

1. Whether the Claimant has complied with the notice limitations that are set forth in Idaho Code §§ 72-701-706 and whether those limitations were tolled pursuant to Idaho Code § 72-604;
2. Whether Claimant suffered a personal injury arising out of and in the course of employment;
3. Whether the condition for which Claimant seeks benefits was caused by the alleged industrial accident;
4. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury or cause;
5. Whether Claimant is medically stable and, if so, the date thereof;
6. Whether and to what extent the Claimant is entitled to the following benefits:
 - a. Medical care;
 - b. Temporary partial and/or temporary total disability benefits (TPD/TTD);
 - c. Permanent Partial Impairment (PPI);
 - d. Disability in excess of impairment (PPD);
 - e. Attorney fees; and
7. Whether apportionment for a pre-existing condition, pursuant to Idaho Code § 72-406, is appropriate.

CONTENTIONS OF THE PARTIES

Claimant contends that while working for Employer she fell down a flight of stairs injuring her back, her head, and her right eye. Her Employer was made aware of the accident several days after it occurred. She required treatment for her right eye, her back (including two back surgeries), shoulder surgery, and evaluation for a closed head injury. Claimant accrued

medical expenses totaling \$107,832.79. She was unable to work for fifty-five weeks, entitling her to temporary total disability (TTD) benefits. The permanent partial impairment (PPI) rating that she received did not include impairment attributable to her second back surgery or her shoulder surgery, increasing her PPI rating from 10% to 15%. Finally, Claimant asserts that Defendants' denial of her claim was unreasonable from the outset and entitles her to attorney fees pursuant to Idaho Code § 72-804.

Defendants argue that Claimant is not entitled to any compensation for medical care, TTD benefits, additional impairment, or attorney fees because she has failed to establish that the injuries for which she sought treatment were the result of her alleged workplace accident, and further, that she failed to comply with the notice and limitations provisions of Idaho Code §§ 72-701-706.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's Exhibits A through S, including a supplement to Exhibit L designated as L-1, and Defendants' Exhibits 1 through 24 admitted at hearing; and
2. The testimony of Claimant, Jack Dobson, Cindy Dobson, Christopher Smith, Michelle Scudder, Kelly Pennington, and Jana Pennington offered at hearing.

After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact, conclusions of law, and recommendation for review by the Commission.

PRELIMINARY MATTERS

A NOTE ABOUT CHRONOLOGY

Despite a voluminous record in this proceeding, it is problematical to ascertain with any certainty even the sketchiest outline of what really occurred and when. In part, this is due to the inability of Employer, Claimant, Claimant's daughter, and Claimant's husband, to tie relevant events to particular dates or to fix those relevant events in any temporal relation to one another. Reviewing the testimony of these witnesses is reminiscent of some Serlingesque universe where time does not flow from past to present to future and events occur at random points in a multi-dimensional space.

A NOTE ABOUT CREDIBILITY

In addition to the chronology issues, the record is rife with inconsistencies that cannot be reconciled or explained away in order to make findings. The Referee notes that Defendants' brief carefully identified where material facts were in dispute and supported their rendering of the facts with specific citations to the record. Claimant's briefing, on the other hand, totally ignored the material inconsistencies and disputed facts and tendered a recitation of facts that goes beyond advocacy and verges on the deceptive.

The considerable inconsistency among and between many of the witnesses creates significant issues of credibility and reliability, particularly with regard to Claimant, her daughter, and her husband, and to a lesser extent, Employer. Measuring the testimonial evidence against the medical and employment records leads to the ineluctable conclusion that the latter provide the only reliable evidence in this proceeding.

FINDINGS OF FACT

1. At the time of hearing, Claimant was 66 years of age and lived in Meridian, Idaho, with her husband, Jack, and adult daughter, Tina.

2. Claimant was a homemaker most of her life, raising seven children and two grandchildren. In her statement to Michelle Scudder, claims investigator for Surety, Claimant stated that she had worked briefly (less than a year) at a local nursing home in 1987, and in 1998 or 1999 she worked for short periods of time as a maid at two local motels. Claimant didn't work outside the home again until she joined her daughter working for Employer.

3. Claimant went to work for Employer on March 8, 2001. She worked Monday through Thursday for three to four hours per night.¹ Claimant earned \$7.50 per hour at the time of her alleged accident. Claimant and her daughter were responsible for cleaning a medical office after hours, including emptying trash, vacuuming, dusting, mopping and cleaning bathrooms and exam rooms.

4. Employer terminated Claimant in June 2002 for reasons unrelated to this workers' compensation claim. Claimant never sought alternative employment.

