

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

SHERICE RACEHORSE-GOULD,)
)
 Claimant,)
)
 v.)
)
 SHOSHONE BANNOCK TRIBES,)
)
 Employer,)
)
 and)
)
 STATE INSURANCE FUND,)
)
 Surety,)
 Defendants.)
 _____)

IC 2001-510854

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND RECOMMENDATION**

Filed: July 27, 2007

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Hailey, Idaho, on November 8, 2006. Richard N. Gariepy of Ketchum represented Claimant. R. Todd Garbett of Preston represented Defendants. The parties submitted oral and documentary evidence and filed post-hearing briefs. The matter came under advisement on May 17, 2007, and is now ready for decision.

ISSUES

The issues to be decided are:

1. Whether the condition for which Claimant seeks benefits was caused by the industrial accident;

2. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury/condition;
3. Whether and to what extent 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. Retraining;
 - e. Disability in excess of impairment; and
4. Whether apportionment for a pre-existing or subsequent condition pursuant to Idaho Code § 72-406 is appropriate.

At the outset of the hearing, the parties agreed that issues regarding whether there was an accident and injury in the course of employment and whether Surety had a subrogation claim, which were included in the Notice of Hearing, were no longer at issue.

While reviewing the hearing issues at the start of the proceeding, Claimant asked that attorney fees pursuant to Idaho Code § 72-804 be added as an issue for hearing, because it had been identified in the Complaint. Defendants objected to the addition of the attorney fees issue at the hearing, noting that the Commission had issued numerous hearing notices that did not include the issue, and it had not been discussed during the pre-hearing conference. Defendants also noted that the Complaint did not include several of the legal issues that were listed in the hearing notices, so if Claimant wished to rely on the Complaint for the issues, impairment and disability should not be considered at hearing. The Referee noted that she was not inclined to allow the addition of attorney fees as a hearing issue, but allowed the parties to brief the issue.

The Commission issued notices of hearing for this proceeding on October 17, 2003, January 16, 2004, February 7, 2005, May 22, 2006, and finally, on August 23, 2006. All

requests for calendaring came at Claimant's behest, and none of them identified attorney fees as an issue to be heard. Inexplicably, the October 17, 2003, notice did include attorney fees as an issue. That hearing was vacated and reset to April 22, 2004 on the same issues by the January 16, 2004, notice. The April 22 hearing was subsequently vacated at the request of the parties. No ensuing request for hearing (and there were three) included attorney fees as an issue. Although three later hearing notices were issued, no party contacted the Commission regarding the issues identified in the hearing notices. The issues were reviewed at a pre-hearing conference held on October 23, 2006, and Claimant agreed that the issues were correct and complete.

Claimant's motion at hearing to add the issue of attorney fees is denied. One of the purposes of issuing a Notice of Hearing is to allow the parties to review the issues and ensure that they are complete and correct. Issues often change between the filing of a complaint and a hearing, and the Commission relies upon the Notice of Hearing and the pre-hearing conferences to assure that all parties are in accord with what will be covered at hearing. Here, Claimant had numerous opportunities to include attorney fees as a hearing issue by identifying the issue in her requests for calendaring. Thereafter, Claimant had an opportunity to review the notices of hearing and request that the issue be added. Claimant had a final opportunity to raise the issue during the pre-hearing conference, but failed to do so. Given that Claimant never filed a pleading pursuant to Rule 8, J.R.P., that sought attorney fees, and her subsequent failure to raise the matter despite multiple opportunities to do so, Defendants were entitled to presume that attorney fees were no longer at issue, and an attempt to reassert them at the eleventh hour was prejudicial.

CONTENTIONS OF THE PARTIES

The parties agree that Claimant sustained an injury as a result of an accident on July 18, 2001, that resulted in two cervical spine surgeries—the first on September 10, 2001, and

a second on September 2, 2002. Surety has paid appropriate medical and income benefits for those two procedures.

Claimant asserts that she needed an additional surgery on February 5, 2005, to remove the hardware that was placed in her cervical spine during the September 2001 and September 2002 surgeries, and that medical care related to her February 2005 surgery is compensable, along with appropriate income benefits, including additional impairment and disability in excess of her impairment.

Claimant claims that she also suffered a shoulder injury as a result of the July 2001 industrial accident that eventually required surgical intervention. She is entitled to medical care, time loss, and income benefits as a result of the shoulder injury and related treatment.

Defendants contend that Claimant was medically stable from her two work-related cervical surgeries and working at her time-of-injury position when she sustained a non-industrial cervical injury on June 15, 2004. It was this non-industrial cervical injury that led Claimant to the University of Utah where she ultimately had an additional surgery. It was only after this additional surgery that Claimant was placed under restrictions that precluded her from her time-of-injury position. Because the June 15, 2004, event was non-industrial and not an aggravation of her previous injury, Defendants are not liable under the workers' compensation laws for medical care, time loss, or other income benefits resulting from the June 15, 2004, event.

Defendants also argue that Claimant's shoulder surgery was not related to her July 18, 2001, industrial injury, so it is not compensable.

Claimant responds that her February 5, 2005, cervical surgery was inextricably linked to her July 18, 2001, injury since the hardware that was removed was the hardware that was placed during the two subsequent cervical surgeries, and it is absurd for Defendants to suggest that the

surgical removal of hardware, which ultimately led to permanent restrictions, loss of her time-of-injury job, additional impairment, and disability beyond her impairment, was not related to the original industrial injury.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Claimant's Exhibits 1 through 24, admitted at hearing;
2. Defendants' Exhibits 1 through 33, admitted at hearing; and
3. Testimony of Claimant and Dolores Siebert, taken at hearing.

