STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY

	)	State File No. P-17351
	)	
Raymond Winckler	)	By: Margaret Mangan Hearing Officer
	)	
	)	
v.	)	For: R. Tasha Wallis Commissioner
Travelers & Foley Rail Co.	)	
	)	Opinion No. 29-01WC

Hearing held in Montpelier, Vermont on October 18 and December 5, 2000
Record closed on January 30, 2001

APPEARANCES:

Heidi S. Groff, Esq. for the claimant
Andrew W. Goodger, Esq. for the defendant

ISSUES:

1. Does the Statute of Limitations bar the claimant's claim for permanent total disability?

2. Are the Claimant's right knee, left knee, lower back, neck, shoulder and arm injuries causally related to his original work injury of June 12, 1979?

3. Is the claimant permanently and totally disabled as the result of his work-related injuries?

4. If so, is the PTD compensation rate capped at the claimant's AWW back at the time of the original injury, or is it uncapped and should continue to be increased by the prevailing annual adjustment rate?

5. If the claimant is found to be entitled to compensation for mileage to his medical appointments, what is the allowance for travel to work?

6. Are defense experts bound by the departmental fee schedule for charges for deposition testimony under Rule 40.111(A)? If so, is the claimant entitled to reimbursement for fees paid to Dr. Johansson in excess of the fee schedule?

THE CLAIM:

1. Permanent total disability compensation pursuant to 21 V.S.A. §644 (b).

2. Medical and Hospital Benefits pursuant to 21 V.S.A. §640, including reimbursement for payments already made for medical treatment and prescriptions. And reimbursement of mileage to medical appointments above mileage to work pursuant to Worker's Compensation Rule 12 (b)(1).

3. Refund of fee charged by defense expert John Johansson, DO in excess of the Vermont Worker's Compensation Fee Schedule, Rule 40.111 (A).

4. Attorneys' fees and costs pursuant to 21 V.S.A. §678(a) and Rule 10.

DEPARTMENT FORMS

Agreement for Temporary Total Disability, July 9, 1979
Wage Statement, July 16, 1979
Notice of Change in Compensation Rate, July 25, 1979
Certificate of Dependency, October 12, 1979
Notice of Intention to Discontinue Payments (mailed Nov. 6, 1979)
Notice of Change in Compensation Rate, July 31, 1980
Notice of Change in Compensation Rate, July 16, 1981
Notice of Change in Compensation Rate, July 1, 1982
Agreement for Permanent Partial Disability Compensation, March 10, 1982 (50% right leg)
Notice of Intention to Discontinue Payments (mailed Feb. 9, 1982)
Notice of Change in Compensation Rate, April 21, 1983
Certificate of Dependency, March 24, 1983
Notice of Intention to Discontinue Payments (mailed June 22, 1984)

STIPULATIONS:

1. Claimant was an employee of Defendant within the meaning of the Vermont Workers' Compensation Act ("Act") at all relevant times.

2. Defendant was an employer within the meaning of the Act at all relevant times.

3. Travelers Insurance was the worker's compensation insurance carrier for Defendant at all relevant times. On June 12, 1979, Claimant suffered a personal injury by an accident arising out of and in the course of his employment.

4. The original right knee work-related injury was accepted by the Defendant who paid associated benefits including temporary total disability, medical benefits, vocational rehabilitation, and permanent partial disability benefits.

5. The Claimant was compensated on a Form 22 on August 17, 1984. He was paid for a 53% permanent partial impairment to his right knee.

6. Claimant seeks all worker's compensation benefits associated with the claim, including permanent total disability benefits, (or in the alternative permanent partial disability benefits) and medical benefits, including mileage and prescription reimbursements, and if successful, attorney fees and costs of the formal hearing process.

7. The parties agree that the Department may take judicial notice of any and all forms or agreements between the parties in its files in this matter.

8. There is no dispute as to the qualifications of any of Claimant's treating health care professionals.

EXHIBITS:

The following exhibits were admitted into evidence:

Joint Exhibit No. I:	Medical records of Claimant (includes VR records)
Exhibit No. II:	Curriculum vitae of Dr. Steven Incavo
Exhibit No. III:	Curriculum vitae of Dr. Jeffrey Davis
Exhibit No. IV:	Curriculum vitae of Dr. Richard Hawkins
Exhibit No. V:	Transcript of Deposition of Dr. John Johansson
Exhibit No. VI:	Transcript of Deposition of Dr. Richard Hawkins
Claimant's Exhibit 1:	Decision of Jerome J. Neidermeier, United States Magistrate Judge in Claimant's Social Security Appeal, Civil Action No. 89-195 (dated January 30, 1991).
Defendant's Exhibit A:	Curriculum vitae of Dr. John Johansson

Transcripts of the depositions of Doctors Johansson and Hawkins were admitted for the purpose of determining whether errata sheets provided to Claimant's counsel the day before the hearing, were substantive changes to their deposition testimony.

FINDINGS OF FACT:

1. Claimant dropped out of high school after completing the eleventh grade. He later earned a GED, then joined the Navy. Claimant left the Navy around 1970 and worked several jobs including steelworker, laying concrete, making wire, and doing roofing. His last job was at the employer, Foley Rail Co. He had no permanent injuries or conditions that affected his daily activities before the work injury.

2. The parties' agreement for temporary total disability compensation (Form 21) dated July 9, 1979, stated that the claimant's average weekly wage was $180.25.

3. A Form 27 was filed to discontinue temporary benefits starting on October 30, 1979. However claimant continued to receive temporary benefits until the Form 22 was later approved.

4. On March 10, 1982 the claimant entered into a Form 22 agreement for permanent partial disability for 50% of his right leg. This agreement was for 107.5 weeks for a "right knee injury," and listed the compensation rate as $120.17 per week.

5. Following the Form 22 agreement the claimant underwent a right knee fusion and was re-assessed for permanency. This time the Form 22 agreement, dated August 17, 1984, was for 53% impairment for a "bruised right knee" and resulted in payment for the difference between 113.95 and 107.5 weeks, or 6.45 weeks. This second Form 22 agreement listed the claimant's compensation rate as $237.72 per week.

6. The claimant continued to receive some medical benefits over the years for his right knee, although not all mileage and prescription reimbursements he claimed.

7. Travelers continued to pay some benefits for the claimant's right knee after the permanency agreement and up until the denial of benefits on May 13, 1998.

BACKGROUND:

8. Claimant injured his right knee for the first time in 1973 when he twisted his right knee while playing softball. That injury resulted in a menisectomy. He missed approximately six weeks of work following the surgery and then worked until the time of the work injury in 1979.

9. The operative findings of the menisectomy of July 27, 1973 indicate that the claimant had "a tear at the midportion of the meniscus right at its attachment to the coronary ligament." There was no osteoarthritis diagnosed or noted during the procedure. On July 30, 1973, after noting that the claimant had "tolerated the procedure well and had no post-operative complications," he was discharged.

10. After the right knee surgery in 1973 when he had the medial meniscus removed, the claimant was asymptomatic until the 1979-work injury to his right knee.

