BEFORE THE BOARD OF INDUSTRIAL INSURANCE APPEALS
STATE OF WASHINGTON

IN RE: DAVID A. REEFF	) **DOCKET NOS. 10 12986 & 10 17685**
CLAIM NO. SA-23751	) **PROPOSED DECISION AND ORDER**

INDUSTRIAL APPEALS JUDGE: Janice A. Grant

APPEARANCES:

Claimant, David A. Reeff, by
Williams Wyckoff & Ostrander, PLLC, per
Wayne L. Williams

Self-Insured Employer, American National Can Co., by
Sather Byerly & Halloway LLP, per
Aaron J. Bass

Department of Labor and Industries, by
The Office of the Attorney General, per
Brian Dew, Assistant

In Docket No. 10 12986, the self-insured employer, American National Can Co., filed an appeal with the Board of Industrial Insurance Appeals on March 25, 2010, from an order of the Department of Labor and Industries dated January 20, 2010. The Department's January 20, 2010 order was received by the self-insured employer on January 25, 2010. This order affirmed the Department order dated December 21, 2009, directing the self-insured employer to allow the condition of ACL tear, left knee, and the treatment of it, and to take such action according to the law and the facts. The Department order is **AFFIRMED.**

In Docket No. 10 17685, the self-insured employer, American National Can Co., filed an appeal with the Board of Industrial Insurance Appeals on August 10, 2010, from an order of the Department of Labor and Industries dated July 21, 2010. In this order, the Department canceled the Department order dated February 11, 2010, determining that the self-insured employer had unreasonably delayed payment of time loss benefits to Mr. Reeff during the period of May 29, 2009 through June 7, 2009, in the amount of $1,580.74, and ordering the self-insured employer to pay an additional amount of $500 to Mr. Reeff. The Department order is **AFFIRMED.**

PROCEDURAL AND EVIDENTIARY MATTERS

On July 20, 2010, the parties agreed to include the Jurisdictional History as amended in the Board's record in Docket No. 10 12986. That history establishes the Board's jurisdiction in this appeal.

On January 12, 2011, the parties agreed to include the Jurisdictional History in the Board's record in Docket No. 10 17685. That history establishes the Board's jurisdiction in this appeal.

A hearing was held in this matter on January 12, 2011, before Industrial Appeals Judge Timothy Wakenshaw. David A. Reeff testified at that hearing. No objections or motions were raised. No exhibits were offered.

The perpetuation deposition of Patrick N. Bays, D.O., taken on December 20, 2010, was published upon receipt at the Board pursuant to the provisions of WAC 263-12-117(2). The deponent waived signature. No objections or motions were raised. No exhibits were offered.

The perpetuation deposition of Walter D. Fife, M.D., taken on December 21, 2010, was published upon receipt at the Board pursuant to the provisions of WAC 263-12-117(2). The deponent waived signature. All objections are overruled. No motions were made. No exhibits were offered.

The perpetuation deposition of Dean S. Ricketts, M.D., taken on January 11, 2011, was published upon receipt at the Board pursuant to the provisions of WAC 263-12-117(2). The deponent waived signature. No objections or motions were raised. No exhibits were offered.

The perpetuation deposition of Richard Martin, M.D., taken on February 4, 2011, was published upon receipt at the Board pursuant to the provisions of WAC 263-12-117(2). The deponent waived signature. One objection was made and is sustained: the objection on page 19, lines 17-19; page 19, line13, beginning with the word "You," through line 22, are stricken. No exhibits were offered.

ISSUES

1. Whether the claimant's condition of ACL tear, left knee, is proximately caused by the industrial injury (Docket No. 10 12986).
2. Whether the self-insured employer unreasonably delayed time loss benefits to the claimant from May 29, 2009 through June 7, 2009 (Docket No. 10 17685).

EVIDENCE PRESENTED

The self-insured employer, American National Can Co. (also referred to in the record as Rexam Beverage North America), presented the testimony of Patrick N. Bays, D.O., Walter D. Fife, M.D., and Dean S. Ricketts, M.D. The claimant, David A. Reeff, presented his own testimony as well as that of Richard Martin, M.D. All admitted evidence was taken into consideration. Relevant evidence will be restated to the extent deemed necessary to explain the rationale for the proposed decision and order.