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

1. At the time of the hearing Claimant was 48 years old, was married to Verlon Gould, and was living in Pocatello, Idaho, with her sister.

2. Claimant graduated from high school and attended Idaho State University (ISU) majoring in accounting. Subsequent to her last cervical surgery, Claimant changed her major to general studies with the goal of obtaining an advanced degree in linguistics. Claimant's vocational goal is to work with the Shoshone and Bannock tribes to preserve their traditional languages. At the time of hearing, Claimant expected to receive her undergraduate degree upon successful completion of the one class she was taking.

VOCATIONAL HISTORY

3. Claimant worked as a bookkeeper and in accounting positions until she returned to Fort Hall in 1997 and was hired by the Tribes. She worked as a credit board chairperson and a budget coordinator and an accountant before taking her time-of-injury position as an

administrative assistant to the director of the tribal enrollment department. Claimant held that position until her termination for medical reasons on October 8, 2003.

MEDICAL HISTORY

4. Claimant has an extensive medical history, including ongoing mental health concerns of long-standing. Diagnoses have included bi-polar disorder, psychosis, paranoia, histrionic and borderline personality, post-traumatic stress disorder, severe depression, anxiety, and somatization tendencies. She has a past history of substance abuse that impacts her current medical treatment.

5. Claimant's spinal complaints date back to at least 1996, at which time imaging showed significant degenerative disc disease. By 1998, Claimant had marked degenerative changes in her cervical and thoracic spine with mild degenerative changes in her lumbar spine. In July 1998, Dr. Blair performed an anterior cervical discectomy and interbody fusion with an autologous bone graft and cervical plating at C4-5 and C5-6 as the result of a non-industrial injury. Claimant made a normal recovery, and subsequent imaging showed that a solid fusion had been achieved.

6. In May 1999, Dr. Blair performed a posterior lumbar interbody fusion at L4-5 using an autologous bone graft, fusion cage, and pedicle screws. The need for the lumbar fusion was not the result of any industrial injury. Claimant contracted a post-operative infection, but otherwise made a good recovery.

JULY 2001 INDUSTRIAL INJURY AND SUBSEQUENT MEDICAL CARE

7. On July 18, 2001, Claimant was unloading old office equipment from the top of several file cabinets in preparation for relocating the cabinets. While lifting a typewriter over her head, the typewriter slipped, hitting Claimant on the head and left shoulder. Claimant kept the typewriter from falling and handed it to a co-worker. As a result of the incident, Claimant

experienced increasing neck pain radiating into her upper extremities. Claimant sought care at Bannock Regional Medical Center on July 21. She was diagnosed with thoracic and cervical strain and possible disc herniation, taken off work, and referred back to Dr. Blair.

8. Dr. Blair saw Claimant on August 2. X-rays showed a solid fusion at C4-5 and C5-6. Dr. Blair ordered an MRI, which showed a herniated disc at C6-7, one level below her previous fusion. Dr. Blair recommended conservative treatment, including cervical epidural steroid injections (ESI). Claimant received no relief from the ESI.

9. On September 10, 2001, Dr. Blair performed an anterior cervical discectomy with interbody fusion at C6-7, removing and re-inserting the hardware from Claimant's 1998 cervical fusion and extending the fusion through C-7 with an additional anterior plate and screws.

10. Claimant continued to complain of neck pain following surgery, and on November 8 she also reported pain into her shoulder blades, which Dr. Blair localized to Claimant's trapezial region. X-rays showed good positioning of the hardware and bone graft, but no solid fusion. Dr. Blair recommended continued conservative treatment for Claimant's neck and shoulders, and continued her release from work.¹

11. Claimant began treating with Eric C. Roberts, M.D., a physiatrist, on January 24, 2002. Dr. Roberts prescribed narcotic pain medications and recommended a comprehensive treatment plan. Before Claimant returned to Dr. Roberts for her second visit, she participated in the opening ceremonies of the 2002 Winter Olympics in Salt Lake City, Utah.

¹ A cryptic note in the November 8, 2001 chart note (Defendants' Ex. 7, p. 41) indicates that Dr. Blair was still concerned about Claimant's "back" and ordered an MRI of her *lumbar spine* with and without contrast. Nothing in the chart note indicated that Claimant was complaining of low back pain. Except for post-operative changes associated with her 1999 lumbar fusion, the MRI was normal, and Dr. Blair diagnosed "post laminectomy syndrome" and referred Claimant to Dr. Eric Roberts, a physiatrist.

Her activities at the Olympics increased her pain level such that she used her entire month's worth of pain medications in a week.

12. When Claimant returned to Dr. Roberts on February 11, he was concerned about her overuse of the narcotics. At that point, he made her sign an agreement regarding treatment of chronic pain with narcotic analgesics. Dr. Roberts also started implementing his comprehensive treatment plan that included trigger point injections, physical therapy, narcotic pain medications, neuropsychological testing, and ergonomic consultation regarding her workplace.

13. Claimant had a second series of trigger point injections on February 26. She reported that she was pleased with her progress after the first series of injections and her return to physical therapy.

14. Claimant followed up with Dr. Blair on March 15, and also told him that she was improving under Dr. Roberts' treatment. X-rays taken that day showed a delayed fusion at the distal fusion site. Dr. Blair wanted to give Claimant another two months to see if a solid fusion could be obtained.

15. Claimant had additional trigger point injections with Dr. Roberts on March 20, April 5, and April 25. On each visit, Claimant reported improvement in her neck and shoulder pain and her headaches.

