

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RICK STEWART,)
)
 Claimant,)
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 v.)
)
 BLACK ROCK MANAGEMENT, LLC,)
)
 Employer,)
)
 and)
)
 STATE INSURANCE FUND,)
)
 Surety,)
 Defendants.)
 _____)

IC 2005-509275

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

Filed: March 17, 2008

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 Coeur d’Alene, Idaho, on June 26, 2007. Starr Kelso of Coeur d’Alene represented Claimant. H. James Magnuson of Coeur d’Alene represented Defendants. The parties submitted oral and documentary evidence. Two post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on December 7, 2007, and is now ready for decision.

ISSUES

By agreement of the parties at hearing, 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. Attorney fees; and
4. Whether apportionment for a pre-existing or subsequent condition pursuant to Idaho Code § 72-406 is appropriate.

EVIDENTIARY AND PROCEDURAL ISSUES

Motion in Limine

On June 18, 2007, Defendants filed a Motion *In Limine* and for Sanctions. The basis for the Motion was that Claimant's counsel (Counsel) "had unlawful, unauthorized and unethical contact" with Alex R. Verhoogen, M.D., by virtue of *ex parte* correspondence and a telephone call. Defendants had asked Dr. Verhoogen to conduct a review of Claimant's medical records, but had not identified him as a witness for hearing. Defendants provided Counsel with a copy of Dr. Verhoogen's report, and Counsel made no attempt to depose Dr. Verhoogen or pursue other discovery related to the doctor's opinions.

Counsel filed a Reply to Motion *In Limine* and for Sanctions on June 21, 2007. Counsel asserted that he became aware of Dr. Verhoogen's opinion letter when he received a copy from Defendants in early May 2007. Upon reviewing the letter, it appeared to Counsel that Dr. Verhoogen had based his opinion on an error of fact concerning when Claimant first complained about his shoulder. Counsel requested, and received, the medical records that Defendants had provided Dr. Verhoogen for his review. Counsel determined that the records provided to Dr. Verhoogen had been incomplete. Counsel asserted that on June 6, 2007, he

contacted Dr. Verhoogen's office "solely in an attempt to determine whether it would be necessary for Claimant to spend at least \$1,000 to take Dr. Verhoogen's deposition . . ." Counsel left a message for the doctor.

Dr. Verhoogen returned Counsel's call, and Counsel inquired whether the doctor was aware of records showing that Claimant had started to complain about his shoulder shortly after the alleged accident. The doctor requested that Counsel fax him a letter along with the records, which Counsel did. The same day, Dr. Verhoogen sent a letter to Counsel and Defendants modifying his previous opinion in light of the additional material. It is this June 6 letter from Dr. Verhoogen that Defendants sought to exclude.

On June 22, 2007, the Referee issued her Order on Motion *In Limine* and for Sanctions. The Referee ruled that Counsel had violated Idaho Code § 72-432(11) by contacting Dr. Verhoogen without first obtaining permission from Defendants. In view of the fact that Counsel's error was in taking a shortcut to get to otherwise discoverable material, and since Defendants' failure to provide Dr. Verhoogen with all the relevant medical records relating to Claimant's injury precipitated Counsel's inquiry, the Referee denied the Motion *In Limine*, but imposed sanctions upon Counsel for his impermissible contact of Dr. Verhoogen.

At hearing, Defendants moved once again to exclude Dr. Verhoogen's June 6, 2007 letter, which objection was overruled by the Referee in light of her June 22 Order. Defendants made a continuing objection to the admission of the disputed letter. Defendants asserted their objection again during the post-hearing deposition of Jonathan S. King, M.D.

Request for Reconsideration

Counsel filed his post-hearing brief on September 20, 2007. Defendants filed their post-hearing brief on October 15, 2007. Concurrent with their briefing, Defendants filed their Motion

for Full Commission Ruling on Motion *In Limine* and for Sanctions. Counsel filed his response to the renewed motion on October 23, 2007, concurrently with his reply brief.

The Commissioners deemed Defendants' Motion as a request for reconsideration of an interlocutory order and agreed to consider the matter, which had the effect of suspending the Referee's taking the matter under advisement. The Commission found no factual or legal basis to reconsider or alter the Referee's interlocutory ruling, and denied the request for reconsideration by Order filed December 7, 2007. In its Order, the Commission strongly admonished that the ruling was not to be read as condoning Counsel's violation of the applicable discovery rules governing workers' compensation adjudications. Rather, the Commission's decision was an acknowledgement that the Referee's ruling had struck a delicate balance between clear violation of the discovery rules, actions of Defendants that contributed to a medical opinion based on incomplete and incorrect information, and the importance of a complete record.

CONTENTIONS OF THE PARTIES

It is undisputed that Claimant sustained some injury to his right upper extremity on April 25, 2007, while working as a landscaper for Employer. Claimant asserts that he sustained injuries to his forearm, elbow, and shoulder when he attempted to redirect a boulder that he was rolling into place while constructing a culvert.

Claimant further contends that his injuries required extensive medical care, including a recommended arthroscopic shoulder surgery for which Defendants denied responsibility. Because of his injuries, Claimant was unable to work from August 15, 2005 through November 5, 2006, and is entitled to temporary total disability benefits for that period. Beginning November 6, 2006, Claimant was employed, but at less than full-time and at a lower rate of pay

than his time-of-injury position and is, therefore, entitled to temporary partial disability benefits from November 6, 2006, until he is medically stable. Finally, Claimant argues that Defendants' refusal to pay for medical care recommended by his treating physician and improperly terminating income benefits constitutes an unreasonable denial or termination of benefits that entitles him to attorney fees pursuant to Idaho Code § 72-804.

