IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2002 MTWCC 11

WCC No. 2000-0258

GERALD WATKINS

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/Insurer for

SORENSON TRANSPORT

Employer

and

CREDIT GENERAL INSURANCE COMPANY

Respondent/Insurer for

T.T.C., INCORPORATED

Employer.

APPEALED 3/5/02

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: Claimant seeks medical and compensation benefits with respect to knee replacement surgery, arguing in the alternative that the surgery is related to a 1997 injury or to an occupational disease.

Held: Claimant is not entitled to benefits. Claimant failed to establish that he suffers from an occupational disease or that the surgery was causally related to his 1997 injury. Rather the surgery was an inevitable consequence of an earlier 1975 injury.

Topics:

Causation: **Medical Condition.** Where surgery was the direct and inevitable result of a prior injury, and a subsequent exacerbation of the preexisting condition did not cause the surgery or materially accelerate the need for surgery, the insurer for the subsequent exacerbation is not liable for the surgery.

Occupational Disease: Disease. Where claimant presented no medical testimony that he suffered from an occupational disease proximately causing his condition, his occupational disease claim must fail.

Occupational Disease: Proximate Cause. Where claimant presented no medical testimony that he suffered from an occupational disease proximately causing his condition, his occupational disease claim must fail.

¶1 The trial in this matter was held on September 18, 2001, in Missoula, Montana. Petitioner, Gerald Watkins (claimant), was present and represented by Mr. Andrew F. Scott. Respondent State Compensation Insurance Fund (State Fund) was represented by Mr. Greg E. Overturf. Respondent Credit General Insurance Company (Credit General) was represented by Mr. Michael P. Heringer and Ms. Lisa A. Speare.

¶2 Exhibits: Exhibits 1 through 9 were admitted without objections.

¶3 Witnesses and Depositions: Claimant and Dr. Dana Headapohl testified at trial. In addition the Court received and has considered depositions of claimant, Dr. Dana Headapohl, Dr. Greg Thomson, Dr. Walter Peschel, Dr. Michael Sousa, and Dr. Wayne L. Davis.

¶4 Issues Presented: The Pretrial Order sets forth nine issues, however, they can be condensed to one overriding issue, which is whether either the State Fund or Credit General is liable for treatment of claimant's left knee after February 1998, including a total knee replacement, and for any compensation benefits on account of disability since that time.

¶5 Having considered the Pretrial Order, the testimony presented at trial, the demeanor and credibility of the witnesses, the depositions and exhibits, and the arguments of the parties, the Court makes the following:

FINDINGS OF FACT

¶6 Claimant is presently 58 years old. Over his lifetime he has worked mostly as a truck driver but has also worked at other jobs, including construction.

¶7 In October 1975, while working as a framing (construction) contractor, claimant fell sixteen feet from a house and suffered a "partially comminuted[(1)] fracture to the proximal tibia" of the left leg, in other words a fracture of the tibia at the left knee. (Watkins Dep. at 15; Ex. 1 at 129.) Initially, he underwent surgery which included the use of hardware. (Watkins Dep. at 21-22; Ex. 1 at 129, 132.) He subsequently underwent four additional surgeries, apparently to remove hardware. The last surgery was in 1980 or 1981 to remove a plate in the knee. (Watkins Dep. at 22.)

¶8 While the medical records pertaining to claimant's treatment for his 1975 knee injury are sparse, claimant testified that he was told by his treating physician that in "8 to 12 years" he probably would have to have additional surgery to his knee. (*Id*. at 21.) According to claimant, the doctor "figured it [the fixed knee] would probably wear out." (*Id*. at 22.)

¶9 Notwithstanding his physician's initial prediction, claimant worked for nearly three decades without the need for additional surgery. (*Id.*) However, during that time he suffered progressive degenerative arthritis of his knee. (¶¶ 16, 31-32.)

¶10 Claimant returned to truck driving in the early 1980s. Between that time and 1997, he occasionally - he estimated once every three or four years - strained his left knee. (Watkins Dep. at 52.) "Once in a great while" his knee ached and he had to elevate it. (Trial Test.; Watkins Dep. at 51.) Also, on occasion his knee did not lock into place and stay straight. (Watkins Dep. at 114-15.) At trial he also said that on occasion he would hold his leg with his hand when stopped in traffic so his foot did not slip off the clutch. (*Id.* at 50-51.)