16. On April 24, Claimant underwent an independent medical evaluation (IME) performed by Rheim B. Jones, M.D., an orthopedic surgeon, at the request of Surety. At the time of her IME, Claimant reported "pain primarily located in the neck, shoulder blade, shoulder joint, left side of face, right upper leg, lower back, and migraine headaches." Defendants' Ex. 4, p. 15. Claimant described the pain as continuous and variable between 6 and 10 on a ten-point pain scale. Following an extensive examination, Dr. Jones opined that Claimant's C6-7 herniation

was a result of her July 18, 2001, work injury, and that she was at maximum medical improvement (MMI) as of April 24, 2002.

17. Dr. Jones awarded Claimant an impairment rating of 13% of the whole person, apportioned 10% to her first, non-industrial two-level cervical fusion, and 3% for her additional level fusion related to the July 2001 industrial accident. He further opined that she could return to her clerical work without any restrictions.

18. Claimant's last visit to Dr. Roberts was May 6. At that time, Dr. Roberts had received and reviewed a copy of Dr. Jones' IME. Additionally, Dr. Roberts did some sleuthing and learned that Claimant had not been compliant with her physical therapy appointments, had no-showed for two scheduled appointments with Mark D. Corgiat, a neuropsychologist, and had presented at the emergency room of a local hospital where she was advised to increase her OxyContin dosage in violation of her treatment agreement with Dr. Roberts. Dr. Roberts was prepared to discharge Claimant from his care and refer her to another pain-management program, but before he could do so, Claimant left his office without explanation and only returned sometime later to pick up her coat and engage in a verbal contretemps with her physical therapist.

19. On May 6, Dr. Roberts wrote to Surety regarding the termination of the doctor/patient relationship and to comment on Dr. Jones' IME report. With regard to the IME, Dr. Roberts took issue with Dr. Jones' finding that Claimant was at MMI, especially in light of the fact that she was being followed for a non-union of her C6-7 fusion. He also disputed Dr. Jones' opinion that Claimant could return to work, noting that he had never had a patient with a cervical fusion, much less two fusions, who could return to work at a medium exertion level. Finally, Dr. Roberts disagreed with Dr. Jones' impairment rating, asserting that Claimant

would have 25% whole person impairment as a result of her *first* non-industrial two-level fusion plus whatever impairment resulted from the fusion of the additional level that was industrial.

20. A copy of Dr. Jones' IME report was sent to Dr. Blair, and on May 13 he returned it to Surety having indicated without comment that he agreed with Dr. Jones' findings. Also on May 13, Dr. Blair saw Claimant, who continued to be symptomatic. He noted that all imaging indicated pseudarthrosis at C6-7. He ordered a myelogram and post-myelogram CT to further delineate the cause of her symptoms. The results of the testing supported his diagnosis.

21. Claimant underwent a third cervical surgery on July 2, 2002, consisting of a posterior cervical fusion at C6-7 and segmental posterior instrumentation at C-5, C-6, and C-7 with plates and an autologous bone graft.

22. Claimant made a good recovery and was released to light-duty work on September 18, 2002, with temporary lifting restrictions of not more than ten pounds and not more than five pounds overhead. Claimant returned to work at her time-of-injury position that month. Dr. Blair found Claimant at MMI as of December 5, 2002, gave her a 14% whole person impairment rating, apportioning 13% to her pre-existing non-industrial injury, and released her without restrictions.

LEFT SHOULDER/INTRASCAPULAR COMPLAINTS

23. On March 4, 2003, Claimant saw Richard A. Wathne, M.D., an associate of Dr. Blair, regarding her ongoing complaints of left shoulder pain. By history, Claimant's left shoulder had been involved in her July 2001 industrial accident. X-rays taken that day showed some mild narrowing of the acromioclavicular (AC) joint. Dr. Wathne diagnosed left shoulder impingement syndrome with possible underlying small rotator cuff tear related to her industrial injury. Dr. Wathne ordered an MRI, which appeared to show a small full-thickness tear

involving the anterior portion of the supraspinatus tendon. Based on the MRI, Dr. Wathne recommended an arthroscopic examination of Claimant's left shoulder.

24. Dr. Wathne performed arthroscopic surgery on Claimant's left shoulder on April 7. The post-operative diagnosis was chronic left shoulder impingement syndrome with no evidence of rotator cuff tear.

25. Claimant made a good recovery and was released to return to light-duty work on April 15. By May 13, Claimant was free of shoulder pain, but was still complaining of intrascapular pain on the left side. Dr. Wathne had nothing else to offer Claimant, and referred her back to Dr. Blair.

26. Claimant returned to Dr. Blair on May 21 with intrascapular pain complaints. The chart note states, "As far as her neck goes, she states she is doing very well and happy with her functional status." Defendants' Ex. 7, p. 70. X-rays of Claimant's cervical spine showed a solid fusion and good positioning of the hardware. In an effort to identify the etiology of Claimant's intrascapular pain, Dr. Blair ordered a myelogram and post-myelogram CT. The testing showed a herniation above the level of her first cervical surgery at C3-4. Dr. Blair reviewed the results with Claimant on June 2, recommending another series of ESI.

JUNE 15, 2003 INCIDENT

27. On June 16, before she could start the ESI therapy, Claimant returned to see Dr. Blair. She reported that on the morning of June 15, her husband heard her neck pop and Claimant awoke in severe pain. X-rays taken at the emergency room showed no change from previous films. Dr. Blair believed that Claimant's symptoms were the result of inflammation and merited observation. He took her off work for a week.

28. On July 31, Dr. Blair released Claimant to return to work with the following restrictions: no typing and no lifting greater than five pounds. An identical letter, dated

August 1, permits Claimant to return to work August 23 under the same restrictions. Claimant and Employer discussed Claimant's return to work in a position that complied with her restrictions, but Employer made no light-duty work offer.

29. By letter dated October 8, 2003, Employer advised Claimant that it did not have any positions available that were consistent with her restrictions, and terminated her employment effective that day.