Defendants contend that Claimant's industrial injuries were limited to his right forearm and elbow. He received treatment for those injuries, and was declared medically stable on June 14, 2006. Claimant was released at that time to return to his time-of-injury work as a landscaper without restrictions. Claimant has failed to prove that his shoulder complaints were the result of his admitted industrial accident, entitling him to additional medical care. Defendants have paid Claimant TTD benefits for the time that he was in a period of recovery, including from November 9, 2005 through July 7, 2006. Finally, Defendants assert that Claimant has failed to establish an entitlement to attorney fees pursuant to Idaho Code § 72-804.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Carol Stewart, Alicia Berg, and Sue Wirsch, taken at hearing;
2. Claimant's Exhibits B-1, B-7, B-8, B-12 through B-18, D-13, F, and G-1 through G-7, admitted at hearing;
3. Defendants' Exhibits 1 through 15, admitted at hearing; and
4. Post-hearing depositions of Jonathan S. King, M.D., taken June 27, 2007, and Stephen R. Sears, M.D., taken August 1, 2007. All objections posed during the deposition of Dr. King are overruled, with the exception of the objection appearing on page 34, which is sustained.

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

ACCIDENT/INJURY

1. On April 25, 2005, at about 4:30 p.m., Claimant was attempting to place a large boulder as part of the construction of a retaining wall and culvert on Employer's property. The boulder was too large to lift, and Claimant rolled it downhill toward the location where he wished to place it. The boulder started to roll off course, and Claimant attempted to slow or stop the boulder and redirect it by extending his hands downward, palms out. The boulder caught Claimant's right arm:

I just—I felt there was a pop and then it just felt like it tore. It just felt like somebody got on me and just stretched my arm out, pulling it out of the socket is what it kind of felt like.

Tr., p. 64. Claimant believed that the “pop” came from his elbow, because that was where he first felt the pain, “. . . but I was so sore the next day, I mean I was just sore from the shoulder down.” *Id.*

2. Claimant reported the injury immediately to his supervisor. It was near the end of the workday, and Claimant finished out the day sweeping and cleaning up. Claimant declined medical care at that time, preferring to see how his arm was the following day. Claimant awoke early the next morning in excruciating pain. When he got to work he told his supervisor, Terry Borders, about his pain. Terry immediately took Claimant to the office where a First Report of Injury was prepared, after which Claimant was taken to North Idaho Immediate Care (NIIC).

MEDICAL CARE

3. Claimant was treated at NIIC on April 26, April 28, and May 3, 2005—each time

by a different physician. On his first visit, Claimant identified right forearm pain as his chief complaint, and was diagnosed with a right brachioradialis strain. Medication, work modification, a sling, and ice were prescribed and Claimant was returned to work. Claimant was rechecked on April 28, and advised to continue with the same treatment. By the May 3 visit, Claimant was also experiencing pain in his right elbow, which was corroborated on exam by a loss of range of motion at the elbow joint. An MRI of the right forearm and elbow was ordered, and Claimant was given a referral to North Idaho Physical Therapy (NIPT) for treatment three times per week for three weeks.

4. Claimant was evaluated and started physical therapy at NIPT on May 3. In the evaluation, Claimant reported “forearm and lateral elbow pain rated at 7-10/10. Experiences ‘shooting’ pains up to shoulder and down to wrist.” Defendants’ Ex. 4. Claimant attended physical therapy on May 4, May 6, and May 9. Claimant also returned to NIIC for a follow up on May 9. The chart note is lacking in detail, but indicates that the Claimant was not progressing well.

5. Claimant continued with his physical therapy, and on May 13, he reported to Matt Lucas, P.T., that his symptoms were getting worse. Claimant believed that his work was aggravating his arm. That same day, Mr. Lucas sent a progress note to NIIC regarding Claimant’s treatment. The progress note referenced Claimant’s initial complaints of shoulder pain. Claimant also attended a follow-up appointment at NIIC on May 13, at which time his physical therapy was extended, and once again an MRI of the right forearm and elbow was ordered.

6. On May 27, Claimant reported to his physical therapist that his elbow pain was worse and that his right shoulder was painful as well. Claimant continued to work, limiting the

use of his right arm as much as possible.

7. Claimant had an MRI of his right forearm on June 6, 2005. The only finding of significance was evidence of mild lateral epicondylitis. The results of the MRI were relayed to Claimant and an appointment was set up for him to see Kirk Hjeltness, M.D., a physician in NIIC's Post Falls facility on June 14. There are no medical records of any visits with Dr. Hjeltness, although his name appears on two referral slips for continued physical therapy at NIPT dated June 21 and July 6, 2005.

8. Claimant continued his physical therapy. On June 21, he reported that he was continuing to do shoveling and lifting at work. On June 27, he reported that he was working under restrictions of no lifting over ten pounds and no shoveling or pick work.¹ On June 29, Claimant reported that his arm was very painful, up into his shoulder. He had been using a backpack sprayer and using his right arm to spray.

9. Claimant returned to NIIC on July 1 for a recheck of his right arm and shoulder. Claimant was not improving. Further restrictions were imposed (no repetitive use of the right arm and no lifting of more than three pounds with the right arm), physical therapy and medications were continued, and Claimant was given a referral to an orthopedist.

10. Claimant saw Spencer D. Greendyke, M.D., an orthopedist, on July 27, 2005. Dr. Greendyke reviewed Claimant's treatment history and examined Claimant. Dr. Greendyke diagnosed a soft tissue injury to the right elbow that was unimproved by conservative treatment. He suggested that injecting the lateral epicondyle might help relieve some of Claimant's symptoms. He also offered to place Claimant in a cast that would prevent additional injury and allow the soft tissue injury to heal. Claimant declined both the injection and the cast. With

¹ It is unclear who imposed the additional restrictions.

limited options remaining, Dr. Greendyke took Claimant off work for three weeks.

