

ripened during the pendency of the matter and should be included in the final decision. The parties agreed that a second hearing was not necessary, and agreed to submit additional documentary evidence to supplement the record.

An Order reopening the proceeding was filed on February 28, 2007, and the Referee awaited the additional evidence that was to be submitted before issuing a briefing schedule. The matter remained inactive on the Commission's docket while the parties attempted, once again, to settle the matter. Finally, in mid-September 2007, the parties requested a briefing schedule. Thereafter, the parties submitted post-hearing briefs, each attaching additional exhibits to which neither party objected. Claimant waived filing of a response brief. The matter came under advisement on November 20, 2007, and is now ready for decision.

ISSUES

By agreement of the parties at and subsequent to hearing, the issues to be decided are:

1. Whether and to what extent Claimant is entitled to the following benefits:
 - a. Medical care;
 - b. Temporary total or temporary partial disability benefits (TTD/TPD);
 - c. Permanent partial impairment (PPI);
 - d. Disability in excess of impairment (PPD);
 - e. Retraining; and
2. Whether Claimant is entitled to permanent total disability pursuant to the odd-lot doctrine.

CONTENTIONS OF THE PARTIES

Claimant asserts that he is entitled to TTD benefits from October 9, 2003, through November 9, 2006. This represents the time period between the date that Michael T. Phillips,

M.D., released Claimant to full-time work in his time-of-injury position, and the date that Richard Radnovich, D.O., declared him medically stable and provided Claimant with an impairment rating. Claimant also contends that he is entitled to the costs of reasonable medical treatment provided by Dr. Radnovich, including a left hip MRI, performed on March 16, 2005.

Defendants contend that Claimant was medically stable from his industrial back, left hip, and left elbow injuries on and after October 8, 2003. He was released to return to his time-of-injury position without restrictions, and TTD/TPD payments were properly terminated at that time.

Defendants assert that they properly refused payment for a lumbar MRI done on September 12, 2003, for the reasons that it was unauthorized and duplicative of a lumbar MRI done on August 29, just two weeks earlier. Defendants initially asserted that they were not liable for any medical care Claimant received after he was found medically stable on October 8, 2003. Defendants held to that stability date, but agreed to pay for Claimant's treatment by Dr. Radnovich from November 17, 2004, through August 23, 2005, with the exception of a left hip MRI that was done on March 16, 2005. After taking the post-hearing deposition of Dr. Phillips, Defendants agreed to pay for the left hip MRI. Defendants remain adamant that their agreement to pay for Dr. Radnovich's treatment up to the date of the hearing was not *carte blanche* for Claimant to continue treatment with Dr. Radnovich into the indefinite future.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, taken at hearing;
2. Claimant's exhibits 1 through 16, admitted at hearing;
3. Defendants' exhibits 1 through 18, admitted at hearing;

4. Additional medical records of Dr. Radnovich, dated November 10, 2004 through January 15, 2007, attached to Claimant's brief and admitted without objection pursuant to agreement of the parties;

5. Additional medical records of: Robert F. Calhoun, Ph.D., dated June 4, 2007; Richard W. Wilson, M.D., dated May 3, 2001; and an analysis of Claimant's vocational situation prepared by Teresa Ballard, Consultant, Industrial Commission Rehabilitation Division (ICRD), dated April 16, 2007, all attached to Defendants' brief and admitted without objection pursuant to agreement of the parties; and

6. The post-hearing deposition of Dr. Phillips, taken January 19, 2006.

Claimant's objections on pages 6 and 33 of Dr. Phillips' 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

1. Claimant was thirty-one years old at the time of hearing. He was separated from his wife, and was living in Nampa, Idaho, at the home of a friend, along with his six-year-old son.

2. Claimant graduated from Vallivue High School in 1993. Claimant's work history is sketchy, particularly in the first six years after his graduation from high school. Starting in 1999, he held jobs as a gas fuser, a molding installer for Employer, and a cable installer. In July 2002, Claimant returned to work for Employer as a framer.

3. On July 7, 2003, Claimant was lifting a floor frame when he felt pain in his *mid-back, between his shoulder blades*. He worked the remainder of his shift, and reported the injury the following morning when he arrived at work.

4. On July 8, 2003, after advising his supervisor about the mid-back injury from the preceding day, Claimant was temporarily reassigned to lighter-duty work. Claimant sustained new injuries when a co-worker knocked some two-by-sixes off a stack of lumber, which hit Claimant as they fell. The lumber struck Claimant on the left elbow and the left hip, knocking him to the floor. Claimant immediately reported the incident to his supervisor, who advised him to ice the injuries.

MEDICAL CARE

5. Claimant first sought medical care on July 10, when he presented at Primary Health - Nampa, complaining of *low back* and left upper hip pain.¹ Gail Tinker, PA-C, saw Claimant, and noted that he had suffered two injuries from two separate accidents.

6. Low Back. Claimant denied any radiating pain associated with the low back complaints. PA-C Tinker observed a limp and noted that Claimant was listing to the left. He exhibited tenderness over the lumbosacral spinous processes and into the soft tissue of the lumbar area. Tinker diagnosed acute lower back pain, prescribed medication, flexing exercise, ice, and heat, imposed work restrictions, and referred Claimant to Howard Shoemaker, M.D., at Primary Health's occupational medicine clinic.