David A. Reeff was 54 years old at the time of the hearing. Mr. Reeff stands five feet eleven and weighs about 240 pounds. He is right-hand predominant. On May 3, 2009, Mr. Reeff was employed as a shipping clerk at Rexam Beverage Can North America. His primary job duties included driving forklift, loading trucks, and tracking warehouse inventory. He has driven forklift for about 20 years. Mr. Reeff normally worked a repeating schedule of four 12-hour days, and then had four days off.

On May 3, 2009, Mr. Reeff injured his left knee as he was climbing onto a forklift, pivoted on his left foot, and felt pain and a pop in his left knee. He reported his injury to his foreman. He had pain and swelling in that knee. He continued working the rest of that day and the remainder of that week.

Mr. Reeff initially sought medical attention from his primary care physician the week of this incident, when his knee did not improve. He had a lot swelling and limited mobility. He understood that his physician did not treat on-the-job injuries, so he saw Dr. Curtis Uehara on May 26, 2009. 1/12/11 Tr. at 10. He recalled being off work for several days around the Memorial Day weekend, during which time he iced his knee and did nothing strenuous. He began treatment with Dr. Richard Martin, an orthopedic surgeon, on May 28, 2009. He was off work for a time, and returned to full-time work at some point during his treatment with Dr. Martin.

Prior to his May 2009 injury, Mr. Reeff had no problems with his left knee. He testified that he had no knee weakness and had not engaged in any team sports. He might have gone to the gym during that time frame, but was not sure. He testified that he does not exercise regularly. His hobbies include fishing and infrequent duck hunting.

Mr. Reeff was seen in separate independent medical examinations (IMEs) by Walter D. Fife, M.D., Patrick N. Bays, D.O., and Dean Ricketts, M.D., each at the request of a third party administrator. All three physicians are orthopedic surgeons who are nationally certified by their peers. The purpose of each of these IMEs was to provide an opinion regarding any injuries or

1 conditions causally related to Mr. Reeff's May 3, 2009 industrial injury, and any additional treatment
2 recommendations. Each IME included taking a patient history, reviewing medical records, and
3 conducting a physical examination of Mr. Reeff. Mr. Reeff's history of the injury and symptoms was
4 consistent in each exam.

5 Walter D. Fife, M.D., retired from active practice around 1999 and has conducted IMEs for
6 the last several years. Dr. Fife saw Mr. Reeff on one occasion, July 21, 2009. His records review
7 included records from Dr. Uehara and Dr. Martin, a digitized copy of the June 11, 2009 MRI films,
8 Dr. Bays' and Ricketts' IMEs, and Dr. Martin's discovery deposition transcript. At the time he
9 examined Mr. Reeff, Dr. Fife only had reference to the MRI report, not the MRI films. Mr. Reeff
10 reported that he sought medical attention about three weeks after his May 3, 2009 injury, and after
11 his vacation, when his knee did not improve. Fife Dep. at 12. On exam, Dr. Fife observed that
12 Mr. Reeff's left knee was swollen (effusion), and that Mr. Reeff walked with a bent knee. He found
13 some loss of muscle bulk in the left thigh, measuring 47 centimeters versus 50 on the right, and
14 found tenderness in the area noted on the MRI, but could not palpate the Baker's cyst reported on
15 that MRI.

16 Dr. Fife diagnosed a medial meniscus tear, which he described as a special tear in that the
17 meniscus was displaced, with evidence of an anterior cruciate (ACL) tear. He attributed the medial
18 meniscal tear to Mr. Reeff's industrial injury, but determined that the ACL tear was not related,
19 based on being inconsistent with the mechanism of injury. Dr. Fife testified that the action of
20 climbing into a forklift, sitting down and feeling a pop in the knee, is a fairly typical low energy
21 mechanism for a torn medial meniscus, but is not typical for an ACL tear, which is a high energy
22 injury that normally occurs in sports or when a person with rapid acceleration quickly changes
23 direction. Dr. Fife further opined that with an ACL tear, Mr. Reeff would probably not have been
24 able to continue working in an uninterrupted fashion, as Mr. Reeff reported he did, due to the
25 intense swelling caused by an ACL tear.