SUBSEQUENT EVENTS

2004

30. In December 2003 Claimant's physician at the Indian health clinic referred her to the neurosurgery department at the University of Utah Hospitals and Clinics (UUHC). Claimant was seen at UUHC on February 11, 2004. Two residents, Paul Klimo, M.D., and Todd McCall, M.D., did her initial work-up. A number of staff physicians in the adult neurosurgery practice were also involved with her case.

31. On her first visit, Claimant's presenting complaint was neck pain radiating down both arms to the back of her hands. She rated the pain as 8/10. Claimant reported her extensive history of cervical surgeries, and noted that she had been doing well until the June 15, 2003, incident. Her neurologic exam was unremarkable, and Drs. Klimo and McCall expressed some concern about a failed fusion at C6-7. Claimant had a CT myelogram on February 13. The report noted the presence of bony fusion at C4-5, C5-6 and C6-7 and went on to note:

There is no evidence of the [sic] to suggest hardware failure or loosening. The posterior fusion screws breach the anterior cortex of the articular pillars bilaterally at several levels. There is no evidence for resultant neural exit foramina narrowing.

Defendants' Ex. 25, p. 22.

32. Claimant returned to UUHC on February 25 for x-rays of her cervical spine. Drs. McCall and Klimo reviewed the results of the CT myelogram and the x-rays and expressed concerns about an incomplete fusion at C4-5 and C5-6, as well as possible nerve root involvement at C5-6.

33. Claimant returned to see Dr. Klimo on March 10. The chart note for that date indicates that Dr. Klimo had discussed Claimant's case with Joel D. MacDonald, M.D., one of the staff neurosurgeons, and they were unclear as to what factors were causing Claimant's neck pain, as there were no obvious non-unions, and adjacent cervical segments were intact. Dr. Klimo posited several possible causes for Claimant's neck pain, including the anterior fusion, an incomplete fusion, poor placement of the posterior screws, and poor cervical posture.

34. Although he could not identify the etiology of Claimant's complaints, Dr. Klimo offered Claimant two surgical options: Remove the posterior hardware or remove posterior and anterior hardware and redo the anterior fusion from C4-C7. Claimant opted for the more comprehensive surgical option and it was scheduled for March 22, 2004. Insurance coverage of the proposed surgery was in question, and Claimant did not return to the UUHC until December.

35. At the same time that Claimant was seeking consultation at UUHC regarding her cervical spine, she was seeking frequent treatment at the student health clinic at Idaho State University for her mental health issues, including a severe bi-polar attack.

36. As a result of Claimant's visits to UUHC, Surety sent her to Paul J. Montalbano, M.D., for another IME. Dr. Montalbano examined Claimant on June 18, 2004. He reviewed her extensive medical records, including the CT myelogram of February 2004, and ordered a bone scan. Dr. Montalbano expressed concern that the imaging was consistent with anterior and posterior pseudarthrosis. Dr. Montalbano opined:

It is my recommendation, and strong recommendation, that [Claimant] undergo a neuropsychological evaluation, preferably by Dr. Robert Calhoun, prior to any further surgery. Although I believe her pseudarthrosis is symptomatic, I believe that there are nonorganic causes which are certainly influencing her symptomatology. If after evaluation these issues [sic], if present, are appropriately addressed, I would recommend further surgical intervention. Surgical intervention would be a combined approach that would include removal of all prior instrumentation and redo fusions at the above levels [C4-C7]. I would recommend using autologous bone graft taken from her posterior iliac crest.

* * *

[Claimant's] current symptomatology is related to her pseudarthrosis from all three of her operations. I do not believe that her symptomatology is related to any other incidents outside of her operative experience.

Claimant's Ex. 15, p. 3.

37. Claimant did see Robert F. Calhoun, Ph.D., on August 4, 2004. When Dr. Calhoun asked Claimant about her treatment goals, he noted her response as follows:

The patient states that she would like to have another surgery. She states she expects herself to be "*as good as gold*" after the surgery. Meaning, that all the pain would be gone following surgery. She believes that she still has pain because she has hardware that is "*switching positions*." She believes that she does have permanent damage in her neck because she has noticed that her voice has changed. She believes she has the wrong size hardware in her neck. She states she also has two pieces of bone that are not fused.

Defendants' Ex. 16, p. 8. Emphasis in original. Dr. Calhoun made several recommendations:

1. At this time, because there are multiple personality, cognitive, affective, and behavioral factors impacting [Claimant's] pain problem and associated level of debilitation, it is recommended that the medical findings which support surgery or other invasive medical procedures be unequivocal.
2. Because of [Claimant's] current high level of psychological instability combined with multiple reinforcers for her ongoing pain behavior, it is advisable to avoid high-risk medical interventions with this patient until she stabilizes psychiatrically.
3. [Claimant] also shows a preexisting history of having difficulties with medical compliance. This is likely to be an issue in the future following further invasive medical procedures. Relatedly, [Claimant] has not responded well to surgery in the past whether it has been on her back or shoulder.
4. Because [Claimant] has such a complicated preexisting psychiatric history, it is impossible for me to conclude that the injury of July 18, 2001, is the

predominant factor above all others combined which is contributing to her current level of psychiatric instability and chronic pain syndrome.

5. Thus, it is recommended, on a self-procured basis, that [Claimant] seek out treatment with a trained pain psychologist, with the goal being her achieving a state of psychological stability, understanding the importance of medical compliance following surgery, and having specific return to work goals prior to undergoing further invasive medical procedures. Such treatment is likely to require a minimum of 12 to 18 visits.

Id., at pp. 12-13.

