

2. Whether Claimant is entitled to reasonable and necessary medical care as provided by Idaho Code § 72-432, and the extent thereof;
3. Determination of Claimant's average weekly wage; and
4. Whether the Claimant is entitled to temporary partial or temporary total disability benefits (TPD/TTD), and the extent thereof.

CONTENTIONS OF THE PARTIES

Claimant contends her condition, *i.e.*, chronic pain, is caused by the industrial accident that occurred on June 15, 2001. She claims entitlement to past, present and future medical treatment with Catherine Linderman, M.D., along with four weeks of temporary total disability at a compensation rate based on an hourly wage of \$7.00.

Defendants contend Claimant had pre-existing chronic pain, and that the pain she continues to have is not caused by her work-related accident. Even if causation were established, Defendants argue that Claimant's medical treatment with Dr. Linderman was neither reasonable nor necessary. Finally, Defendants assert that they have paid Claimant's total temporary disability benefits based on her hourly wage of \$6.75 and Claimant is entitled to no additional income benefits.

EVIDENCE CONSIDERED

The record in the instant case consists of the following:

1. The testimony of Claimant and Tiffany Jolene Orr, offered at hearing;
2. Claimant's Exhibits 1 through 21, and Defendants' Exhibits 1 through 4, admitted at hearing;
3. The post-hearing deposition of Dr. Knoebel, with one exhibit;
and
4. The Industrial Commission legal file.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION - 2

The objections on pages 30 and 32 of Dr. Knoebel's deposition are overruled. After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

FINDINGS OF FACT

CLAIMANT

1. At the time of hearing, Claimant was 52 years of age and living in Kamiah, Idaho. She attended school through the seventh grade. Prior to her time-of-injury job, Claimant worked in a variety of physically demanding jobs, including: skinning cattle, sorting and processing potatoes, cooking in a school cafeteria, working as an aide at a care center, and working in a cafeteria. Subsequent to her work-related injury, Claimant provided occasional childcare for her grandchildren.

2. Employer hired Claimant on May 19, 2001 to do part-time janitorial work, *i.e.*, mopping, sweeping and cleaning bathrooms. Employer provided janitor services to other businesses under contract. Claimant was assigned to the Sears store in Idaho Falls, where Employer had one such contract. Claimant testified that on June 15, 2001, she mopped the mechanics' bathroom, mopping out of the room backward so as to not leave footprints on the floor. As she backed out of the room, Claimant tripped over a set of tires which were leaning against the wall. She fell to the ground, and "[m]y head and my back hit the corner of the – like the door frame." Tr., p. 26. Claimant picked herself up and called for help. A mechanic responded and told her that she was bleeding. Claimant was taken to the emergency room where a head wound was closed with seven staples. She did not return to work that day.

3. Claimant saw Stanley Cheslock, M.D., her family doctor, and David Simon, M.D., a

doctor recommended by Dr. Cheslock, for her continuing care. Dr. Simon sent Claimant to physical therapy which, she reported, did “[v]ery little” to help. *Id.*, at p. 31.

4. Claimant returned to work on July 4, 2001 and told Dana, her supervisor, that she was hurting. Dana advised her to go home and Claimant complied. Claimant next returned to work on July 11, and worked for two hours. Claimant next worked on August 7, 8, 10 and 12. She testified that she was in pain on those days, and that the pain was located “about six inches” down from the top of her left shoulder. *Id.*, at p. 35. She also complained of neck and head pain. Claimant testified that on those days she did “mostly dusting, cleaning the toilets” and avoided “mopping, sweeping, carrying any buckets.” *Id.*, at p. 36.