26 Dr. Fife noted that the MRI report identified both an ACL tear and a displaced meniscal tear.
27 Dr. Fife opined that "the meniscal tear fit very well with the mechanism of injury, but the anterior
28 cruciate tear did not." Fife Dep. at 17. He noted that the MRI report showed no remnant of the
29 anterior cruciate seam, which he would expect to see four weeks after the injury, and it did not
30 show bony edema, which meant that the ligament tear was not acute. He testified that many
31 people have stable knees, particularly if they do not participate in high-impact sports, and they may
32 be unaware that they have a tear. He opined that Mr. Reeff's ACL tear was already present at the

time of the industrial injury, and if it had been a low energy tear, there would probably be evidence of a bone bruise in the tibia, which is present in 70 percent of people with a torn ACL, and which was not present here. Fife Dep. at 20. Dr. Fife would have expected evidence of an ACL tear at the time Mr. Reeff underwent surgery, contrary to Dr. Martin's note that that tear was gone.

On cross-examination, Dr. Fife testified that he noted that the ligamentum mucosum (a small ligament inside of the knee) was likely torn, and that the Baker's cyst was partially ruptured. He testified that Mr. Reeff had a problem inside of his knee for many years in order a get a Baker's cyst. He recorded Mr. Reeff's report of hearing one pop at the time of his injury, and opined that typically with a tear of the cruciate and the meniscus or any other knee ligament, the person will hear two pops. Dr. Fife attributed the report of one pop to the meniscus tear. Fife Dep. at 28.

Patrick N. Bays, D.O., has a full-time active surgical practice, and conducts IMEs about 40 percent of that time. During the course of his practice, Dr. Bays has performed over two thousand ACL reconstructions and probably three times as many meniscus surgeries. Dr. Bays saw Mr. Reeff on one occasion, October 6, 2009. His records review included records from Dr. Uehara and Dr. Martin, the June 11, 2009 MRI films, and Dr. Fife's and Dr. Ricketts' IMEs.

On physical exam, Dr. Bays found a slight antalgic gait, and a slight limp when walking, favoring the left lower extremity. Mr. Reeff was able to walk on his heels and toes with some difficulty. He had a normal neurologic exam. On exam of the left knee, Dr. Bays noted a mild effusion to the left knee; severe instability with Lachman's testing (a test used specifically to diagnose ACL deficiency), indicating a plus three, or severe, rating for Mr. Reeff's left knee, a plus three, or severe instability on anterior Drawer test, and a trace positive Pivot Shift test, considered positive for an ACL deficiency. He found some mild discomfort to compression of the kneecap. Bays Dep. at 14.

Dr. Bays' diagnoses were (1) chronic ACL deficiency to the left knee, pre-existing and not related to the May 3, 2009 industrial injury; (2) left knee synovitis, associated with a moderate partially ruptured Baker's cyst, consistent with a chronic knee problem; (3) early medial compartment osteophytosis or arthritis, and moderate arthritis to the lateral compartment, the medial compartment, and the kneecap, as shown by the left knee MRI scan, all pre-existing and unrelated to the industrial injury; and (4) a bucket handle tear to the medial meniscus, displaced and stuck in the joint. Dr. Bays opined that both the bucket handle tear, and the surgery to repair that tear on August 11, 2009, were related to that industrial injury. He testified that Baker's cysts

typically take months, if not years, to develop, and Mr. Reeff's Baker's cyst was consistent with the other findings on the MRI scan report, particularly the synovitis.