11. Mr. and Mrs. Winckler were married on August 19, 1978. At that time, claimant was active in basketball, softball, golf, skiing and soccer.

1979: RIGHT KNEE INJURY

12. A First Report of Injury was filed with the Department for a June 12, 1979 injury, which occurred when the claimant was putting spikes in railroad ties with a jackhammer. When another employee pulled the compressor, the jackhammer fell out of claimant's hand and hit him in right knee. He spent the night with a painful knee, then went to the emergency room the next day. After an examination, he was sent him home on crutches and told to stay out of work for two weeks.

13. Claimant has not worked since June 12, 1979.

14. After the two weeks, claimant went back to FAHC where x-rays were taken and surgery scheduled.

15. At the time of the claimant's work injury, his daily commute to work was 14 miles.

16. After the claimant's accident with the jackhammer, his knee became swollen, painful and discolored. Because the horn of his posterior meniscus was catching in the knee, it was surgically removed on August 14, 1979.

17. Osteoarthritis involves the breakdown of the surface of the cartilage, the smooth surface of a joint. Once the breakdown starts, it generally continues.

18. The degenerative changes in claimant's right knee, which became symptomatic and progressed after the work injury in 1979, led to the right knee fusion, which was performed in 1983.

19. The claimant has used crutches on and off since the 1979 injury, particularly after the numerous operations he has had. Use at other times has been sporadic.

20. In his August 16, 1979 note, Dr. Howe, the surgeon who performed the menisectomy following the work injury wrote, "conditions in the patient's right knee were evaluated to be of a long-standing nature and not secondary to being struck with a jackhammer recently." He later changed that opinion and drew a link between the 1979 work related injury and that claimant's subsequent knee problems based on the claimant's history that he had been asymptomatic prior to 1979.

1980'S

21. After the claimant's August 1979 surgery, Travelers asked R.F. Kuhlman, M.D., as an orthopedic surgeon, to review the claimant's medical records. Then in an April 4, 1980 letter to Travelers, Dr. Kuhlmann noted that although the claimant had considerable degenerative changes in his right knee, he was able to do "reasonably heavy work until the incident of June 1979." Dr. Kuhlman drew a causal connection "to the sequence of events that occurred from the time of the injury on the 12th of June, 1979 to the time of his evaluation and the doctor opined that the "surgery was accomplished because of the pain and disability Mr. Winckler apparently had as a result of the accidental injury of June, 1979, so that the surgery is related to the injury." Dr. Kuhlman predicted that the claimant's knee would eventually give him trouble because of the progressive nature of the problem. The doctor opined that the June 1979 injury aggravated his situation and "this in turn was compounded by the necessity of surgical intervention."

22. On November 17, 1981, Dr. Dorothy Ford saw the claimant for the Travelers and put him at a medical end point for his right knee injury. She assigned a 50% permanent partial impairment of his right lower extremity as related to his knee injury of June 1979. Her finding was based on the fact that the claimant "now requires the use of a brace at all times for his knee stability, and furthermore needs to lock the brace for long distances because his knee is not in the neutral position (extension only possible to 20%)."

23. A 50% impairment of a lower extremity is more that what a bruise would produce.

24. On February 28, 1983 Dr. Howe performed a right knee fusion identified in the operative record as "intra-articular arthrodesis with external fixateur stabilization." Claimant was hospitalized for three days for the procedure. Two weeks later, on March 14, 1993 claimant was seen at University Orthopaedics where a note refers to that recent fusion and the order that the claimant remain on bed rest for the following couple of days.

25. After the right leg fusion, the claimant was unable to bend the right knee. As a result, he walked with an awkward gait.

26. A March 1983 note from Medical Center of Vermont (now FAHC) notes that at that time the claimant's actual leg lengths, not leg differences when standing, were the right lower extremity at 88 cm and the left lower extremity at 91 cm. This note also noted that the claimant was having difficulty ambulating on crutches because of his large hands. The crutches were necessary due to the recent right knee fusion.

27. Shortly after the claimant had his right knee fusion, Travelers closed its file although it was still paying medical bills and reimbursing the claimant for items such as a treadmill. Travelers continued to pay benefits relating to the claimant's right knee.

28. In 1985 Dr. Howe gave the claimant a shoe lift for a leg length discrepancy. The claimant stopped using the lift because it was hard for him to walk on uneven walkways and his hip began to hurt. Without the lift, he went back to having a dramatic leg length discrepancy and other problems walking.

29. In a letter dated June 15, 1985, Dr. Martin Flanagan at Fletcher Allen Health Care indicated that claimant was having shoulder pain and left arm paresthesias which had not responded to conservative management and had clearly progressed over the previous three months. At that time, claimant complained of weakness in his left arm, such as with golf clubs flying out of his hand.

30. At a bowling alley in 1985 a woman kicked the claimant in his right knee. But the November 5, 1985 University Orthopaedics note indicates that while the claimant did have some temporary pain and swelling from that incident, "x-rays show no break in the fusion and it is well maintained."

31. The claimant first had neck problems in April 1986 when he accidentally stepped off a walk at his house and twisted his neck with a sudden onset of neck pain. On April 4, 1986 Dr. Ferriss of the Rheumatology Clinic wrote that the claimant's "neck problem began when he accidentally stepped off a walk at his house and twisted his neck with a sudden onset of neck muscle pain at that time." At that time the claimant reported that he had had a severe whiplash injury after a motor vehicle accident a year before, but that symptoms from that incident had resolved. Dr. Ferriss diagnosed acute cervical strain.

32. In October of 1986 Dr. Bargar attributed the claimant's neck pain to mild osteoarthritis of the cervical spine. His note also documents a remote history of whiplash.

33. In 1987, J. David Egner, M.S. saw the claimant for two intensive clinical interviews. After those interviews he concluded that "there is no question whatsoever in my mind that Winckler is disabled by pain and/or the medication taken to reduce the pain. His commercial employability is nil. Testing confirms my clinical testing."

34. At that time he found that the claimant demonstrated a full scale IQ of 105, as opposed to the full scale IQ of 79 that was found in 1999. But, Egner's conclusion was that even then with the IQ of 105 that the claimant was not capable of gaining or maintaining employment.

35. Claimant has been diagnosed with a right elbow synovitis that Dr. Michael Barger believes is related to an over-use syndrome from crutch use over the years. He concluded in his May 13, 1987 Rheumatology Clinic note that "there is also synovitis in the right elbow which probably is related to an over-use and mild degree of osteoarthritis in that area as well. It is likely with compensation for the increased pain in the knee with using crutches and his cane more as well as occasionally having to use a wheelchair that this caused a flare in arthritis in the right elbow."

36. A treatment note from University Orthopaedics dated July 10, 1987 documents claimant's complaint of back pain for years, most recently after taking a trip to Florida.

