

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ROSE M. AULT,)	
)	
Claimant,)	
)	
v.)	IC 2005-501681
)	
BOISE STATE UNIVERSITY,)	
)	
Employer,)	FINDINGS OF FACT,
)	CONCLUSIONS OF LAW,
and)	AND RECOMMENDATION
)	
STATE INSURANCE FUND,)	Filed: September 22, 2008
)	
Surety,)	
Defendants.)	
_____)	

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 Boise, Idaho, on November 19, 2007. Darin G. Monroe of Boise represented Claimant. Jon M. Bauman of Boise represented Defendants. The parties submitted oral and documentary evidence. Three post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on April 22, 2008, and is now ready for decision.

ISSUES

Pursuant to the Notice of Hearing, the issues to be decided are:

1. Whether Claimant is medically stable;
2. Whether Claimant is entitled to additional TTD benefits;
3. Whether Claimant is entitled to additional medical treatment for her failed back

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syndrome and epidural fibrosis as recommended by Clinton Mallari, M.D.;

4. Whether Claimant is entitled to payment for medical evaluations and treatment performed by R. Tyler Frizzell, M.D., Ph.D., and Clinton Mallari, M.D.;

5. Whether the Defendant Surety has unreasonably denied workers' compensation benefits; and

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

CONTENTIONS OF THE PARTIES

Claimant asserts that she has not reached medical stability from her October 2004 industrial accident because her treating physician, Dr. Malleri, has recommended that she undergo implantation of a spinal cord stimulator (SCS) to help control her pain, which Defendants have denied. Until she reaches maximum medical improvement, Claimant remains entitled to temporary total disability (TTD) benefits. Claimant further argues that Defendants' failure to pay for medical care she received from Drs. Frizzell and Malleri upon referral from Michael V. Hajjar, M.D., is unreasonable, and together with Defendants' refusal to provide her with an SCS, constitutes a basis for awarding attorney fees pursuant to Idaho Code § 72-804.

Defendants assert that Dr. Hajjar, Claimant's treating physician at the time, declared her medically stable on February 15, 2007. Because it was Claimant's request that she be allowed to see Drs. Malleri and Frizzell after having reached medical stability, Defendants are not responsible for payment to those providers under Idaho Code § 72-423. Defendants also assert

¹ The Referee failed to identify issues 5 and 6 at the outset of the hearing, and neither party pointed out the Referee's oversight. The failure of the Referee to identify all of the issues on the record does not constitute a waiver of the issues by the parties. As all six issues were identified in the Notice of Hearing, filed October 5, 2007, and were touched on in the briefing, they remain appropriate for consideration in this recommendation.

that their denial of an SCS for Claimant was not unreasonable as she does not meet the criteria set out by the manufacturer for an SCS implantation. In particular, Claimant demonstrated psychological traits that contraindicate the use of an SCS. Defendants also argue that use of an SCS is not appropriate for patients with Claimant's diagnosis, and that reliable studies have not established that use of an SCS is so effective in relieving pain that the benefits outweigh the risks. Finally, Defendants assert that Claimant has failed to establish that the pain for which she seeks an SCS is actually the result of her industrial accident.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. Testimony of Claimant and Michael Weiss, M.D., taken at hearing;
2. Claimant's exhibits 1 through 6, admitted at hearing;
3. Defendants' exhibits 1 through 41, admitted at hearing;
4. Depositions of Michael V. Hajjar, M.D., taken February 6, 2008; Clinton Mallari, M.D., taken November 30, 2007; and Craig W. Beaver, Ph.D., taken December 12, 2007. All objections posed during the depositions of Drs. Malleri, Hajjar, and Beaver are overruled.

After having considered all the evidence identified above 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 61 years old at the time of hearing. She has resided in Star, Idaho, since October 2003, having moved from California to Idaho shortly after her husband died.