11. Claimant returned to Dr. Greendyke August 1. He advised the doctor that he had changed his mind, and wanted to try the cast so he could return to work and perform whatever work he could do with the cast. Dr. Greendyke placed Claimant in a long arm cast with instructions to return for follow up and cast removal in two weeks. Claimant experienced some problems with the long arm cast and it was replaced on August 5. The cast was removed August 15. The cast had exacerbated, rather than relieved, Claimant's arm and shoulder pain. Dr. Greendyke described Claimant's symptoms as, "[v]ery atypical lateral epicondylitis." Defendants' Ex. 6, (8/15/05 chart note). Dr. Greendyke was hesitant to offer surgical intervention since Claimant had no improvement with aggressive physical therapy or the cast. Out of options, Dr. Greendyke referred Claimant to Peter Jones, M.D., an orthopedic surgeon, for a consultation.

12. Claimant saw Dr. Jones on September 6. Dr. Jones opined that Claimant did not have lateral epicondylitis. Dr. Jones suggested that Claimant's symptoms were consistent with a partial biceps tendon rupture, but the MRI did not confirm that diagnosis. Dr. Jones recommended that Claimant be referred to someone who specialized in elbow pathology, and directed him to return to Dr. Greendyke.

13. On September 27, Dr. Greendyke summarized Claimant's condition as:

Long-standing right elbow problem with normal radiographs, normal MRI scan and previous evaluation by another orthopaedic surgeon, Dr. Tisdale,² complete evaluation by me followed by physical therapy and casting, again with no improvement whatsoever, and final evaluation by an upper extremity plastic surgeon, Dr. Peter Jones, who felt he should be seen by an expert elbow specialist.

Id., (9/27/05 chart note). Dr. Greendyke referred Claimant to Tycho Kersten, M.D., a Spokane

² The record does not contain any medical records from Dr. Tisdale.

orthopedist, for a consultation.

14. Claimant saw Dr. Kersten on November 9, 2005. Dr. Kersten noted Claimant's main complaint was biceps pain. He observed tenderness along the anterior biceps both distal and proximal to the elbow, but found the biceps intact. Claimant reported no pain with provocative testing for medial or lateral epicondylitis. Dr. Kersten diagnosed right elbow distal biceps strain, but with normal imaging had nothing to offer except conservative therapy. In particular, he prescribed physical therapy, recommended night splinting, an elbow pad, and suggested that Dr. Greendyke order an EMG to document some ulnar nerve symptomology. Dr. Kersten left the imposition of permanent restrictions to Dr. Greendyke.

15. An EMG study was completed on November 11, 2005. The test was essentially normal with subtle abnormalities consistent with a very mild right ulnar neuropathy at the elbow consistent with Claimant's clinical presentation.

16. Claimant returned to Dr. Greendyke on December 16, 2005. The chart note from that date makes reference to what has become the primary factual dispute in this proceeding:

He [Dr. Kersten] sent him to therapy for a different form of therapy and the patient states that his shoulder is getting better. He also states that he has been having problems with his shoulder and says that his shoulder has bothered him ever since the original accident but because the pain was much more severe at the elbow, everybody concentrated on the elbow. I do not actually recall any complaints about his shoulder.

* * *

He points to an area near his coracoid as one of the points of shoulder discomfort, also down at the proximal aspect of the volar forearm near the insertion of the biceps.

Id., (12/16/05 chart note). Dr. Greendyke's clinical assessment was, "[e]xtremely unusual presentation for distal biceps strain injury, unremitting with regard to discomfort after almost 9 months." *Id.* The chart note concludes:

At this point, I think disposition is the most important aspect of [Claimant's] case. I would like to have him undergo an MRI of his right shoulder just to absolutely preclude any possibility of injury to this area. In addition, I would like him to undergo an FCE of the upper extremities to determine any permanent restrictions and the level of activity he is capable of performing at work. I will see him back in followup when both of these studies are complete and go over the results with him and perform a final determination, disability [sic] rating and deem him at MMI at that time.

Id.

17. An MRI of Claimant's right shoulder was done on January 4, 2006. The imaging was read to show:

1. Irregularity of the posterior superior glenoid labrum consistent with tearing of the labrum in this region. There is an associated multilobulated labral cyst between the posterior labrum and infraspinatus.
2. Question of small calcified loose body in the inferior aspect of the glenohumeral joint seen on axial image #15.

Id.

18. Claimant participated in a functional capacity evaluation (FCE) on January 9, 2006. Mark Bengtson, MPT, conducted the testing. Mr. Bengtson described Claimant as cooperative and exerting full effort, validating the FCE results. In particular, Mr. Bengtson noted:

Firstly, proximal radial elbow pain and anterior and posterior shoulder pain were identified as the specific chief complaints during functional activities. Secondly, aggravation of symptoms occurred in a consistent and expected pattern: proximal elbow pain . . . was reportedly aggravated after only 2 maximum grip efforts. Anterior (followed by posterior shoulder pain as manual material handling continued) shoulder pain was provoked by Lift and Carry activities and was reportedly worse during Waist to Shoulder and Shoulder to Overhead Lifting.

Furthermore, [Claimant] reported no distal biceps/proximal radius pain when he held a 40 lb. load at waist level with his elbows bent at 90 degrees of flexion. He did, however, experience an increase in distal biceps pain as he eccentrically lowered the load below his waist (to a position of 60 degrees of elbow flexion). Moreover, he did not report any pain when he performed a Right hand unilateral Carry with his elbow fully extended. These findings are consistent with the clinically expected findings of a distal biceps tendinous pathology.

[Claimant] experienced the same provocation of painful symptoms with eccentrically resisted elbow flexion during the musculoskeletal examination. Overall, these findings indicate objectivity of symptom provocation during functional tasks.

Defendants' Ex. 12. Mr. Bengtson interpreted the testing to permit Claimant to work at the medium physical demand level for an eight-hour day. In his summary and recommendations, Mr. Bengtson remarked on Claimant's pathological posture problems, including a sway back, a depressed and downwardly rotated right scapulae and a depressed right shoulder girdle and clavicle.

All of these pathological postural compensations can affect his Right shoulder function and provoke symptoms of supraspinatus/biceps pathology, increased anterior humeral head translation, superior labral symptoms, etc.

