SOUTH DAKOTA DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT

CURTIS SMITH, **HF No. 238, 2002/03**

Claimant, **DECISION**

vs.

CROWN CONSTRUCTION COMPANY,

Employer,

and

TRAVELERS INSURANCE COMPANY,

Insurer.

This is a workers' compensation proceeding brought before the South Dakota Department of Labor pursuant to SDCL 62-7-12 and Chapter 47:03:01 of the Administrative Rules of South Dakota. A hearing was held before the Division of Labor and Management on August 26, 2004, in Rapid City, South Dakota. Curtis Smith (Claimant) appeared personally and through his attorney of record, Dennis W. Finch. Michael M. Hickey represented Employer/Insurer (Employer).

OVERVIEW

Claimant sustained an injury to his low back on November 17, 1979, that arose out of and in the course of his employment with Employer. Claimant's weekly benefit rate established at the time of the 1979 injury was $175 per week. In 1980, Dr. Lee Ahrlin performed a laminectomy. As a result of that surgery, Dr. Ahrlin assigned a ten percent impairment rating to Claimant's back, which was paid by Insurer.

Claimant experienced a flare-up of back pain in 1997 and 1998. Claimant saw Dr. Frederick Fisher who performed an epidural steroid injection in August 1997 and another one in May 1998. The parties entered into a settlement agreement on July 27, 1998 to resolve a dispute over medical expenses, but left open the issue of payment for future medical expenses.

In the fall of 2002, Claimant encountered further low back problems diagnosed as a recurrent herniation, which resulted in surgery by Dr. Stewart Rice in November 2002. The parties agreed Claimant's problems were causally related to the November 17, 1979 injury.

Thereafter, Claimant experienced pain in his left hip. Both Dr. Brett Lawlor, physiatrist, and Dr. Mark Harlow, orthopedic surgeon, found Claimant to have avascular necrosis of the left hip. Dr. Harlow performed a partial arthroplasty of Claimant's left hip in August 2003. The issue to be resolved here is whether Claimant's work-related injury on November 7, 1979, is a contributing factor to his left hip condition.

FACTS

The following facts have been established by a preponderance of the evidence: Claimant has owned his own company, A-1 Construction, for the past twenty-two years. Claimant is a general contractor/carpenter. Claimant worked steadily in his own business except for the times he was recovering from back surgery and hip replacement surgery.

From 1998 to 2002, Claimant received treatment from time to time for his low back. These treatments consisted of chiropractic treatments, physical therapy and injections. Claimant did not have pain in his left hip at that time, but experienced pain in his left leg all the way down his leg to the bottom of his foot.

On August 22, 1997, Claimant saw Dr. Fisher at the Black Hills Surgery Center for an epidural steroid injection in his low back. After the injection, Claimant experienced "a fair bit of numbness in the lower extremities and some mild paralysis." These symptoms wore off the same day and Claimant was able to go home. Claimant received a second epidural steroid injection on May 22, 1998.

Sometime in late 2002, Claimant began to experience more difficulty with his left leg. Claimant's pain increased to the point where it was intolerable. Claimant went to see his family physician, Dr. Allen Nord, and then was referred to Dr. Larry Teuber to treat his back condition. Dr. Teuber was unavailable so Claimant saw Dr. Rice, one of Dr. Teuber's associates, on November 11, 2002. Dr. Rice noted:

> The patient has a history of a work related injury that resulted in L4-5 diskectomy by Dr. Ahrlin 26 [sic] years ago. He has had intermittent low back difficulties over the course of time. In summary, his symptoms have never completely gone away and he has throughout his adult life experienced periodic discomfort in the low back and in the left lower extremity. Approximately three months ago he began to notice increasingly severe pain in the left lower extremity, specifically pain in the low back radiating into the left hip and the anterolateral left thigh.

