

ISSUES

ALJ Fuller found claimant sustained personal injury by accident arising out of and in the course of his employment on February 2, 2008, and suffered permanent injury to his left knee and low back. The ALJ found claimant did not sustain permanent injury to his right ankle. The ALJ awarded claimant permanent partial disability benefits based upon a 19% whole body functional impairment and subsequent periods of work disability ending with an 87.5% work disability.

Respondent contends ALJ Fuller erred in finding claimant met with personal injury by accident to the left knee and low back arising out of and in the course of his employment. Respondent maintains claimant has not proven he sustained any permanent impairment as a result of the work-related accident and, therefore, he is not entitled to an award of permanent partial disability benefits. Respondent asserts that at most claimant is entitled to a scheduled injury award for the left knee.

Claimant maintains that as a result of work-related left knee and low back injuries, he sustained a 19% whole body functional impairment and an 87.5% work disability. He requests the Board affirm the ALJ's Award.

The issue before the Board on this appeal is the nature and extent of claimant's disability.

FINDINGS OF FACT

After reviewing the entire record and considering the parties' arguments, the Board finds:

Claimant's October 11, 2012, Deposition

Claimant testified he herniated a disk in his neck in the 1990s when removing an inmate from a cell, but never received surgery or any workers compensation benefits.

On February 2, 2008, while a police officer for respondent, claimant was checking pump gauges at the city water plant around 1:45 a.m. After checking the gauges, which was one of his job duties, claimant exited the building and stepped off the sidewalk onto ice. Claimant indicated the ice made a divot and his right foot slipped into the divot and rolled inward. He testified he fell forward onto sand and gravel, landing on his hands and knees in the street next to his car. When claimant fell, it was near the end of his shift, so he went to the office, turned in his activity log sheets and went home. Claimant indicated he lacerated or bruised both wrists and his pants were dirty, but not ripped.

Claimant went home, relaxed a bit and went to bed. After waking later that morning, his right ankle was swollen, his leg had streaks from the ankle to the toes and was painful.

He called the police chief, Deb Farland, who took claimant to the Cheyenne Clinic, where he saw a physician assistant, Tyler Raile, around 10:30 or 11:00 a.m. X-rays were taken of claimant's right ankle and he was given a splint. Claimant testified he was off work three days, which included taking one day off and the weekend. During the three days, he wore the splint and iced his ankle. Claimant was told there was no light duty and he needed to go back to work. About a week later, claimant asked to see Mr. Raile, but was given a release to go back to full duty without seeing him.

Claimant testified he continued performing his usual job duties, but his right ankle continued to be painful. At some point, claimant indicated his left knee was hurting to Chief Farland. According to claimant, Chief Farland theorized claimant's knee was hurting because he was walking with a limp. Claimant testified he was not wearing an ankle splint at the time.

Claimant indicated that in March 2008, he saw Dr. Mary Beth Miller at the Cheyenne Clinic for blood pressure and neck pain. He testified he also mentioned he had problems with his left knee and Dr. Miller prescribed ibuprofen. On October 3, 2008, claimant returned to Dr. Miller for left knee issues. A week later, Dr. Miller referred claimant to Dr. Mekki M. Saba, an orthopedic doctor in Colby. Dr. Saba ordered an MRI of claimant's left knee and after reviewing the MRI results, recommended arthroscopic surgery. Claimant testified that at that time, neither the workers compensation insurance carrier nor his health insurance would pay for surgery, so claimant did not undergo any treatment of his left knee then and was forced to pay his own medical bills.

In June 2009, claimant, on his own because his knee went out, saw Dr. Daniel Pflieger in Greeley, Colorado. Dr. Pflieger, whose records are not in evidence, referred claimant to an orthopedic physician, Dr. Sanderford, who saw claimant in September 2009. Dr. Sanderford looked at claimant's MRI. According to claimant, Dr. Sanderford indicated claimant had no cartilage in an area on the left knee and recommended he take time off from work. A Synvisc injection was given, but claimant indicated it did not do any good. The doctor also x-rayed claimant's right ankle, which was still hurting, but made no treatment recommendations. Claimant underwent left knee surgery by Dr. Sanderford in October 2009. Claimant testified that with the exception of the three days following the accident, he worked the entire time from the date of accident until the October 2009 surgery, performing his regular job duties.

Claimant testified his left knee improved to a point and then plateaued. Claimant indicated he underwent surgery on August 18, 2010, to replace his left kneecap and the end of his fibula. According to claimant, during the surgery he underwent a femoral nerve block that damaged the femoral nerve. Dr. Sanderford prescribed a rigid knee brace, indicated claimant was at maximum medical improvement (MMI) and released him to full duty. Claimant worked up until his second surgery, but never returned to work for respondent after that.

Claimant indicated he has numbness and loss of strength in the quadriceps and sharp pain around the left knee joint. On a pain scale of one to ten, claimant testified he was a constant three, with the pain escalating to a ten when pressure was placed on the knee. Wearing pants makes claimant feel as though he has a sunburn. Consequently, claimant almost always wears shorts. Claimant testified he had pain in both hips and sharp pain at the belt level of the low back. His right ankle is better, but has intermittent pain and is still weak.

October 12, 2012, Preliminary Hearing

Claimant indicated he had experienced hip pain for one to one and one-half years. The pain occurred with ongoing activity such as standing for a long time and especially with walking. He had balance issues, as his left leg would give out without warning. He had tendinitis in the left knee and felt popping when he bent it. With light pressure, claimant had sharp pain in the left quadriceps.