5. Claimant did not return to work again until August 31. She did not have a work release for the work missed between August 12 and August 31. Instead, she called in sick during that time period. Upon her August 31 return, Claimant continued to avoid the more strenuous portions of her job. Claimant testified that she was working approximately the same hours that she had pre-accident, but that, even with the self-imposed light duty, she “was struggling.” *Id.*, at p. 38. She did not ask for even easier work “because I seen [sic] Dana kind of getting upset because I wasn’t doing my, my job the way I was supposed to.” *Id.*, at pp. 38-39. Claimant continued working in the above fashion until March 31, 2002 when her employment with Employer ended.¹

6. Claimant testified that Community Care, an urgent care center where she sought additional treatment for her injuries, referred her to Dr. Linderman. Claimant first saw Dr. Linderman on November 1, 2002, even though she knew that Surety had refused to authorize the referral. Claimant stated that Dr. Linderman’s treatment has improved her pain “[a]bout 60 to 70

¹ There remains some dispute whether Claimant quit or was fired, although the Idaho Department of Labor determined in the course of an unemployment proceeding that Claimant

percent.” *Id.*, at p. 46. Claimant seeks continued treatment with Dr. Linderman for the pain that remains, including six inches down the back of the left shoulder-mid back, her left shoulder, the left side of her neck, and her left arm.

7. Claimant has been unable to pay Dr. Linderman’s medical bills. Her husband’s insurance company has paid for medication but not treatment because “. . . they said it’s a workman’s comp [sic].” *Id.*, at p. 57.

8. Claimant has not returned to work – other than childcare – “because I’m in constant pain.” *Id.*, at p. 55. She takes various medications that have been prescribed by Dr. Linderman, including methadone, Oxycodone, Skelaxin, and Trazadone. The first three medicines are taken daily. The dosage of methadone has increased over time. Claimant stated that Dr. Linderman has not identified a date at which she will be medically stable. “In fact, she told me that I probably - it [cessation of Claimant’s pain] could be never.” *Id.*, at p. 81.

9. Upon cross-examination, Claimant clarified that the original laceration is not painful, but her neck pain begins on her left side and radiates down into the left shoulder. After a confusing exchange with counsel, Claimant stated that the left arm pain of which she complains did not arise immediately after the accident; rather, the pain began sometime later and was the impetus for seeing Dr. Linderman.

10. On cross-examination, Claimant agreed that upon her return to work in September 2001, she worked the most hours for Employer that she ever had, “because I had missed a lot of work. So I needed the money, and I had to try and make up some of that.” *Id.*, at p. 69.

CLAIMANT’S WAGES

11. Claimant asserted that her initial wage was \$6.75 per hour and that after two weeks it

quit because of a shift change.

was to be raised to \$7.00 per hour. She averaged between 26 and 32 hours of work per week.

12. Laurie McCormick, Employer's human resources assistant, prepared a hand-written First Report of Injury or Illness (Form 1), on June 18, 2001. It indicates Claimant's hourly wage at the time of the accident was \$6.75. See Exhibit 1, p. 2. Claimant indicated the same wage on her Worker's Compensation Complaint. See Claimant's Ex. 2, p.1. The Referee finds the Form 1 and the Complaint to be the most reliable record of Claimant's time-of-injury wage.

MEDICAL RECORDS OF JOHN E. LILJENQUIST, M.D.

13. Dr. Liljenquist first saw Claimant on May 12, 1997. His chart note indicates that Claimant weighed 200 pounds and had recently lost 43 pounds. Claimant "was instructed to work as hard as possible on diet and exercise in order to lose weight." Claimant's Ex. 4, p. 7. At the same time, she was diagnosed with non-insulin dependent diabetes mellitus, was given medication, and told to see a dietician and seek some diabetes education. At hearing, Claimant asserted that she was *misdiagnosed* with diabetes in 1997, stating, "I was under a lot of stress." Tr., p. 49.

14. Dr. Liljenquist's June 13, 1997 note states Claimant had gained one pound and "[h]as a lot of posterior neck pain." Claimant's Ex. 4, p. 4. She was given a booklet on neck care that "outlined various neck and shoulder exercises designed to diminish neck muscle tightness and to relieve the headaches associated with neck muscle tension." *Id.*, at p. 5. Written comments also stress the importance of "patient's diabetic treatment regimen." *Id.*, at p. 4. At hearing, Claimant denied making any complaint of neck pain to Dr. Liljenquist on June 13, stating, "I was complaining of headaches." Tr., p. 65.

