BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

GEORGE MCGIVNEY, Claimant, v. AEROCET, INC., Employer, and STATE INSURANCE FUND, Surety, and QUEST AIRCRAFT, Employer, and FEDERAL INSURANCE COMPANY, Surety, Defendants.	**IC 2011-011043** **2014-019179** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** **Filed 12/22/17**

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Michael E. Powers who conducted a hearing in Coeur d'Alene on November 8, 2016. Claimant was present and represented by Starr Kelso of Coeur d'Alene. H. James Magnuson also of Coeur d'Alene represented Aerocet, Inc., (Aerocet) and its Surety, Idaho State Insurance Fund. Eric S. Bailey of Boise represented Quest Aircraft (Quest) and its Surety, Federal Insurance Company. Oral and documentary evidence was presented and the parties took four post-hearing depositions and submitted post-hearing briefs. The undersigned Commissioners have chosen not to adopt the Referee's recommendation and hereby issue their own findings of fact, conclusions of law, and order for different treatment of apportionment and disability in excess of impairment.

ISSUES

As discussed at the hearing, the issues to be decided are:

Claimant has been paid TTD, PPI, and medical benefits by either Aerocet or Quest. *See,* fn 1. The issue between Aerocet and Quest is Quest's entitlement to reimbursement from Aerocet for any benefits paid by Quest.

1. Whether Claimant's condition is due in whole or in part to a pre-existing condition not work-related;

2. Whether Claimant is entitled to reasonable and necessary medical care; and the extent thereof;

3. Whether Claimant is entitled to total temporary disability (TTD) benefits, and the extent thereof;

4. Whether Claimant is entitled to permanent partial disability based on medical factors;

5. Whether Claimant is entitled to permanent partial disability benefits (PPD) and the extent thereof;

6. Whether apportionment for a pre-existing condition pursuant to Idaho Code S 72-406 is appropriate; [1] and

7. Whether Claimant is entitled to an award of attorney fees from Quest.

CONTENTIONS OF THE PARTIES

Claimant contends that he suffered two accidents that involved surgeries to his left knee; one at Aerocet in 2011 and one at Quest in 2014. The restrictions imposed by physicians resulted in disability above impairment. Claimant also seeks an award of attorney fees against Quest for their unreasonable delay/denial of benefits.

Aerocet contends that they have paid all benefits due and owing regarding Claimant's knee injury. Claimant was declared at MMI for that injury, released to full-duty work, and assigned a 2% lower extremity impairment rating. While in the period of recovery, Claimant voluntarily left his employment with Aerocet and began working for Quest where he was employed without incident until his accident with them in 2014.

[1] By *Amended Order Granting Claimant's Motion*, filed October 28, 2015, Quest and its Surety, Federal Insurance Company were ordered to pay past due TTD, medical, and PPI benefits for Claimant's 2014 accident/injury. At the time of the hearing, Quest had paid the past due TTD and medical benefits and was paying the PPI benefits.

Quest contends that Claimant's 2011 left knee surgery was a "temporary fix" due to progressive underlying arthritis which worsened with time. Claimant was assigned no permanent restrictions as a result of the 2011 accident and injury. Claimant's treating surgeon as well as an IME physician found that a 50/50 split between Aerocet and Quest of any benefits awardable or paid is reasonable.

Finally, Quest did nothing in handling Claimant's claim that would justify an award of attorney fees.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant presented at the hearing.

2. Claimant's Exhibits (CE) A-Q admitted at the hearing.

3. Aerocet's Exhibits (AE) 1-12 admitted at the hearing.

4. Quest's Exhibits (QE) 1-22 admitted at the hearing.

5. The post-hearing depositions of: Douglas P. McInnis, M.D., taken by Aerocet, Stephan Fuller, M.D., taken by Quest, and John McNulty, M.D., taken by Quest all on March 8, 2017, and that of Dan Brownell taken by Claimant on March 9, 2017.

All pending objections are overruled.

FINDINGS OF FACT

1. Claimant was 55 years of age and residing in Priest River at the time of the hearing.

2. Claimant has a GED, which he earned in 1990. Claimant also took approximately one year of general education courses at Southwest Oklahoma State University in 1994. Claimant worked as a certified nursing aid (CNA) in Kansas, Oklahoma, and Arizona, but is not currently certified and has not been for at least 15 years. Claimant struggled with alcoholism and "bounc[ed] around working

under the table, doing odd jobs," such as security, roofing, and fast food. Claimant got sober in 2003 and moved to Idaho at around the same time.

3. Claimant began working for Aerocet in Priest River on April 12, 2004. "Aerocet is the world's leader in manufacturing composite airline floats, certified aircraft floats." HT, p. 24.

4. Claimant was originally hired to fabricate cargo pods for Cessna aircraft. Shortly thereafter, Aerocet's mechanic quit so Claimant, who had experience in assemblies, assumed the role of mechanic assembling and installing all of Aerocet's hydraulics in the landing gear of their amphibious floats. Claimant was also charged with being the quality inspector for the machine shop where he would inspect in-house fabricated parts. Claimant's wage was $16 per hour when he was injured.