March 7, 2014, Regular Hearing

Claimant testified that on February 2, 2008, he fell on his hands and knees after stepping onto ice and injured his right ankle, both wrists and left knee. He sought medical treatment the next day. Claimant testified he was asked what his most debilitating injury was by physician assistant Tyler Raile. Claimant told Mr. Raile it was his right ankle. According to claimant, Mr. Raile stated they would focus on the right ankle injury.

Claimant testified he completed the top portion of an employer's report of accident (report of accident) on February 3, 2008. The report of accident was signed by Glorianne Milne, respondent's former Assistant City Clerk, and dated February 6, 2008. On the report of accident, claimant indicated he twisted his ankle and fell on ice at 2:16 a.m. The report of accident asks, "Describe in detail nature and extent of injury, indicate part of body involved." Claimant printed, "sprain to ankle."¹ Claimant did not object to the report of accident being placed into evidence. Claimant testified he completed his portion of the report of accident in the presence of Chief Farland. When he completed the report of accident, claimant listed his ankle as his only injury at the suggestion of Chief Farland. Claimant testified as follows:

Q. And your testimony today is you had a specific discussion with someone else to limit this report only to the ankle and to exclude the left knee and the wrist?

A. Well, the question on the form is: "How did the accident occur?" The answer is: "Twisted ankle and fell on ice."

Q. Right.

¹ R.H. Trans., Resp. Ex. 1.

A. We discussed that. Since Tyler was treating the ankle, that's what was put on there.

Q. And in Question No. 15 says, "Describe in detail the nature and extent of the injury and indicate the body part involved." Your answer to that was, "Sprained ankle."

A. Sprained ankle. That's what Tyler -- Mr. [Raile] was treating was the sprained ankle.²

Claimant indicated that within a week after his fall, he attempted to see Mr. Raile, because his right foot was discolored and swollen. Claimant spoke to a woman at the window in the clinic, who left for a few minutes and later returned with a release to return to work. Claimant testified he spoke to his police chief on more than one occasion about having left knee pain and requested to see a doctor. Claimant indicated he favored his right ankle when walking and that caused his left knee to hurt. According to claimant, he was advised by the police chief there was no light duty and if he wanted to continue drawing a paycheck he needed to keep working.

Claimant testified he underwent two surgeries by Dr. Sanderford. The first surgery was a microfracture surgery. Claimant explained the surgeon fractures the inside of the knee to cause the bone marrow to come out, which creates a coating over the knee. Claimant indicated the surgery failed, so he underwent a second surgery where bone in his knee was taken out and replaced with a metal prosthesis and the inside of his kneecap was replaced. According to claimant, during his second surgery, a femoral nerve block was put in his nerve rather than outside of it, causing him to have weakness in his left quadriceps, a pins and needles sensation in his left leg and stabbing pain when touched.

Claimant testified that following his second surgery, he never returned to work for respondent because he was unable to perform the physical requirements and was terminated. Claimant testified that sometime after he was able to get up and move around, he began experiencing back pain that progressively worsened, which he attributed to walking with an abnormal gait.

At the request of respondent, claimant underwent an evaluation by Dr. David K. Ebelke, an orthopedic surgeon. According to claimant, before he was ever examined by Dr. Ebelke,³ the doctor indicated he could not attribute claimant's back pain to his leg pain and the bad news was that they did not know what the problem was.

² R.H. Trans. at 54-55.

³ The transcript reflects a Dr. Bilkey during this testimony, but the Board believes this is a reference to Dr. Ebelke.

Claimant was asked about telling Dr. Miller on October 3, 2008, that his left knee had been giving him trouble for three weeks and telling Dr. Saba on October 6, 2008, of having left knee symptoms beginning June 2008. Claimant indicated he told Dr. Miller his left knee was popping and getting more painful. He also testified he told Dr. Saba the popping and catching of the left knee was getting more serious. It was claimant's understanding that he was diagnosed by Dr. Saba with a torn meniscus in the left knee. Claimant testified that after he saw Dr. Miller on July 20, 2009, he received no further treatment for his right ankle, other than an x-ray by Dr. Sanderford.

Claimant testified he worked for Cabela's as a firearms inspector for about two months around August 2013. He worked five-hour shifts. Because he was in a great deal of pain after each shift, he and Cabela's mutually agreed to terminate his employment. Claimant testified he was receiving Kansas Police and Fire disability benefits. He applied for Social Security disability benefits, but was denied.

The parties stipulated to several photos claimant took. Most of the photos were taken on or shortly after the date of accident. One of the photos taken shortly after the accident shows claimant's swollen right ankle and abrasions on the inside of the right ankle. Two photos taken on February 2, 2008, show body parts that may or may not be claimant's left knee. Neither of those photos shows any abrasions. Three of the photos have a date taken of February 13, 2007. Two of those photos were of claimant's right ankle and foot. The other February 13, 2007, photo shows an abrasion on claimant's left knee.

Glorianne Milne, Respondent's City Clerk

Ms. Milne, the Assistant City Clerk for respondent at the time of claimant's accident, indicated it is respondent's policy to have injured workers complete a report of accident. The report of accident completed by claimant indicates the accident occurred when he "twisted ankle and fell on ice."⁴ The part of the body involved is listed as "sprain to ankle."⁵ Ms. Milne indicated she signed the report of accident a couple of days after claimant completed his portion. She testified she never gave instructions to claimant or the police chief to limit the nature and extent of the injury being claimed. The report of accident was offered into evidence at Ms. Milne's deposition without objection from claimant.