¶11 In 1992 the claimant went to work for T.T.C., Incorporated (T.T.C.), a trucking firm operated by Jack and Jimmy Tripp. (Watkins Dep. at 59-61.) The trucking firm was headquartered in Missoula. For the next seven years, claimant was a long-haul, flatbed trucker for the Tripps.

¶12 On October 29, 1997, while in Richmond, California, claimant slipped while stepping off the headache rack of his truck and strained his left knee. (Ex. 2.) He thereafter experienced pain which he described as 10 on a 1 to 10 scale, 10 being the worst pain.

¶13 At the time of his knee strain, T.T.C. was insured by Credit General. Claimant later submitted a claim with respect to the October 29 th incident and Credit General accepted liability for the claim.

¶14 Following the strain, claimant returned to Missoula and on the next Monday, November 4, 1997, saw Dr. Walter Peschel, a family practitioner. By that time, his pain had decreased to a "5" on a 10 point scale. (Watkins Dep. at 89.) Dr. Peschel noted that any swelling of the knee had "subsided" and that "the knee seems to be fairly stable." X-rays revealed "considerable degenerative disease of the space between the femur and the tibia" and "considerable deformity at the head of the tibia from old surgery and injury." He found "no sign of any acute injury or fracture or dislocation." (Ex. 1 at 121.)

¶15 Dr. Peschel referred claimant to Dr. Rob Sterling (*id*.) but claimant was thereafter seen not by Dr. Sterling but by Dr. Greg Thomson, a board certified orthopedic surgeon. Dr. Thomson first saw claimant on November 5, 1997, the day after Dr. Peschel saw him. At that time he noted claimant's 1975 injury and surgery but that claimant had been able thereafter to return to truck driving and had been able to walk without limitation and to climb stairs with a "reciprocal gait." He did note, however, that claimant "had occasional episodes of giving way." (Ex. 1 at 59.)

¶16 On November 5th, claimant reported knee pain but Dr. Thomson found no "effusion" in the knee. (*Id*.) The doctor reviewed x-rays of the knee, which were remarkable in a number of structural deformities due to his 1975 injury. (*Id.* at 60.) He also noted "significant arthritic changes that are tricompartmental in nature and loss of the medial and lateral joint space." (*Id*.) Based on his review of the x-rays, he felt that there were a "multitude of surgical options for reconstruction of his proximal tibia" but also noted that claimant had been "functioning at a rather significant level for the past two decades and has been satisfied with this." (*Id*.) He suspected that claimant's immediate problem was a meniscus (cartilage) tear in the knee (*id*.), however, a later MRI showed that the meniscus was missing, apparently as a result of the 1975 injury and surgeries (Thomson Dep. at 11, 21, 33). Dr. Thomson prescribed no specific treatment, taking a wait and see approach.

¶17 Dr. Thomson saw claimant on five more occasions over the following three months. On November 19, 1997, claimant was still complaining of pain and "a sense of instability." (Ex. 1 at 61.) Dr. Thomson noted a significant degree of "posterior translation at 30 degrees of knee flexion" but "suspect[ed] this is related as well to the malunion of his proximal tibia," i.e., to his 1975 injury. (*Id.*) He also noted that claimant "had previous episodes of instability," characterizing his history as "longstanding instability I believe secondary to his malunion." (*Id*.) He approved use of a knee brace. (*Id*.)

¶18 On December 8, 1997, Dr. Thomson noted that claimant was wearing a brace, which had eliminated his feeling of instability. (*Id.*) Claimant reported he was much improved with the brace. (*Id.*) Nonetheless, Dr. Thomson decided to proceed with an MRI of the knee. (*Id*.) The MRI disclosed no "meniscal pathology" but did disclose findings consistent with "acute trauma," possibly an "osseous [bone] contusion," or "degenerative changes." (*Id*. at 62.)

¶19 On February 2, 1998, Dr. Thomson declared claimant at maximum medical improvement (MMI). He noted that claimant "had no mechanical symptoms such as locking but has occasional instability which I suspect is more related to his malunion than to a meniscal injury." (*Id*.) With regard to his October 29, 1997 injury, he commented:

> Again, I think this is an exacerbation of an existing severe knee injury which has resulted in a malunion and tricompartmental arthritis. I believe his **sense** of instability is new in onset and significantly improved with the use of a brace and that he has reached MMI. [Emphasis added.]