7. Left Hip. Tinker noted a greenish-yellow bruise over the left iliac crest. No swelling, guarding, or rebound pain was appreciated on exam. An x-ray of the left hip was normal. Tinker diagnosed a left hip inguinal area contusion, imposed some additional restrictions, and noted Claimant was already on medication and had been referred to Dr. Shoemaker, who would be following both injuries.

¹ The record is unclear as to whether Claimant's low back complaints were related to either of the two industrial accidents. He was, however, treated for both T-spine and L-spine complaints under his workers' compensation claim.

8. Claimant saw Dr. Shoemaker on July 15. Presenting complaints included mid-back, mid-thoracic, and interscapular pain. Dr. Shoemaker was aware of Claimant's other work injuries, but was under the impression that he was only authorized to treat the back problem. X-rays of Claimant's T-spine were normal except for curvature related to muscle spasm. Dr. Shoemaker diagnosed a soft tissue injury, predicted a full recovery, prescribed physical therapy, and placed Claimant on modified duty.

9. On July 17, Claimant was seen at the Job Care clinic, part of St. Alphonsus' occupational health practice. The record is a bit vague on how or why Claimant sought care at the clinic. Claimant complained of soreness in his mid-to-low back.. PA-C Frost diagnosed left rhomboid pain and a lumbar sprain, prescribed medication, and returned Claimant to work with some restrictions.

10. Claimant returned to Job Care on July 24, complaining that his "back was killing him still, especially in his low back." (Defendants' Ex. 4, p. 043). Claimant denied any radicular pain or paresthesias in his lower extremities, but did still report some left upper back pain. PA-C Frost questioned the validity of the result of some of the range-of-motion testing, as he did not believe Claimant made a good effort. Frost's diagnosis remained the same. He prescribed some additional medication and referred Claimant to physical therapy at Intermountain Physical Therapy for six visits.

11. Claimant returned to Job Care on July 30, complaining that he was worse—he reported a lot of mid-back pain, but was most bothered by low back pain on the left that radiated down the lateral aspect of his leg to the knee. Frost's diagnosis remained the same, and he increased Claimant's medications and advised him to continue with physical therapy. Claimant returned on August 7, reporting no mid-back pain, but continuing low back pain without

radicular symptoms. Chart notes include the following objective findings:

The patient kind of limps around the room. . . . Low back shows no erythema, edema, or ecchymosis. During palpation he has tenderness to the left PSIS. He has approximately 80-85% of normal lumbosacral range of motion. DTRs remain symmetrical at the patella and Achilles and are within normal limits bilaterally.

Defendants' Ex. 4, p. 041. Frost diagnosed left sacroiliac (SI) dysfunction, and resolved mid-back pain. He continued Claimant's medications, physical therapy, and work restrictions.

12. The same day, August 7, Claimant returned to the Primary Health Clinic in Nampa and saw PA-C Tinker. He complained of increased left lower back pain and stated that "he cannot stand the pain anymore." (Defendants' Ex. 3, p. 024). Claimant told PA-C Tinker that he had returned because he had been seeing PA-C Frost at Job Care, and Frost said Claimant was doing better, but he was not, and Frost had not made any changes to his treatment.

Objective findings noted in the chart state:

He walks in the room leaning to the right. He is sitting in the chair with his hand over his left lower back and appears to be very uncomfortable. He is unable to flex forward at the waist. He is unable to lie flat on the table. He is weepy from the pain. There is increased tenderness with muscle spasms over the left lower paravertebral muscles. No pain down the legs. DTRs and sensation are normal [in] bilateral lower extremities.

Id.

13. Claimant returned to Job Care on August 13 and saw Douglas Hill, M.D., Claimant complained of constant unremitting pain in his left buttocks region radiating down his posterior thigh but not extending past his knee. Dr. Hill suspected that Claimant's pain might be caused by facet syndrome. He ordered x-rays of Claimant's lumbar spine, discontinued the physical therapy and prescribed two days' bed rest. The x-rays showed a normal lumbar spine and normal SI joints. Claimant saw Dr. Hill again on August 15. He reported that he had some pain relief with the bed rest. Dr. Hill noted that Claimant still had "prominent left paralumbar

spasm.” Claimant’s Ex. 13, p. 15. Dr. Hill’s diagnosis was unchanged. He referred Claimant to Robin W. King, D.C., for five visits.

14. Claimant saw Dr. King for the first time on August 18. He reported constant mid-back, and lumbosacral and left hip discomfort and told Dr. King that the pain often extended down his left leg to his ankle. On exam, Dr. King observed that Claimant’s left leg was rotated externally, and that Claimant over-reacted to palpation. Dr. King diagnosed mild T-spine strain with lumbosacral and left SI dysfunction, and piriformis syndrome. He prescribed ice and mobilization and manipulation of Claimant’s T-spine, lumbosacral junction, and eventually, his SI joint.

15. On August 19, Claimant returned to Job Care, where he again saw Dr. Hill. He reported left lumbar and interscapular pain and radicular symptoms in his left leg that Claimant associated with Dr. King’s treatment. On exam, Dr. Hill observed spasm in the left paralumbar muscles and tenderness in the upper sacrum not specific to the PSIS joint. Dr. Hill diagnosed a lumbosacral sprain with facet component and a mild rhomboid sprain. He recommended that Claimant continue with his medications and chiropractic treatment with Dr. King.