Physician Assistant Tyler Raile

Mr. Raile's notes from February 2, 2008, indicate he reviewed claimant's constitutional, cardiovascular and respiratory systems. Mr. Raile took social, medical and

⁴ Milne Depo., Ex. 5.

⁵ *Id.*

surgical histories and inquired about claimant's medications. The notes indicate claimant was evaluated for ankle pain, primarily right ankle pain. X-rays were ordered. Claimant was diagnosed with a right ankle sprain and was to schedule follow-up appointments on an as-needed basis. Mr. Raile's notes do not mention any complaints of a left knee injury by claimant.

Mr. Raile testified he saw claimant on February 2, 2008, at 10:40 a.m. During the visit, he took a history of claimant's injury. Mr. Raile testified he did not limit the extent of complaints made by claimant. He testified that if, for example, claimant had made a back complaint, he would have included it in the history. Mr. Raile indicated he made a substantial inquiry into the rest of claimant's physical history. Mr. Raile examined claimant's right ankle, which had pain, redness and swelling. He had the right ankle x-rayed, tested claimant's range of motion and made sure claimant had good blood flow to the ankle. Mr. Raile diagnosed claimant with a right ankle sprain. He denied telling claimant he would disregard claimant's injuries to his wrists and left knee and focus only on the right ankle, as it was the most debilitating. Mr. Raile testified that had he been aware of claimant's other injuries, he would have dealt with them and would have recorded them.

Dr. Mary Beth Miller

Dr. Miller first saw claimant on October 3, 2008. Her notes from that visit indicated claimant presented for cough and ankle, knee, neck and back pain, as well as a blood pressure check. Claimant reported twisting his right ankle in February 2008 and having a cough for six months. The history taken by the doctor indicated claimant's left knee had given him trouble for the last three weeks. He reported the left knee felt as if it pops and it was hard to go up and down stairs. Claimant reported not being able to climb a ladder, but could walk and stand okay. The doctor testified she saw claimant for general medical conditions as opposed to specifically seeing him for joint pain. The doctor's examination of the left knee showed normal skin, soft tissue and bony appearance, no gross edema or evidence of acute injury, pain upon palpation noted at the lateral collateral ligament and full active range of motion with extension and flexion. Dr. Miller referred claimant for evaluation of his left knee to Dr. Saba.

On July 20, 2009, Dr. Miller saw claimant because he reinjured his right ankle in June 2009 when he used his right foot to open a door while on a domestic call. The doctor's notes do not mention claimant's left knee or back. Dr. Miller saw claimant for left knee and right ankle pain on August 26, 2009. Her notes indicated claimant fell on February 2, 2008, onto both hands and knees. At the time of the fall, claimant's ankle hurt the most. Her notes indicated claimant's knees started hurting in March. Dr. Miller's examination of claimant's left knee showed no erythema, no ecchymosis, medial and superior edema, no deformity, antalgic gait, pain upon palpation over the patellar tendon and medially, and palpable crepitus. The doctor recommended an orthopedic consultation.

Dr. Miller testified it was impossible for her to say claimant's left knee injury occurred during his initial fall.

At Dr. Miller's deposition, claimant's attorney offered into evidence, without objection from respondent's attorney, notes from claimant's October 6, 2008, consultation with Dr. Saba. The history taken by Dr. Saba indicated claimant slipped on ice in February 2008 and injured his right ankle. Claimant noticed his left knee hurt when he got in and out of a car and when going up and down stairs. Dr. Saba observed small effusion and swelling of the left knee. The doctor stated:

The patient stated to me after he had the initial injury in February and had treatment for the right ankle with the brace, he did not feel any problem with the left knee. He continued to work with the left knee until 6-08 and he felt pain on the outer side of the left knee on bending the knee, especially on going up and down the stairs.

...

Second, he developed pain on the outer aspect of the left knee in June which is almost five months after the initial injury. It could well be related to the original injury. Clinically, we suspect there is a tear of the anterior horn of the latera[] meniscus.⁶

Drs. Pamela C. Guthrie and Hans C. Coester

The parties stipulated to claimant's 1999 medical records from Drs. Guthrie and Coester. Dr. Guthrie saw claimant on May 4, 1999, when claimant complained of having low back pain for the past eight months or so. Claimant reported periods of severe pain, to the point he could not straighten up, then resolving over the course of 15 to 30 minutes. Claimant indicated he was a bull rider as a youth and had the potential for multiple injuries, but no acute single severe episode.

Dr. Timothy J. Birney

By order of the ALJ, claimant was evaluated by Dr. Birney, an orthopedic surgeon, on November 12, 2012. Claimant reported to Dr. Birney of having no prior history of back or left lower extremity pain. Claimant related that on February 2, 2008, he fell on his hands and knees and felt immediate left knee and right ankle pain. Dr. Birney's impressions were: (1) status post left knee arthroscopy with microfracture with subsequent development of post traumatic patellofemoral DJD; (2) status post left knee patellofemoral replacement, secondary to a work-related injury on February 2, 2008; (3) left femoral nerve injury secondary to left femoral nerve block done preoperatively for his left patellofemoral replacement with residual pain, left quadriceps weakness and allodynia (a sensory

⁶ Miller Depo., Ex. 5 at 2.

abnormality where the skin is sensitive to touch); (4) subacute axial low back pain, diskogenic versus facetally based; and (5) consider left lower extremity femoral radiculopathy. The doctor felt additional treatment and evaluation were necessary and ordered a lumbar MRI.