On review of the MRI scan, Dr. Bays opined there was a chronic deficiency of the ACL, testifying that "there was absolutely no evidence of an anterior cruciate ligament." Bays Dep. at 20. Dr. Bays saw no evidence of an acute ACL tear on the MRI scan, where he would have expected the inside of the knee joint to be filled with blood. He noted that the blood is still present for months after such a tear, and there was no indication of any blood on the MRI scan. He further noted no evidence of any signal abnormalities to the ACL remnant, and in the absence of any signal, there was a greater than 95 percent probability that it was a chronic problem. He found no evidence of a bone bruise to the tibia, where he would expect to see such a bruise on the MRI scan if it was an acute tear. He testified that in 70 percent of acute tears, there will be MRI evidence of a bone bruise. He believed that Mr. Reeff had a chronic ACL tear and then suffered an acute bucket handle tear.

Dr. Bays testified that 66 percent of individuals with an ACL deficient knee have no symptoms and either require no treatment, or have treatment such as physical therapy, stabilization with a knee brace, and/or modification of their lifestyle, without the need for surgery. He testified that 33 percent of people with an ACL tear have significant symptoms and cannot overcome the instability without surgery. Bays Dep. at 25-26. He testified that nearly 70 percent of all acute ACL tears have a bone bruise, 30 percent do not.

Dean Ricketts, M.D., has been in private practice since 1975. Dr. Ricketts saw Mr. Reeff on one occasion, December 3, 2009. His records review included records from Dr. Uehara and Dr. Martin, the June 11, 2009 MRI films, and Dr. Fife's and Dr. Bays' IMEs.

Based on Mr. Reeff's report of the mechanism of injury, Dr. Ricketts opined that simply stepping up onto a seat, as Mr. Reeff did on the forklift, with some pivoting, would be a very unusual way to tear the ACL because it was not a high impact type of maneuver, although it is something that could happen. Ricketts Dep. at 11, 14. He further opined that it was unusual that Mr. Reeff would have waited approximately three weeks after that injury to first seek medical treatment. He testified that there were MRI findings of a bucket handle tear which was displaced into the intercondylar notch, which he noted was a quite painful condition, and to be coupled with an ACL tear from the same episode and still be able to continue to walk around for three weeks would be an unusual scenario. He testified that the MRI showed an absent ACL and normal bone marrow under the lateral tibial plateau, which he found significant in that the normal mechanism producing

an ACL tear involves significant impact on that plateau, producing compression and bone marrow edema. He concluded that since these factors were absent in the MRI, the injury to the ACL had occurred sometime prior to the industrial injury.

Dr. Ricketts also noted MRI findings of degenerative cartilage changes in the medial and lateral compartments, or chondrosis. He reviewed Dr. Martin's operative report, in which Dr. Martin found some mild degenerative changes in the medial compartment, and opined that the MRI finding of chondrosis was more significant than mild. On exam, Dr. Ricketts found a two plus positive Lachman's, which he described as a mild degree of anterior translation of the tibia on the femur, with a fairly firm end point.

Richard Martin, M.D., is an orthopedic surgeon nationally certified by his peers. After completing a sports medicine fellowship, Dr. Martin served as a sports medicine physician and director for several years, and has been in active private practice since 2003. Dr. Martin is Mr. Reeff's attending physician.

Dr. Martin first saw Mr. Reeff on May 28, 2009, and continued to see and treat Mr. Reeff for his knee conditions on at least 25 visits between that initial date and visits in 2010. Dr. Martin reviewed Mr. Reeff's history and symptoms at the May 2009 visit. He noted that Mr. Reeff had never had any prior knee problems or injuries. On physical exam, Dr. Martin found that Mr. Reeff lacked the terminal 10 to 15 degrees of full extension, he had significant effusion, limited flexion, and was globally tender to palpation. Dr. Martin found a trace Lachman with a soft endpoint, which was concerning for an ACL tear. It was difficult to get a positive pivot shift because his knee was sore and swollen and Mr. Reeff was guarded.

Based on the history and exam, Dr. Martin opined that Mr. Reeff had a meniscus tear. He further opined that he could not rule out a torn ACL based on the pop and pain in his knee at the time of injury, together with the size of the effusion and a locked knee. He included the ACL tear as a differential diagnosis at that time because the mechanism of injury was unusual for that type of tear. Martin Dep. at 8.

