STATE OF VERMONT
DEPARTMENT OF LABOR

Matthew Purington

v.

Granite Design U.S.A. Inc.

Opinion No. 17-25WC

By: Stephen W. Brown
Administrative Law Judge

For: Kendal M. Smith
Commissioner

State File No. RR-60268

OPINION AND ORDER

Hearing held via Microsoft Teams on March 18, 2025
Record closed on June 6, 2025

APPEARANCES:

Brendan P. Donahue, Esq., for Claimant
William J. Blake, Esq., for Defendant

ISSUES PRESENTED:

1. Is Claimant's right knee chondromalacia causally related to the compensable right knee injury that he sustained on January 12, 2022?

2. Is Claimant entitled to additional permanent partial disability benefits beyond the three percent whole person impairment already paid by Defendant?

EXHIBITS:

Joint Exhibit I:	Joint Medical Exhibit ("JME")
Claimant's Exhibit 1:	*Curriculum vitae* of Timothy Lin, MD
Claimant's Exhibit 2:	*Posterior Cruciate Ligament Deficiency: Biomechanical and Biological Consequences and the Outcomes of Conservative Treatment: A Systematic Review*, Matthew Grassmayr, *et al.*
Claimant's Exhibit 3:	*Long-Term Results of Posterior Cruciate Ligament Tear with or without Reconstruction: A Nationwide Population-Based Cohort Study*, Sheng-Hao Wang, *et al.*
Claimant's Exhibit 4:	*Posterior Cruciate Ligament Injuries*, Christina Allen, MD, *et al.*
Defendant's Exhibit A:	*Curriculum vitae* of David Dent, DO
Defendant's Exhibit B:	*Reliability of Clinical Findings and Magnetic Resonance Imaging for the Diagnosis of Chondromalacia Patellae*, Harri Pihlajamaki, MD, *et al.*

FINDINGS OF FACT:

1. Claimant is a 45-year-old man who resides in Springfield, Vermont. He began working for Defendant in 2018.

2. Claimant's primary job duty for Defendant is measuring countertops for customers. Claimant's job is not physically demanding; he does not carry or install countertops. He carries a laser measuring tool and a notebook to the homes of Defendant's customers to take measurements.

Claimant's Workplace Injury and Subsequent Medical Course

3. On January 12, 2022, Claimant was walking up a set of exterior stairs to a customer's home when he slipped on snow and ice. Claimant's left leg slipped behind him and his right leg hyper-extended; he heard a pop and felt immediate pain in his right knee.

4. Claimant filed a workers' compensation claim for injury to his right knee, and Defendant accepted the injury as compensable for a posterior cruciate ligament (PCL) tear.

5. Claimant first sought medical treatment for his right knee on February 1, 2022 at the Charlestown Health Center. (JME 1). He reported pain and some clicking in his knee, but no instability. He was able to perform all his work duties at this time. (JME 2).

6. Claimant returned to Charlestown Health Center on February 21, 2022, complaining of worsening and constant right knee pain. (JME 5). An x-ray of his knee was unremarkable except for a small to moderate joint effusion. (JME 6).

7. Claimant treated at Connecticut Valley Orthopedics on March 7, 2022. (JME 8). By that time, he was experiencing instability of his right knee joint, especially while walking. On March 17, a right knee MRI showed a full thickness PCL tear. (JME 12-13).

8. Claimant first saw orthopedic surgeon Timothy Lin, MD, at Dartmouth Hitchcock Medical Center, on April 5, 2022. (JME 18-21). During this visit, he reported ongoing knee instability and two instances of his right knee buckling. (JME 18). Dr. Lin credibly testified at the hearing that, based on the 2022 knee MRI, the patellofemoral cartilage in Claimant's right knee was normal on April 5, 2022.

9. On April 8, 2022, Claimant started a course of physical therapy for his PCL tear. The medical record for the initial physical therapy evaluation noted that he had "some mild thinning of the chondral tissue in the Right knee most likely due to age related wear and tear and not from the injury itself." (JME 25).