Id. Mr. Bengtson concluded:

If diagnostic exams rule out any surgical pathology, the [Claimant] is a good candidate for a goal specific Work Readiness program. Addressing postural compensations, scapular and RTC strength, general fitness, work method modification, and body mechanics instruction will facilitate a safe and effective return to work.

Id.

19. Claimant returned to see Dr. Greendyke on February 7, 2006. Dr. Greendyke reviewed Claimant's shoulder MRI, including the superior labral anterior/posterior (SLAP) lesion and associated labral cyst. Dr. Greendyke noted a nine-to-ten month history "of right upper extremity pain, both elbow and shoulder, with normal MRI of biceps insertion right elbow but with MRI documented SLAP lesion right shoulder." Defendants' Ex. 6, (2/7/06 chart note).

Dr. Greendyke proposed the following treatment plan:

. . . I would like to see if we can't get permission to have him evaluated by our shoulder specialist, Dr. King, to have him both look at the MRI, examine the patient and discuss whether or not anything should be done with his shoulder with regard to operative intervention. It is possible that this shoulder pathology has

been present since his original injury and has been radiating discomfort to his elbow and is the reason why even placing him in a long arm cast did not improve his symptoms.

Id.

20. Claimant saw Dr. King on February 15, 2006. Dr. King had Claimant's medical records from Dr. Greendyke, the shoulder MRI results, and the results of the FCE and the EMG. After examination of Claimant, Dr. King opined that Claimant was suffering from right shoulder impingement, rotator cuff tendinitis, proximal biceps tendinitis, and a SLAP tear as well as right distal biceps tendinitis. Dr. King described Claimant's right upper extremity complaints as "extremely complex," noting that while the MRI showed a labral tear, Claimant exhibited minimal pain to testing directed at diagnosing the SLAP lesion. Claimant did demonstrate "a lot of impingement signs on physical exam as well as biceps tendinitis and distal biceps tendinitis." Defendants' Ex. 13, (2/15/06 chart note). Dr. King recommended continued conservative treatment, including a sub-acromial injection and a month of physical therapy for the shoulder and the distal biceps tendinitis, with a discussion of arthroscopic evaluation should conservative care fail. Claimant consented to the injection, which was performed in the office that day.

21. Claimant returned to Dr. King on March 17, 2006. He reported that the injection had caused quite a bit of pain initially, but then provided significant relief. Overall, he felt he was improved. Dr. King continued Claimant's physical therapy for another four to six weeks, and once again discussed the possibility of arthroscopic decompression and debridement since Claimant had relief from the injection.

22. On April 25, 2006, Claimant returned to Dr. King, reporting that his recovery had plateaued and he was no longer progressing with the physical therapy. He remained symptomatic, especially with lifting. After exam, Dr. King's diagnosis remained unchanged, and he recommended a right shoulder arthroscopy with labral repair vs. debridement and subacromial

decompression. Dr. King believed that solving the shoulder problem could help with Claimant's elbow complaints, but if it did not, then further workup of the elbow could be pursued.

23. Defendants sent Claimant for an independent medical evaluation (IME) with Stephen R. Sears, M.D., on June 14, 2006. Claimant completed a pain diagram that indicated diffuse pain from the base of his neck on the right side and extending midway down the right forearm. When asked to identify the area that bothered him the most, Claimant pointed to the right anterior humeral head and advised Dr. Sears that he had some pain at that location all the time since the date of the accident. Claimant identified his second most bothersome area as the posterolateral acromion of the right shoulder, and stated that the pain has been constant since the accident. Claimant pointed to the proximal medial half of the right forearm as his third most bothersome area, stating that the pain was constant, but made worse by activity. Claimant identified his medial right elbow as his fourth concern, indicating that it is painful some of the time. Claimant explained the scapular and neck pain that he marked on the pain diagram as being associated with the pain in his right shoulder.

24. Dr. Sears reviewed the medical records (noting the absence of any records from Dr. Tisdale) and took a history before performing a physical examination of Claimant. He was able to view the right shoulder MRI of January 4, 2006, and relied upon the radiologists' readings of the June 3, 2005 forearm MRI and the February 15, 2006 shoulder x-rays. Claimant's physical exam was essentially normal with the exception of the following findings:

- Tightness of the right trapezius with left foraminal compression;
- Pain in right shoulder blade and right trapezius with thoracic rotation;
- Right trapezial pain in response to Phalen's testing;
- Some loss of range of motion (both abduction and external rotation) of right shoulder, with pain localized to deltopectoral groove.
- Non-radiating tingling with right brachioradialis reflex;
- Pain in the proximal radial forearm with resisted supination of right upper extremity;

- Mild soreness over the distal dorsal right half of the right forearm with right wrist flexion;
- Tenderness proximal to the medial epicondyle;
- Pain, but no tenderness, over the right medial epicondyle;
- Discomfort distal to the right cubital fossa with pronation of the right upper extremity
- Tenderness localized to the acromion, and over the anterior, lateral, and posterior humeral head;
- Occasional crepitation in the right acromioclavicular joint with circumduction;
- Tightness at the right biceps tendon with full flexion;
- Exquisite tenderness over the biceps tendon and all about the right shoulder;
- Limited abduction and internal rotation on the right due to pain near anterior deltoid;
- Lateral right shoulder pain upon crossover testing;
- Diffuse anterior right shoulder pain when touching L1 spinous process with right thumb;
- Pain at right anterior tip of acromion with overhead motion.

Dr. Sears' diagnosis was "diffuse right upper extremity pain and paresthesia complaints, which I am unable to explain by any specific orthopedic diagnosis." Defendants' Ex. 8.