16. Claimant returned to Job Care on August 26, after four visits to Dr. King. He reported that his symptoms were unchanged. Dr. Hill discussed the case with Dr. King, and identified lumbar sprain, SI joint dysfunction, and left piriformis spasm as diagnoses. He ordered a lumbar MRI, held further chiropractic treatment, continued Claimant’s medications, and took him off work pending results of the MRI.

17. Claimant was a no-show for his appointment with Dr. Hill on August 29. He called the office later that day and asked to see a different physical therapist. His request was denied. Claimant saw Dr. Hill on September 3. His symptoms were unchanged. Dr. Hill

discussed the negative MRI with Claimant, and had him start a physical therapy program that day with Morris Physical Therapy. Later that day, Claimant returned to Job Care complaining of “lightning” like pain in his left leg since his physical therapy that day. Claimant was accompanied by his wife, who wanted to change physical therapists. Claimant was seen by C. Harrold, PA-C, received an intramuscular injection of Demerol and phenergan, and was directed to follow up with Dr. Hill by telephone the next day regarding physical therapy. An appointment with Dr. Hill was scheduled for September 9. On September 4, Claimant called Morris Physical Therapy to say he would not be coming in and that he wanted to go somewhere else.

18. On September 12, Claimant presented at St. Luke’s Meridian Medical Center complaining of constant left leg pain, like lightening, from the middle of his buttocks down the outside of his left leg and into his foot. He also complained of pain between his shoulder blades. A caseworker, “Robin,” accompanied him.² He was examined by Ralph Sutherlin, D.O., with Robin in attendance. Dr. Sutherlin did not have the benefit of Claimant’s medical records, and based on Claimant’s report and his own exam, he made the following differential diagnoses:

- 1) Left lumbar pain secondary to ligamentous injury versus disk disease, versus malingering.
- 2) Thoracic pain secondary to muscular contracture versus posture.

Claimant’s Ex. 16, p. 2. Dr. Sutherlin wanted to review Claimant’s prior medical records, and Robin stated that she would send the medical records for the doctor’s review. Dr. Sutherlin noted that Claimant had a negative MRI on August 28, but ordered a repeat MRI apparently without objection from Robin.

19. On September 18, Claimant returned to see Dr. Sutherlin, again accompanied by

² Robin’s affiliation with Claimant’s case was never explained, but it is reasonable to presume that she was a nurse case manager, or employed in some other similar capacity, by Surety.

Robin, as well as his wife. Claimant complained of pain in his left lower sacral region, occasionally radiating as tightness in his hamstring on the left lateral side of his leg, and tightness in his upper back. Claimant raised new complaints of headache. Dr. Sutherlin discussed the MRI results, which were normal. He performed a physical exam and some stretching and manipulation of Claimant's hamstring, SI joint, and quadriceps. Dr. Sutherlin's diagnosis included left SI joint dysfunction, right thoracic muscular strain secondary to the SI joint dysfunction, and dysfunctional posture, also secondary to the SI joint issue. Dr. Sutherlin sent Claimant to HealthSouth for nine physical therapy sessions. Dr. Sutherlin returned Claimant to work with detailed restrictions. Claimant attended physical therapy at HealthSouth on September 19, 22, and 24. Defendants offered Claimant suitable light-duty work, so Defendants terminated TTD benefits after September 18, and began paying TPD benefits.

20. On September 25, Claimant returned to Job Care where he was seen by both PA-C Frost and Dr. Hill. Claimant stated that he was "a little better," but was still experiencing constant pain in his left low back, numbness in his lower left leg medially above the calf, and stiffness in his mid upper back and between his shoulder blades. Both Frost and Dr. Hill examined Claimant, and their chart notes for this visit are extensive. Their conclusion was that Claimant had low back pain and "[n]on-organic physical signs in response to rotation, sensory, and overreaction." Claimant's Ex. 13, p. 28. Dr. Hill discussed work restrictions (Claimant believed he could work four hours in a sedentary position if he could change positions frequently), and noted that Claimant was seeing three separate physical therapists and a chiropractor concurrently.³ Dr. Hill put a hold on further physical therapy, and advised Claimant that he would not prescribe any narcotic pain medication.

³ Dr. Hill did not mention that Claimant was also receiving medical treatment at three other clinics concurrently.

21. On October 1, Dr. Phillips, an orthopedic surgeon, conducted an independent medical evaluation of Claimant at the request of Defendants.⁴ Dr. Phillips reviewed Claimant's medical records and performed an examination.

22. Claimant identified the following medical concerns to Dr. Phillips: 1) constant sharp left hip pain, localized to the iliac crest region of the pelvis with numbness radiating into the left leg in a stocking-like distribution; 2) interscapular pain manifesting during lifting activities; 3) persistent dull and aching pain over the lateral aspect of the left elbow and feeling of weakness in the joint with occasional locking of the joint; and 4) bitemporal headache twice weekly. Claimant told Dr. Phillips that he had experienced only a ten percent reduction in pain with treatment since the date of his injuries.

23. On exam, Dr. Phillips noted:

[Claimant] exhibited considerable pain behavior throughout the evaluation and significant inconsistencies in body posturing were observed. He ambulated from the reception area to the exam room with the left lower extremity held in 90 degrees of external rotation.