15. Dr. Liljenquist's final medical note of August 15, 1997 indicates Claimant lost five pounds, was given medication for her diabetes and, once again, instructed regarding diet and diabetes education. Dr. Liljenquist again assessed posterior neck pain, and, once again, Claimant

was given the neck care booklet. At hearing, when queried by counsel for Defendants as to whether she complained of neck pain on August 15, Claimant responded, “I’m not saying that I didn’t, but I didn’t have neck pain.” *Id.* Claimant asserted she “was under a lot of stress from like working hard.” *Id.*

MEDICAL RECORDS OF STANLEY CHESLOCK, M.D.

16. An industrial accident form included within Dr. Cheslock’s medical records indicates that Claimant “[d]eveloped a lump on my left wrist” while at work on February 15, 1998. Claimant’s Ex. 6, p. 10. A Worker’s Compensation Report dated March 6, 1998, shows that Dr. Cheslock treated Claimant for this injury and returned her to work with a limitation of minimal use of left hand. Claimant’s Ex. 6, p. 9. At the hearing, Claimant denied that she told Dr. Cheslock she had a work-related injury of the left wrist.

17. Dr. Cheslock’s medical records indicate that Claimant was treated for a fall down a flight of stairs on June 6, 1998. The notes indicate Claimant had pain in her right calf and right lower back. Claimant’s Ex. 6, p. 8. At hearing, Claimant testified that she fell down and injured the ribs on her left side when she slipped on the wooden steps at her trailer. Claimant stated the stairs were wet, she weighed about 210 pounds, and she was wearing thongs. Tr., p. 53.

18. Dr. Cheslock’s medical records dated January 12, 2002, indicate that on the previous day Claimant fell on the ice and “hurt her lower back.” Exhibit 6, p. 4. At hearing, Claimant stated that it was her left “butt cheek” that she injured. Tr., p. 54.

19. There are two Worker’s [sic] Comp/Auto Accident Medical Reports included in Dr. Cheslock’s notes that relate to Claimant’s June 15, 2001, work-related accident. Both reports are signed by Dr. Cheslock and indicate that Claimant “[m]ay not return to work pending further evaluation.” *Id.*, at pp. 1-2. One report has the date “7/23/01” crossed out with the date “7/30/01”

written in. The change is not initialed. The other report is dated 7/25/01 and has much more detail; however, the handwriting is difficult, if not impossible, to decipher. The last contact noted is July 26, 2001 – again for back pain.

MEDICAL RECORDS OF COLUMBIA EASTERN IDAHO REGIONAL MEDICAL CENTER

20. Claimant went to the emergency room at Columbia Eastern Idaho Regional Medical Center (ER) on May 6, 1997 complaining of “extreme shortness of breath, sometimes fast heart rate and anxiety.” Claimant’s Ex. 8, p. 1. Thomas C. Thompson, M.D., wanted to admit Claimant to “look at her possible diabetes.” He also “explained to her that this could be her heart as well.” *Id.* Claimant refused to be admitted.

21. On May 8, 1997, Claimant returned to the ER – once again complaining of chest pains. Her history as recorded by Scott Packer, M.D., was significant as to Claimant’s statement that she had a younger sister who died of liver disease from alcoholism and Claimant “admits that she does drink on a regular basis.” *Id.*, at p. 5.

22. On February 28, 2000, Claimant visited the ER and was examined by Iris A. Brossard, M.D. Dr. Brossard wrote:

[Claimant] was working today at the school cafeteria where she is employed when suddenly she noticed a numb sensation in her left neck which went down into her left arm.

Id., at p. 6. The past medical history taken by Dr. Brossard was significant for the following note:

The patient is an alcoholic and drinks 4-5 tequilas a day. She has never been in treatment for this. She suffers from depression. She also complains of continual left hip pain. She is obese.