10. On May 27, 2022, Claimant told his physical therapist about a constant sharp pain under his patella (kneecap). (JME 28-29).

11. Claimant returned to Dr. Lin on May 31, 2022, reporting some knee instability. (JME 30). Dr. Lin diagnosed him with posterior tibial translation, meaning that his tibia bone was moving rearward in the knee joint. (JME 32).

12. Claimant was discharged from physical therapy on July 8, 2022. (JME 41-42). The medical record from that date noted ongoing knee instability. (JME 41).

13. Claimant next saw Dr. Lin on July 26, 2022. He reported ongoing episodes of knee instability, or buckling, about once per week, along with general abnormal movement in the joint. (JME 43). These symptoms are consistent with a PCL injury.

14. Dr. Lin performed PCL repair surgery on January 19, 2023. (JME 59-61). His surgical report noted findings of "grade 1 to 2" chondromalacia throughout multiple compartments of Claimant's knee, including the undersurface of the patella. (JME 59). Chondromalacia is the deterioration of cartilage.

15. On February 3, 2023, Claimant began a second course of physical therapy. (JME 152). During this treatment, he consistently reported pain under his right patella. (JME 181, 184, 189, 190, 192, 193).

16. On March 7, 2023, seven weeks post-surgery, Dr. Lin noted that Claimant was doing well. (JME 163). Similarly, a May 2, 2023 progress note by orthopedic physician Cody Ramirez, MD, noted that Claimant had some intermittent pain but was happy with the surgical results and was not having any instability events. (JME 185). Claimant's medical treatment came to an end at this time, and he successfully returned to work for Defendant, where he is still employed.

17. On January 23, 2024, approximately one year after surgery, Claimant returned to Dr. Lin complaining of knee pain. (JME 226). He also reported popping, clicking, crepitus, and grinding in his right knee with certain motions. These symptoms were new. Dr Lin's medical record noted "degenerative changes on the undersurface of the patella." Dr. Lin thought that Claimant's pain was due to patellofemoral chondromalacia, and he administered an injection to treat the pain. (JME 227).

18. Dr. Lin administered another injection to Claimant's knee on May 7, 2024 and ordered another knee MRI. (JME 235). This MRI, performed on May 14, found patellofemoral chondromalacia under Claimant's right kneecap. (JME 237-238).

19. Claimant credibly testified that he does not have any pain, popping, clicking, crunching, or restricted range of motion in his left knee. Further, he did not have any pain or other symptoms in his right knee prior to the January 12, 2022 injury at work.

Expert Opinions

20. The disputed issues here are whether Claimant's patellar chondromalacia is work-related and what the correct permanent impairment rating is for his work injury. Claimant

offered expert testimony from Timothy Lin, MD, and Mark Bucksbaum, MD. Defendant offered expert testimony from David Dent, DO.

Timothy Lin, MD

21. Timothy Lin, MD, obtained his medical degree from the University of Massachusetts Medical School in 2010 and completed an orthopedic surgical residency at Dartmouth Hitchcock Medical Center in 2016. Dr. Lin is currently an Assistant Professor of Orthopedic Surgery at Dartmouth Medical School and a board-certified practicing orthopedic surgeon with a subspecialty in knee ligament repairs. Dr. Lin has been one of Claimant's treating providers since April 2022, and he performed Claimant's PCL repair surgery in January 2023. Dr. Lin has also reviewed the Joint Medical Exhibit.

Causation Opinion

22. Dr. Lin credibly explained that chondromalacia is damage to a patient's cartilage. He offered his opinion, to a reasonable degree of medical certainty, that Claimant's patellar chondromalacia was caused or accelerated by his PCL tear. Specifically, Claimant's chondromalacia came upon him sooner due to his PCL tear than it would have just due to the normal aging process.

23. Dr. Lin explained that, if the normal aging process had caused Claimant's patellar chondromalacia, he would have expected the damage to have manifested before the PCL injury that destabilized the mechanics of Claimant's knee. Further, Dr. Lin would have expected Claimant's left knee to be similarly symptomatic, but it was not.