Dr. Birney saw claimant again on January 25, 2013, and determined claimant was at MMI. The doctor indicated claimant's MRI revealed an apparent sacralization of the L5 vertebra. Claimant had some degree of loss of disk signal at the L4-5 disk space, but without appreciable loss of height. The remainder of the disks appeared normal and well preserved. Claimant had no evidence of neural impingement at any level on sagittal views. On axial images, claimant had no evidence of neural impingement at T11-12, T12-L1, L1-2, L2-3, L3-4, L4-5 or at claimant's transitional L5-S1 level. Claimant had some moderate facet hypertrophy bilaterally at L4-5 with increased fluid within the left facet joint, and perhaps mild facet enlargement at L3-4. With respect to claimant's back, the doctor's impression was chronic low back pain secondary to resultant gait abnormality, diskogenic versus facetally based and no evidence of left lower extremity radiculopathy.

Dr. Birney testified claimant's gait abnormality was caused by a combination of abnormal painful sensation in the left thigh and ongoing left knee pain. The doctor testified claimant described developing low back pain because of the gait abnormality he developed after the femoral nerve block. The doctor testified:

Q. Okay. And in this case though, it's your opinion that based on the history that was provided to you by the claimant of a single traumatic event injuring his left knee and then two procedures causing a -- an altered gait that he's developed low back pain that you attribute back to February 2nd of 2008?

A. I think that appears more likely than not.

Q. And again, it's fair for me to assume that the history provided to you by the claimant regarding the cause of injury and that course of development is significant for reaching those conclusions?

A. Yes.

Q. And again, if -- if -- if it turned out that that history wasn't accurate, then that could impact the decisions you've reached?

A. Correct.⁷

Dr. Birney also testified:

⁷ Birney Depo. at 25-26.

Given that I had no history of preexisting issues with back pain and that his history was he subsequently developed back pain as a result of the gait abnormality, then I think the gait abnormality has caused his back to become painful. I can't tell you within a reasonable degree of medical probability whether those disks and facet abnormalities were there before and not symptom producing or if they had occurred since that time.⁸

Dr. Gareth E. Shemesh

At the request of his attorney, claimant was evaluated by Dr. Shemesh of Denver, Colorado. Dr. Shemesh is board certified in pain management, internal medicine and physical medicine and rehabilitation. Dr. Shemesh evaluated claimant on June 6, 2011. The doctor's history stated:

At the time of his injury, he was getting out of his patrol car, when he slipped and fell on ice. Apparently, his right ankle gave out on him and he sustained a twisting type of injury landing onto his left knee. He noticed the immediate onset of pain, swelling, and difficulty using his left knee. He continued to have ongoing symptoms. He tried working on it, but the pain did not get better.⁹

Dr. Shemesh assessed claimant with a twisting/contusion injury to the left knee with subsequent development of traumatic degenerative arthritis of the left knee, especially affecting the patellofemoral joint. He noted claimant underwent two subsequent surgeries. The doctor indicated claimant was left with residual pain and stiffness involving the left knee. Dr. Shemesh stated claimant's situation was complicated by the development of a left femoral nerve injury primarily affecting the sensory component with minimal motor findings on clinical examination, which occurred when he underwent a left femoral nerve block during his second surgery. Using the *Guides*,¹⁰ Dr. Shemesh gave claimant a 15% whole person functional impairment because he had an antalgic gait with shortened stance phase, advanced arthritic changes of his knee, needed to use a cane at least on a part-time basis for ambulation and at one point was requiring the use of a brace for stability. He testified claimant sustained no right ankle permanent functional impairment.

Dr. Shemesh testified that within a reasonable degree of medical probability he believed claimant's left knee grade IV chondromalacia of the trochlea and grade II to III chondromalacia of the patella with mild synovitis developed as a direct result of the February 2, 2008, injury. The doctor imposed permanent restrictions for claimant's left knee.

⁸ *Id.* at 11-12.

⁹ Shemesh Depo., Ex. 1 at 1.

¹⁰ American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

Prior to testifying, Dr. Shemesh reviewed Dr. Birney's IME report. Dr. Shemesh acknowledged a gait dysfunction can cause spinal abnormalities, but how fast, how much and where is harder to answer. He went on to testify that degenerative disk disease can be due to the normal aging process, congenital causes or an injury or trauma. The doctor testified he conducted a lumbar examination and found good range of motion and good alignment. A lateral bending test was nonprovocative and the doctor could not detect any significant lumbar paraspinal muscle tenderness. He opined claimant had no low back permanent functional impairment.