25. Dr. Sears discussed his findings at length in his report. He noted that initially, Claimant complained of tenderness and swelling in the radial right half of his right forearm. Dr. Sears states that, subsequently, Claimant's "symptoms expanded" to include a right elbow strain, atypical lateral epicondylitis of the right elbow, a partial right biceps tendon rupture (not confirmed by radiological imaging), tingling in the right elbow causing numbness and tingling in the fingers of the right hand, and "nonspecific right shoulder symptoms first recorded by Dr. Greendyke on December 16, 2005, and a complaint today of pain at the base of the neck on the right side and right scapula, suggesting neck pathology." *Id.*

26. Dr. Sears could only relate Claimant's nonspecific symptoms in and around his right proximal volar forearm to the April 2005 industrial injury. Dr. Sears concluded that Claimant's industrial injury was limited to a minor sprain or strain of his right proximal volar

forearm from which he had recovered and reached medical stability. Dr. Sears awarded no permanent impairment and imposed no permanent restrictions.

27. Dr. Sears specifically disputed any notion of Claimant having sustained a shoulder injury:

I would point out that [Claimant] has neither the symptoms nor physical findings pointing to a tear of the glenoid labrum, as described in his right shoulder MRI on January 4, 2006. I would also point out that that study was not ordered because of specific shoulder symptoms indicating a specific diagnosis but instead was ordered by Dr. Greendyke “just to absolutely preclude any possibility of injury to this area.” I believe that the labral irregularity of [Claimant’s] right shoulder described by Dr. Taylor Reichel is a serendipitous finding.

Id.

28. A copy of Dr. Sears’ report was sent to Dr. King for his review. On July 14, 2006, Dr. King responded that he disagreed with Dr. Sears, noting in particular that Claimant had not had any shoulder problem before the April 2005 injury, and the shoulder MRI confirmed irregularities in the right shoulder consistent with a labral tear and associated cyst. Finally, Dr. King noted that conservative treatment had not helped Claimant, so Dr. King still recommended arthroscopic surgery.

29. Claimant returned to Dr. King on October 17, 2006. His condition was unchanged, as was Dr. King’s recommendation for arthroscopic surgery.

TTDs/TPDs

30. On the day of his accident, Claimant finished out the workday. Following his first visit to NIIC the morning following the accident, he returned to work on modified duty. Claimant remained on modified duty until his first visit with Dr. Greendyke on July 27, 2005. The medical records leading up to that visit are consistent with Claimant’s testimony that there was little work that he could do without using his right arm. Despite his efforts to minimize the

use of the affected arm, Claimant experienced increased pain whenever he used the arm.

31. When Claimant saw Dr. Greendyke for the first time, the doctor recommended casting the arm, suggesting that immobilization could prevent additional micro-traumas to the injured tissue and allow it to heal. Claimant did not want to wear a cast, so Dr. Greendyke took Claimant off work entirely for three weeks, effective July 27, 2005.

32. On August 1, Claimant decided that since he could perform some work if he were in a cast, he would go ahead and have the cast put on. Dr. Greendyke applied a long-arm cast that day and issued a light-duty work release with no lifting of more than ten pounds, limited use of right arm, and that Claimant must wear the cast. Based on the light-duty work release, Sue Wirsch, Director of Human Resources for Employer, believed that there was suitable work available for Claimant at the marina store, and told Claimant to report to the marina store on August 3.

33. On August 2, Dr. Greendyke issued a new release that took Claimant off work entirely for one week, effectively rescinding the August 1 return-to-work authorization.

34. On August 3, Claimant reported to the marina store, with the August 2 work release in hand. Claimant met with Karla Stillwell, the manager of the marina store. Apart from the fact that he had been taken off work through August 9, Claimant testified that a number of things about the proposed assignment concerned him. Claimant's job as a landscape laborer was a five-day a week, eight-to-ten hour a day job. Claimant, a divorced father, had custody of his son in the summer, and working evenings, weekends, and holidays, as was required at the marina store, would work a substantial hardship. Claimant's landscaping job required him to be outdoors and performing physically demanding work; he was not at all sure whether he could tolerate being tied down to working a counter. The marina store was also very busy, especially

at lunchtime and on weekends. Lunch customers, a number of them laborers on the site, had limited time available for lunch, and boating customers wanted to get back to their recreational pursuits. Claimant had no experience in retail or customer service and did not believe he was well suited to the kind of personal interaction that the job required. Learning to operate a cash register with his non-dominant hand conjured images of long lines of impatient customers. Finally, it did not appear to Claimant that the small store was set up in such a way as to allow him to rest his cast at a comfortable height. After the meeting, Ms. Stillwell wrote Ms. Wirsch that she believed Claimant could do the work but that he was “unsuitable for the position,” referencing in particular the evening and weekend hours the position required.

35. Ms. Wirsch wrote Claimant on August 4, 2005, and advised him that Employer was making suitable light-duty work (at the marina store) available to him pursuant to Dr. Greendyke’s limitations. The letter acknowledged that Claimant had met with Ms. Stillwell but that he had not yet accepted or declined the offer of suitable light-duty work. The letter further advised Claimant that he was expected to report to the marina store on August 10 at 9:00 a.m. Failure to do so would be considered a voluntary refusal to accept appropriate light-duty work, and could affect his workers’ compensation benefits.

36. On August 5, Claimant returned to Dr. Greendyke because the cast was causing him pain. The cast was removed, and replaced with a new cast.

37. Claimant did report to the marina store on August 10 as required by the August 4 letter, but none of the conditions that caused him concern had changed, and he did not believe that he could do the work. Ms. Stillwell directed Claimant to discuss the matter with Ms. Wirsch, which he did. Although their testimony varied in some respects, it is fair to say that Claimant and Ms. Wirsch exchanged words and that Claimant uttered a profanity.

38. On August 15, Dr. Greendyke removed Claimant's cast because it was exacerbating, rather than helping, Claimant's pain. Dr. Greendyke also took Claimant off work for the period of August 9 through August 15, releasing him to return to work at the marina store on August 16.

39. Employer terminated Claimant effective August 15, 2005. The termination was considered a voluntary resignation because Claimant had refused to return to work at the marina store on August 10. Claimant's TTD benefits were terminated the same day.

40. By letter dated September 7, 2005, Claimant apprised Ms. Wirsch that he was out of his cast and would like to return to work. Ms. Wirsch responded that there were no light-duty positions available. At hearing, Ms. Wirsch testified that she made no attempt to look for light-duty positions after receiving the September 7 letter.