24. Dr. Lin explained that the PCL helps to stabilize the knee joint by ensuring that the femur and tibia bones correctly align. Tearing the PCL causes these bones to move abnormally, with the tibia moving backwards, causing the underside of the patella to drag across the femur. This abnormal motion, known as posterior tibial translation, causes pressure on the underside of the patella, leading to the breakdown of cartilage. Although PCL repair surgery improves the joint, it does not typically eliminate posterior tibial translation, nor did it do so in Claimant's case. Dr. Lin credibly explained that it is well known in the orthopedic field that PCL insufficiencies may lead to the development of chondromalacia in the patellofemoral and medial compartments of the knee. *See Claimant's Exhibits 2-4.*

25. During Claimant's PCL repair surgery on January 19, 2023, Dr. Lin visually observed grade 1 and grade 2 chondromalacia on the patellofemoral cartilage of his right knee.[1] Dr. Lin explained that he assigns a grade of 1 or 2 to describe cartilage that is "almost perfect" for the patient's age, with just a "speck" of degeneration noted on visual examination.

26. In 2024, Claimant still had some posterior tibial translation and had developed crepitus in his knee joint. Dr. Lin compared imaging studies of Claimant's right knee taken in 2022

[1] Dr. Lin explained that he grades the condition of cartilage on a scale from 0 to 4. Zero represents cartilage in perfect condition, as might be seen in a child. Most adults whom Dr. Lin treats have a baseline of 1 or 2, which is minimal wear for the patient's age. In contrast, grade 4 represents no cartilage, just bone.

with imaging studies taken in January and May 2024. The 2024 imaging studies revealed cartilage damage and bone spurs on the backside of Claimant's kneecap that were not present in 2022. Dr. Lin explained that bone spurs are one of the markers of chondromalacia. Further, Claimant's x-rays and MRIs showed a progression of his chondromalacia after his work injury. In particular, the 2022 MRI showed normal cartilage, while the 2024 MRI showed damage to the patellofemoral cartilage and the presence of osteophytes. Based on Claimant's crepitus and the progression of his chondromalacia, Dr. Lin would expect to see grade 3 to grade 4 chondromalacia on the backside of Claimant's patella now, if he were to perform another surgery on his knee.

27. Defendant offered an opinion from Dr. Dent into evidence at the hearing. *See* Finding of Fact Nos. 47-49 *infra*. In Dr. Dent's opinion, Claimant's chondromalacia was caused by normal wear and tear, unrelated to his PCL tear. Dr. Lin disagreed with this opinion because Claimant did not have any pain prior to the January 2022 injury, and the MRI taken shortly after that injury showed no evidence of chondromalacia. One year later, at the time of the 2023 surgery, Claimant had the beginnings of chondromalacia; one year after that, he had significant chondromalacia and osteophytes. In Dr. Lin's opinion, this time frame for the development Claimant's chondromalacia was accelerated; Claimant would not have developed the condition so quickly in the absence of the PCL tear. Further, the lack of bilateral symptoms is consistent with the cause being related to the right-side PCL tear, rather than the normal aging process.

28. Dr. Lin based his opinions on his training and experience as an orthopedic surgeon, including his experience in diagnosing and repairing PCL injuries, as well as his experience as Claimant's treating physician and surgeon. I find Dr. Lin's opinion on the cause of Claimant's right knee chondromalacia to be credible, objectively supported by Claimant's medical history, and well-supported by Dr. Lin's training and experience as an orthopedic surgeon with a subspecialty in knee ligament repairs.

Mark Bucksbaum, MD

29. Mark Bucksbaum, MD, earned a degree in biomedical engineering from Case Western Reserve University and a medical degree from St. George's University Medical School in Grenada, West Indies. He did his residency in physical medicine and rehabilitation at the Albert Einstein Medical Center in New York, and he is board certified in physical medicine and rehabilitation and as an independent medical examiner. Currently, Dr. Bucksbaum is associated with the Center for Integrative Medicine in Rutland, Vermont.