37. One afternoon in 1989 the claimant slipped and fell while he was helping a friend split wood. The fall occurred when the claimant's right knee was still fused and he had problems with stability and balance. The claimant tore his left medial meniscus in that fall, a tear that Dr. Incavo surgically repaired in August 1989 when he noted Grade II-III osteoarthritic changes in the left knee. The meniscus serves as a cushion between the upper and lower leg bones, therefore, its removal of the meniscus leaves the articular cartilage exposed, leading to an increase in force and damage to the articular cartilage of the knee.

38. The wood splitting incident accelerated the osteoarthritis in the claimant's left knee.

39. Treatment notes of Dr. Incavo at University Orthopaedics dated August 14, 1989 state that claimant hurt his knee when he slipped and twisted his knee while operating a wood splitter. His knee was difficult to move.

40. Dr. Incavo has treated the claimant since 1989 for knee and shoulder problems.

41. The operating room sheet/procedure report from Fanny Allen Hospital dated August 22, 1989 indicates that claimant underwent arthroscopic surgery for osteoarthritis of the left knee with a possible medial meniscal tear with locked knee. Diagnostic arthroscopy revealed grade II-III degenerative arthritis on patello femoral joint.

42. Rheumatology clinic notes of Dr. Leib dated October 13, 1989 state that claimant had a meniscectomy of the left knee since the last visit and can now move the knee although his pain continues. Grade II-III osteoarthritic changes were found at the time of arthroscopy. Subsequently claimant developed chest pains, went to the MCHV emergency room and was admitted for observation.

<u>1990's</u>

43. Claimant developed left knee problems approximately in the early 1990's. The cause, confirmed by Dr. Incavo, was a meniscal tear in 1989 with progression of significant arthritis thereafter.

44. According to a treatment note from Dr. Incavo at University Orthopaedics dated September 24, 1990 claimant went to the emergency room with left shoulder pain and was placed in a sling. He had no prior history of shoulder pain until 3 days before when he arose from a lying down position, putting weight on his left hand. Claimant felt his left shoulder snap followed by severe pain. The pain was constant, although worse at night. His shoulder range of motion was limited. It was difficult to do a neurologic exam distally because of severe pain. Dr Incavo noted that the distribution of pain was out of proportion to the physical findings.

45. A left shoulder arthrogram dated October 1, 1990 from Dr. Incavo at Fletcher Allen Hospital suggested a partial rotator cuff tear. However, treatment notes from Dr. Incavo at University Orthopaedics dated October 4, 1990 indicated that the arthrogram was inadequate and incomplete due to claimant's pain. The claimant was still having severe shoulder pain and numbness in his arm when he was trying to sleep.

46. A radiology report for a left shoulder MRI dated October 23, 1990 from Fletcher Allen Hospital indicated that claimant's rotator cuff tendon appeared to be abnormal and was associated with subacromial fluid. There was concern that there was at least a partial tear in a paper-thin rotator cuff.

47. Treatment notes from Dr. Incavo at University Orthopaedics dated October 29, 1990 reflected that claimant's MRI scan was not 100% diagnostic of a rotator cuff tear, but highly suspicious. The plan was to explore the rotator cuff tendon surgically and repair it if torn.

48. At MCHV on November 8, 1990, Dr. Monsey operated on the claimant's left shoulder. Pre-operatively he diagnosed a left rotator cuff tear, post-operatively, left shoulder impingement. During surgery Dr. Monsey observed that the rotator cuff was intact. On December 6, 1990 claimant returned to Dr. Monsey with a report that he had pain and numbness in his right foot, but that his shoulder was doing well. The doctor recommended physical therapy for the claimant's shoulder and an EMG to evaluate his lower extremity pain and numbness.

49. Claimant had essentially normal CAT and MRI scans of the lower back 1991. The interpretation of March 12, 1991 CAT scan specifically stated that there was no indication of nerve root compression or disc herniation.

50. Dr. Davis has been Claimant's general treating physician since January of 1995.

51. Radiology studies in July 1995 showed spondylosis and narrowing in the cervical area of the spine. On August 21, 1995 the claimant underwent surgery at the cervical spinal levels C4-5 and C5-6 for spondylosis and calcified herniations.

52. On July 29, 1996 the claimant felt something pop in his back with the onset of pain while doing yard work.

53. An August 1, 1996 CAT of the lumbar spine demonstrated a small left paramedian disc herniation, L3-4 and an intraforaminal disc herniation at L5-S1.

54. A note dated September 16, 1996 from Dr. White at Fletcher Allen-SPINE indicates that the claimant had a recent exacerbation a couple of months ago while bending. Claimant noted that pain had increased in his lower back and was radiating down the right leg. Claimant stated his back pain was worse than his leg pain. Assessment was back and right leg pain with possible disc herniation. The disc herniations noted on the 1996 scan were not present in 1991.

55. On January 22, 1997 the claimant underwent a left C7-T1 laminectomy, nerve root exploration and decompression for cervical radiculopathy. Later that spring he was seen for right shoulder pain and the inability to lift his arm.

56. The condition of the claimant's cervical spine could cause his left arm pain and numbness as well as his neck pain. That condition is unrelated to his 1979 work related accident.

57. In April of 1997 claimant was at a car dealership when he tripped on an uneven walkway and landed awkwardly on his left leg. His right leg, fused at the time, had caught on a protruding part of a sidewalk.

58. In July 1997 the claimant suggested to Dr. Howe that the right knee fusion be taken down and a knee replacement done in order to help his left knee and back problems. Dr. Howe expressly rejected the suggestion that a total knee replacement would solve his other problems or would be appropriate given the claimant's size and age.

59. On September 22, 1997 Dr. Steven Incavo replaced the claimant's left knee because of severe osteoarthritis that was unresponsive to nonoperative treatment. Claimant did not call the Travelers to have them pay for his left total knee replacement because at that time he believed the only benefits he was entitled to were those for his right knee.

60. In October 1997 the claimant's crutch broke. He landed on his knee and felt his back snap. He was walking with crutches at that time because of the recent left total knee replacement. Without having been on crutches and having problems with balance and gait, the claimant would not have fallen.

61. In a March 16, 1998 note, Dr. Fitzpatrick at Fletcher Allen noted that while walking with crutches after his left total knee replacement, a crutch broke, claimant fell and "heard his back snap". Since then, claimant's problem had been "going downhill". Claimant noted continuing back pain as well as leg pain, but it was predominantly his back pain, which was bothering him. A radiology report of a CAT scan of the lumbar spine from Fletcher Allen dated April 13, 1998 showed further worsening of his back condition as compared to the scans of 1996.

62. On April 9, 1998 at an appointment at the Spine Institute, claimant learned that his right leg and abnormal gait could have caused his back problems and that he might need a spinal fusion.

63. Within a few weeks after the April 1998 Spine Institute visit, the claimant called Denise Mitchell at Travelers with the suggestion that his back pain and possibly his left leg pain were related to the original work injury.

64. On April 27, 1998 Ms. Mitchell reopened the Travelers file in response to the claimant's telephone call.

65. Travelers first denied this claim in 1998 when it sent the claimant a broad denial letter.

66. Dr. Jeffrey Davis expressed his opinion in a May 19, 1998 to whom it may concern letter that revision of the claimant's right knee fusion with a total knee replacement would contribute significantly to the management of his back pain and improve his balance.