SUMMARY OF PRE-INJURY MEDICAL HISTORY

2. Claimant's medical history prior to her move to Idaho was notable for bilateral

shoulder surgeries (three), right shoulder and left infrascapular pain, degenerative joint disease (multiple sites), osteopenia, osteoarthritis, posterior neck and head pain, peptic ulcer, acid reflux, adrenal gland and/or pancreatic cysts, an approximately 47-year smoking history (2 packs per day), smoker's cough, depression, chronic pain syndrome, and left upper quadrant and lower thoracic pain of unknown etiology.

3. Claimant saw Mark Michaud, M.D., at Primary Health on April 8, 2004 to establish a doctor/patient relationship for her general medical care. She presented with a "very thick stack of old [medical] records" that Dr. Michaud was not able to review at that time. Defendants' Ex. 8, p. 003. Dr. Michaud's chart notes on Claimant's subjective history include references to osteoarthritis, peptic ulcer disease, hiatal hernia, pancreatic cyst, benign colon polyps, hyperlipidemia, insomnia, surgeries on right hand and bilateral shoulders due to osteoarthritis, ninety-pack-year smoking habit, joint pain and swelling, stomach pain, muscle aches, headaches, and back pain. On exam, Dr. Michaud also noted decreased breath sounds.

4. Based on Claimant's first visit, Dr. Michaud's assessment included "Likely COPD" (chronic obstructive pulmonary disease) with risk of lung cancer and death, severe osteoarthritis, history of peptic ulcer disease/hiatal hernia, history of hypocholesterolemia, history of colon polyps, and insomnia. He recommended that she take an acid blocker in conjunction with her pain medication, but she declined.

5. Claimant returned to Dr. Michaud for follow up on April 22. Issues addressed during the visit included Claimant's epigastric discomfort, and "chronic mid to lower back pain and neck pain" which was becoming more severe and was the particular focus of her visit. *Id.*, at p. 007. Dr. Michaud opined that the Advil Claimant was taking for her back and joint pain was a likely cause of her epigastric pain. He recommended that Claimant switch to a Cox II inhibitor

or occasional Norco, and again urged the importance of using an acid-blocker in conjunction with the Cox II inhibitor. Lumbar and thoracic spine x-rays taken the same day show multilevel degenerative disc disease and demineralization in the thoracic spine, and mild demineralization in the lumbar spine. Dr. Michaud advised Claimant that she should have a bone density scan.

6. Claimant returned to Dr. Michaud on July 14, 2004. She complained of diffuse and persistent joint pain in her back, elbows, knees, and in the area in her back just below the band of her bra. The pain was not responding to Vioxx, nor to the twelve to sixteen Advil per day that Claimant was taking. Dr. Michaud advised her to discontinue the Advil immediately. On exam, Dr. Michaud identified trigger point tenderness in more than eleven of eighteen trigger points, a finding consistent with fibromyalgia. He recommended a trial of glucosamine and Darvon for her pain. He also recommended that Claimant follow up with a rheumatologist. Claimant called Dr. Michaud's office two days later, reporting that the Darvon was making her sleepy and was not helping with the pain. Results of lab tests taken at the July 14 office visit indicated that Claimant had an elevated ANA level, which warranted a further rheumatology workup. Dr. Michaud referred Claimant to James E. Loveless, M.D., rheumatologist.

7. On September 2, Claimant returned to Dr. Michaud. She had not yet seen Dr. Loveless, but she was seeking "additional suggestions regarding management of her pain." *Id.*, at p. 025. Claimant identified pain locations unchanged from previous notes, *i.e.*, shoulders, elbows, knees, upper back, and lower back. Dr. Michaud reiterated that he suspected fibromyalgia, but that he preferred to await Dr. Loveless' workup with a firm diagnosis before wandering off into chronic pain management. Dr. Michaud described Claimant's history with medications as follows:

In the past she has tried Darvon which "made her groggy". She has tried Vioxx which caused stomach upset. She has never tried Ultram and reportedly has not

tried Norco, though she has tried Vicodin, which she felt was ineffective. She tried some of her husband's Percocet prior to his death. She has never been on any tricyclic antidepressants and does not recall ever being on any SSRI medications as well.