Claimant's Ex. 7, p. 4. Claimant was not using a cane to ambulate. Other objective findings included:

- Normal cervical spine with full range of motion and no discomfort with provocative maneuvers;
- Upper extremities were normal and equal bilaterally with the exception of intrinsic motor power on the left, attributable to poor effort;
- Reduced range of motion in shoulder, due to poor effort secondary to complaints of interscapular pain; no objective evidence of mechanical rotator cuff dysfunction;

⁴ Dr. Phillips had also participated in a panel evaluation of Claimant in 2001 for an earlier industrial injury. Dr. Phillips' involvement in that case will be discussed in subsequent portions of these findings and conclusions.

- Tenderness over the lateral epicondyle of the left elbow;
- Normal wrists and hands with the exception of grip strength and motor power, which were reduced on the left; Dr. Phillips noted, “Inconsistent diffusely poor effort is present on the left.” *Id.*, at p. 5;
- Markedly restricted range of motion in the low back with tenderness to palpation on the left over paravertebral, sacroiliac and sciatic notch regions with minimal muscle spasm;
- Lower extremities marked by pain with straight-leg raise, diffusely poor motor power bilaterally but worse on left; “Sensory exam reveals loss of touch, temperature, and vibratory challenge in a stocking-like distribution on the left. With passive exam on the table the claimant postured his left lower extremity at maximal internal rotation, inconsistent with his gait posturing of external rotation.” *Id.*; and
- Negative radiographic imaging.

24. Dr. Phillips diagnosed interscapular thoracic muscle strain, contusion of the left elbow, and contusion of the left iliac crest. He opined: “No objective neuromuscular deficits are observed on examination although significant pain behavior and inconsistency in findings is notable.” *Id.*, at p. 6. Dr. Phillips recommended x-rays of the T-spine, left elbow, and pelvis with left hip to rule out occult fracture. Pending the results of the x-rays, Dr. Phillips opined that Claimant could perform light-duty work “as much as eight hours a day.” *Id.*

25. Claimant returned to Job Care on October 3. He was complaining of back and elbow pain. Claimant advised Dr. Hill that his left elbow had been injured in the July 8 incident, but that the symptoms resolved. He had banged the elbow again in late September and it had been hurting since then. Dr. Hill reviewed the x-rays that Dr. Phillips had ordered and found no abnormal findings. On exam, he appreciated some tenderness in the upper sacral area, but no

muscle spasm. He diagnosed low back pain without imaging to corroborate the physical exam findings and left lateral epicondylitis. He continued Claimant on light-duty work restrictions.

26. A hand-written chart note dated October 8, 2003, states that Surety advised Job Care that it would not pay for further treatment. That same day, Dr. Phillips wrote Surety advising that he had reviewed the films he had ordered and found no acute or chronic bone or joint abnormality. He advised that there were no objective neuromuscular or skeletal impairments that would warrant a rating of permanent impairment. He further noted that soft tissue injuries generally reach maximum medical improvement within ninety days, and he did not believe that Claimant required further treatment for his July 2003 injuries and could return to his time-of-injury position as a framer for Employer. Defendants terminated Claimant's TPD benefits pursuant to Dr. Phillips' letter.

27. Later that same day, October 8, Claimant presented at the emergency room at Mercy Medical Center. He complained of left flank and low back pain, and advised the attending physician, Albert Hsiao, M.D., of his history of low back trauma in July. Dr. Hsiao examined Claimant and reviewed the August 28 MRI. He diagnosed low back muscle spasm exacerbation and prescribed Vicodin, Valium, and rest, and took Claimant off work for one day. Claimant was advised to follow up with Dr. Hill at Job Care.

28. Claimant did not return to work and was subsequently terminated by Employer.

POST-MMI MEDICAL CARE

29. Instead of seeing Dr. Hill as ordered by Dr. Hsiao, Claimant and his wife presented at Primary Health - Crossroads. Dr. Shoemaker, who had treated Claimant once before, shortly after his industrial accidents, saw him. Claimant told Dr. Shoemaker that he had "positioned [petitioned?] to the industrial commission [sic] to have a second opinion and this is

where they chose.”⁵ Claimant’s Ex.15, p. 20. Claimant reported severe low back pain ever since his July accidents, with pain radiating down his left leg. He described the leg as numb and tingly. His complained that his back is always in spasm. He told Dr. Shoemaker about seeing Drs. Hill and Phillips, about the negative MRIs, and about being found medically stable and told to return to work. Claimant told Dr. Shoemaker that he had seen a number of physical therapists, and been treated with Norco and Valium which “only helped slightly.” *Id.* On exam, Dr. Shoemaker reported “definite noticeable quadratus lumborum muscle spasm all throughout the left low back starting from about L2 down to the SI area.” *Id.* Dr. Shoemaker found Claimant to be so tender in the left low back and buttock area that he could not identify the source of Claimant’s pain. Motor strength was equal and normal in all muscle groups, and there was diminished sensation along the L4-L5, L5-S1 nerve root distribution. Dr. Shoemaker opined that Claimant was not at MMI, and had severe muscular low back strain and spasm which might be consistent with SI dysfunction and piriformis syndrome. Dr. Shoemaker was at something of a loss as to a treatment plan for Claimant, noting that he did not have the medical records, but he thought injections might relieve some of the muscle spasm and some additional physical therapy could help his SI and piriformis problems. Claimant received a Toradol injection and prescriptions for Zanaflex and Norco. Dr. Shoemaker recommended that Claimant see a physiatrist, but since it was not clear who was in charge of Claimant’s care, Dr. Shoemaker did not make a referral at that time. He advised Claimant that he would track down the medical records and imaging studies, try to sort out the administrative status of the claim, and see Claimant back in the clinic in a week.