67. Dr. Incavo replaced the claimant's right knee fusion with a total knee replacement on August 3, 1998. After that surgery the claimant had a lot of "give" in his knee and surgeons had to "go in and tighten it up." During the surgery, a nerve was injured which led to foot drop. As a result, the claimant cannot now lift his foot. It often drags and catches on the ground causing him to trip.

68. The claimant's abnormal gait and/or leg length discrepancy from the right knee fusion prompted Dr. Incavo to recommend a right total knee replacement surgery to undo the claimant's right knee fusion. Because he felt that the right knee fusion had caused the abnormal gait and leg length discrepancy which were in turn causing claimant's lower back problems, he hoped that a total right knee replacement would alleviate some of claimant's back pain. Dr. Incavo performed the right total knee replacement in 1998, and in fact, claimant's lower back symptoms have improved significantly.

69. As expressed in an August 26, 1998 letter, Dr. Davis estimated that the right leg was then 3-3/8 inches shorter than his left leg. Dr. Incavo opined that the degenerative changes in Claimant's right knee which became symptomatic and progressed after the work injury in 1979, necessitated the right knee fusion, which in turn eventually necessitated a right total knee replacement.

70. On February 11, 1999 Dr. John Johansson evaluated the claimant for the Travelers Insurance Company. His evaluation included a review of multiple progress notes and physician entries from University Orthopaedics and from the New England Spine Center as well as multiple records regarding vocational rehabilitation. Afterwards Dr. Johansson submitted a five-page report to Denise Mitchell at the Travelers. That report referenced treatment the claimant received for his right knee in 1979, 1983 and 1984, for his lower back and left knee in 1985, for his low back in 1987, his left knee in 1989, his shoulder in 1990, his right knee and back in 1991,his right knee in 1993, left knee and back in 1996, left knee in 1997, back and both knees in 1998. Dr. Johansson examined the claimant and developed the following diagnoses: 1) status post multiple surgeries of the right and left knee, most recently a total knee replacement revision from a knee fusion; 2) a left total knee replacement in September 1997; and 3) chronic lower back pain with disk herniation at L-5-S1 on the right with some elements of radiculitis.

71. Dr. Johansson concluded, "in terms of Mr. Winkler's current condition and the relationship to his injury of 1979, certainly all of the knee surgeries I believe are related to the original problem." In what he termed "causality of his lower back," Dr. Johansson noted the difference between the CAT scan of the lower back in 1991 which was normal and the 1996 one which reflected a disc herniation not present in 1991, and the claimant's "rather severe leg length discrepancy and antalgic gait." Dr. Johansson concluded, ""his condition does related to the antalgic gait associated with his right knee fusion which left him with a very short leg until August 1998 when the fusion was replaced by the total knee replacement and his leg lengths were once again equal.

72. Although an official form was not filed, a May 4, 1999 letter from this Department indicates that this claim was referred for hearing in response to the claimant's request for benefits. A pretrial conference was held on June 17, 1999.

73. On May 21, 1999 the claimant was driving when he blacked out then had weakness for 45 minutes, although those symptoms resolved without residual deficits. Claimant's neurological examination on July 3, 1999 was normal.

74. From July 14 to July 16, 1999 the claimant was hospitalized at FAHC with an admitting diagnosis of subacute confusion. The discharge summary relates a history that included osteoarthritis of multiple joints, a cerebral vascular accident in 1997 and spinal surgery at C5-T1, with residual left arm weakness. Since May 1999 "blacking out" incident he had frequent headaches, increasing weakness, gait instability and decreased left-sided hearing. The MRI/MRA of this head revealed no abnormality. The claimant was discharged with instructions to follow-up with an Ear, Nose and Throat specialist, to have neuropsychological testing and to have his cardiac condition monitored.

75. On August 19, 1999, Janis Peyser, Ph.D, examined and tested the claimant. She found that the claimant has a full scale IQ of 79, which corresponds with the 8th percentile and is descriptively classified as borderline. She concluded that the claimant "demonstrates a generally low cognitive function…but there is a quality about his general presentation that makes one question the validity of these results…." She was "reluctant to assign any diagnosis" based upon the testing and did not confirm that the claimant had suffered a TIA or any verifiable cognitive deficits from a suspected TIA.

76. The claimant's presumed TIA in 1999 has had an impact on his mental processes and speech and contributes to claimant's inability to work.

77. According to a December 6, 1999 note from Dr. Nichols, the treatment of the claimant's shoulder in 1999 was complicated by his use of crutches.

2000

78. On February 16, 2000 Claude Nichols, M.D. who has been treating the claimant for shoulder problems, wrote "I feel there is a causal connection between Mr. Winckler's current left shoulder pain and his prolonged use of crutches."

79. When Dr. Incavo first began treating claimant for his shoulder problems he diagnosed rotator cuff tendinitis. His diagnosis today is that claimant's tendinitis over time has worn out the tendon so now it is a complete tear and not just inflammation, which is what the tendinitis was. He opined that the claimant's crutch use over the years has caused this condition to occur.

80. Dr. Davis testified that the cause of claimant's shoulder rotator cuff tears are temporally related and associated with use of crutches which he was using because of problems with his legs and because of surgeries on his knees and back pain. Dr. Davis estimates that since he has been treating the claimant that he ambulates on crutches about half of the time. In addition to crutches, Dr. Davis has also seen claimant use a cane for stability. Dr. Davis has been trying to get claimant off of crutches because of the tremendous amount of upper body weight he uses on crutches, which in turn causes him to get even weaker in his lower extremities and it is likely to further exacerbate his shoulder problems.

81. On August 29, 2000, the claimant underwent a functional capacity evaluation at Work Recovery Services in Colchester, Vermont.

82. The important findings from the FCE were that: "Mr. Winckler does not have a work capacity for vocationally relevant periods of time. His attempt in the past to be retrained for sedentary work was reportedly unsuccessful because he was unable to maintain a position to complete activities which would be expected to continue based upon this evaluation."

83. Claimant was not able to make the whole drive to the appointment; he drove for approximately half an hour before his wife took over. Claimant's ability to sit for long periods is limited. He needs to stand frequently, cannot stand in one place for more than 20 minutes. Walking is limited to eight minutes. He has no ability to bend forward even with support, he was unable to participate in lift testing because of high pain levels, and the need to use a cane and poor balance even with the cane.

Osteoarthritis

84. Claimant's osteoarthritis was asymptomatic before the 1979-work injury. In fact, the diagnosis was not made until after 1979 injury when the symptoms began. One can have an underlying asymptomatic osteoarthritis, which only becomes symptomatic after a trauma, either because of the trauma itself or from an arthroscopic procedure.

85. After claimant sustained a contusion injury to his right knee, instead of resolving in the expected three weeks like a normal bruise, the pain lingered, causing his doctors to look further into what was going on with his knee. The continued pain after the work injury necessitated the arthroscopic procedure.