Dr. Rice diagnosed Claimant with acute L4-5 radiculopathy secondary to a disc herniation. Dr. Rice performed surgery on Claimant's low back on November 15, 2002. Claimant experienced relief following the surgery, but he still had some pain around his left hip area. Claimant remained off work from November 15, 2002, until April 4, 2003, when Dr. Rice released Claimant to return to work. On April 11, 2003, Dr. Lawlor opined that Claimant had a 10% whole person impairment.

After his back surgery, Claimant's hip pain continued to worsen. Claimant never sustained any kind of traumatic event or direct injury to his left hip. Claimant saw Dr. Lawlor on February 21, 2003, for further evaluation of his left hip pain. Dr. Lawlor diagnosed Claimant with probable avascular necrosis[1] of the left hip based upon review of a bone scan and his physical examination. According to Dr. Lawlor, "[a]vascular means without blood vessel and necrosis means that the blood vessel dies off, and so what it implies is that the blood vessel to the ball part of the hip has died off and so that that area of the hip is not getting sufficient blood supply." Dr. Lawlor referred Claimant to Dr. Harlow because physical therapy or medications would not provide much relief.

[1] In some medical records, Claimant's condition was referred to as aseptic necrosis. All of the medical providers agreed that the terms avascular necrosis and aseptic necrosis are synonymous.

Claimant saw Dr. Harlow on March 3, 2003. Dr. Harlow noted that Claimant had reached the point where he was having significant discomfort and pain in his left hip on a daily basis. Dr. Harlow reviewed the bone scan that suggested Claimant had possible avascular necrosis of the left femoral hip. Dr. Harlow performed an examination and had x-rays taken of Claimant's left hip. Dr. Harlow confirmed the x-rays were consistent with the findings on the bone scan. Based upon the examination and diagnostic testing, Dr. Harlow opined Claimant "had ongoing aseptic necrosis of his femoral head with loss of congruity of the joint which was leading to degenerative arthritic change and ongoing pain[.]"

In his treatment note from March 3, 2002, Dr. Harlow wrote:

> Additionally, I met with [Claimant's] rehab counselor today. I advised her of my opinions and findings, as stated above. She had some questions about whether or not there was a cause and effect relationship between his back problem and his hip problem. I advised her that I could not draw that conclusion. There is a plausible connection, but it is certainly not provable. In any event, I advised her that this is likely a separate problem.

Dr. Harlow explained his statement in the medical note from March 3, 2003:

> I would like to just clarify, when I said a separate problem, I meant a separate source of pain pertaining to whether or not the pain was related to the back or related to the hip. Let me see if I can make myself more clear. It was my opinion that it was reasonable to conclude that the steroids that were required to treat his back could have led to the aseptic necrosis of his femoral head. The pain that he was having at the time of this visit could have been residual pain from his back, and at that point, without a clear diagnosis of aseptic necrosis of the femoral head, it could have been pain from the hip. That's what I meant when I said they're separate problems.

After his consultation with Dr. Harlow, Claimant continued to experience significant pain in his left hip. Dr. Harlow recommended left hip replacement surgery and Claimant consented. Dr. Harlow performed a hemiarthroplasty on August 28, 2003, meaning that he replaced half the joint. Dr. Harlow explained, "[t]he ball was damaged and collapsing so we replaced that with an artificial ball, but the socket was still in satisfactory condition so rather than resurface that with a metallic cup, I left his hip socket intact[.]"

In a follow-up visit on September 8, 2003, Claimant asked Dr. Harlow about the cause of avascular necrosis. Dr. Harlow wrote in his note from that date, "[Claimant] also had some questions about his status regarding steroid use contributing to the AVN of his left hip. I told him this is within the realm of the plausible and may in fact be a contributing cause. This is nor [sic] provable but there is medical literature to support that fact."