30. Dr. Bucksbaum performed an independent medical examination of Claimant, at Claimant's request, on October 29, 2024. (JME 248-264). Dr. Bucksbaum testified on Claimant's behalf by preservation deposition on April 16, 2025, and Claimant has submitted the deposition transcript into evidence.

31. Dr. Bucksbaum diagnosed Claimant with multiple conditions, including right knee arthritis and patellar chondromalacia. (JME 263). During his examination, Dr. Bucksbaum specifically tested Claimant's right knee area for sensory loss with several modalities, including light touch, pinprick, vibration and temperature. Based on these

findings, he identified an area of sensory loss in the lateral aspect of the outside of Claimant's right knee.

Causation Opinion

32. Dr. Bucksbaum offered his opinion, to a reasonable degree of medical certainty, that Claimant's PCL tear aggravated his right knee arthritis and patellar chondromalacia. Specifically, Dr. Bucksbaum offered his opinion that Claimant's chondromalacia came upon him earlier than would have occurred in the absence of the work-related PCL tear. (JME 263).

33. Dr. Bucksbaum explained that the PCL is responsible for maintaining the proper alignment and stability of the knee joint. A torn PCL alters the biomechanics of the joint, affecting how the patella moves within its groove, as well as the pressure distribution across the patellofemoral joint. Over time, these altered biomechanics may cause the development of patellofemoral arthritis due to abnormal wear on the patellar cartilage. This may cause chronic pain and the development of patellar chondromalacia, or the softening of the cartilage inside the kneecap. In his opinion, this is what happened to Claimant's knee joint.

34. Dr. Bucksbaum acknowledged that a patient may develop patellar chondromalacia in the absence of an injury, but he offered his opinion that the condition is most often caused by injury. Further, when the condition develops in the absence of an injury, it is typically bilateral. Claimant here has the condition only in his right knee.

35. Dr. Bucksbaum causally related Claimant's chondromalacia to his work injury because his chondromalacia is consistent with the pattern and mechanism of his injury. The causal connection is also supported by the physical findings reflected in Claimant's medical records and shown on his MRIs. Although Claimant may have eventually developed this condition in the absence of his injury, in Dr. Bucksbaum's opinion, to a reasonable degree of medical certainty, the condition came upon him sooner than it would have without the work injury.

36. I find Dr. Bucksbaum's causation opinion to be clear, well supported, and persuasive.

Permanent Impairment Rating

37. Dr. Bucksbaum also offered his opinion that Claimant is at end medical result for his right knee condition, with a six percent whole person impairment under the AMA Guides to the Evaluation of Permanent Impairment (Fifth Edition) (the "AMA Guides"). (JME 263).

38. Dr. Bucksbaum explained that Claimant's knee injury has three components that are ratable for permanent impairment under the AMA Guides. First, he identified Claimant's full thickness PCL tear, which was surgically repaired but with residual mild laxity. He rated this component of the injury with a three percent whole person impairment pursuant to Table 17-33 of the AMA Guides.

39. Second, Dr. Bucksbaum identified sensory impairment on the lateral aspect of the outside of Claimant's right knee, for which he assessed a one percent impairment under Table 17-37 of the AMA Guides.[2] Dr. Bucksbaum explained the AMA Guides' methodology for rating sensory impairments as first identifying the area with sensory loss and then, based on the examiner's knowledge of anatomy, identifying the nerve that is most likely causing the loss. Dr. Bucksbaum explained that there are three nerves in the area of Claimant's sensory loss, but he thought the lateral femoral cutaneous nerve best explained the findings he made during his examination of Claimant. Under the AMA Guides, the lateral femoral cutaneous nerve is associated with a one percent whole person impairment. Dr. Bucksbaum therefore assessed a one percent whole person impairment for Claimant's sensory loss.

40. On cross-examination, Dr. Bucksbaum was asked about Dr. Dent's opinion that the lateral femoral cutaneous nerve stops above the knee and therefore could not be the source of any sensory loss on the lateral aspect of Claimant's knee. Dr. Bucksbaum disagreed with Dr. Dent about the location of this nerve. He explained that the AMA Guides include a chart (Figure 17-8) showing the placement of the sensory nerves in the lower extremity, and the chart shows that the lateral femoral cutaneous nerve reaches the lateral aspect of the knee.