5. As part of his job, Claimant was required to ascend and descend 15 or 16 fairly steep wooden stairs 30 to 40 times a day. On May 6, 2011, "I was going down the stairs, and I was just a few steps from the bottom, and I just - - I felt something in my knee go. I didn't fall. I was carrying something, and I don't recall what it was. It wasn't very heavy. And I was able to kind of walk it off, but it just kept catching and locking, and, I mean, it was - - it was really painful. Everyone was gone, so I didn't - - I didn't even get to report it until the next day." HT., p. 39.

6. While Claimant acknowledged that he had previous left knee problems, "discomfort and aggravation," he never sought medical care and attributed the condition to "old age." *Id.*, p. 40.

7. Claimant came under the care of Douglas P. McInnis, M.D., a board certified orthopedic surgeon, who he first saw on July 13, 2011. Dr. McInnis gave Claimant a choice between arthroscopic meniscus surgery, which could alleviate Claimant's mechanical symptoms, and a partial arthroplasty, which would address Claimant's progressive arthritis; Claimant chose to proceed with the former. Dr. McInnis performed a left knee arthroscopic medial meniscus repair and debridement on September 12, 2011. Claimant understood that he would still have problems with his left knee in the

future due to the progressive degeneration of his arthritis, which was described as "fairly mild" at that time.

8. Post-surgery, Claimant returned to work under restrictions generally assigned for an arthroscopic surgery; that is, no stairs and if it hurts, do not do it.

9. After about two weeks back to work at Aerocet, Claimant accepted a job with Quest, a "sister company," as the receiving inspector lead in the quality department. Claimant had considered leaving Aerocet for some time as he was having problems with the fumes and resins in his work area. Claimant made approximately $16.50 per hour at Quest with occasional overtime, and he received a medical and dental plan as part of his benefits.

10. For about his first year at Quest, Claimant's left knee felt like a "toothache" that would only resolve with rest. His knee would become sore whether he was walking or sitting.

11. On March 5, 2014:

> I was upstairs. I was having a meeting with my quality manager, John Jacobson at that time, and I had had - - in my hand I had some paperwork, drawings and certifications if I recall. And as I was going down the stairs I was looking at one, and I kind of overstepped a step. My heel hit the next step, and I came down hard on the next step, and that's when I jarred everything.
>
> ***** ***** *****
>
> So I felt it, but I really didn't give it much thought. I thought, you know, I got to be more careful. Watch - - you know, watch what you're doing. And on the way home, it really started hurting. And by the time I got home, it had swollen up to a pretty good size.

HT., p. 49.

12. Claimant self-referred to Jeffrey Lyman, M.D., an orthopedic surgeon practicing in Coeur d'Alene. On June 25, 2014, Dr. Lyman performed a left knee medial unicompartmental arthroplasty. Claimant's private health insurer paid for the procedure but was eventually reimbursed by Quest. *See*, fn 1. The denial of Claimant's claim created some animosity between Claimant and Quest; nonetheless, Claimant continued his employment until his surgery. Post-surgery, Claimant

attempted to return to work with restrictions; however, due to a combination of an adverse reaction to gabapentin and a stressful work environment, after a couple of days he opted to use some more family medical leave and eventually resigned.[2]

13. Claimant is currently employed by his wife through the United States Postal Service pursuant to a rural mail delivery contract worth about $51,000 a year gross and $21,000 to $27,000 net. Claimant drives his own 1997 Ford Explorer that he converted into a right-hand drive and to which he made many alterations and modifications to fit his needs. At six feet, three inches tall, Claimant's work space is cramped. His left knee swells and aches when sitting in one place too long while delivering mail and when he is required to get in and out of his vehicle to deliver packages, etc. Claimant's route is 104 miles long and takes between four and five hours, depending on the weather and time of year (more deliveries in the summer) to complete. Claimant's wife also has a mail delivery contract and Claimant does most of the maintenance on their two mail delivery vehicles.

14. Claimant described his physical limitations regarding his left knee as of the time of the hearing as follows:

> Yeah. There's a lot of things that I can't do that I used to do. You know, there's - - I have to - - I do a lot of our own maintenance on our - - rigs to save us money, and there's a lot of times I have to get on my hands and knees. Getting down there are [sic] hard. Getting back up is even harder. Once I'm down there, I pretty much have to roll onto one side to push myself up. I don't have the range of motion or - - actually, or the strength in it [left knee] like I used to have.
>
> I can't - - I can't hike as much as I would like to. Can't walk. After a certain distance, we have to turn around and go to the house.
>
> If we - - if we ride four wheelers up on the trails, I can't - - I can't be on a bike very long. My leg can't stay in that position.
>
> But getting on my hands and knees is the hardest. Trying to work off a ladder, like if I'm painting something on my house, it's difficult.

HT., pp.70-71.

[2] Because Claimant's claim was denied and he was receiving no TTD benefits, he was required to use about six weeks of FMLA from the date of his surgery until he attempted to return to work.