Claimant remained off work after the surgery until January 2004. Claimant was confined to his home as he was unable to drive. Claimant had to use a walker for a few months to get around and then used a cane. In January 2004, Claimant attempted to return to work. Claimant was able to work only an hour or two in the office because he

experienced significant pain. On January 16, 2004, Dr. Lawlor indicated that Claimant could probably return to full duty in about a month. Claimant saw Dr. Harlow for a final visit on January 26, 2004. Dr. Harlow noted that Claimant "is doing well following recovery from his hip surgery. He is nearly ready to return to work. We have agreed that a start date of March 1st would be reasonable." In early February 2004, Claimant returned to full duty at his construction company. On February 10, 2004, Dr. Lawlor assessed Claimant as having a 50% impairment rating to the lower left extremity.

At the time of the hearing, Claimant was not experiencing any problems with his low back or left hip. Claimant does not take any pain medication for either condition. In addition, Claimant is not currently receiving any kind of medical treatment for either condition. Claimant was a credible witness. This is based on Claimant's consistent testimony and on the opportunity to observe his demeanor at the hearing.

ISSUE

WHETHER CLAIMANT'S WORK-RELATED INJURY ON NOVEMBER 7, 1979, IS A CONTRIBUTING FACTOR TO HIS LEFT HIP CONDITION?

Claimant has the burden of proving all facts essential to sustain an award of compensation. King v. Johnson Bros. Constr. Co., 155 N.W.2d 183, 185 (S.D. 1967). Claimant must prove the essential facts by a preponderance of the evidence. Caldwell v. John Morrell & Co., 489 N.W.2d 353, 358 (S.D. 1992). Claimant sustained a work-related injury to his back on November 7, 1979. "The law in effect when the injury occurred governs the rights of the parties." Westergren v. Baptist Hosp. of Winner, 549 N.W.2d 390, 395 (S.D. 1996).

Claimant "must establish a causal connection between [his] injury and [his] employment." Johnson v. Albertson's, 2000 SD 47, ¶ 22. The causation requirement does not mean that Claimant must prove that his employment was the proximate, direct, or sole cause of his injury. Claimant must show that his employment was a contributing factor to his injury. Gilchrist v. Trail King Indus., 2000 SD 68, ¶ 7. "The testimony of professionals is crucial in establishing this causal relationship because the field is one in which laymen ordinarily are unqualified to express an opinion." Day v. John Morrell & Co., 490 N.W.2d 720, 724 (S.D. 1992). When medical evidence is not conclusive, Claimant has not met the burden of showing causation by a preponderance of the evidence. Enger v. FMC, 565 N.W.2d 79, 85 (S.D. 1997).

Dr. Lawlor provided testimony through his deposition taken on March 3, 2004. Initially, Dr. Lawlor did not have an opinion as to whether Claimant's 1979 injury contributed to Claimant's need for left hip treatment. Later, Dr. Lawlor opined:

> My opinion with regard to his hip injury and his avascular necrosis, that it more likely than not - - well, let me just back up. There's as I understand it several different things that can cause avascular necrosis of the hip. One is trauma, and he does not have, that I know of, any significant trauma to both hips. The second is idiopathic condition which means no one knows why it occurred, and the third is from - - as an extremely unusual response to steroid injections. And he did have steroid injections that pre-dated the onset of his symptoms, so I think it's at

least possible that the steroid injections caused his avascular necrosis of the hip. Those steroid injections were for his lumbar spine injury so that was work related.
Q: Okay.
A: So can I say that with reasonable degree of medical certainty that the steroid shots caused his avascular necrosis? No. Is it more likely than not? Given his absence of specific trauma and we look at the list of things that can cause avascular necrosis, he did have steroid shots, that's on the list of things that are known to cause avascular necrosis, so it's certainly reasonable to expect that that's a potential cause for his avascular necrosis.

Dr. Lawlor agreed that he thinks it is a possibility that the steroid injections for Claimant's back injury contributed to his avascular necrosis.

