IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2007 MTWCC 41

WCC No. 2006-1592

SHARON STEWART

Petitioner

vs.

LIBERTY NORTHWEST INSURANCE CORPORATION

Respondent/Insurer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

Summary: While working for Respondent's insured, Petitioner sustained an injury to her right knee. She then underwent two arthroscopic surgeries, after which she continues to experience ongoing pain which she attributes to nerve damage suffered during her surgeries. Petitioner petitioned the Court for an increase in her impairment rating because of her ongoing pain.

Held: Petitioner is not entitled to an increased impairment rating. Although Petitioner's treating physician testified that Petitioner's condition is related to her knee surgery, he further testified that he ultimately has no idea how Petitioner's condition could be related to her surgery. This is insufficient to establish causation. Because Petitioner has failed to prove a causal connection between her industrial injury or subsequent surgeries and her chronic pain condition, her petition for an increased impairment rating is denied.

Topics:

> **Causation: Injury.** "Causation is an essential element to an entitlement to benefits and the claimant has the burden of proving a causal connection by a preponderance of the evidence. *Grenz v. Fire and Cas. of Conn.,* 250 Mont 373, 380, 820 P.2d 742, *citing Brown v. Ament,* 231 Mont. 158, 163, 752 P.2d 171, 174 (1988). Although a treating physician's opinion is generally accorded greater weight, the opinion is not conclusive. Where virtually no evidence that a causal connection between Petitioner's surgeries and the purported damage to her knee exists, and her treating physician's ultimate opinion that there is a causal relationship is belied by the entire

remaining balance of his testimony acknowledging that he has no idea how the surgeries and knee damage are related, Petitioner has not met her burden of proof.

Physician: Treating Physician: Weight of Opinion. Although a treating physician's opinion is generally accorded greater weight, the opinion is not conclusive. Where virtually no evidence that a causal connection between Petitioner's surgeries and the purported damage to her knee exists, and her treating physician's ultimate opinion that there is a causal relationship is belied by the entire remaining balance of his testimony acknowledging that he has no idea how the surgeries and knee damage are related, Petitioner has not met her burden of proof.

¶ 1 The trial in this matter was held on August 9, 2006, in Helena, Montana. Petitioner Sharon Stewart was present and represented by Michael J. San Souci. Respondent Liberty Northwest Insurance Corporation was represented by Larry W. Jones.

¶ 2 Exhibits: Exhibits 1-4, 6-20, 22, 24, 25, 27, and 29-36 were admitted without objection. Exhibits 5, 21, and 23 were objected to by Respondent on grounds of relevance and were excluded by the Court. No formal motion was made for the admittance of Exhibits 26 and 28 and thus, they were excluded.

¶ 3 Witnesses and Depositions: The depositions of Drs. Lowell Anderson and Dana Headapohl were taken and submitted to the Court. Petitioner and Kay Martin were sworn and testified at trial.

¶ 4 Issues Presented: The Court restates the issues in the Pretrial Order as follows:

¶ 4a Whether Petitioner is entitled to an impairment rating of 35 percent or less.

¶ 4b Whether Petitioner is entitled to reasonable attorney fees and costs under § 39-71-611, MCA.[1]

¶ 5 Petitioner filed a Notice of Supplemental Medical Authority after the case was submitted to this Court. Having cited no authority for the admittance of this additional evidence, Petitioner's Supplemental Medical Authority was not considered by the Court.

FINDINGS OF FACT

¶ 6 Petitioner was a credible witness and the Court finds her testimony credible.

[1] Pretrial Order at 3.

¶ 7 Kay Martin was a credible witness and the Court finds her testimony credible.

¶ 8 The following uncontested facts are taken from the Pretrial Order:

¶ 8a On August 26, 2002, Petitioner suffered an injury in the course and scope of her employment with Gallatin Laundry Company, Incorporated of Gallatin County, Montana.

¶ 8b At the time of the injury, Gallatin Laundry Company, Incorporated was enrolled under Compensation Plan No. 2 of the Workers' Compensation Act and was insured by Respondent.

¶ 8c Respondent accepted liability for the claims and has paid certain wage loss and medical benefits.