Id. Dr. Michaud recommended a one-week trial of Ultram. If Ultram was ineffective, he recommended a switch to Norco. If neither Ultram nor Norco was effective, he recommended either an SSRI such as Effexor or Lexapro, or a tricyclic antidepressant such as Elavil.

8. Claimant saw Dr. Loveless on October 6, and he began a thorough rheumatology workup, including a number of lab tests and imaging. Dr. Loveless' chart noted x-rays showing scoliosis with patent SI joints and mild posterior degenerative bone and disk disease in her lumbar spine. On exam, he found Claimant had hyperinflation of her lungs with reduced air movement, indicating COPD, and muscle tests were equivocal to positive for fibromyalgia. Under "Impressions," Dr. Loveless identified fifteen conditions of concern, including: Osteoarthritis, probable fibromyalgia, COPD, untreated depression, untreated hyperlipidemia, multiple allergies, question of systemic autoimmune disease, and on-going tobacco use. Dr. Loveless recommended, among other things, additional laboratory studies, Tramadol for pain relief, and that Claimant stop smoking. He also considered a lumbar MRI, vascular studies, a sleep study, and knee films.

ACCIDENT

9. On or about October 12, 2004, Claimant was moving a bookcase at work and noted pain in her low back and down her right leg. The following day she was involved in a motor vehicle accident (MVA) where she was hit from behind.²

² There is much discussion about two incidents that occurred on or around September 15 or 16, 2004 that involved Claimant's low back. One incident involved loading boxes of conference materials into her Jeep. The second involved her dog jerking on the leash while on a walk, pulling her back. While neither incident is relevant to the underlying low back claim, they are relevant to the issue of whether Claimant's alleged need for an SCS is the result of the accepted industrial accident or due to other denied claims or non-industrial factors.

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POST-ACCIDENT MEDICAL CARE

10. On October 14, 2004, Claimant contacted Dr. Loveless, complaining of “increasing low back pain—‘excruciating’. This was exacerbated by moving furniture and she also was rear-ended in a motor vehicle accident. Her shoulders are also hurting.” Defendants’ Ex. 10, p. 001. Dr. Loveless advised that it was unlikely that her increased pain was related to the conditions that he was attempting to diagnose, and suggested she contact Dr. Michaud. Ultimately, Dr. Loveless determined that Claimant likely had fibromyalgia, but no systemic autoimmune disease. Dr. Loveless referred Claimant to Richard A. DuBose, M.D., to help her manage her pain.

11. Claimant returned to Dr. Michaud on October 15. She complained of increased sciatic pain, and related both the furniture-moving incident and the MVA to Dr. Michaud. Claimant also reported an occasional sensation of an electric shock in her legs, and some neck, left shoulder, and left upper extremity pain. She also complained that the Darvocet made her feel intoxicated, and that Mobic, given to her by Dr. Loveless, made her feel dry. Dr. Michaud took Claimant off work, recommended the addition of Skelaxin to her Darvocet, lumbar spine x-rays, and physical therapy. Cervical spine films, taken the same day, showed narrowing of the C5-6 disc space. Lumbar spine films done October 21 showed diffuse osteopenia and mild multi-level degenerative changes throughout the lumbar spine.

12. On October 25, 2004, Dr. Michaud cleared Claimant to return to work part-time. The same day, Claimant suffered a myocardial infarction (MI), and was hospitalized for several days, during which two cardiac stents were emplaced. Claimant would later report that the left upper quadrant thoracic pain that she had complained of for many years resolved following the insertion of the stents.

13. Claimant's cardiologists released her to return to work November 8, 2004, but Claimant did not feel she could return at that time due to her on-going back and leg pain. Claimant continued with physical therapy, and Dr. Michaud released her to return to work on November 29.

14. Claimant saw Howard Shoemaker, M.D., on December 8, 2004. Dr. Shoemaker is the occupational health physician to whom Employer referred Claimant. He opined that she had a mild low back strain as a result of her work injury, but her pain issues were complicated by her fibromyalgia and history of chronic pain. Dr. Shoemaker noted that Claimant was being treated appropriately for her low back by Dr. Michaud, and he made no changes in her treatment.