30. There is no record that Claimant sought any medical care between October 13,

⁵ Claimant’s explanation is not consistent with any process or procedure of the Commission, nor does the legal file contain any documentation supporting Claimant’s contention.

2003, and April 14, 2004. On the latter date, Claimant saw Michael O'Brien, M.D., a neurologist, at the request of his attorney, Mr. Keenan. Dr. O'Brien had access to some of Claimant's medical records, but his letter report did not identify what medical records he reviewed in reaching his conclusions. Neither did his letter report document what, if any, examination and testing he performed in reaching his conclusions. Dr. O'Brien did state, "It is somewhat obvious in examining this patient that he is spasmed up in the back regions, particularly in the lower portions, which cause him to use a cane and incapacitate him significantly." Claimant's Ex. 6, p. 2. Dr. O'Brien then volunteered that he had treated Claimant's identical twin brother who had a similar affliction of "spastic torticollis," which the doctor described as "an unusual tightening of the muscles of the neck which cause a grotesque postural appearance." *Id.* Dr. O'Brien revealed that Claimant's twin had become asymptomatic with treatment, but then was involved in an auto accident and "his muscles simply locked up to the point where he was distorted in appearance." *Id.*⁶ Dr. O'Brien advised that the best hope for effective treatment was to send Claimant to Georgia for BOTOX injections.

31. Claimant next sought treatment from Richard Radnovich, D.O., in November 2004. His chief complaints were back and leg pain but he also reported nightly panic attacks. Dr. Radnovich diagnosed lumbalgia and muscle spasm in the lumbar paravertebral muscles, gluteals, and deep external rotators. Dr. Radnovich could not identify the underlying etiology of Claimant's complaints, noting that he would need to continue to treat Claimant to identify the source of Claimant's pain. Dr. Radnovich recommended a treatment regimen including physical therapy and medication. No specific restrictions were imposed, merely that Claimant avoid

⁶ Leaving aside issues of doctor/patient privilege, when Claimant was asked about his twin brother's condition, he stated that he did have an identical twin, they were in touch, but Claimant did not know what his brother's condition was.

aggravating activities.

32. Included with Dr. Radnovich's records, and appearing between Claimant's visits of November 6 and December 1, 2004, is an undated page denominated "Cowger impairment notes." The notes include some range of motion measurements and some cursory impairment calculations:

flexion 20 degrees—8% whole person
flexion – 20 degrees
internal rotation- 0, patient fixed in external rotation---4% whole person
adduction- 0--- 2% whole person

total impairment 14% whole person

Id. The notes then identify the following restrictions:

patient requires use of cane for balance and ambulation
No prolonged standing, no carrying greater than [sic] 10 pounds, no bending, no twisting

Id.

33. Claimant returned to Dr. Radnovich on December 1, 2004. He reported that his symptoms were unchanged, and that he had not been taking the medications prescribed. Dr. Radnovich noted that Claimant's pain made it difficult to perform a meaningful examination. He told Claimant to continue physical therapy and start the medications.

34. Claimant's next visit to Dr. Radnovich was in May 2005. He reported that his symptoms were unchanged, and that he had not filled or had run out of his prescriptions. The chart note also mentions that Claimant's wife had been beating both Claimant and their son, was abusing methamphetamine, had been having an affair, and was presently incarcerated. Claimant stated that he would be getting an insurance card that would help him obtain medications in the future. Dr. Radnovich expressed hope that the change in benefits would allow better diagnostics and treatment for Claimant in the future.

35. Claimant returned to Dr. Radnovich in June 2005. His symptoms were unchanged. Dr. Radnovich changed some of the medications. On his July 5 visit, Claimant reported that his symptoms were unchanged, and that he was not sleeping well and was having pain in the left rib area. Dr. Radnovich wanted to focus on Claimant's sleep problems, and then find the cause of his pain. On July 12, Claimant reported that his stomach hurt "and feels the problem is slightly better." It is not clear whether it is the back and hip/leg pain or the stomach pain that has improved. Claimant had not filled the prescription given on July 5. Dr. Radnovich added reactive depression and "pain in joint, pelvis/thigh" to the existing diagnoses, and told Claimant it was important that he take the prescribed medications. On August 9, Claimant reported that he had stopped taking some of the medications. His symptoms were not improved. Dr. Radnovich administered an injection into the left hip joint and three trigger point injections into the left gluteal. On August 23, Claimant reported that the injections had not helped and that his symptoms were unchanged. August 23, 2005, was Claimant's last visit to Dr. Radnovich before his September 1, 2005 hearing.