41. Claimant's TTD benefits were reinstated in December 2005, retroactive to November 9, 2005. Claimant continued to receive TTD benefits through July 7, 2006. TTD benefits were terminated subsequent to Claimant's June 14, 2006 IME by Dr. Sears.

42. Claimant's average weekly wage (AWW) at the time of his injury, calculated using his gross wages from March 3 through April 24, 2005, is: \$452.95 ($\$3,364.75 / 52$ [days in period] x 7).

43. On November 6, 2006, Claimant went to work for S.L. Start. He earned \$7.25 per hour and worked twenty-five hours per week for an AWW of \$181.25 per week.³ This represents a reduction of \$271.70 in Claimant's AWW as compared to his pre-injury wage.

³ No payroll records were offered into evidence regarding Claimant's wages and hours at S.L. Start. While calculation using actual payroll data may provide a slightly different result, this calculation is based on the only information available—the undisputed testimony of Claimant at the hearing.

CREDIBILITY

44. Claimant was a credible witness, both in his demeanor as observed by the Referee at hearing, as well as substantively. Claimant's explanation of how he was injured was clear and consistent throughout the record, and was corroborated by the contemporaneous statement of his supervisor. Claimant's pain complaints concerning his shoulder, elbow, and forearm were consistent, though sometimes one or another was more painful on a given day, depending upon what activities Claimant had been engaged in. None of the medical professionals who treated Claimant, including Drs. Greendyke and King, and several physical therapists, ever suggested that Claimant was exaggerating his symptoms or that his complaints were inconsistent with findings on exam. In fact, Mark Bengtson, M.P.T., explained at some length in his report that Claimant's ability to perform during the FCE was consistent with his specific pain complaints, and the differential diagnoses that his treating physicians were evaluating.

45. Claimant's testimony that he began complaining of shoulder pain just days after the accident is supported by chart notes discussed with specificity elsewhere in these findings. Given the lack of continuity of care that Claimant received during the nearly ten weeks he was treated at NIIC (he was seen by at least six different physicians during this period), it is not surprising that not all of Claimant's complaints were carried over on every chart note. Yet, virtually every chart note describes the *purpose* of Claimant's visit as being to recheck his arm *and* shoulder. Claimant's assertions that he had suffered no prior shoulder or upper arm injuries, and that he had done nothing subsequent to the April 25 accident that could have caused his shoulder problems was unrefuted.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

46. It is undisputed that Claimant sustained some injuries on April 25, 2005, while trying to move a large boulder as part of Employer's construction and landscaping project. What is disputed is the extent of those injuries, particularly, whether Claimant's shoulder was injured during the accident.

47. 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.

48. In the case at bar, the issue of causation comes down to a disagreement between Dr. King, Claimant's treating physician, and Dr. Sears, who conducted an IME for Defendants. Based on the record in this proceeding, the Referee finds Dr. King's opinion by far the more persuasive.

Dr. Sears

49. Dr. Sears began his career in orthopedic surgery in 1979. His first four years of

practice were in the military as an assistant professor. In 1983, he joined a private general orthopedic practice in Spokane, Washington, where he remained until 2000. In 2000, Dr. Sears terminated his surgical practice, but continued to see some patients until April 2003. Since that time, he has limited his practice to performing IMEs on a part-time basis. Dr. Sears was board certified in general orthopedics in 1968, and was never required to recertify in his specialty. In his deposition, Dr. Sears testified that he had never pursued an orthopedics specialty, but had probably treated more spinal complaints than the average orthopedist. Although he had experience with shoulder surgery, it was limited primarily to “open” surgeries. Dr. Sears professed that he had done some arthroscopy, “but I never really billed myself as being an arthroscopic shoulder surgeon.” Dr. Sears Depo., p. 6.

50. Dr. Sears disputes that Claimant actually suffers from any of the right upper extremity injuries that were diagnosed in the more than two years following his industrial accident, although on exam he noted at least eighteen different findings that related to Claimant’s specific complaints. (*See*, finding 22, *supra*.) The doctor concluded that Claimant sustained a minor sprain or strain of his right proximal volar forearm from which he had recovered and reached medical stability. Dr. Sears dismissed Claimant’s on-going upper extremity complaints as “diffuse right upper extremity pain and paresthesia complaints, which I am unable to explain by any specific orthopedic diagnosis.” Defendants’ Ex. 8. Dr. Sears’ opinion does not address:

- the MRI findings of June 2005 evidencing mild lateral epicondylitis consistent with Claimant’s presenting complaints and diagnosed by at least two of Claimant’s treating physicians;
- the EMG findings from November 2005 showing mild ulnar neuropathy consistent with Claimant’s presenting complaints;
- the FCE results, discussing in some detail the congruity of Claimant’s performance on the testing and his presenting complaints;
- the diagnosis of proximal biceps tendinitis by at least three of Claimant’s care-givers; or

- the MRI findings of January 2006 evidencing a SLAP lesion, a labral cyst, and possibly a loose body in the glenohumeral joint.

51. Dr. Sears specifically dismissed the notion that Claimant had sustained a labral tear from any cause, stating in his report that Claimant had neither symptoms nor physical findings consistent with a tear of the glenoid labrum. This assertion directly contravenes the findings of Dr. King and Mr. Bengtson regarding the consistency of Claimant's complaints with his shoulder pathology.

52. Dr. Sears described the MRI results as "equivocal at best," (Dr. Sears Depo., p. 14), and implies that the results of the MRI are of little value because it was not done to *confirm* a diagnosis, but to *rule out* shoulder pathology. Dr. Sears' reading of the MRI is contrary to those of the radiologist and Drs. Greendyke and King.

