following Dr. McKee's other recommendations, so she consented. When that did not help, Drs. McKee, Schwartzman and Surbaugh all recommended TKA. The evidence in the record suggests Claimant is less confident about ambulating following her TKAs than she was before those procedures because she now uses a cane or walker to get around.[10] However, it would work a manifest injustice to declare Claimant's right TKA incompensable, when all three opining physicians recommended the procedure, simply because she did not obtain the hoped-for result. *See Page v. McCain Foods, Inc.*, 2009 IIC 0424.7 (Sept. 8, 2009) ("*Sprague* and its

[10] Some medical records indicate that, at certain points in time, Claimant was not using any assistive devices. Claimant, on the other hand, maintains she has used a cane or a walker ever since her TKAs. Although Claimant's medical records were determined, above, to be generally more credible than Claimant's testimony, the Referee finds the medical records less credible than Claimant's testimony on this point. There is insufficient evidence in the record from which intentional deception could be found, and it is understandable that Claimant could reliably recall the details of an ongoing inconvenient need for assistance even when her recall of dates, names and symptoms from the past is unreliable.

progeny have not created a rule that medical care is compensable only when it is successful.")

100. Even though the record indicates Claimant is still experiencing symptoms and limitations after her right TKA surgery, it establishes the surgery was medically reasonable. To the extent Claimant's meniscectomy is disputed, the Referee also finds this procedure was medically reasonable. No other medical procedures are in dispute. The Referee finds that the medical treatment Claimant has received related to her industrial right knee injury, as evidenced in the record, was reasonable and necessary.

TEMPORARY TOTAL DISABILITY (TTD)

101. Idaho Code §§ 72-408 and 409 provide time loss benefits to an injured worker who is temporarily totally disabled until such time that the worker becomes medically stable. As determined, above, Claimant reached medical stability on December 6, 2011. The record establishes that Claimant was medically released for sedentary work before that date and that she continued to work for Seneca in a modified sedentary duty position during significant periods through November 30, 2010, when she was laid off. Therefore, Claimant is entitled to TTD benefits from March 26, 2010 through December 6, 2011, subject to appropriate offsets for TTD benefits already paid and/or periods during which she was paid for sedentary duty.

PERMANENT PARTIAL DISABILITY

102. **"**Permanent disability" or "under a permanent disability" results when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected. Idaho Code § 72-423. Permanent disability is a question of fact, in which the Commission considers all relevant medical and nonmedical factors and evaluates the purely advisory opinions of vocational experts. *See Eacret v. Clearwater Forest Indus.,* 136 Idaho 733, 40 P.3d 91

(2002); *Boley v. State, Industrial Special Indem. Fund,* 130 Idaho 278, 939 P.2d 854 (1997). The burden of establishing permanent disability is upon a claimant. *Seese v. Idaho of Idaho, Inc.,* 110 Idaho 32, 714 P.2d 1 (1986).

103. "Permanent impairment" is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured employee's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker & Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

104. **Preexisting PPI.** It was determined, above, that Claimant's right knee osteoarthritis was not entirely asymptomatic prior to her industrial injury. However, no physician has assessed any PPI to the preexisting symptomatology. Dr. Schwartsman apportioned 100% of Claimant's right TKA assessment to her preexisting DJD, but this does not address whether she had any PPI prior to her industrial accident. The evidence of record, therefore, is insufficient to establish that Claimant was operating under any permanent impairment related to her right knee DJD prior to her industrial injury. The Referee finds Claimant had no preexisting PPI related to her right knee. The Referee further finds that because there was no preexisting PPI, there could be no preexisting disability.

105. **PPI from industrial right meniscectomy and TKA.** The medical evidence in this case establishes that Claimant suffered permanent impairment due to her industrial right knee injury. Dr. Bates opined that Claimant incurred 1% whole person PPI as a result of her meniscal tear and 12% due to her right TKA, all related to the industrial injury. Dr. Schwartsman opined 2% lower extremity (1% whole person) PPI related to the meniscal tear and 0% related to the right TKA. Because it was determined, above, that Claimant's right TKA was industrially related, and she had no preexisting PPI, Dr. Bates' opinion is more persuasive. The Referee finds Claimant has industrial combined PPI related to her right knee of 13% of the whole person.