(*Id.*) He did not restrict claimant's activities. (Thomson Dep. at 37.)

¶20 Thereafter, claimant did not seek medical care for his knee for a year and a half. Although claimant testified that he saw doctors for his knee during that interval (Watkins Dep. at 91-92, 100), the medical records do not support his testimony. (*Id*. at 93.) Based upon my reading of his deposition and my observation of his trial testimony, I find the medical records more reliable than his recollection.

¶21 Claimant continued to wear the knee brace and continued to work without incident or medical care until August 21, 1999, when he made a wrong step on a ladder and his knee either twisted or buckled. (Watkins Trial Test.; Watkins Dep. at 110; Ex. 1 at 58.) By that time, claimant had changed jobs and was working for Sorenson Transport and driving tanker trucks. (Watkins Dep. at 108, 136.) Part of his job was to periodically climb a ladder on the side of the tanker to check the tanker level while it was being emptied. (*Id*. at 108.)

¶22 No workers' compensation claim was filed with respect to the August 21, 1999 incident.

¶23 Following the August 21, 1999 incident, claimant was seen on August 24, 1999, by Dr. Robert J. Seim, an orthopedic surgeon in practice with Dr. Thomson. (Thomson Dep. at 38). Dr. Seim noted that claimant had slight tenderness of the knee but no effusion. (Ex. 1 at 58.) He also noted that claimant's knee brace had been loose at the time of the incident and that he had since had a readjustment of the brace and was doing better. (*Id*.) He suggested Advil or Ibuprofen for pain. (*Id*.)

¶24 Claimant returned to Dr. Thomson on October 27, 1999, complaining of "a persistent sense of instability and pain along the lateral joint line" of his knee. (Ex. 1 at 63.) Dr. Thomson noted that claimant "believes he is reaching a point in which he is concerned that something would need to be done to assist with his discomfort and functional status." (*Id*.) He opined that the "only surgical option" available to claimant was a total knee replacement and referred him to Dr. Michael Sousa, an orthopedic surgeon specializing in joint replacements, for further evaluation. (*Id*.)

¶25 By this time, claimant was clearly suffering significantly more pain and was more concerned with his knee and his ability to continue truck driving. After the 1997 accident he began using his hand on his leg more often to help him maintain his foot on the clutch, especially in heavy traffic. Climbing stairs and ladders also became more difficult and he began going a step at a time, drawing himself up with his right leg, then bringing his left leg up to the same step, then repeating the movement to reach the next step.

¶26 Claimant saw Dr. Sousa on November 23, 1999. Looking at x-rays, Dr. Sousa found significant deformity of the knee due to claimant's 1975 injury and surgery. He also noted a "cystic formation," which he described as follows:

> A. There was some holes in the bone. What happens is with arthritis you get a wearing of the joint surface and then you get a reaction of the body to this arthritis, and then you can form some pockets in the bone as a result of the inflammation, the irritation of the tissue. The body sets up a phenomena where the white blood cells get into the knee joint, you start breaking down the surface and you actually form some hollowing out of the bone in addition to the wearing of the joint surface. So he had some cysts or some softened bone under the joint surface as a result of his arthritis.
>
> Q. And would that hollowing of the bone be in the - -
>
> A. The tibia.

Q. - - the proximal tibia, the tibia that's close to the knee; is that right?

A. Yes.

(Sousa Dep. at 27-28.) He recommended a total knee joint replacement but indicated it was elective surgery with some risk. (Ex. 1 at 22.) On February 7, 2000, Dr. Sousa performed the surgery, described in his operative report as a high tibial osteotomy and a total knee replacement. (*Id*. at 10.)

¶27 Claimant alleges that his knee surgery and attendant disability are attributable, in the alternative, to an occupational disease or to his October 29, 1997 knee injury. As previously mentioned, he filed a claim for the October 29st injury and that claim was accepted by Credit General. On April 18, 2000, claimant submitted a further claim to the State Fund, which insured Sorenson, alleging that his work as a truck driver had materially aggravated his preexisting knee condition. (Ex. 8 at 219.) The claim was denied and claimant was referred to an occupational disease (OD) medical panel for evaluation. (*Id.* at 226, 230.) After examining the claimant, the panel concluded he was not suffering from an occupational disease. (Ex. 1 at 42-57.)