At the June 17, 2009 visit, Dr. Martin found a little less effusion and a little more extension, but Mr. Reeff still had a locked knee. He reviewed the MRI scan of June 11, 2009, and opined that Mr. Reeff had an ACL tear and a displaced bucket handle tear in his medial meniscus. Knee surgery on the medial meniscus was recommended, and was performed by Dr. Martin on August 11, 2009. Dr. Martin opined that "while the mechanism of injury was pretty low energy and

typically not the typical way we see ACL tears occur, it is not out of the realm of possibility that he could have torn it in that setting." Martin Dep. at 9-10.

At the September 2, 2009 postoperative visit, Dr. Martin clearly opined that Mr. Reeff had a complete tear of his ACL, and that it was related to his injury. He found chondral damage, particularly where the medial meniscus was torn and flipped up. He noted that for a 53-year-old man, Mr. Reeff had surprisingly limited arthritic changes. As of the September 30, 2009 visit, Mr. Reeff reported his first experience of an unstable knee. Dr. Martin opined that if his ACL tear was chronic, Mr. Reeff would have experienced that sensation in the past, which he had not. Dr. Martin found Mr. Reeff genuine. On exam, Dr. Martin found a very tense effusion. Mr. Reeff's knee was full of fluid because of the pivot shift, and was much more swollen at this visit than three weeks earlier, due to that episode of instability.

At the December 16, 2009 visit, Dr. Martin noted another episode of knee instability, and was concerned particularly because this time it was while Mr. Reeff was in a brace. On exam, he found a recurrent effusion that limited his range of motion and was tight. He still had a positive Lachman with a soft endpoint. At the February 24, 2010 visit, Dr. Martin had reviewed the surgical photographs, which showed only a stump where the ACL was, and also showed inflammation, and hemorrhage. Martin Dep. at 17-18.

Dr. Martin reviewed Dr. Fife's and Dr. Bays' IME reports, and also reviewed their deposition transcripts, as well as that of Dr. Ricketts. Dr. Martin disagreed with Dr. Bays' findings. Martin Dep. at 19-20. He testified as follows:

> Well, everybody, it appears, is hanging their hat on this concept that because there is not the classic bone bruise; i.e. edema in the bone in the lateral compartment that we typically see with acute high-energy ACL injuries, that by definition that means this cannot be an acute ACL tear. And that's just – that's false. Okay. So No. 1, I agree. The radiologist did not call the bone bruise; No. 2, I can pull up his MRI now and point to an area of edema in his lateral compartment; No. 3, he's got a medial compartmental bone bruise, also not commented on by the radiologist. We know that some ACL tears you get bone bruising in the medial compartment; not as frequently as lateral, but you can see it. So, again, you have a situation where there is nothing typical about this ACL tear.

Martin Dep. at 15-16. Dr. Martin testified that Mr. Reeff had returned to full duty work and was doing fine in his brace. He noted that as of the time of his deposition in this matter, Mr. Reeff is able to control his knee stability in the brace and he does not foresee another knee operation, noting that "an ACL reconstruction in this age group is not a great operation." Martin Dep. at 18.

DECISION

American National Can Co., a self-insured employer, filed the appeals on Docket Nos. 10 12986 and 10 17685. As such, RCW 51.52.050 and WAC 263-12-115(2)(a) and (c) require that American National Can Co. proceed initially with evidence sufficient to establish a prima facie case for the relief sought. *In re Michael Hansen*, BIIA Dec., 95 4568 (1996).

Left Knee ACL Tear Condition

Four credentialed orthopedic surgeons testified in this matter. There is no dispute that Mr. Reeff had a left knee ACL tear condition. The medical experts disagree as to what caused it. Through the testimony of Drs. Bays, Ricketts and Fife, the self-insured employer established a prima facie case that Mr. Reeff's left knee ACL tear was pre-existing and was not proximately caused by his industrial injury. Once the employer has presented a prima facie case that the Department order is incorrect, the burden shifts to the claimant to prove by a preponderance of the evidence that the Department order on appeal is correct. Injured workers are held to strict proof for their right to receive benefits under the Act. *Olympia Brewing Co. v. Department of Labor & Indus.*, 34 Wn.2d 498, 506 (1949) *overruled on other grounds in Windust v. Department of Labor & Indus.*, 52 Wn.2d 33, 39 (1958); *In re Christine Guttromson*, BIIA Dec., 55,804 (1981).