106. **Medical restrictions and limitations.** Persuasive evidence of Claimant's restrictions and limitations related to her right knee injury is provided by Drs. Surbaugh and Bates. Dr. Surbaugh opined that Claimant could return to sedentary work with a 30-40 pound weight restriction, such as working on a production line perched on a stool. "Really, just - - the restrictions are based on exercise tolerance…And if you have too much pain and too much swelling, you need to take anti-inflammatories and slow down." Surbaugh Dep., p. 44. Dr. Bates assessed no bending, stooping, kneeling, or squatting; climbing (stairs or ladders) limited to five or six times per day; frequent position changes (alternating between sit, walk, stand and stand/walk every half hour, with sitting limited to an hour at a time); lifting/carrying limited to 20 pounds to reduce wear and tear on her knee; and use of a cane or assistive device when walking, especially on uneven ground, to stabilize her gait. Dr. Surbaugh's opinion regarding general medical restrictions is credible, but Dr. Bates' opinion is more reflective of a complete picture of Claimant's abilities based upon both her medical restrictions (to guard

against risk of reinjury) and her legitimate limitations from all physical sources, including pain. The Referee adopts Dr. Bates' medical restrictions in determining Claimant's PPD.

107. **Time of disability determination.** The Idaho Supreme Court in *Brown v. The Home Depot,* WL 718795 (March 7, 2012) held that, as a general rule, Claimant's disability assessment should be performed as of the date of hearing. Under Idaho Code § 72-425, a permanent disability rating is a measure of the injured worker's "present and probable future ability to engage in gainful activity." Therefore, the Court reasoned, in order to assess the injured worker's "present" ability to engage in gainful activity, it necessarily follows that the labor market, as it exists at the time of hearing, is the labor market which must be considered. Here, Claimant resided and worked in Buhl, Idaho at all relevant times, and the record divulges no reason why Claimant's ability to engage in gainful activity would be more accurately measured at any time other than the date of the hearing. Therefore, Claimant's disability will be determined as of the hearing date.

108. **Local labor market.** At the time of the hearing, Claimant resided in Buhl, Idaho; therefore, her disability will be determined with respect to her employability in the Buhl/Twin Falls local labor market.

110. **Nonmedical factors.** The test for determining whether a claimant has suffered a permanent disability greater than permanent impairment is "whether the physical impairment, taken in conjunction with nonmedical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 766 P.2d 763 (1988). In sum, the focus of a determination of permanent disability is on the claimant's ability to engage in gainful activity. *Sund v. Gambrel*, 127 Idaho 3, 896 P.2d 329 (1995).

111. In determining percentages of permanent disabilities, account should be taken of the nature of the physical disablement; the disfigurement, if of a kind likely to handicap the employee in procuring or holding employment; the cumulative effect of multiple injuries; the occupation of the employee; and his or her age at the time of accident causing the injury, or manifestation of the occupational disease. Consideration should also be given to the diminished ability of the affected employee to compete in an open labor market within a reasonable geographical area considering all the personal and economic circumstances of the employee, and other factors as the Commission may deem relevant. Idaho Code §§ 72-425, 72-430(1).

112. Claimant's relevant nonmedical factors are weighed as follows:

a. Age: Claimant is 64. As an older worker, Claimant's age reduces her employability.

b. Education: Claimant only completed the ninth grade, and she has not pursued any additional degrees or certifications. She has no specific computer or keyboarding skills, but she surfs the Internet and plays games on the computer. She likes reading.

c. Work experience: Claimant has significant experience as a production line worker. She has also worked as a janitor.

d. Disfigurement. Claimant has no disfigurement. However, she does use either a cane or a walker to ambulate, which could discourage some employers from hiring her.