15. On the same day, December 8, Claimant saw Dr. DuBose. His assessment of Claimant's conditions included fibromyalgia, generalized whole body pain, osteoarthritis with osteopenia, and probable facet arthropathy of the cervical spine. He went on to note:

. . . clearly this patient has a number of concerning issues. Because of the longevity of the above complaints and their significant impact on the patients [sic] life, it is unlikely that a quick solution will be forthcoming.

Defendants' Ex. 17, p. 003. Dr. DuBose recommended a CT of Claimant's spine, and prescribed Neurontin, Methadone, and Effexor. CT scans of Claimant's cervical, thoracic, and lumbar spine were done on December 9, and showed degenerative changes throughout, with more pronounced degeneration at L3-4 (mild posterior annular disc bulge) and L4-5 (central canal stenosis, broad-based posterior annular disc bulge, and degenerative facet disease). Claimant returned to Dr. DuBose on December 12 to review her CT results and her medications. Dr. DuBose increased her Effexor, started her on Methadone, and told her to follow up in a month. There are no further records from Dr. DuBose regarding Claimant's care.

16. Claimant returned to Dr. Shoemaker December 22. She reported that the

Neurontin and Effexor prescribed by Dr. DuBose were helping. Claimant declined to take the Methadone. She continued to receive physical therapy. Dr. Shoemaker continued her physical therapy with a tapering number of visits per week and a transition to a home exercise program. He expected her to be medically stable within a month with no permanent impairment or disability as a result of the industrial accident. There are no further records from Dr. Shoemaker regarding Claimant's care.

17. Over the next year, Claimant was seen by a number of physicians regarding her low back and radicular pain, and continued to receive conservative care:

- January 2005—John Bishop, M.D., orthopedist, notes that Claimant “has been offered Neurontin and Methadone prescriptions by Dr. DuBose but cannot or will not take either medication.” Defendants’ Ex. 18, p. 001. Dr. Bishop prescribes prednisone, which helped Claimant’s pain, and a CT myelogram, which Claimant refused. Dr. Bishop declines to continue Claimant on prednisone, prescribes Dilaudid for pain, and refers her to George R. Lyons, M.D., neurologist, for consultation regarding her low back and radicular pain. Dr. Lyons sees Claimant but has no access to relevant medical records. Dr. Lyons orders a lumbar MRI.
- February 2005—Dr. Lyons performs an EMG of Claimant’s lower extremities which is normal and shows no active radiculopathy. Dr. Bishop suggests Claimant may be a surgical candidate, but recommends conservative care and refers to Christian Gussner, M.D., for a course of epidural steroid injections (ESI) at L4-5 and L5-S1. Claimant reports 95% reduction in leg pain (but not back pain) following injections.
- March 2005—Dr. Gussner performs right SI joint ESI.
- April 2005—Dr. Gussner performs right L4-5 and L5-S-1 ESI.

- May 2005—Dr. Gussner performs right L5-S-1 intralaminar ESI, followed two weeks later by right SI joint ESI.
- June 2005—Dr. Gussner discusses pain treatment options with Claimant, including pain medications, muscle relaxants, antidepressant medications, physical therapy, or return to Dr. Bishop. Claimant “reports that she becomes sedated with pain medications, even with Advil.” Defendants’ Ex. 21, p. 25. She does not want to consider surgery as proposed by Dr. Bishop.

- July 2005—Dr. Gussner performs right L4-5 and L5-S1 facet ESI. Dr. Gussner states:

I discussed with [Claimant] that I do not know if any specific treatment will get rid of all of her back pain. I feel that at least a portion of her back pain is coming from the right L4-5 and L5-S1 facet joints and she may benefit from medial branch nerve blocks. If this is successful then radiofrequency is recommended. She is willing to try this procedure.

Id., at p. 031. Dr. Gussner refers Claimant to Monte H. Moore, M.D., who performs blocks at right L3 and L4 medial branch nerves and the right L5 dorsal ramus,³ with Claimant reporting “significant improvement in back pain although not complete relief.”