¶ 8d After initially paying Petitioner a 13 percent impairment rating, Respondent eventually paid Petitioner an 18 percent whole person impairment rating.[2]

¶ 9 Dr. John Campbell treated Petitioner following her injury. He diagnosed a probable medial meniscal tear in Petitioner's right knee.[3] On October 1, 2002, Dr. Campbell performed a diagnostic arthroscopy with a 75 percent medial meniscectomy and small abrasion chondroplasty over the medial femoral condyle.[4] Petitioner was reported to have tolerated the surgery well and nothing remarkable about the procedure was noted.[5]

¶ 10 Because she was suffering from knee pain and limited range of motion, Petitioner began a post-operative course of physical therapy on October 14, 2002.[6]

¶ 11 On November 26, 2002, Petitioner underwent a diagnostic arthroscopy of her right knee with lysis of adhesions and manipulation of the knee, performed by Dr. Campbell. Dr.

---

[2] Pretrial Order at 2.

[3] Ex. 1.

[4] *Id.*

[5] *Id.*

[6] Ex. 6 at 1.

Campbell's preoperative diagnosis included "POSTOPERATIVE COMPLICATION OF COMPLEX REGIONAL PAIN SYNDROME."[7, 8]

¶ 12 Following her second surgery, Petitioner continued physical therapy to improve her pain and knee range of motion but did not note improvement.[9]

¶ 13 On April 21, 2003, Dr. John A. Vallin examined Petitioner, placed her at maximum medical improvement (MMI), and assigned Petitioner a 3 percent whole person impairment for her medial meniscectomy. Dr. Vallin opined that Petitioner did not warrant an impairment rating based on the diagnosis of Complex Regional Pain Syndrome (CRPS) because she "has no neurogenic source for her ongoing symptoms."[10] Dr. Vallin opined that Petitioner "should be issued an additional impairment not on the basis of her RSD diagnosis but rather impairment due to knee ankylosis in flexion."[11] Under this rationale, Dr. Vallin assigned an additional 10 percent impairment with a total whole person impairment of 13 percent.[12]

¶ 14 Dr. Lowell Anderson examined Petitioner on October 27, 2003. His notes document the following:

> Right knee discomfort. **Etiology unknown**. Possible chronic thrombophlebitis. Possible locked medial meniscus. Possible complex regional pain syndrome. Possible saphenous nerve neuroma.[13]

¶ 15 A three-phase bone scan was performed on November 6, 2003, and reported by Dr. James Jutzy. Based on the static images obtained from the scan, Dr. Jutzy opined that there was a very mild increased activity in the right knee compared to the left and very minimal increased activity in the right femur. Dr. Jutzy noted, "Usually with reflex

---

[7] Ex. 2 at 1.

[8] Throughout the exhibits and depositions in this case, physicians refer to Petitioner's chronic pain condition variously as complex regional pain syndrome (CRPS) and reflex sympathetic dystrophy (RSD). Although the medical literature distinguishes between Type I and Type II CRPS, for purposes of the Court's decision in this case, distinguishing between the different diagnoses (Type I CRPS, Type II CRPS, and RSD) is inconsequential. Therefore, the Court's Findings of Fact, Conclusions of Law and Judgment reflect the differing terms referred to by the various physicians in this case.

[9] Ex. 6 at 2.

[10] Ex. 4 at 1.

[11] *Id.*

[12] Ex. 4 at 1-2.

[13] Ex. 6 at 3 (emphasis added).

sympathetic dystrophy there is increased activity in the lower extremity clear to the foot with abnormality in the uptake on all three phases in this region. . . . Reflex sympathetic dystrophy without involvement of the distal ankle and foot would be unusual."[14]

¶ 16 On November 18, 2003, Dr. Joan C. Murray performed a nerve conduction study on Petitioner and found "[n]o electrical evidence for saphenous neuropathy, diffuse peripheral neuropathy, or radiculopathy" in Petitioner's right lower extremity.[15]

¶ 17 Dr. Anderson examined Petitioner again on November 24, 2003. He remarked, "This is an extremely complex problem and she may need further evaluation and treatment considerations by further specialists. This is a highly unusual pathology combination."[16]

¶ 18 On December 10, 2003, Dr. Anderson placed Petitioner under a spinal anesthetic and observed her response to sensory stimuli. Dr. Anderson then performed a closed manipulation and measured 17 to 125 degrees of motion with a goniometer. Additionally, Dr. Anderson mapped the articular and infrapatellar branches of the saphenous nerve. Petitioner identified to Dr. Anderson the articular branch as the area of discrete tenderness. After the mapping, a femoral nerve catheter was placed to identify the location of the nerve.[17]