113. When calculating Claimant's loss of access to employment pursuant to *Fisher v. Peterbilt,* 2012 IIC 0068, utilizing Dr. Bates' restrictions (adopted, above), Mr. Porter and Mr. Jordan reach nearly the same conclusion. Mr. Porter determined Claimant suffered a 75%

loss of access (*see* Porter Dep., pp. 74-76), while Mr. Jordan assessed 71% (*see* Jordan Dep., pp. 31-32.). As to wage earning capacity, Mr. Porter opined Claimant suffered a 27% loss based upon her pre-injury wage of $11.95 per hour and the post-injury average of the median wages from jobs she could still do based upon Dr. Bates' restrictions ($8.75). Mr. Jordan assumed Claimant's post-injury earning capacity would be limited to the minimum wage ($7.25), for a 40% loss in earning capacity. Ultimately, Mr. Porter averaged his loss of access and wage loss assessments to arrive at a Claimant's PPD. Mr. Porter's figures amount to 51% PPD (inclusive of impairment). Mr. Jordan averaged his respective assessments (56%), then "bumped up" that number to account for Claimant's non-medical factors (age, education, and the way she would present to an employer), for a total PPD of 69% (inclusive of impairment.) (*See* Jordan Dep., p. 33.)

114. Mr. Porter's wage analysis rests on a sounder methodology than does Mr. Jordan's, justifying a downward adjustment to Mr. Jordan's PPD assessment. However, Mr. Jordan's PPD assessment more clearly accounts for Claimant's non-medical factors, justifying an upward adjustment to Mr. Porter's assessment.

115. Having considered and weighed the opinions of Mr. Porter and Mr. Jordan along with the balance of the evidence in the record, the Referee finds Claimant has established she is 63% disabled, inclusive of impairment.

ODD-LOT DOCTRINE

116. A claimant who is not 100% permanently disabled may still prove total permanent disability by establishing she is an odd-lot worker. An odd-lot worker is one "so injured that he can perform no services other than those which are so limited in quality, dependability or quantity that a reasonably stable market for them does not exist." *Bybee v.*

State, Industrial Special Indemnity Fund, 129 Idaho 76, 81, 921 P.2d 1200, 1205 (1996). Such workers are not regularly employable "in any well-known branch of the labor market – absent a business boom, the sympathy of a particular employer or friends, temporary good luck, or a superhuman effort on their part." *Carey v. Clearwater County Road Department,* 107 Idaho 109, 112, 686 P.2d 54, 57 (1984). The burden of establishing odd-lot status rests upon the claimant. *Dumaw v. J. L. Norton Logging,* 118 Idaho 150, 153, 795 P.2d 312, 315 (1990).

117. A claimant may satisfy her burden of proof and establish total permanent disability under the odd-lot doctrine in any one of three ways:

a. By showing that she has attempted other types of employment without success;

b. By showing that she or vocational counselors or employment agencies on her behalf have searched for other work and other work is not available; or

c. By showing that any efforts to find suitable work would be futile.

Lethrud v. Industrial Special Indemnity Fund, 126 Idaho 560, 563, 887 P.2d 1067, 1070 (1995).

118. Claimant has neither attempted to secure employment, nor been assisted by any vocational counselors or employment agencies in any job search effort. Mr. Porter, however, did opine that any efforts to find suitable work for Claimant would be futile. Mr. Porter's opinion is based upon sedentary to limited light restrictions that he assessed based, in relevant part, on a residual functional capacity evaluation (RFCE) he administered to Claimant; Claimant's non-industrial medical issues; and Claimant's non-medical factors including education, age, and past work experience.

119. Mr. Porter's opinion as to Claimant's functional capacity based upon his RFCE is unpersuasive because he is not a physician. Dr. Bates' restrictions were adopted, above, and Mr. Porter opined that these make Claimant physically eligible for jobs in the limited medium

duty category. Therefore, Claimant has access to significantly more jobs than Mr. Porter assumed in his odd-lot analysis. Also, Mr. Porter does not indicate which non-industrial medical issues he believes would impact Claimant's employability, or how. Claimant has no prior medical restrictions, and she testified that none of her non-industrial medical conditions impacted her ability to work. Further, Claimant's non-medical factors were already considered in determining she was 63% disabled, above.

120. Mr. Porter also cited the economy's impact on Claimant's ability to obtain employment. He assessed an 8% unemployment rate to her local labor market, but acknowledged that the Twin Falls area, at this time, has one of the best employment outlooks in Idaho and did not argue the point when challenged by the suggestion that the relevant unemployment rate was closer to 6.4%.