As Mr. Reeff's attending physician, Dr. Martin's opinion is entitled to special consideration. *Hamilton v. Department of Labor & Indus.,* 111 Wn.2d 569 (1988). Dr. Martin had the advantage of examining Mr. Reeff about three weeks after the industrial injury, much closer in time to the injury than any of the IME doctors. Dr. Martin continued to see and treat Mr. Reeff for his left knee conditions, including knee surgery, for about 25 visits over the course of a year and a half. The self-insured employer's doctors each examined Mr. Reeff one time.

Dr. Martin's opinion is that the left knee ACL tear was related to the industrial injury. He based his opinion on the lack of any history of knee problems, his review of the left knee MRI, showing bone edema, and his many examinations and surgery of the left knee. Dr. Martin initially gave a differential diagnosis for this condition, due to the low energy nature of the injury, but saw no other cause, and eventually clearly diagnosed the ACL tear as acute, not chronic, and related it to the industrial injury. I find Dr. Martin's opinion and reasoning persuasive. I conclude that even if Mr. Reeff's ACL tear pre-existed his May 3, 2009 industrial injury, his ACL tear condition should be allowed on the basis that a pre-existing asymptomatic condition that is aggravated by the industrial

injury and becomes symptomatic, entitles the worker to treatment. *See., e.g., In re Aaron Libby,* 04 20487 (2005).

I conclude that Mr. Reeff has proven by a preponderance of credible evidence that his left knee ACL tear condition was proximately caused or aggravated by his May 3, 2009 industrial injury. The Department order dated January 20, 2010, affirming a Department order of December 21, 2009 that directed the self-insured employer to allow the left knee ACL tear condition, and the treatment of it, is correct and should be affirmed.

Unreasonable Delay in Payment of Time Loss

The appeal in Docket No. 10 17685 concerns the issue of whether the self-insured employer unreasonably delayed or refused to pay time loss benefits to Mr. Reeff. The statutory authority for this issue is contained in RCW 51.48.017, which provides:

> If a self-insurer unreasonably delays or refuses to pay benefits as they become due there shall be paid by the self-insurer upon order of the director an additional amount equal to five hundred dollars or twenty-five percent of the amount then due, whichever is greater, which shall accrue for the benefit of the claimant and shall be paid to him with the benefits which may be assessed under this title. The director shall issue an order determining whether there was an unreasonable delay or refusal to pay benefits within thirty days upon the request of the claimant. Such an order shall conform to the requirements of RCW 51.52.050.

The Board has determined that ordinarily the test of whether a self-insured employer's delay or refusal to pay benefits is "unreasonable" within the meaning of RCW 51.48.017 is whether the self-insured employer had a genuine doubt from a medical or legal standpoint as to its liability for benefits. *In re Jackie Washburn,* BIIA Dec., 03 11104 (2004). The Board has also agreed with Professor Larson in his *Law of Workmen's Compensation*, Section 83.41(b)(2), that the employer's failure to pay due to a good faith belief that payment is not due does not warrant imposing a penalty. *In re Frank Madrid*, BIIA Dec., 86 0224-A (1987).

In the present case, the record contains no evidence directly bearing on the issue of the self-insured employer's delay in paying time loss benefits during the period of May 29, 2009 through June 7, 2009. In the absence of testimony supporting a genuine doubt regarding the claimant's time loss entitlement in this regard, I must conclude that the self-insured employer has not established a prima facie case for the relief sought in this appeal. Therefore, the Department order dated July 21, 2010 ordering the self-insured employer to pay an additional amount of $500 to

Mr. Reeff for unreasonably delaying time loss for the time period at issue is deemed correct and should be affirmed.