FURTHER CARE WITH DR. RADNOVICH

36. Claimant saw Dr. Radnovich on twenty occasions from September 20, 2005 through January 15, 2007. During this period, Claimant reported no improvement in his low back, hip, and leg pain. At various times during the course of treatment, he complained of additional symptoms, including:

- Left abdominal pain and kidney pain (9/20/05);
- Back "went out" and Claimant "could hardly walk" (11/17/05);
- Abdominal wall and elbow pain (3/20/06);
- Left knee gives out, loss of urinary control, burning pain in arms radiating to hands, and feeling of cervical instability (5/8/06);

- Sharp pain in mid-thoracic area (6/5/06);
- Left leg gives out causing falls, fatigue, memory difficulties, aphasia, panic attacks with smell of burning rubber, tachycardia, chest pain, shortness of breath, feeling of impending doom, and burning numbness on the left side of face (6/12/06);
- Headache requiring treatment at emergency room—treatment relieved headache, caused agitation (9/6/06);
- Sinus congestion and pain (10/4/06);
- Left lower quadrant abdominal pain (10/25/06);
- Abdominal pain, allergy symptoms (possible hernia?) (11/6/06);
- Abdominal pain, difficulty urinating, constipation requiring treatment at emergency room; no hernia but testicular pain, and sharp pain in SI region, and pain in throat and coming up his back (12/18/06);
- Sore chest from fall, neck locks up and gets tight, sharp pain across lower abdomen (1/15/07).

37. During this period of treatment, Dr. Radnovich referred Claimant to a surgeon for consultation on the abdominal pain and urological complaints, a neurologist for an EMG, and a psychiatrist. Dr. Radnovich repeatedly expressed frustration over the inability to identify the cause of Claimant's complaints, or effectively manage his symptoms. In addition to the referrals, Dr. Radnovich ordered a number of tests, including a full blood panel, bone scan, cervical spine MRI, left hip MR arthrogram, facet joint diagnostic block, and a brain MRI, all of which were normal. In addition to medications, trigger point injections, and the other treatment modalities previously discussed, Dr. Radnovich tried treating Claimant with steroids. Nothing relieved or changed Claimant's symptoms. By December 2006, Dr. Radnovich had referred Claimant to a psychiatrist to rule out a conversion disorder.

MISCELLANEOUS MEDICAL

38. Robert F. Calhoun, Ph.D., conducted a psychological evaluation of Claimant on

June 4, 2007. The evaluation included a review of Claimant's medical care relating to the July 2003 injuries, a patient history, and psychological testing. Dr. Calhoun made the following findings:

1. At this time, there are significant personality, cognitive, affective, and behavioral factors impacting [Claimant's] pain problem and level of physical debilitation . . .
2. [Claimant] meets psychiatric illness for pain disorder with psychological factors, a probable conscious component to his current presentation as his primary motivation for presenting himself as disabled is out of anger toward those he feels have dishonored and betrayed him [*sic*]. He demonstrates a history positive for chronic depression, anger, and anxiety.
3. Because of [Claimant's] current psychiatric presentation, he is not likely to respond positively to further medical intervention.
4. [Claimant] has not sustained any permanent partial psychiatric impairment as related to the industrial injury of 07/08/03, and his current psychiatric presentation is way out of proportion of the objective medical findings contained within the medical record.

Defendants' Reply Brief, Exhibit 1, p. 15.

2001 Panel Evaluation

39. In his report, Dr. Calhoun made reference to a report from a medical panel that evaluated Claimant in 2001 with relation to an earlier industrial injury. The report, dated May 3, 2001, prepared by Dr. Phillips and Richard W. Wilson, M.D., a neurologist, appears as Exhibit 2 to Defendants' Reply Brief. The report summarizes a care and treatment history that is eerily similar to the treatment history of the instant proceeding.

40. Claimant initially reported that on February 7, 2001, he was feeding flexible gas pipe into a trench when the pipe snapped out of the trench and hit him in the chest. Claimant asserted that the pipe launched him about thirty feet, then dragged him on the ground.⁷ When

⁷ Claimant later told another doctor that the pipe had sent him thirty feet "into the air."

seen later that day at Primary Health in Nampa, he reported that he had fallen on his right upper back. He was complaining of discomfort in the right upper back and with range of motion in his right arm. Subsequently, he voiced a number of other physical complaints, including:

- Right shoulder discomfort;
- Tingling and numbness in both hands;
- Low back pain;
- Neck, shoulder, and interscapular pain;
- Pain radiating down the posterior thigh;
- Left arm “pins and needles” pain;
- Diminished left arm strength;
- Upper lumbar pain;
- Hot spots in left leg;
- Dizziness, racing heart, and a smell of burnt rubber; and
- Bitemporal headaches twice a day, each lasting about four hours;

During the course of treatment, a primary care physician, a chiropractor, a neurologist, a physiatrist, two physical therapists, and one emergency room doctor saw Claimant. He was referred to a psychologist, but did not go. After a thorough exam, the panel opined:

The record would suggest that [Claimant] may have sustained a left shoulder girdle muscle contusion and possibly a cervical strain on February 7, 2001. He now presents as a portrayal of invalidism with over-determined symptoms, overt pain behavior, diffusely diminished spinal motion of the cervical, thoracic and lumbar regions, as well as non-anatomic sensory loss in the left arm and leg and left upper trunk posteriorly as well as bilateral give away weakness in the arms and legs more prominent on the left than the right, and an inconsistent pseudo ataxic gait. He has had no neurologic signs or symptoms or documentation by MR imaging studies to suggest a significant cervical myelopathy or radiculopathy, and does not have clinical evidence of intrinsic pathology [in?] the left or right shoulder joint. His myriad of subjective complaints are not substantiated by findings on examination.