86. The claimant's lower back problems stemmed from an underlying osteoarthritis.

Expert Medical Witnesses

87. John Johansson, D.O. was hired by the Travelers Insurance to do an Independent Medical Examination of the claimant in February 1999. Dr. Johansson graduated from the New England College of Osteopathic Medicine in Biddeford, Maine for a four-year medical degree program. He has a degree of osteopathic medicine. He did a family practice residency program at Brighton Medical Center, which he completed in 1984. He returned to Burlington, Vermont for private practice several years ago. he practices osteopathic and orthopaedic medicine for acute and chronic pain, musculoskeletal in nature.

88. At the time of his initial report, dated February 17, 1999, Dr. Johansson opined that the claimant's condition and "certainly all of the knee surgeries, I believe are related to the original problem." With regard to causation of the claimant's back problems, Dr. Johansson noted that claimant had a history of a leg length discrepancy that altered his gait. His CAT scan in 1996 showed a herniated disc not present on the 1991 scan. Dr. Johansson concluded that the claimant's back condition related to the abnormal gait "associated with his right knee fusion which left him with a very short leg until August 1998 when the fusion was replaced by the total knee replacement and his leg lengths were once again equal."

89. After Dr. Johansson completed his IME report, his opinion changed and at his first deposition in April 2000 he disclosed new opinions which were contrary to his original IME opinions. Dr. Johansson's second opinion was that the claimant's current conditions are not causally related to the 1979 work-related contusion. He explained that he did not have all of the claimant's records when he issued his earlier opinion.

90. At the hearing he testified that records dated October 10, 1986 documented significant osteoarthritis of the left knee, and a June 20, 1988 note indicated claimant's arthritis was systemic and not related to trauma such as from overuse of a sore leg. He reached that conclusion after reviewing additional medical records and a summary of "intervening events" prepared by defense counsel.

91. Dr. Steven Incavo, who has treated the claimant, is Board Certified in Orthopaedic Surgery. He is an Associate Professor and member of the Graduate Faculty of the Department of Orthopaedics and Rehabilitation at the University of Vermont College of Medicine. He is the Director of the Total Joint Replacement Service at the Department of Orthopaedics and Rehabilitation at the University of Vermont. His expertise is in joint replacement surgery. He has been teaching Orthopaedic surgery for thirteen years at the University of Vermont. He recently taught a course titled Arthritis Prevention and Treatment, Key factors in the Management of Osteoarthritis.

92. Dr. Incavo began treating the claimant in 1989 and has been claimant's treating Orthopaedic surgeon since that time. He began seeing him for shoulder problems and subsequently began treating his knee problems. The treatment he has provided claimant is both operative and non-operative orthopaedic treatment. He has performed approximately eight to ten of claimant's surgeries over the past twelve years. Before his testimony, and in the course of treating claimant over the years, Dr. Incavo has reviewed the claimant's entire chart at Fletcher Allen and some records from outside treatment providers dating back to 1973.

93. Dr. Incavo based his opinion that the claimant's neck, shoulder, back left and right leg problems are all related to the his 1979 work-related accident on his personal knowledge of the claimant, his clinical and surgical observations and his review of the medical records.

94. Dr. Jeffrey Davis, who has also treated the claimant, is a physician licensed in the State of Vermont with a specialty is general internal medicine. He is an Assistant Professor of Internal Medicine at the University of Vermont and a treating physician for the Primary Care Internal Medicine Department at University of Vermont/Fletcher Allen Health Care. Dr. Davis has been Claimant's general treating physician since January of 1995.

95. Over the past several years, Dr. Davis has treated claimant's osteoarthritis in knees, low back, and neck. He has also treated him for esophagus spasms, recurrent chest pain, and difficulty with speech and weakness in his arms. When claimant consulted him about knee and lower back problems, Dr. Davis referred him to a specialist. However, Dr. Davis counsels the claimant directly on management of chronic pain, using both medications and physical therapy.

96. In his IME report Hawkins wrote that the claimant has had to ambulate on crutches for many years because of his osteoarthritis and continued problems with his right knee. He stated that claimant's crutch use over the years could have led to the claimant's rotator cuff tears and carpal tunnel syndrome. He agreed that someone who uses crutches and is a large person, like the claimant, would be more likely to develop a rotator cuff tear than someone who does not use crutches would.

97. During his deposition, Dr. Hawkins testified that it was not possible to say to a reasonable degree of medical certainty what caused the 1996 disk herniation.

98. Dr. Hawkins did testify that in his opinion, Claimant Winckler is permanently totally disabled from returning to work. He is disabled from numerous orthopedic injuries. He cannot say with medical certainty that any one injury in isolation causes the disability.

FAILED ATTEMPT AT VOC. REHABILITATION

99. Claimant attended the Joyal School for Vocational Rehabilitation in 1982 in a daily program to learn clerical skills. This was before the right knee fusion. He completed only half of the program because he was always getting up, moving around, and leaving the classroom. He was getting up and moving around because he could not sit comfortably for such a prolonged period of time because his right leg was causing so much pain. He eventually was asked to leave the program.

CLAIMANT'S FUNCTIONAL CAPACITY

100. Claimant cannot walk on a treadmill, ride a bike, or climb stairs. Claimant suffers from chronic pain. He has no work capacity.

101. At the hearing, Claimant barely sat at all. He was standing, leaning, and moving around in a small area for most of the testimony, including his own.

ATTORNEY'S FEES AND EXPENSES

102. Claimant has requested fees based upon the statutory rate of $70.00 per hour for 341.7 hours of time. An affidavit and itemized statement for hours and expenses support this request. The expenses incurred by Claimant in this case total $6,069.51. All expenses were reasonable and necessary for the prosecution of this hotly disputed claim.

CONCLUSIONS OF LAW:

Statute of Limitations

1. The Vermont Supreme Court recognizes that two statutes, 21 V.S.A. §656 and §660, govern the time in which a claim may be made for an injury under the Workers' Compensation Act. *See Hartman v. Ouellette Plumbing and Heating*, 146 Vt. 443 (1985).

2. Under 21 V.S.A. §656(a), a claimant is required to file a notice of injury to an employer, "as soon as practicable after the injury occurred" and file a claim for compensation within six months after the date of the injury. Title 21 V.S.A. §660, however, extends the six-month deadline under §656(a) to six years as long as the employer had knowledge of the accident or had not been prejudiced by the delay or want of notice.

3. Furthermore, §656(b) states that "the date of injury… shall be the point in time when the injury or disease, and its relationship to employment is reasonably discoverable and apparent."

4. While defendant cites the most recent Vermont Supreme Court decision on the statute of limitations in workers' compensation cases, *Longe v. Boise Cascade Corp.*, 762 A.2d 1248, 1253 (1999), in this particular case *Hartman v. Ouellette Plumbing and Heating* controls. *Longe*, while discussing *Hartman*, concerns a case where the claimant and defendant do not disagree on the date of injury. In the present case the fundamental disagreement between parties, in regards to the statute of limitations, is exactly when the date of injury occurred under §656(b). Since neither claimant nor defendant here challenges the application or equity of either §656 or §660, the use of *Longe* will serve primarily in its capacity to illuminate *Hartman*.