15. Claimant does not believe he can continue with his mail route due to his left knee and leg pain. He applied for a job as quality inspector at a business in Spokane, but was turned down. He has not applied for any other jobs.

Medical testimony:

Douglas P. McInnis, M.D.

16. Dr. McInnis is a board certified orthopedic surgeon who has practiced in Coeur d'Alene for the past 14 years. His practice of late has focused on adult reconstruction of the hip and knee. Dr. McInnis's CV may be found at Exhibit 1 to his deposition.

17. Dr. McInnis had not seen Claimant for several years[3] prior to the taking of his deposition, but had reviewed his medical records to refresh his memory. Dr. McInnis first saw Claimant on July 13, 2011 for a torn medial meniscus in his left knee. *See,* Aerocet Ex. 1, p.1. Dr. McInnis, upon examination and review of diagnostic studies, recommended arthroscopic surgery to address Claimant's torn meniscus:

> I would not use the word "cure," but the recommendation for arthroscopy would be purely recommended on the belief and assumption that the arthroscopy could improve, if not resolve, the mechanical symptoms in their entirety. And frequently no other means of treatment will resolve those mechanical symptoms. As opposed to the aching and swelling that a lot of 50-year-old people have in their knee just from the fact that they're 50.

Dr. McInnis Dep., p. 9.

18. Dr. McInnis noted that Claimant had "very mild" arthritis in his left knee.

19. Dr. McInnis briefly discussed with Claimant a knee replacement:

> No. I mean, other than perhaps very much in passing. The nature of my discussion with such a patient would be that, in truth, arthritis is not simply wear and tear. There's genetics. There's occupational history. There's recreational history.

[3] When asked if he had any independent recollection of Claimant, Dr. McInnis responded: I do not. It's been five years since I saw the man. As far as I can tell from my records, I met him about four times in a span of about a month and a half. And that was five years ago, and in the interim I've seen several thousand patients. This man could walk in here right now; I do not believe I would recognize him. Dr. McInnis Dep., p. 7.

> Lots, if not most, 50-year-old people do not have the same pristine knee they had when they were born, and many of those degenerative changes are present, and it's logical to assume that these degenerative changes would continue to progress throughout the patient's lifetime.
>
> When injury is added to that more or less natural deterioration, that injury may be addressed arthroscopically, as this one was. The arthroscopy is intended to address the effects of that injury while remaining cognizant of the fact that there were degenerative changes present before.
>
> And it's quite possible that I might have mentioned, logically, if your knee continues to deteriorate, presumably at some point, rather far down the line, this may result eventually in a knee replacement. I may have mentioned such a thing. I certainly didn't focus on it.

Dr. McInnis Dep., pp. 10-11.

20. Dr. McInnis testified that Claimant reached MMI as a result of his meniscus tear on November 17, 2011. Dr. McInnis rated Claimant's left knee at 2% of the left lower extremity without apportionment for any pre-existing arthritic condition. He assigned no permanent physical restrictions. Dr. McInnis could not say whether Claimant's pre-existing arthritis was ratable at that time.

21. Dr. McInnis was unaware at the time of his deposition that Claimant sustained another left knee injury in 2014. Dr. McInnis could not say to a reasonable degree of medical probability that a meniscal repair will lead to a total knee replacement in time. He did discuss with Claimant the option of a total knee replacement:

> So the talk about arthroplasty is that, listen. You're a 50-year-old man. Your knee is deteriorating. You've got this injury on top of a preexisting condition, and the injury's certainly not going to help the preexisting condition. If the preexisting condition continues to deteriorate, the knee replacement will eventually be the, quote/unquote, definitive treatment for arthritis, the timing of which is dependent on a host of factors unique to each individual patient.

Id., p. 20-21.

22. When asked if he thought the meniscal surgery he performed hastened the need for a unicompartmental surgery or total knee replacement in the future, Dr. McInnis responded:

> I wouldn't say hastened the need for. Certainly the medial meniscectomy is one of a thousand contributing factors that could result in that outcome. Based on the information I have in front of me, to be perfectly truthful, I'm surprised to hear that he's

> had a unicompartment arthroplasty. I had no knowledge of it till you mentioned it, and based on what I've got, I'm surprised to hear that.

Id., p. 26.

Stephen Fuller, M.D.

23. Dr. Fuller is a board certified orthopedic surgeon living in Lake Oswego, Oregon. He is also a member of the American College of Forensic Medicine, which is a group that specializes in the forensic analyses of medical files, etc. He has performed meniscectomies and TKRs, "too numerous to count," however, he has not performed any surgeries since 1988. He has performed IMEs since 1988, mostly for insurance companies. Dr. Fuller Dep., pp. 6 and 37. His IME report may be found at Quest Ex. 12.

24. Dr. Fuller conducted an IME at Quest's request on May 28, 2014. He talked with Claimant at the same time that he reviewed various medical records. *See,* pp. 4-7 of his May 28, 2014 report at Quest Ex., 12. Dr. Fuller also reviewed standing x-rays of Claimant's knees as discussed in a June 25, 2014 addendum to his earlier report.