FINDINGS OF FACT

1. On June 17, 2009, the claimant, David A. Reeff, filed an Application for Benefits with the Department of Labor and Industries, alleging he sustained an injury to his left knee in the course of his employment with American National Can Co., on May 3, 2009. On June 25, 2009, the Department issued an order allowing the claim and ordering American National Can Co. to pay all medical and time loss benefits as may be indicated in accordance with the industrial insurance laws.

   On December 21, 2009, the Department issued an order directing American National Can Co. to allow the condition of ACL tear, left knee, and the treatment of it, and to take such action according to the law and the facts.

   On January 20, 2010, the Department issued an order affirming its December 21, 2009 order. American National Can Co. received the Department's January 20, 2010 order on January 25, 2010. On March 25, 2010, American National Can Co., through its attorney, appealed the Department's January 20, 2010 order. On April 16, 2010, the Board granted American National Can Co.'s appeal, assigning it Docket No. 10 12986.

   On February 11, 2010, the Department issued an order determining that the self-insured employer had unreasonably delayed payment of time loss benefits to Mr. Reeff during the period of May 29, 2009 through June 7, 2009, in the amount of $1,580.74, and ordered the self-insured employer to pay an additional amount of $500 to Mr. Reeff. On March 3, 2010, the self-insured employer protested the Department's February 11, 2010 order.

   On July 21, 2010, the Department issued an order cancelling its February 11, 2010 order and determining that Rexam Beverage Can Co. had unreasonably delayed payment of time loss benefits to Mr. Reeff during the period of May 29, 2009 through June 7, 2009, in the amount of $1,580.74, and ordered Rexam Beverage Can Co. to pay an additional amount of $500 to Mr. Reeff. On August 10, 2010, the self-insured employer appealed the Department's July 21, 2010 order. On August 17, 2010, the Board granted the self-insured employer's appeal, assigning it Docket No. 10 17685.

2. On May 3, 2009, David A. Reeff sustained injuries to his left knee in the course of his employment as a shipping clerk with American National Can Co. Mr. Reeff injured his left knee as he was climbing onto a forklift, pivoted on his left foot, and felt pain and a pop in his left knee. Mr. Reeff had significant left knee effusion, limited flexion, and pain. He

had a positive Lachman with a soft endpoint. He had MRI findings of bone edema in the lateral compartment.

3. Mr. Reeff sustained a medial meniscus tear, proximately caused by his May 3, 2009 industrial injury, and allowed by the Department. He also sustained a left knee ACL tear proximately caused or aggravated by his May 3, 2009 industrial injury.

4. The self-insured employer presented no evidence establishing a genuine doubt regarding Mr. Reeff's eligibility for time loss benefits from May 29, 2009 through June 7, 2009.

CONCLUSIONS OF LAW

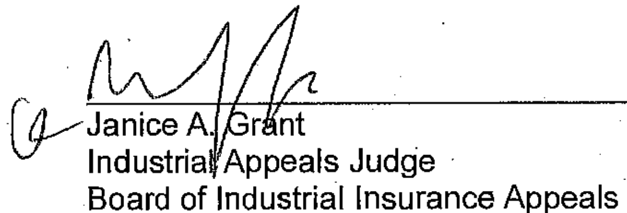
1. The Board of Industrial Insurance Appeals has jurisdiction over the parties to and the subject matter of these appeals.

2. The self-insured employer unreasonably delayed payment of time loss compensation benefits when due pursuant to the requirements of RCW 51.48.017.

3. The Department order dated January 20, 2010, affirming a Department order of December 21, 2009 that directed the self-insured employer to allow the left knee ACL tear condition, and the treatment of it, is correct and is affirmed.

4. The Department order dated July 21, 2010, ordering the self-insured employer to pay an additional amount of $500 to Mr. Reeff for unreasonable delay in payment of time loss benefits, is correct and is affirmed.

DATED: APR 18 2011.



Janice A. Grant
Industrial Appeals Judge
Board of Industrial Insurance Appeals