Id. The family history is also pertinent: Claimant’s mother had diabetes mellitus and “[a]lcoholism runs very strongly in her family with one brother having hepatitis from this and three sisters having died in their late 40s or early 50s of alcoholism and cirrhosis of the liver.” *Id.* Dr. Brossard’s

impression was:

The patient with transient left sided numbness [sic] which could have been neurological or cardiac despite lack of chest pain. She has significant risk factors for stroke including hypertension, diabetes mellitus, obesity, alcoholism, and a strong family history of heart disease and strokes.

Id., at p. 7. Dr. Brossard referred Claimant to Kenneth E. Krell, M.D., for a consultation. Under “history of present illness,” Dr. Krell wrote: “She drinks about a half of a fifth of tequila a day up to a fifth on the weekends, including a fifth each day Saturday and Sunday.” *Id.*, at p. 9. His assessment and plan included in pertinent part:

Episode of minimal chest discomfort with left arm and left neck numbness, uncertain etiology; Type II Diabetes Mellitus requiring treatment; alcohol abuse and obesity requiring treatment.

Id., at pp. 10-11. Dr. Brossard wrote a Discharge Summary on March 2, 2000 wherein she noted Claimant met with a representative from Alcoholics Anonymous in the hospital in order to set up outpatient follow-up, and that Dr. Krell “took care of her prescriptions and she was instructed to follow-up with him.” *Id.*, at p. 12.

23. At hearing, Claimant testified that she did not participate in any formal treatment for her alcohol abuse, but stopped drinking after her hospitalization “because it scared me when I got sick.” Tr., p. 73. In response to whether she currently drinks, Claimant responded “No. I’ll have – no, I don’t. . . . I haven’t for a few months now. That [last drink] was at a party in Utah.” *Id.*, at p. 51.

24. On November 15, 2000 Claimant went to the ER complaining of abdominal pain. After being examined and scheduled for an outpatient CT of her abdomen, Claimant was given Vicodin and sent home. Significantly, the ER report states that Claimant “says she hasn’t drank [sic] for several years. . . . She did have a long history of alcoholism prior to that.” Claimant’s Ex. 8, p.

19.

25. The Emergency Room Report of June 15, 2001 concerns Claimant's current work-related injury. Initially, in "history of present illness," Claimant describes her fall over the tires and "denies any neck pain." *Id.*, at p. 35. The head wound was cleansed and stapled. Prior to discharge, Claimant "did complain of some neck and back discomfort." *Id.*, at p. 36.

EASTERN IDAHO REGIONAL MEDICAL CENTER PHYSICAL THERAPY RECORDS

26. Claimant had a physical therapy evaluation on August 10, 2001 for her June 15, 2001 work-related injury. The evaluation notes in pertinent part:

She states she has numbness and stabbing pain across upper back and down left arm.
Also she has numbness in both hands. . . . she is presently on restricted work duty of 15 pounds.

Claimant's Ex. 13, p. 2. A three-week program was set up with the goal that Claimant would become independent with home exercise, trigger point release techniques and use of moist heat, and would also "demonstrate correct sitting posture." *Id.*

27. Claimant attended seven out of the nine scheduled physical therapy appointments. Carol McClelland, the physical therapist, indicates in her August 29 note that Claimant "states she is able to manage pain with self release, as pain increases she is able to decrease it." *Id.*, at p. 11. In her August 31 note, Ms. McClelland indicates Claimant's "pain decreased with treatment." *Id.*, at p. 12. At hearing, Claimant testified that the physical therapy was of little use.

28. Claimant did not appear for her scheduled September 5 appointment, and no further appointments were scheduled.

MEDICAL RECORDS OF DAVID SIMON, M.D.