41. Dr. Bucksbaum also addressed Dr. Dent's opinion about Claimant's sensory loss. (*See* Finding of Fact Nos. 52-55 *infra*.) Dr. Dent thought the affected nerve was the saphenous nerve. As the AMA Guides do not specifically provide an impairment rating for the saphenous nerve, Dr. Dent declined to assess any whole person impairment for Claimant's sensory loss. In response, Dr. Bucksbaum credibly testified that the AMA Guides expressly permit an examining physician to provide an impairment rating by analogy, as the AMA Guides cannot include every possible injury or impairment. Dr. Bucksbaum quoted the AMA Guides as follows:

> Given the range, evolution, and discovery of new medical conditions, the Guides cannot provide an impairment rating for all impairments. . . . In situations where impairment ratings are not provided, the Guides suggests that physicians use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.
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> AMA Guides, at 11.

Further, Dr. Bucksbaum credibly testified that the AMA Guides endorse the method of rating nerve impairment for nerves that are not included in Table 17-37 by tracing the affected nerve back to its root nerve. He quoted the AMA Guides as follows:

[2] Table 17-37 identifies the main lower extremity nerves and specifies an impairment rating for each identified nerve. The Table does not specify an impairment rating for every nerve in the lower extremity.

> Impairment of a specific spinal nerve that is not mentioned in this section should be estimated by considering the percents suggested for a nerve that has fibers from the specific spinal nerve.
>
> AMA Guides, at 488.

42. Dr. Bucksbaum explained that, under the AMA Guides, sensory impairment from the femoral nerve (from which the saphenous nerve derives) carries a one percent whole person impairment. Accordingly, even if Dr. Dent is correct about the affected nerve being the saphenous nerve, that would not change Claimant's impairment rating. Claimant would still have a one percent whole person impairment for sensory loss. I find Dr. Bucksbaum's testimony on this issue to be clear, well supported, and persuasive.

43. The third ratable component of Claimant's knee injury, according to Dr. Bucksbaum, is his right knee chondromalacia, with patellofemoral pain, for which Dr. Bucksbaum assessed a two percent impairment under Table 17-31 of the AMA Guides.

44. Applying the combined values chart set forth on page 604 of the AMA Guides, Dr. Bucksbaum combined the impairment ratings for the three ratable aspects of Claimant's knee injury into a six percent whole person impairment. (JME 263). Based on Dr. Bucksbaum's experience in performing IMEs and impairment ratings, I find his opinion of a six percent whole person impairment to be clear, well supported, and persuasive.

David Dent, DO

45. David Dent, DO, earned a degree in biochemistry from Texas A&M University and a medical degree from the Texas College of Osteopathic Medicine. He completed a residency in occupational medicine at the University of Illinois Medical Center in Chicago, and he is board certified in both occupational medicine and pain medicine. Dr. Dent practices clinical medicine at the Northeastern Vermont Regional Hospital in St. Johnsbury; his clinical practice includes pain management though injections and radiofrequency ablations. Dr. Dent also has his own business performing independent medical examinations and impairment ratings.

46. Dr. Dent performed an independent medical examination of Claimant, at Defendant's request, on December 12, 2023. (JME 213-225). He also prepared two addenda to his report, on March 31, 2024 and January 3, 2025. (JME 233-234; 265-266). During his physical examination, Dr. Dent identified an area just below Claimant's right kneecap as having some sensory loss.

Causation Opinion

47. Dr. Dent agreed that Claimant's PCL tear is causally related to his January 12, 2022 work accident. However, he could not say, to a reasonable degree of medical certainty, that Claimant's chondromalacia is causally related to his work injury. Rather, Dr. Dent attributed Claimant's chondromalacia to normal wear and tear. (JME 233).