5. In *Hartman* a claimant injured his left knee in a work accident in 1976. In 1982, the claimant broke his right ankle in a home accident, but with the right foot in a cast, the claimant began to suffer increasing problems in his left knee due to the weight shift. The claimant applied to his insurance company for relief in 1983 for the increasing left knee problems, was denied, and formally filed for a hearing. *See Hartman* at 445. The court had to decide whether the statute of limitations began to run from the original work accident or from 1982 when the home accident began to affect the left leg. The court held that the date of the injury could only be the point when an injury becomes reasonably discoverable. See Id. at 447. To support its conclusion the court cited several persuasive sources including Larson's treatise on workers' compensation, which says, "[the better practice is to] read in an implied condition suspending the running of the statute until by reasonable care and diligence it is discoverable and apparent that a compensable injury has been sustained." *See Hartman* at 446 citing 3 A. Larson, *The Law of Workmen's Compensation* §78.41(b) (1985).

6. *Hartman* also follows a parallel line of case embodied by *Lillicrap v. Martin*, 156 Vt. 165 (1991) and *Ware v. Gifford Memorial Hospital*, 664 F.Supp. 169 (D. Vt. 1987). In both cases the Vermont Supreme Court and the Federal District Court held that a statute of limitation cannot begin to run on a right of action until the statute specified injury had occurred and its causal source was established. Furthermore the *Ware* court emphasized the special role doctors hold with their patients and the objectionable policy of the law to require a patient to act on every response by the doctor merely to preserve a legal right. *See Ware* at 171.

7. The current defendant argues that the statute has run, specifically that the claimant either knew or should have known on six different occasions that his right knee/left knee/back problems were related. Defendant first cites reports from August 1983, September 1983, and March 1984 from University Orthopaedics where claimant complained of left knee pain. While the record does attest that claimant began suffering left leg pains as early as 1983, their mere existence does not demonstrate that claimant knew or should have know that the left leg pains were related to his work injury. Common sense and case law suggest that if claimant had attempted to make a claim for his left leg at that time, he would have been unsuccessful due to a lack of credible medical evidence. *See Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Lapan v. Berno's, Inc.*, 137 Vt. 393 (1979).

8. Defendant also argues, however, that the relationship between injuries became apparent during three medical appointments between 1985 and 1987. From the December 4, 1985 Rheumatology clinic notes, defendant points out that treating physician, Dr. Ferriss recorded the claimant's belief that his right knee was aggravating his left knee. Importantly, the doctor's notes only record a belief that the right knee may be aggravating his condition but end there. In fact, Dr. Ferris's analysis suggests he believed the left knee condition to be the result of crystal arthropathy, mentioning nothing about the right knee fusion or its contribution to the left's deterioration. Thus if claimant had the beginning inklings of what was causing his left knee problems, the record shows that the treating physician soon obfuscated that notion with a completely different theory. In holding with the nature of *Hartman* the claimant's perception that his left knee might be suffering because of his right knee fusion when his doctor tells him otherwise cannot begin the running of §660.

9. The next date cited by the defendant, August 1, 1986 is a similar situation. Again the claimant reports a belief to the doctor that his right knee injury has aggravated his left knee. Again, the treating physician does not credit the claimant's theory and offers a counter proposal. Like the Ferriss report, the claimant's subjective report is not followed up by any further tests demonstrating a lack of credence by the treating physician. The claimant was once again rebutted and pushed away from any attempt to discover a causal link. *Cf. Holmes v. Gold*, Opinion No. 31-00WC (Oct. 2, 2000) (Interpretation of §656 date of injury upheld and case reversed for other reasons).

10. Finally defendant offers evidence of knowledge in a treatment note from a University Orthopaedics report dated July 9, 1987. More than the previous notes, the July 9th note demonstrates that the claimant while aware of his left knee and lower back pain, had no clear idea of their connection. The note concerns a request by the claimant for right knee replacement to ease problems in his left knee and lower back. The note, however, does not suggest any connection between the injuries. In fact in the University Orthopaedics report from the following day the right knee is barely mentioned. Instead the focus is on recent back problems and a 1960 motor vehicle accident. At no time in either report did the treating physician offer an opinion or discuss causation. Again, relying on the medical record, there is no reason to conclude that the causal link was reasonably apparent or discoverable.

11. Additionally, the claimant in this case is unique in the sheer volume of misfortune he has suffered. The defendant points out three plausible moments where the link seems ripe for discovery, but in each moment, the opportunity for reasonable discovery slipped away because the medical authority addressed the aliments separately, rather than as symptoms of a larger problem. Thus the July 1987 treatment focuses on the origins of the back pain from their most obvious lineage, the 1960 back injury. The facts clearly show that the claimant needed to decipher the causal relationship between a number of injuries, illnesses, and falls in order to understand the full compensability of his condition. Without any medical opinion of support on record linking claimant's right knee and left knee/back injuries, before 1998, it is unreasonable to find that claimant should have discovered the causal chain of his injuries amidst a sea of preceding injuries. Therefore under 21 V.S.A. §656, there was no point prior to the April 1998 interview with Dr. Hazard where claimant's injuries were reasonably discoverable and apparent in their relationship to claimants work injury given the lack of expert medical support, claimant's dearth of knowledge, and the large number of alternative aggravating possibilities.

12. Furthermore, to bar a claim by setting the date of injury at a moment where claimant's belief alone was correct goes against the spirit of §656, §660, and the intent of workers' compensation. "While there are problems which attend a claim filed as late… as this one, the liberal application of the Act required by the statute does not compel a preclusion of this claim." *Folsom v. Rock of Ages Corp.*, Opinion No. 14-95WC (April 20, 1995).

13. Since the date of claimant's injury for purposes of 21 V.S.A. §656 is April 9, 1998 and the claim was filed within the six-year statute of limitations under §660, defendant's argument to bar the claim under §660(a) is denied. Furthermore, since the employer's agent, the insurance adjuster, had notice of the claim within a few weeks of the claimant's discovery and the claimant was not working at the time, there was no prejudice to the employer which would bar this claim within the six-month period of §656.

Causation

14. In worker's compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *Goodwin v. Fairbanks, Morse Co.*, 123 Vt. 161 (1963). The claimant must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press,* 144 Vt. 367 (1984).

15. Where the causal connection between an accident and an injury is obscure, and a layperson would have no well-grounded opinion as to causation, expert medical testimony is necessary. *Lapan v. Berno's Inc*., 137 Vt. 393 (1979). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden & Martin Lumber Co*., 112 Vt. 17 (1941).

16. Claimant alleges that as a result of his work-related injury on June 12, 1979, he is entitled to permanent and total benefits pursuant to 21 V.S.A. §644.

17. Every expert agrees in this case that before the work injury, the claimant had an underlying asymptomatic osteoarthritis in his right knee.