Occupational Disease Claim

¶28 Dr. Headapohl, who participated in the OD medical panel and testified in person at trial, Dr. Sousa, and Dr. Thomson addressed the claimant's occupational disease contention. All concluded that claimant does not meet the causation criteria for an occupational disease. (Headapohl Trial Test.; Ex. 1 at 42-57; Sousa Dep. 52-53, 69-70; Thomson Dep. at 64-65.) Their testimony is persuasive, and indeed there is no medical testimony to the contrary.

1997 Injury Claim

¶29 The medical testimony as to whether claimant suffered a material, permanent aggravation of his knee condition is less straightforward.

¶30 As an initial matter, all physicians addressing the point agreed that claimant's knee replacement was not caused by or attributable to the 1997 accident, rather it was a direct result of his 1975 injury and the internal deformities and degenerative arthritis resulting from that injury. Indeed, claimant had been told in 1975 that he could expect further surgery within eight to twelve years. (*See* ¶ 8.) At best, the 1997 accident may have accelerated the need for the surgery, and there was disagreement among the doctors even on that proposition.

¶31 While the 1997 MRI disclosed an increased T2 signal at the proximal tibia, all doctors ultimately agreed that at worst it was indication of a bone bruise that typically heals within six to twelve weeks without any permanent physical consequence. (Davis Dep. at 14-15, 28; Sousa Dep. at 53, 57, 65; Thomson Dep. at 18.) Dr. Wayne L. Davis, a radiologist, testified as to the significance of the MRI findings, indicating that in addition to disclosing long standing deformities caused by the 1975 injury (Davis Dep. at 22-23), the January 29, 1997 MRI of claimant's knee was read as indicating a bone bruise or arthritis. He testified that the MRI showed an increased T2 signal which is

"commonly associated with a small hemorrhage or edema within the bone marrow," which in turn "is most commonly associated with an acute/subacute injury to the bone. Some people refer to this in a more common vernacular as a bone bruise." (*Id*. at 14.) It is also referred to as a "microtrabecular injury." (*Id*.) Dr. Davis said that bone bruises generally "resolve after a few weeks and go away," usually within six to eight weeks. (*Id.* at 14-15, 28.) Finally, he testified that the MRI findings could also indicate advanced arthritis, which can also cause the edema, and that it is difficult to separate bone bruise from arthritis based on the MRI. (*Id*. at 14, 29-30.) Dr. Sousa testified that the bone edema could just as well have been caused by claimant's long standing arthritis. (Sousa Dep. at 57, 65.)

¶32 Dr. Sousa opined that the 1997 injury was a temporary aggravation of claimant's preexisting condition and that claimant would have required knee replacement in any event. Indeed, Dr. Sousa considered claimant a candidate for knee replacement prior to his 1997 accident and testified that claimant's knee condition and need for surgery was the product of a natural progression and deterioration of the preexisting knee condition which was not materially affected by the 1997 accident or other post-1997 incidents or work. His explanations, while lengthy, merit quoting:

> A. No, it [the 1997 accident] was not a major contributing factor. The biggest issue with Mr. Watkins was that his knee - - basically, the configuration of his knee, the anatomical configuration of his knee was probably fairly static and he became more symptomatic throughout this period of time and finally elected to proceed with the knee replacement. You know, it's difficult to say specifically these - - you know, these activities were causing the need for the total knee replacement. It was, you know, years of wear and tear. One could, you know, argue, I guess, that there are - - if he had a desk job then maybe he could have had a total knee replacement two years hence rather than at that particular time. You're just asking for some speculation, we can't fit the apportionment rules on this patient's case. Off the records.
>
> (Discussion held off the record.)
>
> Q. (By Ms. Speare) So is it fair to say that after 1975 and that significant injury as it was described it looked like a grenade went off, that the condition just simply worsened, worsened to the extent that Mr. Watkins eventually felt that he needed the knee replaced?
>
> A. Well, I think that from a strict medical point of view that's more probable. His contention was he had these - - - you know, these occurrences that tripped him over the edge, so to speak, the straw that broke the camel's back. But we don't have any anatomic changes that occurred during those times.

(Sousa Dep. at 52-53.)

> Q. So you're unable to tell if in fact he did have the bone marrow edema?
>
> A. All he says on this T2-weighted image, it's more bright. So it's either - - the edema could be representative of either a consequence of minor trauma, if you

will, or of the arthritic change that he had. So I mean, yeah, the abnormality was there, present on the scan, but what it means is somewhat subject to some conjecture.