38. Claimant continued to see mental health providers at the ISU student clinic erratically throughout the summer and early fall. Chart notes do not indicate that Claimant received any therapy, merely that her mental status and medications were monitored. In October, the ISU counseling and testing center referred Claimant to the ISU psychology clinic. Claimant appeared for an intake appointment on October 14 and returned for one appointment on November 8.

39. On October 19, Claimant saw Mark D. Corgiat, Ph.D., at Surety's request. In his report to Surety, Dr. Corgiat reported:

The evaluation does reveal a significant psychological overlay to [Claimant's] current pain difficulties. This was discussed in detail with [Claimant] She is not very open to the idea of pursuing any form of chronic pain treatment other than surgical intervention. The potential benefit of combination biofeedback and cognitive-behavioral pain interventions were discussed in detail. Eventually, [Claimant] did acknowledge that there may be some benefit to pursuing that form of treatment at least in terms of reducing the chronic pain at this point. She does not accept the idea of psychiatric instability. However, she does acknowledge that she has significant anxiety and depression. She does not accept the notion of histrionic and borderline personality characteristics.

At this point, [Claimant] has agreed to participate in psychotherapy/counseling. She is scheduled for treatment on a once per week basis. The treatment will include biofeedback interventions, as well as cognitive-behavioral psychotherapy/counseling approaches.

Defendants' Ex. 15, p. 9. There is no record that Claimant ever attended any counseling sessions.

40. In November 2004, Claimant checked herself into Portneuf Medical Center complaining that her neurosurgeon (Dr. Montalbano²) had refused to refill any of her medications. She had not been able to find anyone to prescribe for her, and after she ran out she became suicidal. Claimant was in the hospital for seven days. Upon discharge, Claimant was scheduled for follow-up medical management at the Indian health services clinic. She was also scheduled for counseling through ISU student health and additional counseling with an individual named Steve Brown. There are no medical records from the Indian health clinic, ISU student health, or Steve Brown regarding mental health counseling. It is unknown whether Claimant ever pursued the recommended counseling.

41. On December 15, 2004, Claimant returned to UUHC neurosurgery complaining of severe neck pain with symptoms similar to those she had previously reported. The resident who saw Claimant made the following note in her chart:

[Claimant] is very frustrated today saying that she does not have anyone to prescribe her pain medications for her neck and in addition she is primarily interested in finding someone to sign her disability paperwork today. . . . [Claimant] is very emotional that she has not been getting care for her neck pain and she is very adamant that she does need surgery to relieve her neck pain, and says today that she has a new insurance [sic] and would like to reexplore this option.

Claimant's Ex. 14, p. 30. Additional flexion/extension x-rays of the cervical spine were ordered and it was determined that once the films were received the residents would meet with Dr. MacDonald to review Claimant's case. Claimant was advised that she would be contacted once her case had been reviewed with Dr. MacDonald.

2005

42. The next relevant medical record is the February 15, 2005, operative report from

² Claimant had seen Dr. Montalbano at Surety's request for an IME. Dr. Montalbano was never Claimant's treating physician. At this same time, Claimant was being treated at both the ISU student health center and the Indian health center.

UUHC. Dr. MacDonald, assisted by two residents, removed Claimant's posterior and anterior plates and screws. Germane findings included that Claimant had a solid anterior bony fusion from C4 to C7, that significant scarring in the cervical neck region made the anterior surgical approach difficult, that the posterior lateral screws were easily removed, appeared loose, and did not have strong fixation, and finally, that there was no evidence of abnormal motion in the fused portion of Claimant's cervical spine. Claimant was discharged from UUHC on February 19.

43. Claimant returned to UUHC for follow-up on March 16, 2005. She reported that her neck pain had improved significantly. She was advised to avoid lifting more than five to ten pounds, and to walk and lightly jog on an elliptical machine and slowly increase her activity with time as tolerated. This is the last medical record from UUHC.

44. On August 8, 2005, Claimant started treating with William S. Huneycutt, M.D., upon referral from the Indian health center. Claimant complained of pain in her neck at the base of her occipital bone, as well as pain in her midscapular region just to the left of the midline. Claimant also complained of generalized pain through her operative site radiating into her left upper extremity, over her shoulder and biceps, down into her forearm and into her left hand. She reported to Dr. Huneycutt that her pain prevented her from participating in school or work duties, particularly sitting or lifting her arms for any length of time. Claimant advised Dr. Huneycutt that she was under the care of Dr. Kevin Hill, a physiatrist, in Pocatello, but there are no medical records from Dr. Hill, nor was his involvement discussed at hearing. Dr. Huneycutt wanted to review her medical records from UUHC and assess her bony fusion, so he ordered cervical x-rays in extension and flexion as well as another CT scan.

45. Claimant returned to Dr. Huneycutt on September 12.

The patient reports she remains markedly symptomatic with neck pain, particularly in her posterior cervical musculature and some numbness and tingling, which radiates over her arms predominantly on the left side and to the

second, third, and fourth digits of her left hand. The patient reports that her symptoms have been exacerbated by sitting in a classroom and looking up. She also requested I fill out numerous forms for her insurance status.

Defendants' Ex. 26, p. 4. Review of the imaging showed a slight loss of disc height at C3-4, with some slight slippage that was within normal physiologic range. There was no evidence of abnormal motion at any of her previously fused segments, no evidence of neural foraminal narrowing, and good evidence of a bony fusion at all operative levels. Dr. Huneycutt diagnosed "[c]hronic neck pain following multiple neck surgeries." He eschewed additional surgical intervention and referred Claimant to Marc J. Porot, M.D., for a series of ESI. He also recommended massage therapy, physical therapy, and cervical collar immobilization, and considered that a TENS unit might be effective.

46. Claimant met Dr. Porot the same day, but did not have her first treatment until October 11, at which time Dr. Porot performed an ESI at C7-T1 with sedation. Claimant had additional treatments October 25 and November 8.