The panel concluded that Claimant needed no further treatment and that he had sustained no permanent impairment. *Id.*, at pp. 4-5.

VOCATIONAL EVIDENCE

41. Claimant was initially referred to the ICRD in August 2003, and Danny Ozuna, rehabilitation consultant, was assigned to his case. Claimant worked with Mr. Ozuna off and on until the file was closed in August 2004. During that time, Mr. Ozuna obtained an experience summary from Claimant, performed several job site evaluations and collected medical records. The reason for the closure was “severe medical prognosis and [C]laimant is not interested in seeking employment at this time until he gets his medical issues resolved.” Claimant’s Ex. 2, p.20.

42. Claimant returned to ICRD sometime in early 2007. Mr. Ozuna had left the Commission and Teresa Ballard staffed Claimant’s case. Ms. Ballard interviewed Claimant at the ICRD office, and reviewed his employment experience and his medical records. Ms. Ballard prepared a report, dated April 16, 2007, attached as Exhibit 3 to Defendants’ Reply Brief. Claimant was 32 years of age and had a limited work history beginning in 1999 and ending in 2003 with the industrial injuries that are the subject of this proceeding. Ms. Ballard determined that Claimant’s wages varied from \$8.00 per hour to \$11.00 per hour. At the time of his injuries, he was earning the higher rate performing framing work for Employer. Ms. Ballard noted that Dr. Phillips had released Claimant to his time-of-injury employment without restrictions, and that Dr. Radnovich had given Claimant an impairment rating and imposed substantial restrictions that would limit him to sedentary work. During their interview, Claimant told Ms. Ballard that he could not work and did not expect to improve.

43. Ms. Ballard analyzed Claimant’s employability in both heavy and sedentary

occupations based upon his education, labor market, age, and transferrable skills. She identified a number of occupational titles in both sedentary and heavy occupations that were regularly available in the Claimant's labor market, all with pay comparable to his time-of-injury wage. Ms. Ballard did not believe that Claimant's age or education were factors that unduly limited his employment opportunities, but did note that at the time of the interview Claimant lacked access to a vehicle and would have to rely on public transportation to get to and from work. She concluded:

. . . many local jobs offer the potential within a reasonable time frame of providing for a restoration of the time of injury wage within either sedentary range occupations or heavy range occupations.

Defendants' Reply Brief, Exhibit 3, p. 5.

DISCUSSION AND FURTHER FINDINGS

MEDICAL CARE

44. In an industrial accident case, the claimant carries the burden of proving to a reasonable degree of medical probability that 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).

45. 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 the injured employee such reasonable medical, surgical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus, as

may be required by the employee's physician or needed immediately after an injury or disability from an occupational disease, and for a reasonable time thereafter. If the employer fails to provide the same, the injured employee may do so at the expense of the employer. Idaho Code § 72-432 (1). It is for the physician, not the Commission, to decide whether the treatment was required. The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989).

46. There is no dispute that Claimant sustained soft-tissue injuries to his back, left elbow, and left hip on July 7 and 8, 2003. Defendants accepted the claim, and provided Claimant with reasonable diagnostic testing, treatment, and medication for those injuries as prescribed by the six physicians, one chiropractor, three physical therapists and three physician's assistants from whom he sought care. None of Claimant's treating physicians were able to find any objective cause for Claimant's continuing complaints about his T-spine, L-spine, left hip, and left elbow, despite extensive diagnostic testing. With the exception of Dr. O'Brien, all commented at some time during their treatment of Claimant that his complaints were not consistent with objective physical findings. Several raised questions of malingering, psychological issues, or a conversion disorder.

47. Claimant continued to seek treatment for his identified industrial injuries, as well as a host of other physical complaints of unknown etiology, long after he had been found to be medically stable. None of these other complaints was ever causally related to his industrial injuries.⁸ While Dr. Phillips' determination might have been subject to reasonable dispute at the

⁸ Claimant's physical complaints following the injuries in this case are remarkably similar to physical complaints that he made following an earlier, relatively minor work-related injury that could not be validated by objective medical evidence.

time he made it, the test of time proved him right. After three more years of treatment by Dr. Radnovich, Claimant reported his condition remained unchanged.

48. Despite Dr. Phillips' finding of medical stability in October 2003, Defendants agreed to, and did, pay for most of Claimant's treatment by Dr. Radnovich up to the date of hearing, September 1, 2005. With one exception, discussed in a subsequent finding, Defendants met and exceeded their obligations under Idaho Code § 72-432 to provide reasonably necessary medical care to Claimant, and had no obligation to pay for the on-going care by Dr. Radnovich on and after the hearing date.

49. During the course of his care, Claimant had a number of MRIs. Three are relevant to this discussion: August 28, 2003 lumbar spine; September 12, 2003 lumbar spine; March 18, 2005 left hip. Defendants refused payment for the September 12, 2003, MRI because it was unauthorized and was duplicative of the one taken two weeks earlier. Defendants initially denied payment of the March 18, 2005, MRI ordered by Dr. Radnovich, but reconsidered their position in light of the post-hearing deposition of Dr. Phillips. Then, by mistake, Defendants paid for the September 12, 2003, MRI instead of the March 16, 2005, MRI. Defendants argued in their brief that since they had paid for two out of the three MRIs in issue, it really did not matter which two had been paid, as Claimant remained responsible for one of the MRIs.