(*Id*. at 58.)

Q. So you don't feel that there was any permanent aggravation of his condition as a result of the 1997 injury?

A. Well, you know, his knee was so bad and there weren't any acute changes other than this marrow edema, which could either be from arthritis or minor micro trauma, that the likelihood of causing permanent damage is not great. You know, I think what Mr. Watkins was contending to me was that, you know, he was able to do his work and do most things and then he had that injury, and they - - you know, he had to start wearing a brace, he started having more and more discomfort and finally pushed him over the edge. But it's a real difficult situation because he had such a bad knee that to ascribe that - - you know, significant enough injury to result in his need for a total joint replacement.

Q. Not speaking about the need for the total joint replacement, but just from the standpoint of his disability in general, you said that he started wearing the brace after 1997; is that correct?

A. That's correct.

Q. And in your opinion does his need for a brace after 1997 indicate that there was a permanent increase in his disability as a result of that injury?

A. All one cay say is that there is a temporal association at that particular time. Whether, you know, finally after 22 years it was just enough that his knee was continuing to bother him. We have a lot of patients that ascribe certain physical characteristics or problems to a specific act or incident that may or may not be influencing their overall picture, that it may have been from, you know, another set of circumstances, i.e., the severe fracture and deformity in just a matter of time. And, you know, we all take missteps, stumble or slip on the ice, you know, all the time, and so in that realm of certain set of circumstances he started having more symptoms.

(*Id*. at 59-61.)

Q. In regard to the 1999 injury, when he had that, do you have an opinion of whether that was a temporary or a permanent aggravation?

A. It, again, sounded like a temporary aggravation. He bobbled or twisted his knee and had some knee effusion, swelling. Anytime you have a bad joint or you kind of twist it or overuse it - - I got kicked in the knee by a horse, I have a shot knee anyway, so I know that if you overdo it, it's going to talk to you. So it can be quite disconcerting at times. And generally, that gets better and goes down. So it did not appear to have, you know, significant structural changes that could be

easily documented because of his preexisting severe knee deformity, then, you know, one would have to say it probably was a temporary aggravation of that underlying condition.

(*Id.* at 62.)

Q. In 1997 would it have been a reasonable treatment for him to have a knee replacement at that time?

A. Sure. Oh, he had all the criteria that would fit for having a total knee joint replacement.

(*Id.* at 72.)

Q. Let's turn our attention to the 1997 injury with the MRI scan that we have talked about earlier. Same line of questioning; considering that injury, the MRI scan, is there, and in conjunction with Dr. Headapohl's report for answer No. 1, is there even one percentage point of aggravation on a permanent basis attributed to the 1997 injury?

A. Permanent basis?

Q. Yes.

A. Probably not. Usually that sort of injury would heal, that aggravation would heal and in that there was no anatomic lesion in the injury that would lead to - - would be of long-term consequences and one would say it would be more probable than not that that would lead to a healing and would be more of a temporary aggravation.

Q. Even considering the condition of his knee at the time of that injury?

A. Well, it didn't break anything, basically, he - - you know, it was like having a sore thumb, you hit it with a hammer it's going to be sore, but it's going to be sore for a while and eventually fade on out. That would be the character of that specific type of injury on his knee, not something that would permanently lead to structural changes and then push you over the edge.

(*Id.* at 79-80.)

¶33 Dr. Thomson opined that the claimant's need for knee replacement was a direct result of his 1975 accident; that laxity (looseness) of claimant's knee identified in 1997; and 1999 was due to the malunion of his 1975 tibial fracture, and that his pain was due to his arthritis. (Thomson Dep. at 8, 30, 43, 44-46.) He testified that "the magnitude of his arthritis and the need for a knee replacement was related to his injury in '75." (*Id*. at 46.) With respect to the claimant's 1997 injury, he agreed with Dr. Headapohl that the incident probably exacerbated claimant's preexisting arthritis and that it could have accelerated claimant's need for knee replacement, however, he said that it was speculative as to how much; overall he opined that the 1997 injury was not significant.

Referring to a statement by Dr. Headapohl that the 1997 injury had materially worsened claimant's preexisting condition he testified

> I'm in agreement that the [1997] MRI did show a level of injury that likely exacerbated a preexisting level of arthritis. Although, I don't know that that degree can be qualified or quantified in an objective fashion.