121. The *Brown* court acknowledged the impact of on-going changes in the local labor market on a claimant's disability finding. However, it, also cautioned against allocating too much weight to the effects of temporary labor market fluctuations:

> We do not intend to suggest that an injured worker is automatically qualified for odd-lot status solely due to a lack of employment opportunities in the applicable labor market due to temporary economic conditions at the time of hearing. Nor do we suggest that a worker may be disqualified from odd-lot status due to a labor market that is unusually favorable to prospective employees at the time of hearing. Rather, there are ebbs and flows in broad economic conditions which may affect local labor markets. Given the humane objectives underlying our worker's compensation scheme, the Commission may disregard the effects of temporary fluctuations in the applicable labor market resulting from changing economic conditions when determining whether the employee's personal circumstances demonstrate a compensable need.

Id.

122. The evidence of record is inadequate to establish that the state of the economy in the Twin Falls local labor market is a factor that should tip the evidentiary scale either way in determining whether Claimant is an odd-lot worker.

123. In addition, Mr. Jordan inquired of some specific employers and opined that Claimant could obtain work, for example, as a greeter at Walmart, a van driver for River Ridge Retirement Home, a cashier at St. Luke's Regional Medical Center cafeteria or Fred Meyer gas station, or a scale clerk at certain beet harvest locations (seasonal).

124. The Referee finds Claimant has failed to establish any of the three *Lethrud* requirements necessary to prove odd-lot status.

CONCLUSIONS OF LAW

1. Claimant has proven that she sustained an injury to her right knee medial meniscus as a result of an industrial accident on March 26, 2010.

2. Claimant has proven that her preexisting right knee osteoarthritis (DJD) was permanently exacerbated by her industrial accident.

3. Claimant has proven entitlement to reasonable and necessary medical treatment for her right knee conditions, including but not limited to her right meniscectomy and TKA surgeries.

4. Claimant has proven she is entitled to temporary disability benefits from March 26, 2010 through December 6, 2011.

5. Claimant has proven that she has sustained 13% permanent partial impairment of the whole person, all related to her industrial injury.

6. Claimant has proven that she has sustained 63% permanent partial disability in excess of impairment.

7. Claimant has failed to prove that she totally disabled, as an odd-lot worker or otherwise.

RECOMMENDATION

Based upon 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 _10___ day of May, 2013.

INDUSTRIAL COMMISSION

/s/_____
LaDawn Marsters, Referee

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __23_____ day of _____May_____, 2013, 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:

DENNIS R PETERSEN
PETERSEN PARKINSON & ARNOLD
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IDAHO FALLS ID 83403-1645

ALAN K HULL
ANDERSON JULIAN & HULL
PO BOX 7426
BOISE ID 83707-1426

sjw

/s/_____

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

MARCELLA WOODY, Claimant, v. SENECA FOODS, Employer, and INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Surety, Defendants.	**IC 2010-012114** **ORDER** May 23, 2013

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 an injury to her right knee medial meniscus as a result of an industrial accident on March 26, 2010.

2. Claimant has proven that her preexisting right knee osteoarthritis (DJD) was permanently exacerbated by her industrial accident.

3. Claimant has proven entitlement to reasonable and necessary medical treatment for her right knee conditions, including but not limited to her right meniscectomy and TKA surgeries.

4. Claimant has proven she is entitled to temporary disability benefits from March 26, 2010 through December 6, 2011.

5. Claimant has proven that she has sustained 13% permanent partial impairment of the whole person, all related to her industrial injury.

6. Claimant has proven that she has sustained 63% permanent partial disability in excess of impairment.

7. Claimant has failed to prove that she totally disabled, as an odd-lot worker or otherwise.

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

DATED this __23____ day of ____May_____, 2013.

INDUSTRIAL COMMISSION

/s/_____
Thomas P. Baskin, Chairman

/s/_____
R.D. Maynard, Commissioner

/s/_____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the __23____ day of _____May_____, 2013, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

DENNIS R PETERSEN
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sjw /s/_____