48. Dr. Dent explained that patellar chondromalacia, or the breakdown of cartilage on the underside of the kneecap, is typically caused by "doing too much activity that places extra stress on the kneecap." (JME 233). Dr. Dent did not offer any testimony about what activities Claimant might have engaged in that would have caused chondromalacia in his right knee through excessive wear and tear.

49. Dr. Dent acknowledged that posterior tibial translation caused by PCL injuries can cause degeneration of the patellofemoral cartilage, but he could not say to a reasonable degree of medical certainty that Claimant's chondromalacia was caused in this manner. Dr. Dent acknowledged that Claimant had only mild chondromalacia at the time of his 2023 surgery and severe chondromalacia in 2024. However, he did not offer any explanation for the rapid development of the condition in Claimant's right knee, without a corresponding development of the same condition in his left knee. Dr. Dent did explain that patients often have symptoms in one knee but not the other, and he offered his opinion that genetics or other factors may be in play. Nevertheless, he did not adequately explain why he discounted the role of Claimant's posterior tibial translation in his development of right knee chondromalacia. This omission significantly undermines his opinion.

50. Overall, Dr. Dent's causation opinion is not well supported and is less persuasive than the opinions of Dr. Lin and Dr. Bucksbaum.

Permanent Impairment Rating

51. Dr. Dent assessed a three percent whole person impairment for Claimant's work-related knee injury based on the mild residual laxity of his repaired PCL. (JME 265). This portion of Claimant's impairment rating is undisputed, as both Dr. Bucksbaum and Dr. Dent agree that Claimant's PCL laxity is work-related and that it merits a three percent impairment rating under Table 17-33 of the AMA Guides. However, Dr. Dent disagrees with the remainder of Dr. Bucksbaum's permanent impairment rating.

52. Dr. Bucksbaum assessed Claimant with a one percent impairment for sensory loss on the lateral side of his knee, attributing the sensory loss to Claimant's right lateral femoral cutaneous nerve. Dr. Dent disagreed with Dr. Bucksbaum's assessment for sensory loss. Dr. Dent identified the area of sensory loss as just below Claimant's kneecap, not on the lateral side of his knee. Dr. Dent attributed Claimant's sensory loss in this region to the saphenous nerve. Specifically, Dr. Dent offered his opinion that the lateral femoral cutaneous nerve terminates above the kneecap and therefore cannot be the cause of Claimant's sensory loss. Further, the AMA Guides do not specify an impairment rating for sensory loss to the saphenous nerve. Accordingly, Dr. Dent declined to assess any permanent impairment for Claimant's sensory loss.

53. Neither Dr. Bucksbaum nor Dr. Dent explained why their physical examinations found sensory loss in different regions of Claimant's knee. However, Dr. Bucksbaum used multiple testing methods for sensory loss, *see* Finding of Fact No. 31 *supra*, and he expressed confidence that the area he identified was the correct area of sensory loss on the date of his physical examination.

54. Citing various diagrams of the nervous system, including the diagram set forth in Figure 17-8 of the AMA Guides, Dr. Bucksbaum and Dr. Dent both testified about the location of the lateral femoral cutaneous nerve, Dr. Bucksbaum declaring that it reaches the side of the knee and Dr. Dent testifying that it does not. Nevertheless, they were unanimous in agreeing that Claimant had sensory loss somewhere in the area of his repaired PCL.

55. In offering his opinion that Claimant's sensory loss pertained to the saphenous nerve, Dr. Dent did not deny that the loss was related to Claimant's compensable work injury. Rather, his opinion was that the nerve he identified, the saphenous nerve, is not listed in Table 17-37 the AMA Guides and therefore he declined to assess an impairment rating.

56. I find Dr. Bucksbaum's analysis here more persuasive than Dr. Dent's. *See* Finding of Fact Nos. 39-42 *supra*. The AMA Guides cannot include every possible injury that someone might suffer, nor is it practical for the Guides to list hundreds of nerves in Table 17-37. Instead, the AMA Guides permit the examiner to assess unlisted injuries by making an informed analogy to conditions that are expressly included in the AMA Guides. Even Dr. Dent acknowledged that the AMA Guides permit such reasoning, although he declined to engage in such reasoning here.