29. On August 1, 2001, Dr. Simon saw Claimant at Dr. Cheslock's request. Under "history of present illness," Dr. Simon noted: (1) Claimant reported that she had a work-related

injury and went to the ER where she received head staples; (2) Claimant was evaluated by Dr. Cheslock on June 15; (3) a radiology report from July 20 for x-rays of the cervical and thoracic spine indicated some scoliosis in the thoracic spine; and (4) Claimant “reports continued pain in her neck and upper back that she describes as unbearable.” Claimant’s Ex. 14, p. 4.

30. Dr. Simon referred Claimant to physical therapy for “myofascial therapy,” prescribed medications and kept her off work. *Id.*, at p. 5. *See*, Findings 26 through 28, above.

31. On August 7, Dr. Simon gave Claimant a restriction of “[l]ight duty work; no lifting over 15 pounds below shoulder level; no lifting over 8 pounds above shoulder height.” *Id.*, at p. 11.

32. On August 13, Dr. Simon indicated that Claimant was unable to work “at least until MRI is reviewed.” *Id.*, at p. 10. In his August 13 note, Dr. Simon recommends an MRI of the cervical spine, continuation of myofascial therapy, and no work “pending further testing.” *Id.*, at p. 3.

33. On August 28, Dr. Simon recorded the following impressions:
no obvious cervical radiculopathy based on the MRI . . .

. . . [though it is] unlikely that she sustained any intracranial injuries that are causing her continued problems, a head CT should probably be done . . .

Possible depression with numerous psychosocial stressors. . . . [Claimant] is raising her grandchildren because her daughter is now in prison. This is putting financial and emotional stress on her. It is difficult to determine how much is contributing to her ongoing physical problems.

Id., at p. 2.

34. Also, on August 28, Dr. Simon ordered a CT scan, prescribed medications, noting that Claimant “is mad that I have not been giving her more and stronger pain medications,” and released her to light duty work with this caveat: Claimant “should be capable for light duty work at

this time from a physical standpoint; emotionally I am not certain that she will be able to do this.”

Id. Lastly, he writes that Claimant “seems to have lost her confidence in my ability to adequately treat her medical problems,” and has requested another physician. *Id.*

35. On September 19, 2001, Dr. Simon made his final medical note. He noted that Claimant “reports continued pain in her left upper back and head. She had the CT scan of her head and this was normal.” *Id.*, at p. 1. In his impression, he writes:

It has been over three month since her injury and it is not clear to me why she has not improved. I think another opinion is needed. . . . I do not have any further treatment ideas or plans at this time.

Id.

CATHERINE L. LINDERMAN, M.D., MEDICAL NOTES

36. Dr. Linderman first saw Claimant on November 1, 2001, at which time Claimant complained of “left head, left shoulder, and arm pain.” Claimant’s Ex. 16, p. 74. Dr. Linderman noted a “history of alcoholism after a divorce [Claimant] had 10 years ago.” *Id.* Dr. Linderman started Claimant on methadone and gave her samples of Celebrex and Senokot. *Id.*, at p. 76.

37. Dr. Linderman’s next three notes show the following course of treatment: On July 8, Dr. Linderman “refilled [Claimant’s] methadone early due to her accidentally washing the bottle in the washing machine.” *Id.*, at p. 73. On November 21, Claimant was given more Celebrex and Senokot samples, and a prescription for Oxycodone. On December 4, Claimant was given Paxil samples and a refill on her methadone.

38. Dr. Linderman’s December 19, 2001 note indicates that Claimant presented “with severe left shoulder, neck and arm pain.” *Id.*, at p. 67. She reported a pain score of 7/10. The note continues in pertinent part:

On numerous visits with us, [Claimant] has adamantly stated that she did not want

trigger point injections. However, after spending time with her today, we have explained how we have had the injections ourselves and how much relief we have received from them. . . . she has consented to have trigger point injection today.

Id., at p. 67. Claimant cried during the injections. In addition to an ultrasound treatment, Claimant was given a prescription for Paxil noting that Claimant “believes this medication has drastically helped her,” samples of Zanaflex, and “an order to not do any heavy mopping at her job for the next 2 weeks.” *Id.*, at p. 67. Claimant was scheduled for a new patient visit with Ahyoung, Dr. Linderman’s pain physical therapist and more trigger point injections for the following week.