25. Claimant informed Dr. Fuller that he had a good, but not complete, recovery from Dr. McInnis's meniscectomy. He has waxing and waning of pain in his left knee. Claimant estimated his recovery at between 80 and 90 percent and believed his less than full recovery was due to the arthritis discovered in 2011. Dr. Fuller testified that a partial meniscectomy would not save a knee from the further progression of Claimant's underlying arthritis. Claimant is also bow-legged which creates additional forces in the medial compartment that can cause progressive wear and persistent aching. Dr. Fuller agrees with Dr. McInnis that taking out the meniscus would not necessarily relieve Claimant's left knee pain, but would improve his mechanical symptoms.

26. Dr. Fuller agrees with Dr. McInnis's 2% left lower extremity PPI rating which he states is standard for a partial meniscectomy.

27. Dr. Fuller believes that the failure to address Claimant's bow-leg on the left in 2011 is responsible for the eventual "surrender" of his medial compartment. Dr. Fuller would have performed the same surgery as did Dr. McInnis, but would have also addressed Claimant's knee mal-alignment from his bow-legs. He compared not addressing Claimant's mal-alignment to putting more air in a tire that is not properly aligned and expecting the addition of air to cure the problem.

28. Dr. Fuller has doubts regarding whether Claimant's 2011 industrial accident caused, by itself, the need for surgery:

> Probably not. If you look at the history, he was simply coming downstairs, which is a normal physiological mechanism, and he didn't report any history of a misstep or a twist. The casting mechanism to tear a meniscus is a running back going through the line and he loads and twists his knee and he tears the meniscus. And so extrapolating that into the industrial arena, loading and twisting will tear a meniscus, but it won't cause arthritis.

Dr. Fuller Dep., pp. 20-21.

29. Dr. Fuller opined that Claimant's 2014 accident was but a "…temporary flare of the preexisting condition, meaning, that there was preexisting arthritis, preexisting bowleg and preexisting anticipated chewed-up meniscus." *Id.*, p. 22. However, Dr. Fuller explained that Claimant's 2014 accident could have caused the meniscal tear repaired at surgery - - it could go either way and it was "certainly a possibility" that the accident caused the meniscal tear.

30. Dr. Fuller does not believe that Claimant's 2014 accident accelerated or objectively worsened his pre-existing arthritis, although his 2011 accident may well have.

31. Dr. Fuller disagrees with Dr. McNulty's 50-50 apportionment between Claimant's two accidents, "Well, I'd probably apportion 90 percent to preexisting arthritis, because all of the surgical indications existed prior to the work injury. I would probably apportion 10 percent to the work event as a precipitating cause." *Id.*, p. 26.

32. Dr. Fuller agrees with Dr. McNulty's 21% lower extremity PPI which he deems to be the standard for total knee replacements because the *Guides* do not provide a PPI rating for partial knee

replacements. Because the criteria for establishing a PPI for a total knee replacement based on ADLs and function, it does not really matter whether a knee is totally versus partially replaced. Dr. Fuller would also apportion this PPI rating on a 90% preexisting, 10% accident basis. Dr. Fuller would apply the same apportionment to medical benefits.

33. Dr. Fuller also agrees with Dr. McInnis that physical restrictions are generally not appropriate for a partial medial meniscectomy, which in and of itself is a relatively minor procedure. Post-unicompartmental surgery, Dr. Fuller opined that the only restriction, as such, that he would impose would be to avoid using ladders.

34. Dr. Fuller does not know why Claimant is continuing to complain of left knee pain and sees no reason why he cannot continue his employment as a mail carrier. He disagrees with Dr. McNulty's 2-hour walking restriction as well as kneeling and repetitive squatting. Dr. Fuller did not examine Claimant post-unicompartmental knee surgery.

John McNulty, M.D.

35. Dr. McNulty is a board certified orthopedic surgeon who has practiced in St. Maries since 1998. Quest asked Dr. McNulty to examine Claimant and review pertinent medical records. He authored an IME report dated February 26, 2016. *See,* Quest Exhibit 17.

36. Dr. McNulty recorded Claimant's complaints on the date of his examination:

> And that is in my Current Complaint section at the bottom of page 1. He mentioned he is improved from his knee arthroplasty surgery. He's still having some discomfort in the back of his knee. He's having trouble with squatting and kneeling. He has some soreness in his knee with standing and walking for - - after an hour. And those were the main problems. He still has some aching at night.

Dr. McNulty Dep., p. 6.

37. Dr. McNulty testified that Claimant's unicompartmental left knee surgery had gone well:

> Yes, even though - - and I didn't get to see the postoperative radiograph after the unicompartmental. His knee was well aligned. He had good movements but he was

> still having some pain. And even though a doctor does a good surgery, a technically good surgery, not everyone gets 100 percent outcome, and I think that's what happened with Mr. McGivney.

Id., p. 7-8.