Dr. Terrence Pratt

Dr. Pratt, by order of the ALJ, first evaluated claimant on December 27, 2011. Claimant indicated he was injured in a fall on February 2, 2008. At the time of the examination, claimant was 5'10" tall and weighed 294 pounds. Dr. Pratt reviewed Dr. Saba's notes after claimant underwent an MRI in October 2008. Dr. Pratt indicated the MRI revealed increased signal intensity within the patellar tendon and plain films showed minimum degenerative disease. Dr. Saba's notes indicated claimant had tendinitis of his left patellar tendon. Dr. Pratt indicated claimant underwent an arthroscopic left knee surgery on October 1, 2009, with microfracture of the trochlear, chondroplasty of the patellar with limited synovectomy for grade IV chondromalacia of the trochlear with a small area II to III chondromalacia of the patellar and mild synovitis. According to Dr. Pratt, claimant underwent a patellofemoral replacement on August 18, 2010, because of severe osteoarthritis of the left patellofemoral joint.

Dr. Pratt testified claimant had an abnormal gait, or a limp. Claimant denied having left knee, right ankle or lumbosacral involvement prior to his work accident. Dr. Pratt's history contains the following excerpt:

There was ice on a curve. His right ankle slipped and twisted. He fell, landing on his hands and knees. He had discomfort involving his wrists, left knee, and right ankle. He presented to a nurse practitioner and reports that the nurse informed him that they would concentrate on the most significant area of involvement which was his right ankle. He reports that he reported all of his symptoms. He recalls plain films and then reports that a splint was placed. Over-the-counter medications were suggested. One week later, he returned with continuous symptoms and reports that he received a release to return to regular duty work. He presented to Dr. Miller in March. Medications were recommended. He reports that he informed the physician of all of the symptoms. . . .¹¹

Dr. Pratt's report indicated claimant complained of having a sensation of a knot across his low back with prolonged standing, which palliated with time. Claimant reported the low back involvement began approximately a year earlier. The doctor testified claimant

¹¹ Pratt Depo., Ex. 2 at 1.

had Scheuermann's disease, an abnormality where an individual has wedging of the vertebral bodies causing a kyphosis or a curvature of the spine. Claimant had diskogenic marrow signal changes, which suggest arthritis in the spine. He also had facet arthropathy at L4-5 and partial sacralization at L5. The doctor explained facet arthropathy is arthritis where the vertebrae join together and sacralization is a congenital abnormality where the transition between the lower lumbar and the upper sacral region is not as clear as it could be in a typical spine. The doctor indicated the sacralization is like a fusion. Dr. Pratt testified claimant's lower extremity symptoms did not correlate with the MRI findings.

With respect to causation, Dr. Pratt opined:

At this time, I have been asked to address specific issues including diagnosis of his condition which has been outlined. Also diagnosis causally related to the February 2, 2008 event. In direct relationship to the reported event, he had involvement of his right ankle and left knee. The left knee is more complex because he reports a subsequent injury with aggravation on the underlying involvement and that had a role in his presentation and care as well. He reports that that event was subsequent to his initial surgical evaluation with recommendation for a possible arthroscopic procedure. He did have left knee involvement in relationship to the February 2008 event. I could not relate lumbosacral involvement directly to the reported vocationally related activities. I did not identify guarding or significant loss in range of motion of the lumbosacral region to result in permanent partial impairment. The femoral nerve involvement was a complication of his treatment based on all of the information.¹²

Dr. Pratt determined claimant was at MMI. The doctor opined claimant had a 0% impairment of the right lower extremity and a 37% impairment of the left lower extremity for the patellofemoral involvement and the femoral nerve involvement, for a 15% whole person impairment.

Also by order of the ALJ, Dr. Pratt evaluated claimant a second time on July 30, 2013. The doctor noted claimant was seen by Dr. Birney and underwent a lumbar MRI. Dr. Pratt testified claimant presented with a cane and was able to ambulate without the cane, but had diminished range of motion of the left knee without the cane. Claimant complained of intermittent, dull aching across the lumbosacral region and a sensation inside the left hip as sharp, but not in the groin. Claimant also had left knee symptoms of dull pain anteriorly, worse laterally and medially. He also reported the left knee would give way and he experienced falls. In his summary, Dr. Pratt stated that claimant presented with continuing symptoms which claimant related to a February 2008 vocationally related event.

¹² *Id.*, Ex. 2 at 5.

Using the *Guides*, Dr. Pratt opined claimant was in DRE Lumbosacral Category II for his lumbosacral involvement and had a 5% whole person impairment. His functional impairment ratings for claimant's right and left lower extremities remained unchanged. Using the Combined Values Chart of the *Guides*, the doctor determined claimant had a 19% whole person functional impairment. The doctor's restrictions for claimant were: avoid lifting in excess of 30 pounds; pushing and pulling in excess of 50 pounds; activities requiring climbing, squatting, crawling or running; no prolonged standing or walking; and no frequent bending or twisting. Dr. Pratt opined that of the 32 nonduplicative job tasks identified by vocational expert Karen Crist Terrill, claimant could no longer perform 24, for a task loss of 75%.

On cross-examination, Dr. Pratt confirmed it was his understanding that when claimant fell, he had immediate pain in his left knee. The doctor testified with regard to claimant's left knee injury and back condition:

Q. And if in fact he didn't report that to health care providers until several months later and noted an onset of knee symptomatology in June 2008, that would be distinct -- that would be distinct and different, wouldn't it?

A. That's correct.

Q. And if that was accurate, then that would impact your ability to reach a conclusion within a reasonable degree of medical probability that any of his left knee symptomatology is related to February 2nd, 2008, true?

A. That's correct.

Q. Now, is it -- with your first report you concluded that he did not have a lumbosacral involvement reported -- directly to the reported vocationally related activities. In other words, you couldn't relate the back problem to February 2nd, 2008; is that what you're saying?