39. The notes from January 2, 2002 through April 29, 2002 indicate Claimant received a series of 13 trigger point injections. At times Claimant also received ultrasound and massage, and returned to physical therapy – though with much less frequency. Claimant’s reported pain score varied from a low of 4-5/10 to 8/10.

40. The April 10 note written by Jonnie P. Landis, CRNA, indicates that Claimant once again received an early refill of methadone “as her bottle of medicine was washed in the laundry.” *Id.*, at p. 51. Claimant was informed to be more careful with her medication as future early refills would not be authorized.

41. An unsigned April 22 note states in pertinent part: “[Claimant] is under a great deal of emotional stress today as she is not working and has not received as good of benefit [sic] as when she was previously working due to financial stress.” *Id.*, at p. 45.

42. Dr. Linderman’s May 8 note states that Claimant reported a pain score of 8/10 in her left neck and shoulder and was given trigger point injections. Dr. Linderman observed that Claimant “gets benefit with t[h]e trigger point injections, but they are not long lasting.” *Id.*, at p. 42. Dr. Linderman’s plan included scheduling Claimant for some stellate ganglion blocks x 4. Dr. Linderman also noted that Claimant no longer had insurance, stating, “[w]e would like to limit her

cost as much as we are able to. We will talk about having her clean our office and do some housecleaning for reimbursement of her debt.” *Id.*

43. Claimant received stellate ganglion blocks on May 13, 15, 21, and 23. On May 22, June 3 and 11, and July 8, Claimant received trigger point injections, ultrasound and massage. A July 30 note written by Ms. Landis indicates that Claimant had been referred to Jerry Garner, an acupuncturist, and that Claimant would continue her treatment with Garner.

44. On October 8, Claimant returned to Dr. Linderman reporting a pain score of 8/10. She was crying and upset about her finances and returning pain. Claimant was seen again January 28, 2003 reporting a pain score of 6/10, on June 25 reporting a pain score of 7/10, and on October 13 reporting a pain score of 6-7/10.

45. The October 13, 2003 note states in pertinent part: Claimant “returns stating her back pain has increased recently since the weather changes . . . now it gets very cold which increases her pain.” *Id.*, at p. 5. Dr. Linderman’s last note is dated February 5, 2004 and reports that Claimant presents with a pain score of 5/10. She was continued on her medication and advised to return in two weeks.

DEPOSITION TESTIMONY OF RICHARD KNOEBEL, M.D.

46. Dr. Knoebel, a board-certified orthopedic surgeon, saw Claimant on September 27, 2001 for an IME. In the body of his September 27, 2001 written report, Dr. Knoebel references medical records that were *Claimant’s*; however, in the medical record review summary, at the end of the report, the listed medical records belong to *another* patient. Subsequently, Dr. Knoebel was asked to review additional medical records that were Claimant’s. After this second medical record review, Dr. Knoebel wrote a report dated July 28, 2004, admitted as deposition Exhibit 1. Dr.

Knoebel's conclusions remained the same.

47. Dr. Knoebel testified as to his diagnosis of Claimant:

I diagnosed nonspecific left-sided neck shoulder and left upper extremity pain complaints without objective findings; and also I diagnosed a healed head laceration that occurred at the time of the industrial accident.

Dr. Knoebel Deposition, p. 13. He explained his zero impairment rating:

. . . [Claimant] had subjective complaints of symptoms, only without significant clinical findings. There was nothing accompanying her pain complaints, and when there are simply subjective complaints in the absence of objective findings, that does not fit the criteria for a permanent medical impairment or medical problem or injury.

Id., at p. 14. Dr. Knoebel opined that Claimant did not need additional medical treatment:

Rather, she had significant subjective complaints and pain amplification behavior which does not respond to treatment of physical abnormalities. So it's an error to continue assuming there are physical abnormalities present, and treat accordingly, when there is [sic] not. And in fact pain amplification was predominant.