47. Claimant saw Dr. Huneycutt on November 22 and reported that she had excellent relief following the series of ESI, and was essentially pain-free. Dr. Huneycutt identified one trigger point that was painful, and injected it with Marcaine, providing immediate relief. Dr. Huneycutt also wrote a prescription for physical therapy. This is the last medical record from Dr. Huneycutt. There is nothing in the record to indicate that Claimant participated in physical therapy.

2006

48. Claimant had another series of three ESI in May 2006 with Dr. Porot. According to Dr. Porot's records, the second series was not as effective as the first series. Claimant's last injection was on May 16, 2006. This is also the last medical record from Dr. Porot.

Pierre M. Dreyfus, M.D., IME

49. On September 12, 2006, Claimant had an IME with Pierre M. Dreyfus, M.D., a board-certified neurologist. Dr. Dreyfus issued his report on October 20, 2006. Dr. Dreyfus took Claimant's history, reviewed medical records,³ and performed an examination.⁴

Dr. Dreyfus opined:

[Claimant's] need for surgery on her neck, including the need for hardware removal and left shoulder surgery on February 15, 2005, are the result of the injury she sustained on July 18, 2001. The incident of June 15, 2003, consisting of neck pain was the aggravation of her injury of July 18, 2001. The incidents of June 15, 2003 and March 7, 2005,⁵ consisting of neck pain were the aggravations of her injury of July 18, 2001.

Claimant's Ex. 2, p. 3. Dr. Dreyfus determined that Claimant was at MMI for her cervical spine on or about May 15, 2005, and at MMI on her left shoulder on July 7, 2003. Dr. Dreyfus calculated an impairment rating for Claimant of 8% of the whole person for her July 18, 2001 injury (13% for her spine, plus 5% for her left shoulder, minus 10% for her first, non-industrial, cervical surgery).

Richard T. Knoebel, M.D., IME

50. Richard T. Knoebel, M.D., conducted an IME of Claimant at the request of Surety on October 19, 2006. Dr. Knoebel's in-depth report was prepared the same day. Although the report alludes to an attached summary of the medical records and diagnostic tests that Dr. Knoebel reviewed, that summary was not included in the record. Dr. Knoebel's review of Claimant's imaging studies only included those performed after her last cervical surgery in

³ Dr. Dreyfus did not identify the particular medical records he reviewed in reaching his conclusions.

⁴ Although the pages in Dr. Dreyfus' report are consecutively numbered, most of the portion of the report that included the clinical exam and objective findings is missing. See Claimant's Ex. 2, pages 2-3.

⁵ On March 7, Claimant fell at school while ascending stairs and had immediate pain in her cervical spine. X-rays were negative. Claimant was treated and released with a prescription for Norco.

February 2005. At the time of the IME, Claimant was complaining of neck pain, upper back pain, bilateral trapezial pain, and bilateral anterior clavicular pain. Claimant was neurologically intact, but demonstrated loss of range of motion in her cervical spine and in her left shoulder.

51. Dr. Knoebel opined as follows:

- Claimant's lumbar and shoulder surgeries were remote in time from, and not related to, her July 18, 2001 cervical injury;
- The July 18, 2001, industrial accident resulted in a permanent aggravation of Claimant's pre-existing cervical disease that necessitated three subsequent cervical surgeries, including the February 2005 surgery to remove hardware;
- Claimant was medically stable and able to return to work with a fifteen pound (occasional) and ten pound (frequent) lifting restriction and no bending, squatting, kneeling, climbing, pushing, or pulling;
- Claimant sustained a 4% whole person impairment as a result of the July 18, 2001 industrial accident;
- No further active medical treatment, including ESI, is reasonable or indicated as a result of Claimant's July 18, 2001, industrial injury; a self-directed exercise program and continued use of OTC Aleve as needed for pain is all that is reasonably necessary.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

52. The crux of the dispute in this case pertains to Claimant's February 2005 cervical surgery at UUHC, at which time surgeons removed all of the hardware from Claimant's previous fusions. Claimant asserts that because the hardware removed was put there as a result of her July 18, 2001, industrial injury, the need for the surgery was clearly related to the industrial injury and is compensable. Secondary to the dispute about the last cervical surgery is a dispute about whether Claimant's left shoulder surgery was also related to her July 2001 accident.

February 2005 Cervical Surgery

53. Defendants argue that Claimant's February 2005 surgery was not related to her

July 2001 industrial accident, and support their position by noting the following points:

- Claimant was working at her time-of-injury position and doing well prior to June 15, 2004;
- On June 15, Claimant reported a non-industrial incident that coincided with the onset of increased pain;
- Claimant has not worked since June 15, 2004;
- It was pain resulting from the non-industrial aggravation on June 15 that led Claimant to seek care at UUHC;
- No physician stated with reasonable medical probability that it was Claimant's hardware that was causing her neck and intrascapular pain;
- It was the June 15 incident and Claimant's last surgery that resulted in the imposition of restrictions that prevent Claimant from returning to work;
- Within six months of her last surgery, Claimant was seeking medical care from Dr. Honeycutt for the same symptoms that she reported before undergoing the last surgery.

54. 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). Once a claimant has met his burden of proving a causal relationship between the injury for which benefits are sought and an industrial accident, then Idaho Code § 72-432 requires that the employer provide reasonable medical treatment, including medications and procedures.