(*Id*. at 53.) Concerning the nature of the aggravation, he testified:

> A. . . . [M]y impression [in 1999] of his injury and current complaints were that they were, in large part, related to his injury in '75, and that these episodes in '97 and '99, although significant, were not going to play a role in his long-term outcome and recommendations for treatment.
>
> Q. And then, likewise, Doctor, do you have an opinion with respect to whether the '97 injury played a role with respect to the timing of the knee replacement?
>
> A. It may have brought him to that point earlier than otherwise would have been the case.
>
> Q. You couldn't speculate, though, on how much sooner or anything, could you.
>
> A. No.

(*Id.* at 50.) When pressed further on the subject, he said:

> Q. You said earlier about how you agree with Dr. Headapohl's conclusions. With that additional testimony that you provided clarifying some of that, do you still have that same view?
>
> A. The MRI shows evidence of an injury. And I would agree with her impressions that there was evidence of a bone contusion, there was evidence of a knee effusion that are evidence of an acute injury.
>
> The statement that significant material worsening, as an assessment of an MRI, I do not believe that somebody could render that type of subjective opinion based on that rather objective study.
>
> Q. And it was your opinion that the 1997 incident may have sped up the need for the total knee replacement?
>
> A. Insofar as it contributed to his symptoms and function limitation, I believe that's a reasonable statement to make.

(*Id*. at 58-59.) Putting, the 1997 injury in perspective, however, he considered the 1997 injury of little significance to claimant's condition and need for surgery:

Q. . . . Do you have an opinion, to a reasonable degree of medical probability, of whether Mr. Watkins' injury that he suffered in 1997 permanently aggravated his underlying condition of his knee?

A. It would be my opinion that that was an exacerbation - - his current exacerbation and his current discomfort. But based on his progress, I would not anticipate that to be a significant factor in him ultimately needing to have his knee replaced.

Q. So in other words, was the incident in 1997 a temporary aggravation of his underlying condition, and then he returned to the progression that he was in following 1997?

A. I have no evidence in my chart or his x-rays to suggest otherwise.

Q. And in regard to the incident in 1999, did that represent a permanent aggravation of his underlying knee condition? Or, again, was that a temporary blip, would you say, and then he returned to the same natural progression?

A. If I can just make a general statement. Folks with this degree of arthritis often have events that are old, to the point where they can no longer tolerate where they're at.

I can't specifically state whether his injury in '97 or that in '99 was that sentinel of an event. In my mind, he was on a course that would lead him ultimately to need to have something done, like a knee replacement.

And these events in '97 and '99, you know, were exacerbations of an underlying degree of arthritis as to be expected on some level.

Whether he would recover to his preinjury status or not, I don't know that I can say with a reliable - - in an objective fashion. I think they were events along a course that were gong to lead to a major effort to resolve his degree of arthritis.

(*Id*. at 55-57.)

¶34 While Dr. Headapohl was deposed, she also testified at trial. At trial she had the benefit of reviewing Drs. Davis', Sousa's and Thomson's depositions, which led her to modify her opinions in minor respects. It is her trial testimony that I rely upon in assessing her opinions.

¶35 Initially, Dr. Headapohl did not challenge the other doctors' interpretations and conclusions concerning the 1991 MRI findings and conceded that there is doubt as to whether the 1997 accident caused a material and permanent physical change in claimant's knee condition. Nonetheless, on a more probable than not basis, she still felt the 1997 accident caused some physical change, although she could not point to any objective evidence supporting her opinion. As to the effect of the injury, she testified that it increased claimant's pain and accelerated his need for surgery. She "estimated" that it moved up his need for surgery by a year. On a more probable than not basis, she

testified that it moved up his need for surgery by one to five years. She agreed that the surgery was inevitable and was caused by his 1975 injury.

¶36 Finally, Dr. Peschel was also asked for an opinion concerning the 1997 injury. He opined that it was a temporary exacerbation. (Peschel Dep. at 33.)

¶37 After considering the various medical opinions in this case, I have no doubt that the claimant's knee replacement was caused by his 1975 injury and not by any subsequent exacerbations. The surgery was inevitable irrespective of the 1997 and 1999 events and irrespective of the nature of his work. That he would ultimately require knee replacement or some other surgery was predicted after his 1975 surgery.