ACCIDENT

5. On the night of the alleged accident,² Claimant had finished cleaning and was returning the large garbage can to the utility room located downstairs at the medical office. The garbage can was mounted on a rolling cart or platform that allowed the can to be pushed from

¹ Claimant and her daughter both testified at hearing that they worked Monday through Friday. Employment records, which both conceded were most likely to be correct, showed that they actually worked four days a week, Monday through Thursday.

² The actual date of the alleged accident is uncertain. Claimant initially maintained that the accident occurred on November 21, 2001, and that date appears on the Complaint and Notice of Injury, among other records. At hearing, Claimant agreed that the relevant events occurred in mid-October, 2001. Tr., pp. 143-144.

room to room and also carried necessary cleaning supplies. At the landing part way down the stairs, the garbage can became separated from its rolling cart and Claimant fell or slid down the remaining steps, hitting her head and back.

6. It is unclear whether Claimant was working alone the night of the accident, or whether her daughter was also there. It is undisputed that no one witnessed the alleged fall.

7. Claimant picked up the items that had spilled from the garbage can, put everything away, finished her work and went home. Claimant testified that she felt okay, and experienced no pain as a result of the fall. A large bruise developed three or four days later.

8. Claimant told her daughter about the fall sometime after it occurred.

9. Claimant's daughter told Employer about Claimant's fall sometime after it occurred.

10. At some time after Claimant's fall, Employer either asked Claimant about the fall, or Claimant told Employer of the fall. Employer asked Claimant if she was all right and she replied that she was okay.

11. A First Report of Injury or Illness was prepared September 23, 2002 by Employer.

MEDICAL CARE

12. Claimant's first visit to any medical provider after the fall was on November 21, 2001 when she saw Dr. Lamers at America's Best Contacts and Eye Glasses (America's Best). She complained of a floater in her right eye. She told Dr. Lamers that she had fallen approximately one month earlier and that the floater had appeared one or two weeks after that. Claimant was given a prescription for corrective lenses and information regarding floaters--in particular that they could come and go. She was advised to follow up in three months and return

to the clinic sooner if she noticed any decrease in her visual functioning. Dr. Lamers' notes also indicate he suspected Claimant had borderline hypertension, and advised her to consult with her primary care physician on that account as well as to rule out a closed head injury that might have resulted from her fall. Dr. Lamers expressed no opinion regarding what might have caused the appearance of the floater, nor did he indicate in any way that it could have resulted from her fall the month before.

13. Claimant returned to Dr. Lamers at America's Best almost a year later (October 31, 2002), complaining of a cyst on her eyelid. She had developed Bell's palsy a week before the cyst appeared and was concerned that the two were related. The chart notes reflect that the two conditions were unrelated. Claimant was advised to see her primary care physician for treatment of her high blood pressure and the Bell's palsy.

14. On December 4, 2001, Claimant saw her primary care physician, James Weiss, M.D., at Primary Health for a general physical exam. This was Claimant's first visit to Dr. Weiss since her fall approximately six weeks before. Claimant complained of upper respiratory tract symptoms with sinus congestion, runny nose, and post-nasal drip with no fever. She was given antibiotics. Nothing in the chart notes for the December 4, 2001, visit reference a fall or other trauma or include complaints of back pain or head injury. Claimant specifically denied any symptoms of neck injury, pain or stiffness in her neck, head injury, or unusual headaches. The chart notes for that visit are significant for a previous history of chronic low back pain³ and a 1998 motor vehicle accident with fractures.

³ This chart note is consistent with the medical records as a whole which show back complaints dating back to at least 1987, and includes images of the lumbar spine in 2000 that revealed mild degenerative disk disease at L4-5.

15. Claimant sought no further medical care until she presented at the emergency room at St. Luke's Meridian Medical Center on March 18, 2002, complaining of right upper arm weakness and dizziness. While Claimant described her work-related fall, which she stated had occurred six months previously, and her visit to Dr. Lamers, she did not complain of any back injury. Claimant was thoroughly examined, placed on a heart monitor, and had a brain MRI to rule out a stroke or other brain abnormality. No abnormal findings were noted. Claimant was released to Dr. Weiss for follow up for possible ulnar nerve symptomatology, and it was suggested that Claimant have additional work-up of her dizziness and perhaps an ophthalmologic consult regarding the floaters in her right eye.

16. Claimant saw Dr. Weiss for the recommended follow up on March 26, 2002. The March 26 notes do not include any report of back pain nor do they reference the October 2001 fall.

17. On July 2, 2002, Claimant saw Dr. Weiss, complaining of low back pain. This was Claimant's first complaint of back pain since her workplace fall some eight-and-a-half months earlier. Significantly, the chart notes for this visit do not mention the fall, and do not relate the complaint to a workplace injury. The notes also address Claimant's prior history of back pain and that she had stopped taking the medication she had previously been prescribed for her low back pain. On exam, Claimant's back was non-tender.