55. The Referee finds that the need for Claimant's February 2005 cervical surgery was related to her July 2001 industrial injury. Defendants' analysis on this issue is logical and is

coherent with a commonsense understanding of the medical records. How could Defendants be liable for Claimant's last surgery when Claimant reported that she was doing well and working at her time-of-injury position prior to the June 15 incident that ultimately sent her to UUHC? In late May or early June, imaging ordered by Dr. Blair showed that Claimant had a *new* herniation at C3-4, one level above her first, *non-industrial* fusion. There is nothing in the record relating that new herniation to any industrial cause. Defendants' argument that this herniation was caused by the June 15 event, or that this herniation was the subject of surgical intervention at UUHC, is not supported by the record. Nothing in the record establishes that Claimant *ever* received *any* treatment for this C3-4 herniation.

Although imaging showed posterior screws that were not optimally placed, none of the imaging showed any impingement and no doctor stated with any reasonable probability that the screws were the cause of Claimant's pain. And, in fact, within six months of the surgery to remove the screws, Claimant was complaining of the same neck and shoulder pain she had before the surgery.

Further, Claimant's psychiatric problems were substantial contributors to her medical conditions. Given a choice of surgical or non-surgical treatment, Claimant always opted for the surgery, however risky, and despite clear warnings that outcomes were unpredictable. Claimant clearly had unreasonable expectations regarding surgical outcomes, as evidenced by her statements to Dr. Calhoun that she would be "good as gold" and pain free if she could just have surgery. Since Claimant had never had a good surgical outcome from any procedure, this continued stubborn optimism is baffling, and given her propensity to seek invasive solutions to her medical problems, her persistent failure to comply with her physicians' directives is inexplicable.

Finally, Claimant's self-referrals made consistent and comprehensive care for her condition impossible. Once Claimant stopped treating with Dr. Blair, none of her subsequent medical providers had a comprehensive view of her case. Without complete medical records, providers relied on Claimant's history, which was not always accurate. This resulted in duplicative testing, and the possibility of duplicative prescriptions for controlled substances, and the cost of Claimant's care was needlessly increased as a result.

56. But then there are the medical opinions. All of Surety's physicians opined that Claimant's February 2005 surgery was related to her July 2001 industrial accident, as did Claimant's IME physician, Dr. Dreyfus. Drs. Knoebel and Dreyfus both saw Claimant after her February 2005 surgery, when they had the benefit of the findings from that procedure. Although it turned out that virtually every doctor who saw or treated Claimant prior to the February 2005 surgery was wrong in opining that Claimant had a failed fusion, the consensus remained that the surgery was necessary because of the previous two fusions related to her July 2001 accident.

In a more typical workers' compensation case, multiple medical experts may disagree as to medical causation. Here, however, there is no credible medical opinion that supports Defendants' position. However persuasive the commonsense analysis may be from a lay perspective, it fails in the face of substantial competent medical evidence to the contrary.

Shoulder

57. The Referee finds that Claimant's shoulder surgery was not related to her July 2001 industrial accident. While Dr. Wathne originally believed that Claimant had a torn rotator cuff, his operative notes indicate that Claimant had chronic left shoulder impingement syndrome and no evidence of a tear. These findings do not support an acute injury such as would have occurred during the industrial accident in July 2001. Dr. Knoebel notes that Claimant's left shoulder complaints began eighteen months after the accident, and that Dr. Wathne relied on

Claimant's reported history when he opined that the shoulder was related to the industrial accident. Dr. Knoebel's opinion regarding the etiology of Claimant's shoulder pathology is persuasive.

TTDs

58. Idaho Code § 72-408 provides for income benefits (temporary total and temporary partial disability, TTDs or TPDs) for injured workers during the period of recovery. Having found that Claimant has a compensable claim, she is entitled to income benefits from the date she last worked until she is declared medically stable.

59. Defendants paid TTDs from July 19, 2001, through May 1, 2002, presumably the date Surety received Dr. Jones' opinion that Claimant was at MMI as of April 24, 2002. Since Claimant was not, in fact, medically stable between May 2, 2002 and her third surgery, she is entitled to TTDs for the period of May 2, 2002, through July 1, 2002, a period of 8 weeks and 5 days. Defendants restarted Claimant's TTD benefits on July 2, 2002, the date she underwent her third cervical surgery, and continued to pay TTD benefits through September 24, 2002, at which time Claimant was released to light-duty work.

60. Claimant was taken off work again on June 16, 2003. She was cleared to return to light duty on August 23, but Employer did not make a suitable light-duty work offer. Claimant remained off work, and was terminated on October 8, 2003. On March 16, 2005, UUHC essentially released Claimant from care with some restrictions, although the chart note does not specifically state that she was released to return to work. However, Claimant's own IME physician, Dr. Dreyfus, opined that Claimant was at MMI on May 15, 2005. Claimant is, therefore, entitled to TTDs from June 16, 2003, through May 14, 2005, a period of 99 weeks, 6 days.

PPI/APPORTIONMENT

61. “Permanent impairment” is any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or non-progressive at the time of the evaluation. Idaho Code § 72-422. “Evaluation (rating) of permanent impairment” is a medical appraisal of the nature and extent of the injury or disease as it affects an injured worker’s personal efficiency in the activities of daily living, such as self-care, communication, normal living postures, ambulation, elevation, traveling, and non-specialized activities of bodily members. Idaho Code § 72-424. When determining impairment, the opinions of physicians are advisory only. The Commission is the ultimate evaluator of impairment. *Urry v. Walker Fox Masonry Contractors*, 115 Idaho 750, 755, 769 P.2d 1122, 1127 (1989).