¶38 At best, the 1997 injury may have led to the surgery being done earlier than would have been required absent that injury. Sorting through this testimony, I give Dr. Sousa's testimony the most weight since he both treated claimant and also specializes in diagnosis and treatment of knee injuries. He concluded that claimant's need for surgery was the result of the natural progression of his condition and that subsequent exacerbations were not material to claimant's need for surgery. Dr. Thomson, who is also an orthopedic surgeon and who has also performed knee replacements, indicated that the 1997 injury probably hastened the surgery but by how much was speculative and that the 1997 injury was not significant. Only Dr. Headapohl quantified the period by which surgery may have been moved up, estimating one year and on a more probably than not basis between one and five years. I am not persuaded that the 1997 injury hastened surgery significantly or materially, or even by one year, especially in light of the long period claimant had been able to postpone the inevitable. Reinforcing my conclusion is the fact that claimant did not seek medical care for his knee for a year and a half following Dr. Thomson's February 1998 MMI determination, and Dr. Thomson's skepticism that claimant's use of a knee brace during that period significantly benefitted him. (Thomson Dep. at 24-25, 31, 63.)

CONCLUSIONS OF LAW

¶39 This case is governed by the 1997 version of the Montana Workers' Compensation Act since that was the law in effect at the time of the claimant's industrial accident. *Buckman v. Montana Deaconess Hospital,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

¶40 Claimant bears the burden of proving by a preponderance of the evidence that he is entitled to the benefits he seeks. *Ricks v. Teslow Consolidated,* 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wicken Bros. Construction Co.*, 183 Mont. 190, 598 P.2d 1099 (1979).

¶41 "Causation is an essential element to benefit entitlement." *Hash v. Montana Silversmith,* 256 Mont. 252, 257, 846 P.2d 981, 983 (1993). To be compensable, the medical condition for which compensation is sought must be caused by the industrial accident. *Id*. That an insurer is responsible only for medical conditions and disability **caused** by a work-related injury for which the insurer is liable is evident from the statutes governing benefits. Section 39-71-704, MCA (1997), which governs medical benefits, provides in relevant part:

> **39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation.** (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:
>
> (a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions **resulting** from the injury for those periods as the nature of the injury or the process of recovery requires. [Emphasis added.]

Section 39-71-701, MCA (1997), which governs temporary total disability benefits, provides in relevant part:

> **39-71-701. Compensation for temporary total disability -- exception.** (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:
>
> (a) when the worker suffers a total loss of wages **as a result** of an injury and until the worker reaches maximum healing . . . . [Emphasis added.]

Section 39-71-702, MCA (1997), which governs permanent total disability benefits, provides in relevant part:

> **39-71-702. Compensation for permanent total disability.** (1) If a worker is no longer temporarily totally disabled and is permanently totally disabled, as defined in 39-71-116, the worker is eligible for permanent total disability benefits. Permanent total disability benefits must be paid for the duration of the worker's permanent total disability, subject to 39-71-710.
>
> . . .
>
> (3) Weekly compensation benefits **for an injury resulting** in permanent total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. [Emphasis added.]
>
> . . .

Section 39-71-703, MCA (1997), which governs permanent partial disability benefits, provides in relevant part:

> **39-71-703. Compensation for permanent partial disability.** (1) If an injured worker suffers a permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the worker is entitled to a permanent partial disability award if that worker:
>
> (a) has an actual wage loss as a **result** of the injury . . . . [Emphasis added].

¶42 The claimant in this case has failed to prove that his knee replacement surgery, and disability resulting from that surgery, is causally related to his 1997 injury or to an occupational disease. The surgery was inevitable given his 1975 injury.

JUDGMENT

¶43 The claimant has failed to prove that his knee replacement surgery and resultant disability were caused by his 1997 injury or an occupational disease. His petition is **dismissed with prejudice**.

¶44 This JUDGMENT is certified as final for purposes of appeal.

¶45 Any party to this dispute may have 20 days in which to request a rehearing from these Findings of Fact, Conclusions of Law and Judgment.

DATED in Helena, Montana, 22nd day of February, 2002.

(SEAL)

\s\ Mike McCarter
JUDGE

c: Mr. Andrew F. Scott
Mr. Greg E. Overturf
Mr. Michael P. Heringer
Ms. Lisa A. Speare
Submitted: September 18, 2001

1. "A comminuted fracture means that it's in many pieces . . . ." (Sousa Dep. at 19.)