38. Dr. McNulty was aware that Dr. Fuller posited that Claimant's current symptoms may be the result of a mal-alignment due to Claimant's bowlegs. While Dr. McNulty did not review any post-surgery diagnostic studies such as x-rays, he did not detect any mal-alignment on his physical examination.

39. Dr. McNulty believed Claimant's mail delivery job to be appropriate for him given his understanding of that job.

40. Based on Claimant's subjective complaints and the results of his physical examination, Dr. McNulty restricted Claimant from walking/standing for more than two hours continuously, limited squatting, but approved the occasional use of ladders. Dr. McNulty did not see anything abnormal regarding Claimant's pre-existing arthritis on his 2011 left knee x-ray (there was no contemporaneous right knee x-ray for comparison) and agreed with Dr. McInnis that Claimant could be released to activities as tolerated following his meniscectomy in 2011.

41. Dr. McNulty would expect that the Grade 2 arthritis found in Claimant's left knee in 2011 would continue to progress at a rate greater than what may have been present in Claimant's right knee due to his left knee injury. Dr. McNulty's expectation proved to be true by the 2014 weight bearing x-rays that demonstrated a decreased joint space of the left knee as compared to the right and was considered to be a Grade 4 at that time. Dr. McNulty also opined that Claimant's 2014 accident caused some additional tearing of Claimant's left knee medial meniscus according to the left knee MRI and Dr. Lyman's operative report.

42. Given that Dr. McInnis removed 50% of Claimant's medial meniscus in 2011 and that he had another accident in 2014 resulting in an additional meniscus tear, Dr. McNulty would not have proceeded with a unicompartmental surgery:

> Looking at his x-rays and reviewing his MRI, he does have a meniscal tear, and I think this was fairly evident before the surgery. As noted in the conclusion of my records, it is a worker's compensation case and trying to make a determination of permanent aggravation of preexisting left knee condition - - I think that's important in this scenario - - and I would have treated him initially with a knee arthroscopy, and removed the meniscal tear that was as a result of the most recent injury. Sent him to physical therapy. Maybe treated him with injections for a while and then see how he does.
>
> So even though he's got Grade 4 changes, there are a lot of patients who have Grade 4 changes and don't need a unicompartmental arthroplasty. So the - - not that Mr. McGivney would have been as good as new after the surgery I propose, but I think he would have gotten by for a while, I should say, had a chance to get by for a while without doing the arthroplasty right away.
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> He's only 53 when he gets his arthroplasty and those don't last forever. He's going to need another arthroplasty.[4] I would have tried to push him out longer before doing that type of surgery. That's my opinion.

Dr. McNulty Dep., pp.14-15.

43. Dr. McNulty testified that Claimant's 2014 accident was "probably" a permanent aggravation of his pre-existing medial compartment arthritis; however, he would most likely have needed a compartmental arthroplasty at some point anyway, but probably not just three months post-2014 accident. Dr. McNulty also testified that Claimant's 2011 accident hastened the need for his unicompartmental arthroplasty, but could not say by how much.

44. Dr. McNulty testified that he would apportion Claimant's impairment at 50% to the 2011 accident/injury, and 50% to the 2014 accident and injury:

> There is no road map or algorithm how to figure that out. There's a book from the AMA. The author is Mel - - Melhorn, and I think it's - - I get the title wrong - - the Evaluation - - Guides to the Evaluation of Disease and Injury Causation.[5] So it gives

[4] Dr. McNulty declined to "guess" how long it would be before Claimant would need another arthroplasty.

[5] Dr. McNulty utilized this "guide" rather than the AMA Guides to the Evaluation of Permanent Impairment, 6th Ed. in his apportionment analysis.

> you just an idea that there's no set way doing it, and I think - - you know, my reasoning for apportioning 50/50 is, I've looked at MRIs, I've looked at the X-rays, and I've also looked at the treatment, and that's the best I can do. This is not a - - this is a judgment call, and it's the best that I can come up with and justify.
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> *** * ***
>
> I guess the thing in Mr. McGivney's case, I looked at the x-rays on 5/28/14, and I compared the right and the left knees, and I saw advanced changes in the left knee compared to the right, and I - - my reasons for apportioning 50/50 is that he had Injury No. 1. His knee got worse radiographically, which is easy to see comparing the left and right knees, and that was the major factor in determining his need for arthroplasty.
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> So absent - - absent Injury No. 1, X-ray right knee looks the same as X-ray left knee, I would have done Dr. McInnis' - - what Dr. McInnis did. So the reasoning, again, for my apportionment is that the first surgery had a significant affect on the deterioration of his left knee, radiographically easy to see, resulting in the arthroplasty surgery. So that's how I figured that out.

Id., pp-18-19; 24.

45. In response to Dr. Fuller's 90/10 apportionment, Dr. McNulty testified:

> I can understand how he - - how he came to that. And the reason I would not go with that 90/10 is that I - - I don't see that he - - you know, that we can justify that with any certainty. We jumped the gun, at least in my opinion, on the unicompartmental, so I can't agree with that. I think the 50/50 is the best I can do. I think that's the fairest.