57. In the event that Claimant's sensory loss is attributable to the saphenous nerve, rather than the lateral femoral cutaneous nerve, I accept Dr. Bucksbaum's methodology of tracing the saphenous nerve back to its root and assessing the permanent impairment associated with the root nerve. *See* Finding of Fact No. 41 *supra*. In this case, whether the impacted nerve is the lateral femoral cutaneous nerve or the femoral nerve (from which the saphenous nerve derives), the whole person impairment rating is the same one percent under the AMA Guides, according to Dr. Bucksbaum's credible testimony. *See* AMA Guides, Table 17-37. Thus, I accept Dr. Bucksbaum's one percent whole person impairment rating for Claimant's sensory loss as the more persuasive opinion.

58. Finally, Dr. Bucksbaum assessed Claimant with a two percent whole person impairment for his patellar chondromalacia. Dr. Dent agreed with Dr. Bucksbaum's methodology under the AMA Guides for assessing permanent impairment for this condition, but he declined to assess Claimant for this impairment because, in his opinion, Claimant's chondromalacia was not work-related.

59. Having found Dr. Bucksbaum's causation opinion to be more persuasive than Dr. Dent's that Claimant's chondromalacia is work-related, I find Dr. Bucksbaum's assessment of a two percent whole person impairment for Claimant's patellar chondromalacia to be the more persuasive opinion.

CONCLUSIONS OF LAW:

Burden of Proof

1. A claimant has the burden of proof to establish all facts essential to the rights asserted. *Goodwin v. Fairbanks Morse & Co.*, 123 Vt. 161, 166 (1962); *King v. Snide*, 144 Vt.

395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury, *see Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17, 20 (1941), as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367, 369 (1984). 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 resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton, supra*, 112 Vt. at 20; *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

Causal Relationship Between Claimant's Patellar Chondromalacia and his Work Injury

2. An injury is compensable if it arises out of and in the course of the worker's employment. 21 V.S.A. § 618(a)(1)(A). The workplace accident need not be the sole cause of the injury to be compensable. Rather, a workplace injury is compensable if it "accelerates the progression of a pre-existing condition, or disrupts its stability such that an individual's ability to work and function is disabled[.]" *Taub v. Shippee Family Eye Care, PC*, Opinion No. 12-23WC (May 15, 2023), quoting *S. B. v. Homebound Mortgage*, Opinion No. 29-07WC (November 6, 2007).

3. In the context of progressively degenerative conditions, the standard for causation is "whether, due to a work injury or the work environment, the disability came upon the claimant earlier than otherwise would have occurred." *Stannard v. Stannard Co.*, 2003 VT 52, ¶ 11. The "[m]ere continuation or even exacerbation of symptoms, without a worsening of the underlying disability, does not meet the causation requirement." *Id.*

4. In this case, Claimant asserts that his chondromalacia was caused or accelerated by the PCL tear that he sustained at work on January 12, 2022. Defendant denies a causal relationship. Where expert medical opinions are conflicting, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

5. In this case, the first *Geiger* factor favors Dr. Lin, as he is the treating provider. The fifth factor also favors Dr. Lin, as he is an orthopedic surgeon with a subspecialty in ligament repairs. The second factor weighs substantially equally among the three experts, as they all reviewed the medical records. Further, both of the retained experts performed comprehensive evaluations, as contemplated by the fourth factor.

6. As is often the case, the third *Geiger* factor is most important here. For the reasons explained in greater detail at Finding of Fact Nos. 22-28 and 32-36, *supra*, I find Dr. Lin's and Dr. Bucksbaum's causation opinions to be clearer and better supported than Dr. Dent's. In particular, Dr. Lin and Dr. Bucksbaum persuasively explained the mechanism of injury, where posterior tibial translation may cause the femur to scrape against the

underside of the kneecap. Both physicians also credibly testified that, if Claimant's condition were just due to the normal wear and tear of aging, it would most likely have occurred in both knees, not just his right knee. Their causation opinions are also supported by the rapid progression of Claimant's chondromalacia from cartilage that was normal for his age in 2022 to significant deterioration by early 2024.