18. Claimant returned to Dr. Weiss on August 2, 2002. She was complaining of increased pain of one week's duration in her thoracic spine. Significantly, the notes indicate that the back pain was not associated with any known trauma.

19. On September 3, 2002, Claimant returned to Dr. Weiss complaining of chronic back pain radiating into her leg. The physician record indicates that the back pain started "a long

time ago.” Defendants’ Exhibit 6, p. 5006. Lumbosacral x-rays taken that day were negative for scoliosis, spondylolysis or spondylolisthesis and were unchanged from imaging studies done in March 2000.

20. On October 7, 2002, Claimant saw Richard P. Sampson, R.N., D.C., complaining of lumbosacral and left lower extremity pain. She related the story of the fall to Dr. Sampson. Dr. Sampson treated Claimant for lumbar strain/sprain on eleven occasions from October 7 through November 8. She responded well to conservative care and made significant improvements in ambulation. She was scheduled for further treatment, but did not return to Dr. Sampson and he eventually released her from his care.

21. By the end of October 2002, Claimant was reporting new left sided low back pain with radiation to her buttock and leg. X-rays of Claimant’s lumbar spine taken October 30 showed a partially sacralized L-5 segment and mild anterolisthesis at L-4 and disc space narrowing at L4-5.

22. On November 19, 2002, Claimant had an MRI of the lumbar spine. Significantly, the MRI report states “[p]atient with complaint of low back pain and bilateral leg pain. No known trauma.” Defendants’ Ex. 6, p. 5082. The MRI report concluded:

1) Moderate central canal stenosis at L5-S1 due to bulging disk and degenerative facet disease. 2) Posterior and far left lateral disk bulge at L4-L5 associated with mild left neural foraminal narrowing. 3) Mild degenerative disk disease at L3-L4 through L5-S1.

Id., at p. 5083.

23. Dr. Weiss referred Claimant to Christian G. Gussner, M.D., for consideration for an epidural steroid injection. Of significance in the December 4, 2002, chart note is Claimant’s statement that her low back pain had begun four to five weeks previously without precipitating injury and had initially radiated into her left leg, and was now radiating bilaterally. Treatment

options offered included physical therapy and epidural steroid injections. Claimant opted to try both, but did not follow through with the physical therapy. An epidural steroid injection was done on December 6. Claimant's daughter called St. Luke's that evening and reported that Claimant had a severe headache. When Claimant returned to Dr. Gussner for follow up on December 17, she reported no improvement from the injection. Claimant did not return to see Dr. Gussner thereafter.

24. Claimant did follow through with Dr. Gussner's referral to physical therapy, however, and saw Stacey Scanlan, PT, on December 23, 2002. Claimant reported to PT Scanlan that her low back pain started in January 2002 and became worse in September 2002.⁴ She related the story of her fall to PT Scanlan, but indicated that she was not sure that the fall was related to her onset of low back pain. Claimant returned for physical therapy on December 26 and December 31, and then stopped treatment.

25. Claimant saw John E. Bishop, M.D., on January 2, 2003. Claimant's report to Dr. Bishop regarding her workplace fall varied significantly from her previous renditions of the event:

She states she slid down the stairs and thinks she hit predominantly on her tailbone, but also struck her head, and *since that fall has had significant low back pain* with radiating left hip and left thigh pain spreading in sciatic fashion down to her foot.

Defendants' Ex. 17, p. 8001 (Emphasis added). Claimant further advised Dr. Bishop that she had tried a number of epidural injections and physical therapy without relief.⁵ Based on Claimant's history and her recent imaging, Dr. Bishop recommended lumbar decompression.

⁴ This version of the timing of the onset of Claimant's low back pain is at odds with the version given to Dr. Gussner on December 4.

⁵ In fact, the medical records indicate she received one treatment with epidural injections and attended physical therapy twice.

26. Surety denied coverage of the recommended back surgery, but Claimant opted to proceed. Eventually, Claimant underwent a second back surgery. At some point in her recovery from the back surgery, she fell getting out of bed and injured her shoulder, which ultimately required surgery as well.

27. Dr. Weiss provided no opinion regarding the cause of Claimant's low back pain. In particular, he noted in a letter to Surety:

While I have multiple visits for her back pain documented in her record, I can find nothing that traces her back pain to an injury in November 2001. We have not seen her for any worker's [sic] compensation claims for her back pain.

Defendants' Ex. 6, p. 5085.