A. That's correct.¹³

Dr. Pratt testified that if claimant completed an accident report and did not mention a knee injury, claimant's history would not be consistent with the accident report. The doctor indicated his opinion on causation hinges completely upon claimant's report he injured his left knee on February 2, 2008.

Dr. Pratt indicated claimant reported having no preexisting low back pain. The doctor agreed the validity of his opinions could be affected if claimant's medical records showed he had preexisting low back pain. The doctor acknowledged a 5% permanent

¹³ *Id.* at 33.

functional impairment rating based on DRE Lumbosacral Category II he provided for claimant's low back essentially means someone has subjective complaints of pain relating to a specific event that has occurred in the past.

Dr. David K. Ebelke

At the request of respondent, on July 29, 2013, claimant was evaluated by Dr. Ebelke, an orthopedic physician who limits his practice to treatment of the spine. He physically examined claimant and reviewed claimant's medical records. Dr. Ebelke also obtained 10° Werner and flexion lateral x-rays. He noted the first complaint in claimant's medical records of low back pain was made in Dr. Miller's October 2008 notes. Claimant denied having any prior history of back problems.

Dr. Ebelke reviewed a January 25, 2013, lumbar MRI which showed loss of disk height at L5-S1, with normal signal intensity, implying a transitional level. Nerve root foramina were open at all levels. Mild reactive bone changes were present at the anterior/inferior aspect of T11, adjacent to the disk. Disk heights were otherwise well maintained at all lumbar levels, but there was early or mild loss of disk signal intensity at L4-5, claimant's effective lumbosacral level. No bulges were seen on the sagittal images at any level. Axial images were normal at T12-L1, L1-2, L2-3, L3-4 and L4-5 both in the canal and foraminal/extraforaminal areas. There was mild effusion in the left L4-5 facet, and perhaps to a lesser degree in the bilateral L3-4 facets. Claimant was mildly arthritic in the right L4-5 facet and L5-S1 showed sacralization on the left.

Dr. Ebelke opined:

After extensive review of this case, it's my opinion that Mr. Wolters has benign, non-work related low back pain. He has far more subjective complaints than objective findings on exam, x-ray, or MRI. Although medical professionals do sometimes tell patients that their back pain may be related to abnormal gait, this is anecdotal and not evidence-based. There's no medical evidence of a significant or serious back problem in this man. He has mild, relatively normal age-related degenerative changes in his low back. His back pain is probably part[l]y contributed to by his body habitus; I advised him to lose weight, in order to lower the loads on his low back. The mild degenerative changes are not something that would likely have developed over the 5 years that preceded [sic] the MRI. . . .¹⁴

There is no evidence of a permanent injury to the spine, nor is there any actual evidence of an abnormal gait aggravating or contributing to his back pain, so there

¹⁴ Ebelke Depo., Ex. 2 at 2.

would be no impairment rating from me (0%); this corresponds to DRE Lumbosacral Category I. There are no permanent restrictions with respect to the low back.¹⁵

Dr. Ebelke testified claimant was morbidly obese and that places a lot of load on his back. He indicated claimant's physical examination revealed no significant findings and was basically a normal examination. Claimant had normal range of motion, a normal neurological examination and no signs of a pinched nerve. The doctor testified the x-rays he obtained were basically normal x-rays. He also indicated an abnormal gait might in some circumstances cause an individual to have transient pain, but not a permanent injury. The doctor testified neither sacralization nor a loss of disk signal intensity is thought to cause pain. However, he did admit arthritis can cause pain.

Dr. David J. Clymer

On May 5, 2014, at the request of respondent, claimant was evaluated by Dr. Clymer, an orthopedic physician. The doctor reviewed claimant's extensive medical records, took a history and physically examined claimant. Claimant's history was that on February 2, 2008, he slipped and fell on his hands and knees, sustaining some abrasions and contusions and injuring his right ankle. Claimant recalled skinning his left knee. The history indicated claimant reported the full extent of his injuries, including hand, back, knee and ankle symptoms, to his supervisor, but only the ankle injury was listed on the accident report. Dr. Clymer testified the history claimant gave of his left knee injury was significantly different than the version in Dr. Miller's records. Claimant indicated he reported wrist, left knee and right ankle injuries to Mr. Raile, but felt the right ankle injury was the principal problem. Dr. Clymer noted this was not recorded in the medical records.

Dr. Clymer opined claimant had no permanent impairment regarding the right ankle. The doctor indicated he could not say within a reasonable degree of medical certainty there was a significant left knee injury that occurred on February 2, 2008.

Dr. Clymer testified he reviewed an October 13, 2008, MRI ordered by Dr. Saba and agreed with the radiologist there was some signal irregularity in the region of the patellar tendon, which was consistent with patellar tendinitis. However, the remaining objective findings were normal. According to Dr. Clymer, the MRI revealed no bony fractures, meniscus tears, cartilage tears or ligament injuries. The doctor indicated he would defer to the court or fact finder as to whether there was a sufficient report and evaluation of a knee problem at the time of the accident which would suggest a workplace injury to the left knee. Using the *Guides*, Dr. Clymer opined claimant had a 25% permanent functional impairment to the left lower extremity which converts to a 10% whole person functional impairment. The doctor testified that 20% of the left lower extremity functional impairment was for claimant's left knee surgeries and 5% was for persistent femoral neurapraxia.