Id., pp. 19-20. Dr. McNulty would also apply his 50/50 apportionment to medical benefits.

46. Dr. McNulty agreed that Dr. McInnis's 2% lower extremity without apportionment for Claimant's 2011 accident was accurate at the time given. He opined that Claimant's arthritis at the time of Dr. McInnis's rating would have been 0%.

47. Claimant was also diagnosed with anxiety, thyroid disease, and Wolff-Parkinson-White syndrome. No doctor has assigned restrictions related to these conditions.

DISCUSSION AND FURTHER FINDINGS

Pre-existing condition (arthritis):

48. The Commission finds, based on the records of Drs. McInnis and McNulty, that Claimant suffered from some degree of progressive mild degenerative arthritis in his left knee that pre-existed his 2011 accident/injury rated at 0% PPI.

Permanent Partial Impairment (PPI):

49. "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 nonprogressive at the time of the evaluation. Idaho Code § 72-422. "Evaluation (rating) of permanent impairment" is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker's personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and nonspecialized 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).

50. The Commission finds that Claimant has suffered a 21% lower extremity PPI as assigned by Dr. McNulty and agreed to by Dr. McInnis for his left knee. *See,* CE 17, pp. 689-690. A 21% lower extremity rating equates to 42 weeks of benefits as calculated pursuant to Idaho Code § 72-428.

Permanent Partial Disability (PPD):

51. "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. "Evaluation (rating) of permanent disability" is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of impairment and by pertinent non-medical factors provided in Idaho Code §72-430. Idaho Code § 72-425. Idaho Code § 72-430(1) provides that 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 the accident causing the injury, or manifestation of the occupational disease, consideration being 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, provided that when a scheduled or unscheduled income benefit is paid or payable for the permanent partial or total loss or loss of use of a member or organ of the body no additional benefit shall be payable for disfigurement.

52. 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. ISIF*, 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).

53. 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 non-medical factors, has reduced the claimant's capacity for gainful employment." *Graybill v. Swift & Company*, 115 Idaho 293, 294, 766 P.2d 763, 764 (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, 7, 896 P.2d 329, 333 (1995).

54. A two-step analysis is appropriate in impairment and disability evaluations and requires, "(1) evaluating the claimant's permanent disability in light of all his physical requirements, resulting from the industrial accident and any pre-existing conditions, existing at the time of the evaluation; and (2) apportioning the amount of permanent disability attributable to the industrial accident." *Horton v Garrett Freightlines, Inc.*, 115 Idaho 912, 915, 772 P.2d 119, 122 (1989).

55. A claimant's disability is to be determined, in most cases, as of the date of the hearing rather than the date of medical stability. See *Brown v. Home Depot*, 152 Idaho 605, 272 P.3d 577 (2012).

Vocational testimony:

56. Claimant retained **Dan Brownell** to assess his employability.[6] He was the only expert to opine on Claimant's disability in excess of impairment. Mr. Brownell's qualifications are well-known to the Commission and he is qualified to testify as an expert witness in this matter. However, in this case, his opinions are given reduced weight for reasons explained below.

57. Mr. Brownell did not prepare a report. At deposition, he explained his process for assessing labor market loss and wage loss to arrive at permanent disability. He utilizes statistical programs in which he inputs physical limitations, work history, and transferable skills. He explained his extensive professional experience in the North Idaho area developing employer contacts and also maintaining a list of jobs in the area that stretches back at least two years. He reviewed Claimant's deposition and hearing testimony, interviewed Claimant three or four times, and reviewed medical records informing his opinion.

58. Mr. Brownell determined that Claimant suffered a 50% permanent partial disability, inclusive of impairment, regarding his left knee injury, utilizing the limitations provided by Dr. McNulty and considering the Sandpoint/Priest River labor market. He opined that both Claimant's wage and labor market loss following his last accident were equal at 50%. He did not average these two numbers in arriving at 50% PPD, but stated they were two separate measures that "are consideration [sic] in coming up with an estimate of PPD." He opined, based on Dr. McNulty's restrictions, Claimant could not return to work at Quest. However, Mr. Brownell believes Claimant's current employment as a rural mail deliverer is ". . . quite ideal for his current capabilities." *Id.* p. 20.

[6]Mr. Brownell testified preliminarily that he did not attempt to apportion his disability rating

59. Unfortunately, there is no explanation of how Mr. Brownell reached his opinion. He describes his general methodology, then gives a specific opinion; he did not articulate how he arrived at his specific figure. Due to his lack of explanation, Mr. Brownell's opinion is given little weight in our disability analysis.

60. Claimant is currently employed by his wife delivering mail. However, at hearing, Claimant testified that he was no longer performing this job full-time (six days a week) and that he and his wife had hired a subcontractor that summer to come in and help him with his route. According to Claimant's description, his current job exceeds his restrictions; specifically, standing for more than two hours, which Claimant frequently does while sorting mail.[7] Because Claimant is employed by a sympathetic employer and because this job exceeds his restrictions, we give this employment little weight in our analysis.