¶ 19 Petitioner underwent a neuroablation on the right saphenous nerve in her knee on December 19, 2003. This surgery was performed by Dr. Vallin.[18]

¶ 20 Because of the complexity in treating Petitioner for her condition, she was seen on March 17, 2004, by Dr. Douglas J. Pritchard of the Mayo Clinic, Department of Orthopedic Surgery. After reviewing Petitioner's history and performing a physical examination, Dr. Pritchard opined that Petitioner has "a chronic regional pain syndrome [CRPS]."[19] He further opined that "her diagnostic tests have been virtually exhausted."[20]

---

[14] Ex. 11 at 1.

[15] Ex. 9 at 2.

[16] Ex. 10.

[17] Ex. 12 at 1.

[18] In Ex. 13, Dr. Vallin referred to the "suprapatellar" branch of the saphenous nerve (as opposed to the articular branch identified by Dr. Anderson). Respondent takes issue with this discrepancy in disputing Dr. Anderson's opinion. However, for purposes of this Court's decision, whether the difference in terminology is attributable to a mistake, oversight, or alternate medical vernacular used by different practitioners, is ultimately of no consequence.

[19] Ex. 15 at 2.

[20] *Id*.

¶ 21 Dr. Anderson again examined Petitioner on October 6, 2004. At that time, he did not believe reassessment of her previous impairment rating was appropriate because he opined that Petitioner was not at MMI. Dr. Anderson did, however, anticipate a significant increase in her impairment rating at the time she reached MMI due to her significant physical deterioration.[21]

¶ 22 In a June 1, 2005, letter to Respondent's Case Manager, Kay Martin, Dr. Anderson opined that Petitioner was at MMI. Dr. Anderson assigned Petitioner a 35 percent impairment rating using the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Ed., because her "physical findings . . . most closely resemble the diagnostic findings in reflex sympathetic dystrophy."[22]

¶ 23 On June 28, 2005, Dr. Gary Rischitelli, Medical Director for Respondent, reviewed Dr. Anderson's impairment rating and disagreed with the 35 percent impairment rating. After reviewing several records in the case, Dr. Rischitelli assigned Petitioner an 18 percent impairment rating.[23]

¶ 24 In his deposition, Dr. Anderson testified that he was not certain whether Petitioner had CRPS. He opined that there was "a good chance" that she had some components of CRPS in addition to a peripheral nerve pathology "of some sort."[24] Dr. Anderson testified that he did not understand how Petitioner's saphenous nerve could have been injured by her surgery but that sometimes putting a portal site into the knee can irritate a nerve. However, in those instances, he acknowledged that usually those symptoms resolve and, in Petitioner's case, they did not.[25] Dr. Anderson further testified that he saw nothing out of the ordinary, nothing remarkable, and nothing unusual about the surgery Dr. Campbell performed, and he could not see how the nerve would have been damaged in the surgery.[26] Finally, despite acknowledging that he had "no idea how" the saphenous nerve could have been injured during the surgery, Dr. Anderson concluded that Petitioner's symptoms were related to the surgery because:

> The symptoms prior to the surgery were indicative of a meniscus tear, and the MRI indicated that she did not have these kind of symptoms prior to

---

[21] Ex 17 at 2.

[22] Ex. 24 at 1-2.

[23] Ex. 36 at 1, 3.

[24] Anderson Dep. 29:2-8.

[25] Anderson Dep. 30:2-9.

[26] Anderson Dep. 30:2-17.

the surgery, so there's a relationship between the first surgery and the symptoms developing.[27]

¶ 25 Dr. Anderson opined that one of the possible explanations for Petitioner's nerve damage may be that she has an atypical distribution of nerves in her knee, but Dr. Anderson was unable to point to any specific medical findings supporting such a conclusion.[28]

CONCLUSIONS OF LAW

¶ 26 This case is governed by the 2001 version of the Montana Workers' Compensation Act since that was the law in effect at the time of Petitioner's industrial accident.[29]

¶ 27 Petitioner bears the burden of proving by a preponderance of the evidence that she is entitled to the benefits she seeks.[30]

¶ 28 "Causation is an essential element to an entitlement to benefits and the claimant has the burden of proving a causal connection by a preponderance of the evidence."[31]