62. Claimant was given impairment ratings for the July 2001 industrial accident as set out in the table below:

Physician	Date	Rating for July '01 Accident (Whole Person)	
		Cervical	Shoulder
Jones	4/24/02	3%	
Blair	12/5/02	1%	
Dreyfus	7/12/06	3%	5%
Knoebel	10/19/06	4%	

Given that Claimant had two more surgeries after the 2002 ratings, the ratings from Drs. Dreyfus and Knoebel represent the best picture of Claimant’s impairment. Dr. Dreyfus’ 5% impairment for the shoulder is disregarded as the Referee has determined that the shoulder surgery was not related to the industrial accident. Dr. Knoebel’s evaluation of impairment is thorough and fully explained in his report. The Referee accepts his rating of 4% whole person impairment related to the July 2001 cervical injury. Claimant is entitled to 20 weeks at \$272.25 for PPI benefits

totaling \$5,445.00. Defendants have already paid PPI benefits of \$3,832.02, leaving a balance due of \$1,612.98.

RETRAINING

63. At the time of her injury, Claimant was working as an administrative assistant, a clerical position that required keyboarding, filing, and lifting in excess of five pounds. Claimant had attended ISU as a degree-seeking student both prior to and subsequent to her injury. At the time of hearing, Claimant was taking the last class she needed for an undergraduate degree, and expected to graduate in December 2006. Claimant seeks retraining benefits in the amount of 104 weeks (two years) of TTD benefits so that she can obtain a Ph.D. and restore her earning capacity.

64. Idaho Code § 72-450 provides that retraining may be considered as an alternative to an award of permanent disability where the Claimant is receptive to retraining and the Commission finds that retraining will allow an injured worker to restore his or her earning capacity. While Claimant may be receptive to retraining, the Referee declines to order retraining benefits in this case. First, the record in this proceeding is entirely devoid of any vocational evidence. Since Claimant has never looked for work, it is speculative to presume that she can not equal or better her time-of-injury wage now that she has an undergraduate degree. Neither do we have any evidence that two additional post-graduate degrees are attainable or will provide additional employment opportunities once attained.

PPD

65. The definition of “disability” under the Idaho workers’ compensation law is:

. . . a decrease in wage-earning capacity due to injury or occupational disease, as such capacity is affected by the medical factor of physical impairment, and by pertinent nonmedical factors as provided in section 72-430, Idaho Code.

Idaho Code § 72-102 (10). A permanent disability results:

when the actual or presumed ability to engage in gainful activity is reduced or absent because of permanent impairment and no fundamental or marked change in the future can be reasonably expected.

Idaho Code § 72-423. A rating of permanent disability is an appraisal of the injured employee's present and probable future ability to engage in gainful activity as it is affected by the medical factor of permanent impairment and by pertinent nonmedical factors. Idaho Code § 72-425. Among the pertinent nonmedical factors are the following: the nature of the physical disablement; the cumulative effect of multiple injuries; the employee's occupation; the employee's age at the time of the accident; the employee's diminished ability to compete in the labor market within a reasonable geographic area; all the personal and economic circumstances of the employee; and other factors deemed relevant by the commission. Idaho Code § 72-430.

The burden of proof is on the claimant to prove disability in excess of impairment. Expert testimony is not required to prove disability. The test is not whether the claimant is able to work at some employment, but whether a physical impairment, together with non-medical factors, has reduced the claimant's capacity for gainful activity. *Seese v. Ideal of Idaho*, 110 Idaho 32, 714 P.2d. 1 (1986).

66. Claimant seeks disability in excess of impairment of 80%. Claimant's permanent impairment certainly exceeds the impairment that is attributable to her industrial injury and includes her non-industrial cervical injury, her lumbar injury, and her shoulder surgery. Dr. Knoebel rated Claimant's permanent impairment from all ratable causes to be 30%. However, Claimant presented no evidence regarding her loss of access to the labor market or to her loss of earning capacity. While proof of disability in excess of impairment does not require *expert testimony*, it does require more than anecdotal evidence. Claimant has failed to carry her burden of proving disability in excess of her impairment.

CONCLUSIONS OF LAW

1. Claimant's February 2005 cervical surgery was related to her July 2001 industrial accident. All medical care provided by UUHC related to the cervical surgery and aftercare through March 16, 2005, is compensable.

2. Claimant is entitled to time loss benefits from May 2, 2002, through July 1, 2002, (eight weeks and five days) and from June 16, 2003, through May 14, 2005, (99 weeks, 6 days).

3. Claimant sustained permanent partial impairment in the amount of 4% of the whole person as a result of her July 2001 industrial injury. Claimant's total PPI benefit is \$5,445.00 ($500 \times .04 = 20$ weeks \times \$272.25). Defendants are credited with PPI benefits paid, which at the time of hearing amounted to \$3,832.02.

4. Claimant has proven no disability in excess of her impairment that is attributable to the July 2001 accident.

5. Retraining benefits are denied as unsupported by the record, excessive in their duration, and speculative.

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 3 day of July, 2007.

INDUSTRIAL COMMISSION

/s/ _____
Rinda Just, Referee

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 27 day of July, 2007 a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

RICHARD N GARIEPY
PO BOX 3869
KETCHUM ID 83340

R TODD GARBETT
PO BOX 191
PRESTON ID 83263

djb

/s/ _____

\$5,445.00 (500 x .04 = 20 weeks x \$272.25). Defendants are credited with PPI benefits paid, which at the time of hearing amounted to \$3,832.02.

4. Claimant has proven no disability in excess of her impairment that is attributable to the July 2001 accident.

5. Retraining benefits are denied as unsupported by the record, excessive in their duration, and speculative.

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

DATED this 27 day of July, 2007.

INDUSTRIAL COMMISSION

/s/ _____
James F. Kile, Chairman

/s/ _____
R.D. Maynard, Commissioner

/s/ _____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 27 day of July, 2007, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

RICHARD N GARIEPY
PO BOX 3869
KETCHUM ID 83340

R TODD GARBETT
PO BOX 191
PRESTON ID 83263

djb

/s/ _____