Claimant also provided the medical opinions from Dr. Harlow through his deposition testimony taken on April 26, 2004. Dr. Harlow is a board certified orthopedic surgeon. In addition, Dr. Harlow completed a Fellowship in hip and knee replacement at the University of Utah in 1992. Dr. Harlow explained this means he has "extra training and credentials in hip replacement." Dr. Harlow performs approximately 400 joint replacement surgeries a year. Of those 400 replacements, he sees 15 to 25 cases of avascular necrosis per year.

During one appointment, Claimant asked Dr. Harlow as to the cause of his avascular necrosis. Dr. Harlow testified:

> He was concerned as to what the causative agent of this disease process was and I told him the most common cause was trauma. Secondary causes would include alcohol abuse and steroid use, were the other principal causes that we are aware of. There are some that we call idiopathic, meaning we don't really know why, they happen spontaneously. But in taking his history, there was no history of trauma, there was no history of alcohol abuse, but there was history of steroid use from his ongoing back problem.

Dr. Harlow stated that steroid use is a common risk factor for developing avascular necrosis. Dr. Harlow testified:

> Q: So in terms of the number of steroid injections that Dr. Fisher performed -- well, first of all, would you agree that even a single large dose can increase the risk?
> A: Yes, I would. And I'm aware of one patient I cared for quite a few years ago who lost most of his femoral heads from a single dose for an epidemiological condition, so it can be very profound.

Dr. Harlow opined that the 1979 work-related injury was a source of contribution to Claimant's left hip condition. Dr. Harlow was asked to respond to the following question:

> I'd like you to assume, Doctor, the following facts: That Mr. Smith had a low back injury November 17th of 1979; that as a result of that injury, he underwent a laminectory [sic] in February of 1980. He had a flare-up of back pain in 1998 - -

1997 and ’98, I should say - - and as a result of that flare-up he went to Dr. Fisher and had the epidural steroid injections that we’ve talked about that show up in Exhibit 3 here. He had a recurrent disc herniation in November of 2002 and underwent microdecompression on November 15, 2002, by Dr. Stuart Rice. He was then treated by Dr. Lawlor, who referred him to you because of continued complaints of left hip pain.

Assuming all of those facts to be true, do you have an opinion within reasonable medical probability as to whether that November ’97 low back injury and the resulting treatment and those items that I’ve suggested serve as a source of or contributed to his left hip condition for which you saw and treated him?

. . . .

A: And the answer is yes, I do have an opinion.

Q: And what is that opinion?

. . . .

A: That there is a plausible but not absolute provable connection between the events.

Dr. Harlow clarified his opinion:

Q: But specifically you advised the rehab nurse that you could not draw a conclusion that there was a cause and effect relationship between his back problem and his hip problem.

A: Not provable.

Q: It was plausible.

A: Plausible.

Q: And that continues to be your opinion here today?

A: Plausible, and I don’t know where to draw the line on probable. I think, knowing the history that I know now, knowing that there was no prior history of trauma, knowing that there was no alcohol abuse, <u>then in that setting, the most probable cause of aseptic necrosis is steroid use.</u> Sometimes it’s something as minor as oral steroid use from a dermatologic condition.

(emphasis added). Dr. Harlow was asked about the timing between the steroid injections and the onset of Claimant’s hip pain:

Q: Is there a time sequence between the giving of the steroids and the onset of the condition?

A: I always have to say in relative proximity. By that I mean several months. You couldn’t have a steroid injection five years ago and now develop AVN and connect the dots on that one.

Q: So in this case, when he had steroid injections in ’97 and ’98 and you saw him in 2003, that’s well beyond the narrow time frame that you’re talking about?

A: I think it would have to be in relative proximity, several months. Again, the science is not exact on this. Several years would be a reach.