7. Accordingly, I conclude that Claimant's patellar chondromalacia arose out of and in the course of his employment with Defendant, when he sustained a PCL tear at work on January 12, 2022 that caused or accelerated the deterioration of the cartilage under his kneecap.

Permanent Partial Disability Benefits

8. Where an injury results in a partial impairment that is permanent, the injured worker is entitled to permanent partial disability benefits. 21 V.S.A. § 648(a). Under the workers' compensation statute, determination of the existence and degree of permanent impairment shall be made in accordance with the whole person determinations set out in the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment. 21 V.S.A. § 648(b).

9. In this case, the parties agree that Claimant has a three percent whole person impairment related to the residual mild laxity of his repaired PCL. In dispute is Claimant's assertion, based on Dr. Bucksbaum's opinion, that he also has a one percent whole person impairment for sensory loss and a two percent whole person impairment for patellar chondromalacia. Defendant relies on Dr. Dent's opinion to the contrary.

10. Relying again on the third *Geiger* factor, the clarity, thoroughness, and objective support underlying the opinion, I find Dr. Bucksbaum's opinion to be clearer and more thorough than Dr. Dent's. Dr. Bucksbaum explained why he identified the affected nerve as the lateral femoral cutaneious nerve and credibly explained how the AMA Guides provide for a one percent impairment for sensory loss of that nerve. He further explained that, even if Dr. Dent's identification of the saphenous nerve was the correct one, the appropriate method of assessing permanent impairment is to trace that nerve back to its root, the femoral nerve. The AMA Guides provide a one percent whole person impairment for sensory loss of the femoral nerve as well. Therefore, either way, Claimant has a one percent whole person impairment for sensory loss in his right lower extremity. In contrast, Dr. Dent acknowledged that, while the AMA Guides permit a physician to assess impairment of unlisted conditions by analogy to listed conditions, he chose not to do so in this case. Based on Dr. Bucksbaum's persuasive testimony here, I conclude that Claimant has a one percent whole person impairment for sensory loss.

11. Finally, whether Claimant has a compensable two percent whole person impairment for patellar chondromalacia depends on whether that condition is work-related. The only basis for Dr. Dent's opinion that Claimant has no permanent impairment for this condition is his conclusion that the condition was not causally related to Claimant's work injury; he did not otherwise dispute Dr. Bucksbaum's assessment of two percent. Having concluded that the condition is causally related to Claimant's work injury, *see* Conclusion

of Law No. 7 *supra*, I accept Dr. Bucksbaum's opinion and conclude that Claimant has a two percent whole person impairment for patellar chondromalacia.

12. Finally, Dr. Bucksbaum combined the impairment ratings for Claimant's ratable conditions into a single impairment rating of six percent of the whole person. Defendant has offered no evidence to the contrary as to the correct combination of these three ratings. Accordingly, I conclude that Claimant has a six percent whole person impairment for his right knee injury of January 12, 2022.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Defendant is hereby ORDERED:

(1) Pursuant to 21 V.S.A. § 618, to adjust Claimant's claim for patellar chondromalacia as a compensable workplace injury, including payment for reasonable medical treatment of the condition pursuant to 21 V.S.A. § 640(a);

(2) Pursuant to 21 V.S.A. § 648, to pay permanent partial disability benefits based on Dr. Bucksbaum's six percent whole person impairment assessment, less the amount already paid for Claimant's three percent whole person impairment for the residual laxity of his repaired PCL, with interest on any portion of permanent partial disability benefits that was not paid when due, as provided in 21 V.S.A. § 664;

(3) To pay necessary costs and reasonable attorney fees in amounts to be determined, provided a timely petition for costs and attorney fees is filed pursuant to 21 V.S.A. § 678.

DATED at Montpelier, Vermont this 14 day of November 2025.

_____
Kendal M. Smith
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 Court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§ 670, 672.