28. On August 29, 2004, J. Gerald McManus, M.D., performed a review of Claimant's orthopedic records. Dr. Manus's detailed and thorough report is identified as Defendants' Ex. 23. Dr. McManus opined in part:

[Claimant's] low back problems were not caused by, or more than transiently aggravated by the injury of mid October 2001. The linkage between the fall and her low back problems was made by [Claimant] and she asserted that it was progressive over the first year. The medical records do not support that linkage. Low back pain was not mentioned in contemporary records until 9 months following the mid October 2001 fall. The first assertion that the back pain was related to the October 2001 injury was not until nearly 1 year following the mid October 2001 fall.

Id. at p. 2. Dr. McManus went on to observe that Claimant had a poor memory of events, and that inconsistencies in her reporting to various caregivers resulted in much variation and inconsistency in the medical records. Dr. McManus noted that the medical records showed a long history of low back problems prior to the October 2001 fall, and that the slow progression of symptoms was consistent with the underlying degenerative lumbar disc disease that was evident on the imaging but inconsistent with a traumatic injury. He concluded that Claimant's treatment was reasonable but unrelated to her October 21 accident. Dr. McManus stated his

opinions to a reasonable degree of medical certainty.

29. Dr. Bishop was asked for his opinion on the cause of Claimant's low back problems, to which he replied: "Our records do not document major involvement by an industrial accident. . ."

DISCUSSION AND FURTHER FINDINGS

CAUSATION

30. Because the issue of causation is dispositive of all other issues raised in this proceeding, it is addressed at the outset.

The burden of proof in an industrial accident case is on the claimant.

The claimant carries the burden of proof that to a reasonable degree of medical probability the injury for which benefits are claimed is causally related to an accident occurring in the course of employment. Proof of a possible causal link is insufficient to satisfy the burden. The issue of causation must be proved by expert medical testimony.

Hart v. Kaman Bearing & Supply, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (internal citations omitted). "In this regard, 'probable' is defined as 'having more evidence for than against.'" *Soto v. Simplot*, 126 Idaho 536, 540, 887 P.2d 1043, 1047 (1994).

The Referee finds that Claimant did fall down the stairs at her workplace sometime in October 2001. Referee cannot find, however, that Claimant sustained any permanent injury as a result of that fall and that she has failed to carry her burden of proof that her low back problems or the floater in her right eye were in any way connected with her fall. Dr. McManus tendered the only medical opinion regarding causation, and he specifically found no medical causal connection between the fall and Claimant's low back symptomatology. Claimant's primary care physician and her back surgeon could not relate her back complaints to a traumatic workplace

injury. No medical professional tendered any opinion that either explicitly or implicitly connects the vision problem or the low back complaints to the fall.

Medical testimony is not required to prove causation. Medical records can be competent evidence on the question of causation. *Langley v. State*, 126 Idaho 781, 786-87, 890 P.2d 732, 737-38 (1994). But when a Claimant relies upon medical records to prove causation, the medical records themselves must “establish the cause of injury to a medical probability.” *Jones v. Emmett Manor*, 134 Idaho at 162, 997 P.2d at 623 (2000). The medical records relied upon do not have to include the magic words “medical probability” or “more likely than not.” What is required is that the medical evidence plainly and unequivocally conveys the opinion that events are causally related. See, *Jensen v. City of Pocatello*, 135 Idaho 406, 412, 18 P.3d 211, 217 (2000), citing *Paulson v. Idaho Forest Indus., Inc.*, 99 Idaho 896, 901, 591 P.2d 143, 148 (1979).

Nothing in the medical records supports a plain or unequivocal opinion that Claimant’s low back and visual problems were causally related to her October 2001 fall. And, as noted at the outset of these findings as well as by Dr. McManus in his review of the medical records, the incredibility of the Claimant casts doubt about the medical records, at least insofar as they rely on Claimant’s subjective reports of events.

OTHER ISSUES

31. Because there is no finding of causation, all remaining issues are moot.

CONCLUSIONS OF LAW

1. The conditions for which Claimant seeks compensation were not causally related to her workplace fall in October 2001.
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 3rd day of June, 2005.

INDUSTRIAL COMMISSION

/s/_____

Rinda Just, Referee

ATTEST:

/s/_____

Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of June, 2005 a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

ROGER BROWN
PO BOX 6190
BOISE ID 83707-6190

JAMES A FORD
PO BOX 1539
BOISE ID 83701-1539

djb

/s/_____

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

DATED this 10th day of June, 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 10th day of June, 2005, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

ROGER BROWN
PO BOX 6190
BOISE ID 83707-6190

JAMES A FORD
PO BOX 1539
BOISE ID 83701-1539

djb

/s/ _____