Even with this testimony, Dr. Harlow did not retract his opinions that there is a plausible connection between the steroid injections and the onset of Claimant's hip condition. Dr. Harlow testified:

> Q: If other physicians looked at this and said that there was not a cause and effect, a provable cause and effect relationship, that would be consistent with your opinion here today?
> A: Yes. As I said, I cannot prove it. It is plausible and, in fact, probable, but it is not absolutely provable.

Finally, Dr. Harlow recognized that Dr. Lawlor's assessed Claimant as having a 50% impairment rating to the lower left extremity. Dr. Harlow testified that he had no reason to disagree with that impairment rating.

Dr. Wayne Anderson, an occupation medicine specialist, performed a records review of Claimant's file. Dr. Anderson is not a surgeon and has never done hip surgery of any type. Dr. Anderson also does not perform steroid injections, but he does give trigger point and joint injections. Dr. Anderson was asked to opine on the causative relationship between the steroid injections Claimant received in 1997 and 1998 and the subsequent avascular necrosis in his left hip joint.

Dr. Anderson generated a written report on June 7, 2004. Dr. Anderson did not examine Claimant. Dr. Anderson reviewed Dr. Harlow's deposition, Dr. Lawlor's deposition and the medical records associated with the depositions. In addition, Dr. Anderson conducted medical research using Ovid, the system used by Rapid City Regional Hospital Medical Library, Merck Medicus, MD Consult and Google.

First, Dr. Anderson noted that Dr. Fisher injected 80 milligrams of DepoMedrol, which is Methylprednisolone, on two separate occasions. Dr. Anderson considered this to be a medium dose each time. Dr. Anderson stated:

> So the problem in this case is we've got two injections, which are not particularly high dose. They're epidural injections. And then the temporal relationship, I mean, yes, this happened after the injections, but a long time after the injections. Too long to make sense that they would have caused it, even if we were to assume they did, which it's never been shown to do.

Dr. Anderson opined that the injections in 1997 and 1998 did not serve as a source of contribution to Claimant's left hip condition. Dr. Anderson explained, "[a]s I told you earlier, my opinion is based on two factors. That's short-term, limited use of steroid, along with the temporal relationship is too long. So, yes, if he had hip pain and limping and evidence of avascular necrosis within six months of these injections, it would be more possible. Still not probable, but more possible."

Employer argued that Claimant's reliance on the opinions expressed by Dr. Harlow was misguided as Dr. Harlow was only able to express opinions based upon possibility and not probability, as required by South Dakota law. It is true that the "medical evidence must indicate more than a possibility that the incident caused the disability." Maroney v. Aman, 565 N.W.2d 70, 74 (S.D. 1997). Further, Claimant's

burden is not met when the probabilities are equal. Hanten v. Palace Builders, Inc., 558 N.W.2d 76 (S.D. 1997).

Dr. Harlow opined it "is plausible and, in fact, probable" that the work-related steroid injections contributed to Claimant's left hip condition. According to the American Heritage Dictionary (Second College Edition), plausible is defined as "seemingly or apparently valid, likely, or acceptable." Possible is defined as "capable of happening, existing, or being true without contradiction proven facts, laws, or circumstances." Probable is defined as "likely to happen or to be true; relatively likely but not certain; plausible." Given these meanings in the context of Dr. Harlow's testimony, his opinions were expressed to the appropriate legal standard of medical probability.

Both Dr. Harlow's opinions and Dr. Anderson's opinions have the proper foundation. Both physicians reviewed Claimant's medical records and were aware of the same history of Claimant's pain complaints and condition. However, Dr. Harlow's opinions are entitled to more weight and are more persuasive than those opinions expressed by Dr. Anderson. "The trier of fact is free to accept all of, part of, or none of, an expert's opinion." Hanson v. Penrod Constr. Co., 425 N.W.2d 396, 398 (S.D. 1988).