18. It is well settled that an employer takes each employee as is and is thus responsible under our worker's compensation law for an accident or trauma which disables one person but which might not disable another. *Morrill v. Bianchi,* 107 Vt. 80 (1979). Because the claimant developed severe osteoarthrits after the injury, where some employees would not, does not effect compensability of his claim if the causal link is established.

19. It is also well settled that if the claimant establishes that he has, prior to the work injury, an asymptomatic pre-existing condition, and that condition is aggravated as a result of the work injury, then the claim is compensable. *Campbell v. Heinrich Savelberg, Inc.,* 139 Vt. 31 (1980). So here, through undisputed evidence, the claimant has established that the right knee injury is compensable.

20. The medical experts are in unanimous agreement that as a result of the 1979 injury to the claimant's right knee, an arthroscopy was performed that was reasonably medically necessary. Each expert agrees that either the work injury itself or the arthroscopy, necessitated by the work injury, or a combination of the two, caused the claimant's asymptomatic osteoarthritis to become symptomatic.

Right leg

21. There is overwhelming evidence and Department forms to prove that that the condition of the claimant's right leg is related to his 1979 injury. He is entitled to recover costs of medical care provided to treat the right leg.

22. According to a recent Vermont Supreme Court case, *Humphrey v. Vermont Tap & Die Alexis, Inc. & CNA Insurance*, Docket No. 99-030 (Dept. Nos. H-00678/D18559), when an insurer "had all the information required to accept the claim, investigated the claim, gathered medical records…all of which constituted an acceptance of the claim," they ruled that the carrier by not then contesting the claim until years later had "thus by sleeping on its rights, has lost the ability to contest the [earlier] injury in the future."

23. This case presents an even stronger argument against the carrier's disavowing responsibility for the right knee claim than did *Humphrey*. One Form 21 and two Forms 22 were signed, approved and paid in this case. The first Form 22 was approved in 1982 for 50% for a "right knee injury," and one was approved in 1984, after the claimant underwent a right knee fusion, for 53% for a "bruised right knee." The carrier is certainly justified in challenging the compensability of the claimant's other injuries and their relatedness to the original right knee injury. But under *Humprey,* supra, *Merling v. Barrows Coal Company*, Opinion No. 25SJ-98WC and *Voland v. South Burlington School District*, Opinion No. 1-85WC, an agreement for payment of compensation, either in the form of a Form 21 or a Form 22, entered into between an injured employee and defendant becomes an enforceable contract after approval by the Commissioner. Therefore, the Defendant cannot now claim that the right knee injury is not a compensable injury.

24. Defendant argues that the claim it accepted in 1979 was a bruised right knee, not the complex knee problems that have since become evident. However, with a 53% permanency back in the early 1980's Travelers was on notice that the claimant's injury was more than a simple bruise. It cannot now disavow coverage for that injury.

<u>Other injuries</u>

25. There is some evidence that in addition to the claimant's right leg, his shoulder, neck, left knee, lower back, and arm injuries are all also related to his original injury.

26. Evidence related to the claimant's shoulder problems does not rise to the level necessary for the claimant to sustain his burden of proof. Claimant's treating doctors believe that these shoulder problems could be related to the claimant's crutch use. However, the medical records detailing the events and treatment related to his shoulder do not establish that crutch use was the most probable cause. In fact, the first indication of shoulder pain was in September, 1990 when the claimant went to the emergency room after his shoulder snapped and he felt severe pain as he was trying to push himself up. Nothing in Dr. Incavo's note from September 24, 1990 implicates crutch use in any way with the onset of the shoulder pain. Subsequent records indicate that the shoulder problems began with that September 1990 incident and progressed from there. Attributing the shoulder problems to crutch use would be impermissible speculation given that the problems began with a specific incident unrelated to crutch use.

Neck and arms

27. Claimant's neck problems began in April 1986 when he accidentally stepped off a walk at his house and twisted his neck with a sudden onset of neck pain. He now argues that his knee problems accounted for the misstep that led to the neck pain. Back in 1986 he reported to his physician that he had suffered a severe whiplash injury from a motor vehicle accident a year earlier, but insisted that his symptoms from that incident had resolved. However, with a history of a whiplash injury as well as generalized osteoarthritis, it is no more likely that the sudden onset of neck pain in 1986 was due to the claimant's knee problems than to factors wholly unrelated to his lower extremities. Although it is possible that such a connection exists, it is not the more probable hypothesis, with reference to the possibility of other hypotheses. *Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17, 20 (1941). The arm symptoms that the claimant has had are likely related to his neck or shoulder problems, and no more likely connected to claimant's 1979 injury than those injuries are.

28. Two treating doctors concluded that the claimant's post-June 1979, right knee, left knee and lower back problems were and are the direct and natural result of claimant's prior work-related injuries. The defendant argues that external events sever any causal link that might exist.

29. To evaluate the impact these activities have had on the claimant's condition and specifically whether all or any of them were sufficient to sever the causal chain from the 1979 injury requires an examination of the body part affected, the time of the specific incident and the resultant condition.

Back

30. Medical records and testimony in this case support the conclusion that claimant has degenerative osteoarthritis of the lumbar spine which is the cause of his low back condition and symptoms. A treatment note from University Orthopaedics dated July 10, 1987 documents claimant's complaint of back pain for years, most recently after taking a trip to Florida. A CAT scan report of the lumbar spine from FAHC dated March 12, 1991 indicates a normal study with no evidence of nerve root compression or disc herniation.

31. The next significant report of low back pain is noted in a July 26, 1996 FAHC note which indicates claimant was seen for sudden onset of acute low back pain. Claimant indicated that he had been doing light yard work and suddenly felt as though something popped in his back and he developed acute severe low back pain. Associated symptoms included numbness and tingling in both legs with sharp pain radiating from the right lumbosacral area and anteriorly. Claimant was unable to move.

32. An August 1, 1996 CAT of the lumbar spine demonstrated disc herniations at L3-4 and L5-S1. A note dated September 16, 1996 from Dr. White at Fletcher Allen-SPINE indicates that the claimant had a recent exacerbation a couple of months ago while bending. Claimant noted that pain had increased in his lower back and was radiating down the right leg. Claimant stated his back pain is worse than his leg pain. The diagnosis was back and right leg pain with possible disc herniation. The disc herniations noted on the 1996 scan were not present in 1991. Medical testimony, the obvious worsening evidenced on the CAT scan and the claimant's report to his physician that he heard a "pop" in his back, all support the defense position that the yard working incident of July 1996 represented the onset of back pain, unrelated to the claimant's right knee.

Left Knee

33. The medical records dating back to 1983 are consistent in that they attribute claimant's left knee condition to osteoarthritis. A June 20, 1988 note indicated claimant's arthritis was systemic and not related to trauma such as from overuse of a sore leg. Although the abnormal gait caused by claimant's fused right knee might add strain to the muscles and ligaments of the left knee; persuasive medical testimony supports the conclusion that it would not necessarily worsen the underlying osteoarthritic condition of the left knee.