53. Dr. Sears disputed the existence and the relevance of the labral cyst that was apparent on the MRI, noting that such a cyst could be congenital, and could arise in the absence of an injury. In support of his opinion that Claimant had not sustained a labral tear as a result of the industrial accident, Dr. Sears repeatedly referred to the many months that intervened between the date of the accident and Claimant's first complaints about his shoulder. As discussed elsewhere in these findings, Claimant's complaints about his shoulder began within days of the accident, and continued, to a greater or lesser extent, throughout his course of treatment. After being advised of Claimant's early shoulder complaints by counsel for Defendants prior to his deposition, Dr. Sears continued to dismiss their relevance while maintaining his position that the "ouch" was too remote from the injury to support causation. *Id.*, at p. 24.

54. Dr. Sears repeatedly referred to Claimant's "expanding symptom" syndrome, characterizing his complaints as beginning with forearm pain, then expanding to elbow pain, which expanded to tingling and numbness in his hands, which then extended into his shoulder,

and which, by the time of Dr. Sears' exam, had also moved into his neck. This characterization of Claimant's complaints is not supported by the record, and lends credence to an unsolicited observation made by Dr. Verhoogen, M.D.,⁴ that Dr. Sears was "well known to virtually always be 100% for the insurance carrier." Defendants' Ex. 13 (3-27-07 letter from Verhoogen to Surety).

Dr. King

55. Dr. King attended medical school at Case Western Reserve University, and did his residency in orthopedic surgery in southern California. After his residency, Dr. King had a fellowship in sports medicine at a Los Angeles orthopedic clinic. At the time of his deposition, Dr. King was eligible for board certification and was scheduled to take his certification boards two weeks following his deposition. Dr. King testified that two years of practice is required before an individual can sit for board certification. Although Dr. King was not the seasoned practitioner that Dr. Sears was, his practice focused on sports medicine, and he had treated the largest volume of shoulder injuries in the practice and had performed a number of arthroscopic shoulder surgeries. The flip side of his limited time in private practice is the recency of his education, residency, and fellowship experience, which suggest that Dr. King brings with him the most current thinking regarding the diagnosis and treatment of orthopedic injuries.

56. Dr. King had the benefit of Claimant's treatment history with Dr. Greendyke, and the opportunity to examine Claimant on several occasions over a three-month period. He was able to observe changes in Claimant's condition with different therapeutic approaches, including individualized physical therapy modalities, and a trial of subacromial injection. Dr. King documented objective evidence of Claimant's upper extremity injuries, including the shoulder

⁴ Retained by Defendants to review the medical records.

injury, based on radiographic imaging, on examination, and in response to provocative testing. Dr. King explained that while a labral cyst can arise without an acute trauma, it generally only does so in individuals, such as baseball pitchers, whose repetitive throwing motion may inflict microtraumas that can eventually result in a cyst. Noting that Claimant's daily activities were not of a repetitive nature, Dr. King concluded that it was unlikely that Claimant could have developed a labral cyst in the absence of an acute trauma, and when considered together with the radiographic evidence of a labral tear, it was more probable than not that Claimant injured his shoulder in the April 2005 accident. Compared with Dr. Sears' dismissive and conclusory reasoning in support of his opinion, Dr. King explained the basis of his opinion clearly, logically, and persuasively, citing to the objective findings that supported his opinion.

57. Dr. King frankly admitted that the only way to confirm a diagnosis of a SLAP lesion is to visualize it arthroscopically, and that it was possible that when he scoped the shoulder, he would find no pathology. But, given the radiological evidence, the mechanism of injury, the documented symptomology, and Claimant's failure to improve with conservative treatment, an arthroscopic examination of the shoulder was the medically reasonable thing to do.

58. Dr. King's experience with typical injuries presenting in atypical ways also lends credence to his medical opinions in this proceeding. In his deposition, Dr. King testified that it was possible that Claimant's undiagnosed shoulder injury was the source of some or all of his forearm and elbow complaints all along. Dr. King noted that he had a patient with complaints of elbow pain that he treated for over six months without success. Further testing revealed that the patient had a shoulder injury, which, when repaired, resolved the elbow complaints. Dr. King was not so brash as to suggest that an arthroscopic surgery was going to be a panacea for Claimant, but his willingness to consider all possibilities in reaching his opinion is far more

persuasive than Dr. Sears' narrow and dismissive approach.

59. In summary, the Referee finds Dr. King's causation opinion to be the more persuasive of the conflicting causation opinions. Factors that support such a finding that stand out among all of those discussed herein include Dr. King's relationship with Claimant as a treating physician, his particularized knowledge of shoulder pathology and arthroscopic surgery, and his willingness to evaluate and consider all of the evidence, explaining how and why each piece of evidence influenced his decision. Causation having been established, Claimant is statutorily entitled to the medical care that Dr. King has determined to be reasonably necessary as a result of his injury.

PRE-EXISTING/SUBSEQUENT INJURY

60. Claimant's testimony that he had no shoulder problems prior to the April 2005 accident, and that there was no subsequent incident that could have injured his shoulder, is uncontroverted in the medical records or by any other evidence. The Referee finds that Claimant's shoulder injury was not the result of any prior or subsequent injury or disease.

TTD/TPD

61. Pursuant to Idaho Code § 72-408, a claimant is entitled to income benefits for temporary total and temporary partial disability during a period of recovery. The burden of proof is on the claimant to present expert medical evidence to establish periods of disability in order to recover income benefits. *Sykes v. C.P. Clare & Company*, 100 Idaho 761, 763, 605 P.2d 939, 941 (1980). Claimant was to be off work from August 2 through August 15, 2005. Employer terminated Claimant on August 15, 2005, because he had not returned to work, and his TTD benefits were terminated at the same time for refusing to accept a light-duty assignment. But as the record establishes, Claimant was not released to return to light-duty work until August 16.