Dr. Harlow's opinions are more persuasive for several reasons. First, Dr. Harlow was one of Claimant's treating physicians for the hip condition. Dr. Harlow actually performed the hip replacement surgery and saw Claimant on multiple visits. More importantly, Dr. Harlow possesses specialized training and superior experience in hip replacement surgeries and familiarity with avascular necrosis. Dr. Harlow performs hundreds of surgeries per year and has treated many patients with avascular necrosis. In comparison, Dr. Anderson is not a surgeon, has never performed a hip replacement surgery and obtained his information on avascular necrosis from medical research and articles off the internet.

Throughout his testimony, Dr. Harlow maintained that the steroid injections Claimant received for his work-related injury were a contributing factor to his avascular necrosis. Dr. Harlow did not retract this opinion even when questioned about the length of time between Claimant's steroid injections and the development of avascular necrosis. Dr. Harlow consistently opined that "the most probable cause of aseptic necrosis is steroid use." Given the opinions expressed by Dr. Harlow, Claimant established by a preponderance of the evidence that his work-related injury on November 7, 1979 was a contributing factor to his left hip condition.

Claimant requested temporary total disability (TTD) benefits for the periods from November 15, 2002 to April 4, 2003, and again from August 28, 2003 to February 1, 2004. Dr. Rice performed the lumbar microdiskectomy on November 15, 2002. On November 27, 2002, Dr. Rice stated, "I discussed with Curtis also his activity and how long it would take him to heal up before he could get back to doing construction type of work." Dr. Rice indicated that Claimant was "to continue his current level of activities." On December 10, 2002, Dr. Rice stated that Claimant would "require one more month off work before he can return." On April 4, 2003, Dr. Rice finally determined that Claimant was at maximum medical improvement. Based on Dr. Rice's medical records, Claimant is entitled to TTD benefits for the weeks from November 15, 2002 to April 4, 2003. In addition, Dr. Lawlor and Dr. Harlow restricted Claimant from working after his hip replacement surgery. Therefore, Claimant is entitled to TTD for the weeks from August 28, 2003 to February 1, 2004.

In addition, Claimant requested payment for permanent partial disability (PPD) benefits based on the 10% impairment rating given by Dr. Lawlor in April 2003. Claimant also requested PPD benefits for the 50% rating to the lower left extremity given by Dr. Lawlor in February 2004. In his testimony, Dr. Harlow agreed with the 50% rating. Dr. Anderson indicated that he had no reason to disagree with Dr. Lawlor's assessment that Claimant sustained a 50% impairment to the lower left extremity as a result of the hip replacement surgery.

Insurer already paid Claimant PPD benefits for the 10% impairment rating given by Dr. Ahrlin after Claimant's back surgery in 1980. There was no evidence presented to suggest that Dr. Lawlor's 10% impairment rating was in addition to the 10% rating already given. Claimant is not entitled to be paid for PPD benefits for the 10% whole person impairment rating given by Dr. Lawlor on April 11, 2003. However, Claimant is entitled to receive PPD benefits for the 50% impairment rating to his lower left extremity as no evidence was presented to refute Dr. Lawlor's 50% impairment rating.

Claimant has established by a preponderance of the evidence that he is entitled to TTD benefits and PPD benefits based on the 50% impairment rating to the lower left extremity. As per the parties' agreement at the hearing, the Department shall retain jurisdiction over the question of any outstanding medical bills.

Claimant shall submit Findings of Fact and Conclusions of Law, and an Order consistent with this Decision, and if necessary, proposed Findings and Conclusions within ten days from the date of receipt of this Decision. Employer shall have ten days from the date of receipt of Claimant's proposed Findings and Conclusions to submit objections or to submit proposed Findings and Conclusions. The parties may stipulate to a waiver of Findings of Fact and Conclusions of Law and if they do so, Claimant shall submit such Stipulation along with an Order in accordance with this Decision.

Dated this 19th day of April, 2005.

SOUTH DAKOTA DEPARTMENT OF LABOR

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Elizabeth J. Fullenkamp
Administrative Law Judge