61. **Nature of the physical disablement**. Claimant is restricted from standing or walking for more than two hours at a time, and from kneeling and repetitive squatting. This restriction precludes Claimant from employment in many positions for which he may otherwise be qualified, such as a cashier or dishwasher or from returning to work as a CNA.

62. **The occupation of the employee**. At Aerocet, Claimant "wore a lot of different hats over the years." Claimant gained or utilized skills in assembling, inspecting, and customer service. At Quest, Claimant was the lead receiving inspector, though he later voluntarily demoted himself to receiving inspector. Claimant gained or utilized skills in supervising, inspecting, and record keeping.

63. **Age.** Claimant is an older worker at age 55, and may have a harder time competing against younger workers for jobs that require only a GED or less.

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between Claimant's two accidents; he defers to the medical evidence regarding apportionment.

[7] Dr. McNulty relied on Claimant's description of his job in concluding it was appropriate for him. He did not review Claimant's deposition or hearing transcript in coming to that conclusion.

64. **Reasonable geographic area.** Claimant commuted for his job at Quest. He drives a 104 mile route as a mail carrier. Claimant also applied for a quality inspector job in Spokane, approximately an 80 minute drive from his home in Priest River. While Priest River is small, Claimant is clearly willing to commute for the right position.

65. **Personal and economic circumstances.** Claimant has a GED and limited college experience. His job history prior to 2004 was not provided in detail, but it indicates Claimant mostly performed low skill work with on-the-job training, with the exception of his work as a CNA. On the other hand, Claimant has shown remarkable aptitude for 'wearing many hats' as he puts it; if you can train him how, then he can do it. The Referee noted at hearing that Claimant is well-spoken, articulate, and quite intelligent. Upon a review of the hearing transcript, the Commission agrees with the Referee's assessment of Claimant. He held high-level jobs at Aerocet and Quest, including a supervisory position.

66. In summary, we are confident Claimant could obtain a comparable wage in a quality assurance position based on his work history at Aerocet and Quest. For any other position, we are confident that Claimant would impress Employers with his ability to learn and work hard, once given the chance. However, all other factors reduce Claimant's employability: his work restrictions, his age, his lack of formal education, his spotty work history prior to 2004, and the fact that no matter where he works, he will most likely have to commute. Ironically, we reach the same conclusion as Mr. Brownell, that Claimant has suffered 50% permanent partial disability. We reach this conclusion, for all the factors noted above, but most importantly, the combination of Claimant's work restrictions and lack of formal education. It will be difficult for Claimant to earn a comparable wage without education and within his restrictions, even if he is willing to drive to Spokane for the position.

67. Therefore, the Commission concludes that Claimant has permanent disability of 50% of the whole person, inclusive of his 21% lower extremity impairment.

Apportionment:

68. Having determined that Claimant has suffered disability of 50% of the whole person, inclusive of his 21% lower extremity impairment rating, it is next necessary to address Quest's claim that some part of Claimant's disability must be apportioned to Aerocet, if not to a condition that pre-dated Claimant's employment by Aerocet. On or about September 11, 2015, Claimant filed a motion under Idaho Code § 72-313, seeking an Order from the Commission requiring Quest to pay TTD, PPI, and medical expenses owed to Claimant during the pendency of a determination of the responsibility of Quest and Aerocet for the payment of these worker's compensation benefits. The Commission entered such an Order on or about October 28, 2015. Pursuant to Idaho Code § 72-313, when the issue of which of several employers or sureties is responsible for the payment of benefits is resolved, the employer or surety held not liable shall be reimbursed for any such payments by the employer or surety actually liable.

69. The Commission has jurisdiction to consider Quest's claim for reimbursement pursuant to Idaho Code § 72-313, and *Brooks v. Standard Fire Insurance Company*, 117 Idaho 1066, 793 P2d 1238 (1990).

70. Claimant has been given a 21% lower extremity impairment rating for his left knee. Dr. McInnis originally proposed that following the 2011 meniscectomy, Claimant was entitled to a 2% lower extremity rating, with no impairment assigned to Claimant's pre-existing left knee arthritis. Dr. McNulty acknowledged that this 2% rating was appropriate at the time it was issued. However, Dr. McNulty ultimately concluded that half of Claimant's current 21% lower extremity rating should be apportioned to the 2011 accident. Explaining his reasoning, he testified that the 2011 meniscectomy destabilized Claimant's left knee, and caused the progression of arthritic changes in the medial compartment of the left knee much faster than would otherwise have happened. Proof of this acceleration is found in the bilateral knee x-rays performed after the 2014 accident. These films

demonstrate much more severe degenerative arthritis in the left medial compartment as compared to the right medial compartment. At the same time, Dr. McNulty and Dr. Lyman proposed that the 2014 accident caused additional trauma to the medial compartment; and had further hastened Claimant's need for the uni-compartmental knee arthroplasty. Based on these findings, Dr. McNulty believes it appropriate to apportion Claimant's impairment on a 50-50 basis as between the accident of 2011 and the accident of 2014, with no apportionment to whatever mild degenerative changes Claimant may have had in the left knee prior to the 2011 accident. Dr. Lyman, the surgeon who performed Claimant's left knee arthroplasty, concurs with this analysis. While we recognize that following the 2011 accident Claimant was given only a 2% lower extremity rating, and released without limitations/restrictions, the important point is that Claimant's left knee condition continued to deteriorate following the date of Dr. McInnis's rating, and that this deterioration has been persuasively linked to the 2011 accident. By the time of the 2014 accident, Claimant's medial compartment arthritis had significantly progressed to Grade III-IV changes, with the two areas of complete cartilage loss. The accident-caused progression of Claimant's left knee condition between 2011 and 2014 amply supports the apportionment scheme arrived at by Dr. McNulty.