While it might not have made a difference to Claimant or Defendants which of the MRIs remained unpaid, it may well matter to the provider, as there is every likelihood that Claimant will be unable to pay for the MRI for which he remains financially responsible. Further, the reasons given by Defendants for refusing to pay for the September 12, 2003, MRI do not withstand careful scrutiny. Defendants argued that Dr. Sutherlin must not have known about the earlier lumbar MRI when he ordered the second lumbar MRI. In fact, Dr. Sutherlin's chart note

specifically discusses the existence of the August 28 lumbar MRI (*See*, finding of fact 18). Dr. Sutherlin's note also reflects that "Robin," ostensibly an agent of Surety, accompanied Claimant on the September 12 clinic visit. Robin raised no objection to Dr. Sutherlin ordering a second lumbar MRI. For these reasons, the Referee finds that Defendants are liable for all three of the MRIs discussed herein.

TTD/TPD BENEFITS

50. Idaho Code § 72-408 provides for income benefits (temporary total and temporary partial disability) for injured workers during the period of recovery. Defendants paid Claimant TTD benefits for the time he was off work during his period of recovery, and TPD benefits when he returned to light-duty work. Defendants terminated Claimant's income benefits once he was released to return to work without restrictions. Claimant presented no credible evidence that he remained in a period of recovery subsequent to October 8, 2003. Defendants fully complied with their obligations to pay income benefits pursuant to Idaho Code § 72-408, and Claimant is not entitled to additional income benefits for the period from October 9, 2003 through November 9, 2006.

PPI/PPD

51. "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).

52. Dr. Phillips determined that Claimant sustained no permanent impairment from his industrial injuries of July 2003. Dr. Radnovich prepared some rough calculations that resulted in 14% whole person impairment. Dr. Radnovich never formalized his impairment rating, never provided an explanation of how he arrived at the figures that appeared in his notes, and never explained his methodology. Although undated, their appearance between chart notes of November 4 and December 1, 2004, suggest they were jotted down following Claimant's first visit to Dr. Radnovich. Yet, no impairment rating ever appeared in the chart notes, nor did Dr. Radnovich ever impose the restrictions discussed in the undated note. Moreover, it is not clear whether Dr. Radnovich's rating was limited to the undisputed industrial injuries, or included the various other physical complaints that could not be verified or causally connected to the industrial accident. For these reasons, the Referee is not persuaded by Dr. Radnovich's impairment rating, and finds that Claimant sustained no permanent partial impairment as a result of his industrial accident.

53. 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. Without permanent impairment, there can be no permanent disability.

Urry, 115 Idaho 750, 769 P.2d 1122 (1989).

RETRAINING

54. Claimant presented no evidence on the issue of retraining and did not argue the matter in his brief. The Referee finds no basis on which to determine that Claimant is either amenable to retraining, or would benefit from a retraining program.

TOTAL PERMANENT DISABILITY

55. Claimant asserted that he was entitled to total permanent disability as an odd-lot worker. Because Claimant sustained no disability as a result of his July 2003 industrial injuries, he cannot claim odd-lot status as a result of those injuries. In fact, Claimant did not present any evidence or make any argument on the issue of total and permanent disability under the odd lot doctrine, and the Referee finds that Claimant has failed to establish that he is an odd-lot worker.

CONCLUSIONS OF LAW

1. Claimant has failed to establish entitlement to medical care beyond that which he received through September 1, 2005;
2. Defendants remain liable for payment of the MRI ordered by Dr. Radnovich and performed on March 16, 2005;
3. Claimant has failed to establish entitlement to income benefits (TTD/TPD) beyond those paid through October 8, 2003;
4. Claimant has failed to establish entitlement to permanent partial impairment resulting from his industrial accidents in July 2003;
5. Claimant has failed to establish entitlement to any disability in excess of his impairment, including total permanent disability under the odd lot doctrine, resulting from his industrial accidents in July 2003;

6. Claimant has failed to establish entitlement to retraining resulting from his industrial accidents in July 2003.

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 31 day of January, 2008.

INDUSTRIAL COMMISSION

/s/ _____
Rinda Just, Referee

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 8 day of February 2008, a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

J BRENT GUNNELL
1226 E KARCHER RD
NAMPA ID 83687-3075

ERIC S BAILEY
PO BOX 1007
BOISE ID 83701-1007

djb

/s/ _____

3. Claimant has failed to establish entitlement to income benefits (TTD/TPD) beyond the amounts paid through October 8, 2003;

4. Claimant has failed to establish entitlement to permanent partial impairment resulting from his industrial accidents in July 2003;

5. Claimant has failed to establish entitlement to any disability in excess of his impairment, including total permanent disability under the odd lot doctrine, resulting from his industrial accidents in July 2003; and

6. Claimant has failed to establish entitlement to retraining resulting from his industrial accidents in July 2003.

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

DATED this 8 day of February, 2008.

INDUSTRIAL COMMISSION

/s/ _____
James F. Kile, Chairman

R.D. Maynard, Commissioner

/s/ _____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 8 day of February, 2008, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

J BRENT GUNNELL
1226 E KARCHER RD
NAMPA ID 83687-3075

ERIC S BAILEY
PO BOX 1007
BOISE ID 83701-1007

djb

/s/ _____