Id. Dr. Knoebel imposed no work restrictions.

Dr. Knoebel's testimony provided the best discussion of why Dr. Linderman's opinions were not persuasive. He was not impressed with the medical treatment Claimant received from Dr.

Linderman, noting:

[Claimant] continued to have diffuse and migratory pain complaints, they kept changing. She had narcotic seeking behavior. . . .

The narcotics were continued for a prolonged period of time with no evidence that they were improving her function. She had continued chronic pain behavior and pain amplification behavior, with red flags associated with this, including a history of alcoholism, a history of depression. Yet she was continued on increasing narcotics, and on multiple and continuing trigger point injections without any evidence that there was improvement.

[sic] Then moved on to acupuncture, and [Dr. Linderman] discussed possible cervical injections and rhizotomies for treatment, all without any clear indication for those, and with no indication of any improvement from any of those treatments. [See Claimant's Ex. 16, p. 8.] That, again, points to the fact that there's psychosocial problems here, and chronic pain presentation associated with that, rather than any

physical or organic cause for the patient's pain.

Id., at pp. 18-19. He also noted inconsistencies in Dr. Linderman's opinion of Claimant's work ability, with Dr. Linderman first stating that Claimant was not able to work:

And yet May 8 of 02 records suggest that [Claimant] could do some janitorial work around Dr. Linderman's office to help pay for the bills, because she was apparently accumulating unpaid bills with Dr. Linderman for all of this care that she was receiving. That is – if the patient can clean Dr. Linderman's office, she could reasonably return to her work, which was cleaning buildings of the time of her industrial incident job, [sic] and that, too, is inconsistent.

Id., at p. 22. Dr. Knoebel noted that Claimant has long had a history of chronic pain:

Well, Dr. Linderman was treating the patient for neck and shoulder and upper back pain complaints, and the records from Dr. Lilenuist [sic] note similar pain in June of '97. Dr. Behrend noted those same complaints in November of 2000. [See Claimant's Ex. 11, p. 7.] And there's a history of muscle tightness and headaches, longstanding tension headaches and tension muscle and upper – neck and upper back pain, long before this industrial incident in a chronic condition.

So it's pretty unrealistic to think that those complaints are going to be going away. They are longstanding, and its part of the patient's chronic pain condition. So I don't think that it's reasonable to assume that any of the treatments that Dr. Linderman was offering were going to have an effect on those, which are essentially pre-existing conditions.

Id., at p. 24.

DISCUSSION AND FURTHER FINDINGS

48. **Causation.** Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. *See, Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). A claimant must provide medical testimony that supports a claim for compensation to a reasonable degree of medical probability. *Langley v. State, Industrial Special*

Indemnity Fund, 126 Idaho 781, 890 P.2d 732 (1995). “Probable” is defined as “having more evidence for than against.” *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). No “magic” words are necessary where a physician *plainly and unequivocally* conveys his or her conviction that events are causally related. *Paulson v. Idaho Forest Industries, Inc.*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979). Emphasis added.

In the present case, there is no dispute that Claimant suffered a work-related accident. However, Claimant’s head injury has healed; and, as Claimant clarified upon cross-examination, she has no pain from that particular injury. She does continue to complain of left-sided pain in her neck, shoulder, and back. Nonetheless, the record simply does not support a causal link between Claimant’s chronic pain and the work-related injury.

First, the medical records are replete with references to left-sided pain *prior* to the work-related accident. As far back as June 13, 1997, Dr. Liljenquist noted that Claimant “[h]as a lot of posterior pain.” And again, Dr. Liljenquist’s final medical note of August 15, 1997 noted neck pain. Claimant’s assertion that in the first instance she was “complaining of headaches” is not credible. Her assertion that in the second instance, “I’m not saying that I didn’t [complain of neck pain], but I didn’t have neck pain” is inherently incredible--Claimant essentially states that she made a false complaint. Moreover, Dr. Cheslock’s records of June 6, 1998 and January 12, 2002, indicate that Claimant “hurt her lower back.” At hearing, Claimant unpersuasively transforms back into “ribs” for June 6 and “butt cheek” for January 12. Tr., p. 54. *See also*, November 29, 2000 letter from Clint E. Behrend, M.D., to Jeffrey Baker, M.D., indicating that Claimant had “frequent neck tension.” Claimant’s Ex. 11, p. 7.