71. As to the issue of whether Claimant's disability should be apportioned between the 2011 and 2014 accidents, we conclude that the medical evidence referenced above supports a similar apportionment of disability over and above impairment. The principal reason for performing the left knee arthroplasty was to address the profound medial compartment damage noted in 2014. As both Dr. McNulty and Dr. Lyman have indicated, Claimant's medial knee arthritis was the product of both the 2011 and 2014 accidents. While Claimant may have been able to return to his time-of-injury job following the 2011 accident this fact does not denigrate our conclusion that Claimant's current disability is referable to significant medial compartment arthritis caused by both the 2011 and 2014 accidents. While we recognize that arguments could be made to support a different outcome, like Dr.

McNulty and Dr. Lyman, we believe that ours is the fairest approach. Therefore, Claimant's disability over and above impairment is apportioned equally between Aerocet and Quest.

72. We further conclude that medical expenses incurred by Claimant from June 25, 2014 forward should be equally apportioned between Quest and Aerocet. Certainly, the 2014 accident caused Claimant to require left knee arthroplasty sooner than he would have otherwise required it, but the same assertion may be made against the 2011 accident, possibly even more so. Therefore, Aerocet and Quest shall equally share responsibility for medical expenses incurred in connection with the left knee arthroplasty and for other medical expenses incurred following the date of that surgery. Prospectively, Quest shall initially pay for all left knee treatment to which Claimant may be entitled pursuant to Idaho Code § 72-432, but Quest shall be entitled to reimbursement for 50% of the expenditures from Aerocet.

73. We decline to apportion TTD benefits owed prior to the June 25, 2014 left knee arthroplasty. Those benefits are appropriately the responsibility of Quest. However, in keeping with our analysis of how medical benefits should be apportioned, we conclude that time loss owed to Claimant following the June 25, 2014 left knee arthroplasty should be equally borne by Aerocet and Quest, based on our conclusion that both accidents equally contributed to the need for that surgery. Prospectively, Quest shall initially pay all time loss benefits to which Claimant may be entitled as a result of his left knee injury, pursuant to Idaho Code § 72-408, but Quest shall be entitled to reimbursement for 50% of such benefits paid from Aerocet.

Attorney fees

74. Idaho Code § 72-804 provides for an award of attorney fees in the event an employer or its surety unreasonably denies a claim or neglected or refused to pay an injured employee compensation within a reasonable time.

75. Claimant seeks an award of attorney fees from Quest for their unreasonable reliance on Dr. Fuller's IME to support their denial of his claim. While the Commission (and Referee) questions some of the conclusions reached by Dr. Fuller; i.e., his 90/10 apportionment, his inserting Claimant's bow-leggedness into the equation, his skepticism regarding whether Claimant's 2014 accident caused the need for his 2014 surgery, and his opinion that Claimant suffered no PPI from his 2014 accident/injury. However, the Commission is not persuaded that Quest's reliance on Dr. Fuller's report and opinions would support an award of attorney fees. This matter did involve a legitimate question of apportionment.

CONCLUSIONS OF LAW AND ORDER

1. Claimant's condition is not due to a pre-existing condition.

2. Claimant is entitled to PPD of 50% (inclusive of impairment) as the result of his left knee condition, responsibility for which is apportioned equally between Quest and Aerocet.

3. Responsibility for medical expenses incurred for Claimant's left knee arthroplasty and for treatment subsequent thereto, shall be apportioned equally between Quest and Aerocet. Prospectively, Quest shall initially pay for all left knee treatment to which Claimant may be entitled pursuant to Idaho Code § 72-432, but Quest shall be entitled to reimbursement for 50% of the expenditures from Aerocet.

4. Responsibility for time loss benefits to which Claimant may be entitled following the June 25, 2014 surgery and through the date of hearing shall be apportioned equally between Quest and Aerocet. Prospectively, Quest shall initially pay all time loss benefits to which Claimant may be entitled as a result of his left knee injury, pursuant to Idaho Code § 72-408, but Quest shall be entitled to reimbursement for 50% of such benefits paid from Aerocet.

5. Claimant is not entitled to an award of attorney fees against Quest.

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

DATED this _22nd_ day of _December_, 2017.

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 _22nd_ day of __December__, 2017, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** was served by regular United States Mail upon each of the following:

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