Claimant attempted to return to light-duty work for Employer once he was released, but was advised by Ms. Wirsch that there were no light-duty positions available. Ms. Wirsch admitted at hearing that she made no inquiry to determine whether there were any light-duty positions available for Claimant, and subsequently Employer made no light-duty offers of work to Claimant. For whatever reason, Claimant's TTD benefits were reinstated in December 2005, retroactive to November 9, 2005. Defendants provide no explanation as to why Claimant's TTD benefits were not reinstated retroactive to August 16, 2005, and the Referee can find nothing in the record that would explain why Claimant did not receive TTD benefits from August 16 through November 8, 2005. Claimant was not medically stable during that period, and had not been released to return to the type of work he had been doing at the time of the injury, and was in need of arthroscopic shoulder surgery. Claimant is entitled to TTD benefits for the period from August 16 through November 8, 2005, at the statutory rate based on the average weekly wage calculated in finding 42, *supra*.

62. Once TTD benefits were reinstated on November 9, 2005, Claimant continued to receive them until Dr. Sears determined that he was medically stable on June 14, 2006. Because the Referee finds that Dr. Sears' opinion as to Claimant's medical condition was not persuasive, Claimant is entitled to TTD benefits from June 15, 2006 until he began working for S. L. Start on November 6, 2006. Thereafter, Claimant was entitled to TPDs at the statutory rate until such time as Dr. King declares him medically stable.

ATTORNEY FEES

63. Attorney fees are not granted to a claimant as a matter of right under the Idaho Workers' Compensation Law, but may be recovered only when a claim has been contested without reasonable grounds, the surety or employer refuses or neglects to pay compensation as

provided by law within a reasonable time, or discontinues payment of benefits without reasonable grounds. Idaho Code § 72-804. The decision that grounds exist for awarding a claimant attorney's fees is a factual determination that rests with the commission. *Troutner v. Traffic Control Company*, 97 Idaho 525, 528, 547 P.2d 1130, 1133 (1976).

64. The Referee finds that an award of attorney fees is appropriate in this proceeding *on the limited issue of payment of TTD benefits for the period of August 16 through November 8, 2005*. Employer's pretextual termination of Claimant at a time that he was not released to work, its disinclination to make even a token effort to find Claimant a light-duty position, and Surety's refusal to pay TTD benefits at a time that no physician had found Claimant to be medically stable, support a limited award of attorney fees. While the Referee was not persuaded by Dr. Sears' IME report, and while Surety's reliance on Dr. Sears' report as grounds for terminating benefits was questionable, the Referee cannot find that Surety's reliance on Dr. Sears's opinion necessarily justifies an award of attorney fees on those disputed benefits.

CONCLUSIONS OF LAW

1. Claimant has carried his burden of proving that injuries to his shoulder were, to a reasonable medical probability, caused by the April 25, 2005 industrial accident;

2. Defendants have failed to carry their burden of proving that Claimant suffered from a pre-existing shoulder problem, or that his shoulder injuries were the result of an event subsequent to his April 25, 2005 industrial injury;

3. Claimant is entitled to TTD benefits, payable based on an average weekly wage of \$452.95, for the period from August 16 through November 8, 2005, and to TPD payments based on a wage differential of \$271.70 per week from November 6, 2006 until Claimant has been deemed medically stable. Defendants are to be credited with TTD payments already paid.

4. Claimant is entitled to an award of attorney fees on the limited issue of payment of TTD benefits from August 16, 2005 through November 8, 2005.

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 4 day of March, 2008.

INDUSTRIAL COMMISSION

/s/ _____
Rinda Just, Referee

ATTEST:

/s/ _____
Assistant Commission Secretary

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RICK STEWART,)
)
 Claimant,)
)
 v.)
)
 BLACK ROCK MANAGEMENT, LLC,)
)
 Employer,)
)
 and)
)
 STATE INSURANCE FUND,)
)
 Surety,)
 Defendants.)
 _____)

IC 2005-509275

ORDER

Filed: March 17, 2008

Pursuant to Idaho Code §72-717, Referee Rinda Just submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has carried his burden of proving that injuries to his shoulder were, to a reasonable medical probability, caused by the April 25, 2005 industrial accident;
2. Defendants have failed to carry their burden of proving that Claimant suffered from a pre-existing shoulder problem, or that his shoulder injuries were the result of an event subsequent to his April 25, 2005 industrial injury;
3. Claimant is entitled to TTD benefits, payable based on an average weekly wage of \$452.95, for the period from August 16 through November 8, 2005, and to TPD payments based on a wage differential of \$271.70 per week from November 6, 2006 until Claimant has been

deemed medically stable. Defendants are to be credited with TTD payments already paid.

4. Claimant is entitled to an award of attorney fees on the limited issue of payment of TTD benefits from August 16, 2005 through November 8, 2005.

5. Attorney fees pursuant to Idaho Code § 72-804 are awarded to Claimant. Unless the parties can agree on an amount for reasonable attorney fees, Claimant's counsel shall, within twenty-one (21) days of the entry of the Commission's decision, file with the Commission a memorandum setting forth the amount and basis for attorney fees requested in this case on either a contingent fee or hourly basis. Counsel shall also provide a copy of the fee agreement executed by Claimant and his attorney, and an affidavit in support of the claim for fees. The memorandum shall be submitted for the purpose of assisting the Commission in discharging its responsibility to determine reasonable attorney fees in this matter. Within fourteen (14) days of the filing of such documentation, Defendants may file a response to Claimant's information. If Defendants object to any representation made by Claimant's counsel, the objection must be set forth with particularity. Within seven (7) days after Defendants' counsel files the above-referenced response, Claimant's counsel may file a reply. The Commission, upon receipt of the foregoing pleadings, will review the matter and issue an order determining attorney fees.

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

DATED this 17 day of March, 2008.

INDUSTRIAL COMMISSION

/s/ _____
James F. Kile, Chairman

Participated but did not sign
R.D. Maynard, Commissioner

/s/ _____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 17 day of March, 2008, a true and correct copy of the foregoing **FINDINGS, CONCLUSIONS and ORDER** were served by regular United States Mail upon each of the following persons:

STARR KELSO
PO BOX 1312
COEUR D'ALENE ID 83816-1312

H JAMES MAGNUSON
PO BOX 2288
COEUR D'ALENE ID 83814-2288

djb

/s/ _____