34. The weight of the evidence supports the conclusion that claimant's left knee condition is the result of the natural progression of pre-existing underlying osteoarthritis, which is unrelated to claimant's work injury or his right knee condition. Years after the work-related incident, other events occurred which widened further the gulf between the claimant's 1979 injury and his current left knee condition.

35. The first occurred in August 1989 when the claimant slipped and twisted his knee while operating a wood splitter, an incident that ultimately resulted in a torn medial meniscus and the need for surgery. When Dr. Incavo performed a surgical menisectomy on August 15, 1989 he noted Grade II-III osteoarthritic changes in the left knee. The meniscus serves as a cushion between the upper and lower leg bones, therefore, its removal of the meniscus leaves the articular cartilage exposed, leading to an increase in force and damage to the articular cartilage of the knee.

36. The wood splitting incident accelerated the osteoarthritis in the left knee to a point where a total knee replacement ultimately was required and performed in 1998. The medical records and the expert testimony are in agreement that the injury claimant suffered to his left knee while operating a wood-splitter in August 1989 tore his medial meniscus, requiring a menisectomy, and that claimant's left knee condition rapidly deteriorated as a result, as demonstrated by the findings in the August 1996 arthroscopy.

37. The claimant argues that but for the fused right leg, he would not have fallen while splitting the wood. He contends that the injury resulting from the wood splitting incident was one more link in an unbroken chain from the claimant's 1979 injury to his current knee condition. The turning involved in placing logs in the splitter was undoubtedly the cause of the incident that day. However, the accident involving the wood-splitter occurred when he was helping a friend split wood, an activity that goes beyond what can be characterized as an activity of daily living. In performing that work, unrelated to the 1979 injury, the claimant injured his knee to the point that surgery was required. That incident and resultant osteoarthritis, not the 1979 injury, accounts for the claimant's left knee condition.

38. Claimant's knee condition is a consequence of the meniscectomy and his osteoarthitis, not the 1979 work-related injury as demonstrated by the changes noted during surgery. When Dr. Incavo performed surgery in August 1989 he found Grade II-III osteoarthritic changes in claimant's left knee. Seven years later, when he performed an arthroscopy of claimant's left knee on August 22, 1996, he found that the condition of the knee had worsened to include Grade IV osteoarthritic changes.

39. In a March 16, 1998 note, Dr. Fitzpatrick at Fletcher Allen noted that while walking with crutches after his left total knee replacement, a crutch broke, claimant fell and "heard his back snap". Since then, claimant's problem had been "going downhill". Claimant noted continuing back pain as well as leg pain, but it was predominantly his back pain, which was bothering him. A radiology report of a CAT scan of the lumbar spine from Fletcher Allen dated April 13, 1998 showed further worsening of his back condition as compared to the scans of 1996. If the left knee condition were causally related to the claimant's original 1979 work-related injury, his current back condition would also be related because crutch use related to treatment of the left knee caused the fall that injured his back. But without inclusion of the left leg condition in the causal link, the back condition after 1998 cannot be included either.

40. The defense argues that another incident severed the causal link between the claimant's 1979 injury and his current left knee condition. That was in June 1997 at a car dealership when he slipped on an uneven sidewalk and hyperextended his knee. But the simple act of walking on a surface that might be uneven is expected in one's everyday life. Had the claimant's right knee not been fused, it is unlikely that such a fall would have happened. Consequently, tripping on the walkway and injuring his knee was not sufficient to sever the causal link from the original injury. However, as noted above, the wood splitting incident already had.

<u>Permanent Total Disability</u>

41. Experts who offered opinions in this case unanimously agree that the claimant is permanently and totally disabled. However, as explained above, only the claimant's right leg condition is causally related to his 1979 injury. And that injury alone does not totally disable him. Myriad factors, including his back, neck, shoulder and TIA problems combine to render him permanently totally disabled. But because the problems that disable him are not related to his 1979 injury, he is not entitled to permanent total disability.

Fee Schedule For Defense Experts

42. Vermont Worker's Compensation Fee Schedule, Rule 40.111 (A) states that for any health care provider who gives a deposition, "reimbursement shall be $300.00 for one hour or less. Additional time shall be reimbursed at $75.00 for each additional 15 minutes." 18 V.S.A. §9432 (8) defines Health care provider as "a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement." Dr. Johansson is a health care provider subject to Rule 40.

43. Claimant issued Dr. Johansson a $700.00 check for his first deposition testimony that lasted one and one half-hours. His pre-pay fee was $700.00. Under Vermont's Workers' Compensation System, particularly Rule 40, Dr. Johansson was not entitled to advance payment. In fact, "[p]re-payment under this schedule is prohibited." Rule 40.021.

44. Under Rule 40 he was limited to $450.00 ($300 for the first hour plus $75 x 2 (two 15 minute periods after the first hour). Claimant is, therefore, entitled to the $250.00 overpayment.

Mileage:

45. The claimant drove 14 miles round trip to work the day he was injured at Foley Rail Company. Since then he has traveled to medical appointments at distances that exceed his commute to work, although he has not received reimbursement for all of those trips. The claimant requests mileage reimbursements for the mileage traveled in excess of 14 miles round trip for all necessary medical appointments for all compensable injuries at the prevailing rate of the time of the medical appointment. This payment is authorized by Worker's Compensation Rule 12 (b)(1).

46. Therefore, the claimant is entitled to mileage for travel beyond the 14-mile round trip for travel related to treatment for his right knee. Within 30 days of this decision, the claimant is to submit a precise accounting of this mileage to this Department and to the defense.

Medical Benefits:

47. Over the years, the claimant has only received payment for some medical bills relating to some treatment for his right knee injury. Claimant requests payment of all medical costs, prescriptions, co-pay reimbursement, hospitals and medical plan liens, and all past medical benefits for all compensable injuries. The claimant also requests payment for all future medical benefits relating to treatment and cost for compensable injuries.

48. The claimant is entitled to payment for medical expenses related to the treatment of his right knee, including past medical expenses and co-payment. Payment for future medical expenses will be limited to treatment of the right leg and, as with all medical expenses, to those that are reasonable. 21 V.S.A. § 640.

Attorney fees

49. Having prevailed on part of this case, the claimant is entitled to reasonable attorney fees as a matter of discretion and necessary costs as a matter of law. 21 V.S.A. § 678. Although an hourly rate is claimed here, such an award would be unjust given the limits on the award in this case. Claimant is therefore awarded 20% of the total award.

ORDER:

THEREFORE, based on the Foregoing Findings of Fact and Conclusions of Law, the claimant is awarded:

1. All medical expenses related to the treatment of his right knee;

2. Mileage for trips to doctors' visits for treatment of his right knee. Calculation for each visit shall be based on mileage above the 14 mile round trip commute the claimant had to work;

3. Reimbursement of $250.00 overpaid to Dr. Johansson for the deposition.

Dated at Montpelier, Vermont this 12th day of September 2001.

____
R. Tasha Wallis
Commissioner

Appeal:
Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior (county) court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§ 670, 672.