¹⁵ *Id.*, Ex. 2 at 3.

Dr. Clymer was questioned by claimant's attorney about the records of Dr. Sanderford concerning claimant's left knee. Respondent did not object. Dr. Sanderford did not testify, nor were his records placed into evidence. According to Dr. Clymer, Dr. Sanderford's impression was there was some abnormality on the cartilage surface in the left knee in the region of the lateral femoral condyle that abuts against the patella. Dr. Clymer testified that can occur for a variety of reasons, including traumatic injury, but the most common cause is time, wear and tear and degeneration.

With regard to claimant's low back, Dr. Clymer saw no evidence in the medical records of any significant low back injury related to the fall at work and found no significant evidence of structural problems either clinically or on an MRI study. The doctor opined claimant had no ongoing permanent partial impairment of the lumbar spine.

Steve Benjamin

Vocational rehabilitation consultant Steve Benjamin interviewed claimant by telephone on April 4, 2014, and reviewed the restrictions placed on claimant by Drs. Pratt and Shemesh. He determined claimant performed 34 nonduplicative job tasks during the 15 years preceding his February 2, 2008, accident.

Karen Crist Terrill

Vocational rehabilitation consultant Karen Crist Terrill interviewed claimant by telephone on April 11, 2012.¹⁶ Ms. Terrill reviewed the medical records of Drs. Reichhardt, Pratt and Shemesh. She determined claimant performed 32 nonduplicative job tasks during the 15 years preceding his February 2, 2008, accident.

ALJ's Findings

With regard to the nature and extent of claimant's injuries, the ALJ stated:

The left knee injury and resulting back condition were considered carefully. The knee injury did not appear in the original medical records but injury/bruising was apparent on the photographs presented. Further, the fall as reported was found to be consistent with the reported knee injury. After careful review of all the evidence presented, it is found that the claimant met with personal injury by accident arising out of and in the course of his employment on February 2nd, 2008. He injured his

¹⁶ The parties stipulated that Ms. Terrill's August 27, 2013, report and attached task analysis be admitted into evidence as they pertain to claimant's educational history, Ms. Terrill's considerations and Ms. Terrill's opinions utilizing Dr. Pratt's restrictions. Although Ms. Terrill's report states the telephone interview was conducted on April 11, 2011, the Board believes Ms. Terrill intended to say April 11, 2012. It appears Ms. Terrill's original report is dated April 17, 2012, and two of the three doctors' restrictions she reviewed were after April 2011.

right ankle and left knee. Subsequently, he developed low back pain from an altered gait. The claimant sustained no permanent injury to his right ankle. He did sustain permanent injury to his left knee and low back. Dr. Pratt was court ordered and in his opinion, the claimant suffered a 19% whole person impairment and suffered a 75% task loss. He is found to be credible. Dr. Birney's findings and opinions were consistent with Dr. Pratt's.

From the claimant's date of injury through August 16th, 2010, the claimant would suffer a 19% permanent partial impairment to the body as a whole. From August 17, 2010 through May 12, 2013, he would suffer an 87.5% work disability based on the 75% task loss and 100% wage loss. From May 13th, 2013 through July 20th, 2013, the claimant worked part time and had an average weekly wage of \$250.00 for a 63% wage loss. That averaged with the task loss yields a 69% work disability. From and after July 21st, 2013, the claimant would suffer an 87.5% work disability.¹⁷

PRINCIPLES OF LAW AND ANALYSIS

The Workers Compensation Act places the burden of proof upon the claimant to establish the right to an award of compensation and to prove the conditions on which that right depends.¹⁸ "Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."¹⁹

Right Ankle

The physicians who evaluated claimant's right ankle and provided a functional impairment opinion opined claimant had a 0% permanent functional impairment for the right ankle. Therefore, the Board will affirm the ALJ's finding claimant suffered no permanent right ankle injury.

Left Knee

The ALJ found claimant's fall, as reported, was consistent with the reported left knee injury. The ALJ found claimant subsequently developed low back pain from an altered gait. ALJ Fuller concluded claimant sustained permanent left knee and low back injuries. The Board disagrees with the ALJ's finding that claimant sustained a work-related left knee injury for the following reasons:

¹⁷ ALJ Award at 12.

¹⁸ K.S.A. 2007 Supp. 44-501(a).

¹⁹ K.S.A. 2007 Supp. 44-508(g).

1. Mr. Raile's notes do not mention a left knee injury. Claimant asserts he reported his left knee injury to Mr. Raile, but Mr. Raile said they would focus on the ankle injury as it was the most debilitating injury. Mr. Raile denies claimant's version of what occurred. The Board finds Mr. Raile's testimony more credible than that of claimant. Mr. Raile's notes indicate he took social, medical and surgical histories and assessed claimant's body systems. Mr. Raile also inquired about claimant's medications. It is extremely unlikely that a medical provider who carefully detailed claimant's medical history would have omitted any mention of a left knee injury from his notes.

2. On the report of accident, claimant listed only his right ankle injury. Claimant's explanation that he did not list the left knee injury on the advice of his police chief is not credible. Only claimant completed responses on the report of accident regarding the details and extent of his injuries. He could have listed any and all injuries, but did not do so.