Second, the medical records do establish a credible cause for Claimant’s chronic pain condition other than the industrial injury--numerous medical records indicate a long-term pattern of

alcoholism and depression, as well as diabetes and obesity. A May 9, 1997 note by Dr. Packer, M.D., indicates that Claimant admits drinking regularly. On February 28, 2000, Dr. Brossard chronicled Claimant's alcoholism and depression. Dr. Krell, on the same day, also noted alcohol abuse and described consumption as a half of a fifth daily and a fifth on Saturdays and Sundays. Claimant denies any current alcohol problem, but her denial is unconvincing. She has never participated in a recovery program and testified at hearing that she drank at a party in Utah just a few months earlier.

The medical records of treating physician Dr. Simon are particularly revealing. He provided her with extensive and excellent medical care. He referred her to physical therapy; took her off work, and then gave her a light duty work restriction when needed. He ordered an MRI and CT scan. He also prescribed appropriate medication. Tellingly, Claimant was "mad" at Dr. Simon when he did not provide "more and stronger medications." Claimant's Ex. 14, p. 4. Significantly, Dr. Simon noted "possible depression with numerous psychosocial stressors" and the difficulty of determining its impact upon her physical problems. *Id.*, at p. 2. In the end, Dr. Simon was perplexed -- from a physical standpoint - as to why Claimant did not improve.

The September 27, 2001 IME, July 28, 2004 report and the deposition of Dr. Knoebel make good sense and are consonant with Dr. Simon's perceptions. He, too, finds that Claimant has a history of alcoholism and depression, he notes her "psychosocial problems" and finds no "physical or organic cause for her pain." Knoebel Depo., p. 19.

Finally, the Referee finds Claimant's testimony to be consistently at odds with the medical records. These discrepancies, the most blatant of which involve her continuing denial of her alcoholism and diabetes, are noted throughout the findings. Claimant's inconsistencies reflect far more than just a casualness of attention to accuracy.

In sum, the Referee finds that Claimant's chronic pain was not the result of her June 15, 2001 industrial injury.

49. Having found no causal link between Claimant's complaints of chronic pain and her industrial injury, all remaining issues, including reasonable medical care, average weekly wage, and entitlement to temporary total disability (TTDs) are moot.

CONCLUSIONS OF LAW

1. The condition for which Claimant seeks benefits, chronic pain, is not the result of her June 15, 2001 industrial injury.

2. All other issues are moot.

RECOMMENDATION

The Referee recommends that the Commission adopt the foregoing findings of fact and conclusions of law and issue an appropriate final order.

DATED This __27 day of April, 2005.

INDUSTRIAL COMMISSION

_____/s/_____
Rinda Just, Referee

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _6_ day of __May_____, 2005, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

DENNIS R PETERSEN
PO BOX 1645
IDAHO FALLS ID 83403-1645

DAVID P GARDNER
PO BOX 817
POCATELLO ID 83204-0817

djb

_____/s/_____

3. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this __6th_ day of __May_____, 2005.

INDUSTRIAL COMMISSION

_____/s/_____
Thomas E. Limbaugh, Chairman

_____/s/_____
James F. Kile, Commissioner

_____/s/_____
R.D. Maynard, Commissioner

ATTEST:

_____/s/_____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the _6_ day of __May_____, 2005, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

DENNIS R PETERSEN
PO BOX 1645
IDAHO FALLS ID 83403-1645

DAVID P GARDNER
PO BOX 817
POCATELLO ID 83204-0817

djb

_____/s/_____