¶ 29 Petitioner has failed to carry her burden of proof in this case. There is virtually no evidence that a causal connection exists between her initial industrial injury or subsequent surgeries and the chronic pain condition from which she currently suffers. The only medical opinion purporting to address any causal connection between Petitioner's knee surgery and her subsequent pain is that of Dr. Anderson. However, despite concluding there is a causal relationship between Petitioner's surgeries and the purported damage done to her knee, Dr. Anderson goes on to acknowledge that he has no idea how the two are related. Moreover, his ultimate conclusion of a causal connection is belied by the entire remaining balance of his testimony which was that:

¶ 29a He didn't understand how Petitioner's saphenous nerve could have been injured by her surgery.[32]

---

[27] Anderson Dep. 29:22 – 30:1.

[28] Anderson Dep. 31:6-14.

[29] *Buckman v. Montana Deaconess Hosp.,* 224 Mont. 318, 321, 730 P.2d 380, 382 (1986).

[30] *Ricks v. Teslow Consol.,* 162 Mont. 469, 512 P.2d 1304 (1973); *Dumont v. Wickens Bros. Constr. Co.*, 183 Mont. 190, 598 P.2d 1099 (1979).

[31] *Grenz v. Fire and Cas. of Conn.,* 250 Mont. 373, 380, 820 P.2d 742 (1991), *citing Brown v. Ament,* 231 Mont. 158, 163, 752 P.2d 171, 174 (1988).

[32] Anderson Dep. 30:2-3.

¶ 29b Although speculating that sometimes putting a portal site into the knee can irritate a nerve, usually those symptoms resolve and, in Petitioner's case, they did not.[33]

¶ 29c Dr. Anderson saw nothing out of the ordinary, nothing remarkable, and nothing unusual about the surgeries Dr. Campbell performed and he could not see how the nerve would have been damaged in the surgery.[34]

¶ 30 Dr. Anderson is Petitioner's treating physician. "[A]s a general rule, the opinion of a treating physician is accorded greater weight than the opinions of other expert witnesses."[35] However, a treating physician's opinion is not conclusive. To presume otherwise would quash this Court's role as fact-finder in questions of an alleged injury.[36] In this case, Dr. Anderson's opinion ultimately boils down to a conclusion that, despite having no idea how Petitioner's symptoms and surgeries may be related, he concludes they must be related because Petitioner did not exhibit these symptoms before her surgery. Respondent asserts that Dr. Anderson's opinion can be reduced to the legal maxim of *post hoc, ergo propter hoc* ("after this, therefore because of this"). Being the product of a post-Vatican II Catholic education, I would be disinclined to employ the Latin phraseology Respondent embraces. Nevertheless, Respondent's point is well-taken. When all of the medical evidence fails in any way to demonstrate a causal relationship between Petitioner's symptoms and her surgeries, Dr. Anderson's opinion that the two are related is insufficient to meet Petitioner's burden of proof.

¶ 31 In light of the number of different physicians Petitioner has seen regarding her condition and the fact that I found her to be a credible witness at trial, I have no doubt that she is suffering from some sort of chronic pain condition. However, without evidence establishing, on a more-probable-than-not basis, that her condition was related in some way to her surgeries, Petitioner fails to meet her burden of proof. Dr. Anderson's opinion, when viewed in light of the medical evidence in its totality, including Dr. Anderson's own testimony, is insufficient.

¶ 32 Because Petitioner's request for an increased impairment award is denied, the Court does not consider Petitioner's request for attorney fees and costs.

---

[33] Anderson Dep. 30:4-9.

[34] Anderson Dep. 30:2-17.

[35] *EBI/Orion Group v. Blythe*, 288 Mont. 356, ¶ 12, 957 P.2d 1134 (1998), *citing Blythe,* 281 Mont. 50, 931 P.2d 38 (1997).

[36] *EBI* at ¶ 13.

JUDGMENT

¶ 33 The relief requested by Petitioner in her petition is **DENIED**.

¶ 34 Petitioner's petition is **DISMISSED WITH PREJUDICE**.

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

¶ 36 Any party to this dispute may have twenty days in which to request reconsideration from these FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT.

DATED in Helena, Montana, this 14th day of September, 2007.

(SEAL)

/s/ James Jeremiah Shea
JUDGE

c: Michael J. San Souci
Larry W. Jones
Submitted: August 25, 2006