3. Claimant worked every day without restrictions, performing his regular job duties, until he complained of knee pain to Dr. Miller on October 3, 2008, approximately eight months after his fall at work. When he presented to Dr. Miller, claimant complained of several health issues, one of which was his left knee. The doctor testified she saw claimant for general medical conditions as opposed to joint pain. Dr. Miller's notes from the October 3, 2008, visit indicated claimant reported his left knee had been giving him trouble for the last three weeks. That corroborates Mr. Raile's testimony that claimant did not complain of a left knee injury. Moreover, Dr. Miller testified she could not say claimant's left knee injury occurred during his initial fall.

4. The history taken by Dr. Saba indicates he was told by claimant that after he had the initial injury in February 2008 and was treated for the right ankle with the brace, he did not feel any problem with the left knee. Dr. Saba indicated claimant developed pain on the outer aspect of the left knee in June 2008, four to five months after the accident.

5. Dr. Clymer indicated an October 13, 2008, MRI showed only some signal irregularity in the region of the patellar tendon, which was consistent with patellar tendinitis. Dr. Clymer testified the remaining objective findings were normal and the MRI revealed no bony fractures, meniscus tears, cartilage tears or ligament injuries.

6. Dr. Shemesh's opinion that claimant's left knee injury was work related was predicated on claimant reporting he injured his left knee during his initial fall. The history taken by Dr. Shemesh indicated claimant noticed an immediate onset of pain, swelling and difficulty using his left knee. At his deposition, claimant indicated that because his right ankle was swollen, he was taken by the police chief to see Mr. Raile. He did not testify that after the fall he had an immediate onset of pain, swelling and difficulty using his left knee. Moreover, claimant continued to work at his regular job duties for eight months until he sought treatment for his left knee.

7. Dr. Clymer testified the history claimant gave of his left knee injury was significantly different than the version in Dr. Miller's records. Dr. Clymer reviewed Dr. Sanderford's records, which noted claimant had an articular cartilage injury on the lateral femoral condyle of the left leg. Dr. Clymer indicated that type of injury can be caused by a traumatic injury, but the most common cause is time, wear and tear and degeneration.

8. Dr. Pratt testified that if claimant completed an accident report and did not mention a knee injury, claimant's history would not be consistent with the accident report. The doctor indicated his opinion on causation hinged completely upon claimant's report he injured his left knee on February 2, 2008.

9. The ALJ found claimant had photos showing an injury/bruising on his left knee. However, the photos taken shortly after claimant's fall do not depict any left knee bruising. Only a photo taken on February 13, 2007, shows any form of left knee injury, an abrasion. Thus, the photos do not support claimant's version of events.

Low Back

The Board further disagrees with the ALJ's finding that claimant sustained a permanent whole person functional impairment as the result of a work-related low back injury for the following reasons:

1. Because claimant did not sustain a work-related knee injury, his low back injury that allegedly resulted from an antalgic gait is also not work related.

2. Dr. Ebelke opined claimant had benign non-work-related low back pain.

3. Drs. Shemesh, Ebelke and Clymer opined claimant had no permanent functional impairment as the result of his alleged low back injury.

4. Claimant did not report he had back symptoms preexisting his work accident to Drs. Ebelke, Birney and Pratt. However, in 1999, claimant sought medical treatment for low back symptoms. Dr. Pratt testified it would be significant if claimant had low back treatment ten years earlier possibly related to bull riding as a youth.

5. Dr. Pratt acknowledged his permanent functional impairment rating for claimant's low back was based on claimant's subjective complaints and the history he gave. Additionally, Dr. Pratt's first report contained no low back impairment rating.

6. Dr. Birney indicated it was his opinion that, based on the history provided by claimant of a single traumatic left knee injury and two subsequent procedures causing an altered gait, that claimant developed low back pain attributable to the February 2, 2008, accident. Dr. Birney testified that given he had no history of claimant having preexisting

issues with back pain and that claimant's history was he subsequently developed back pain as a result of his gait abnormality, claimant's gait abnormality caused his back pain. Dr. Birney indicated that if the history given by claimant was not accurate, his opinions could be impacted. The doctor could not tell within a reasonable degree of medical probability if claimant's disk and facet abnormalities were there before the accident and not symptom producing or if they had occurred since his accident. Therefore, Dr. Birney's opinion is flawed as it was based on the false premises that claimant had no preexisting back pain and claimant's left knee injury was work related.

CONCLUSION

1. Claimant did not sustain a permanent functional impairment with regard to the right ankle.
2. Claimant did not prove by a preponderance of the evidence he sustained work-related left knee or low back injuries or impairment.
3. Claimant is not entitled to any temporary total disability benefits for the alleged left knee and low back injuries.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.²⁰ Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

AWARD

WHEREFORE, the Board modifies the June 12, 2014, Award entered by ALJ Fuller and finds claimant sustained only a work-related right ankle injury, but no permanent functional impairment. Claimant is entitled to payment of all authorized medical bills associated with his right ankle injury, future medical treatment for his right ankle upon application and approval by the Director and unauthorized medical up to \$500. Claimant did not prove by a preponderance of the evidence he sustained a work-related left knee or low back injury. Therefore, claimant is not entitled to permanent partial disability nor temporary total disability payments for those alleged injuries.

The Board adopts the remaining orders set forth in the Award to the extent they are not inconsistent with the above.

IT IS SO ORDERED.

²⁰ K.S.A. 2013 Supp. 44-555c(j).

Dated this ____ day of November, 2014.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Kerry McQueen, Attorney for Claimant
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Honorable Pamela J. Fuller, Administrative Law Judge