Id., at p. 038. Dr. Moore performs radiofrequency denervation of right L4-5 and right L5-S-1 facet joints.

- August 2005—Claimant reports only 30% improvement from radiofrequency denervation. Dr. Moore discusses alternatives, including exercise, trigger point injections, and referral to a psychologist. Dr. Moore returns Claimant’s care to Dr. Gussner. Dr. Gussner performs right gluteal trigger point ESI, and recommends follow

³ The typewritten operative report for the July 21, 2005 procedure refers to blocks of the *left* L3-4 medial branch nerves and L5 dorsal ramus, but the handwritten Minor Procedure Record (Defendants’ Ex. 21, p. 033) refers to the procedures being done on the *right* L3-4 medial branch nerves and the right dorsal ramus nerve. At this time, Claimant was only complaining of right side radicular pain, so the Minor Procedure Record appears to correctly identify the procedure.

through with a psychologist.

- September 2005—Dr. Gussner’s chart note documents that Claimant is having more difficulty tolerating her chronic back pain, most of which (more than 90%) is in the back and the right gluteal. Treatment options include continuing home exercise program, non-opioid medications, opioid medication, or return to Dr. Bishop. Claimant is given a prescription for OxyContin.
- October 2005—Dr. Gussner reports Claimant will only take OxyContin when pain is very severe. “She is reluctant to take the medication on a scheduled basis every 12 hours.” *Id.*, at p. 051. Dr. Gussner continues Claimant on OxyContin and prescribes Lyrica.
- November 2005—Dr. Gussner performs right S1 transforaminal ESI. Claimant returns to Dr. Bishop who recommends decompression surgery and refers Claimant to Peter Reedy, M.D. Claimant complains to Dr. Gussner that Lyrica helps at bedtime, but makes her feel sedated and foggy.
- December 2005—Claimant sees Dr. Reedy, who orders a repeat lumbar MRI, and performs a right L4-5 partial hemilaminectomy and L4 discectomy on December 27, 2005.

18. At Claimant’s first post-surgical follow up with Dr. Reedy in early February 2006, she reported that she was not doing well, with pain in her buttock and leg. Dr. Reedy attributed part of Claimant’s difficult recovery to her refusal to take pain medications. Dr. Reedy authorized Claimant to return to work effective February 6, 2006, on a graduated schedule. Shortly after returning to work, Claimant fell, hitting her head and neck, spraining her wrist, and landing flat on her back. In March, Claimant reported increasing “pins and needles” pain that

made it difficult to walk. Further testing showed a recurrent disk protrusion, which led to a second surgery on April 11, 2006.

19. Claimant did not do well following the second surgery, complaining of continued nerve pain. Dr. Reedy had nothing further to offer her, and suggested she consult with Dr. DuBose or Gussner or discuss a fusion surgery with Dr. Hajjar. Claimant returned to see Dr. Gussner, who prescribed a Duragesic patch and advised her to follow through with a surgical consult with Dr. Hajjar. Claimant reported that the Duragesic patch helped with the pain, but she was allergic to it. Dr. Hajjar ordered new films and determined that she had yet another disc herniation at the site of the previous surgeries. Dr. Hajjar scheduled Claimant for a June 27, 2006, L4-5 posterior lumbar interbody fusion with instrumentation and autologous bone graft.

20. In mid-September 2006, Dr. Hajjar contacted Surety and advised that Claimant was approaching maximal medical improvement, which he anticipated would be in mid-November 2006.⁴ Claimant was still reporting significant back and leg pain when she returned for follow up in early November. Dr. Hajjar recommended a work-hardening program. By December 2006, Dr. Hajjar had determined that Claimant had a technically good result from the fusion surgery with instrumentation well placed, and indications that a solid fusion was forming, and no additional surgery was indicated. He did think that Claimant would benefit from a referral to a pain management specialist.

21. Claimant returned to see Dr. Moore in January 2007. For the first time, she complained of radicular pain in her left leg in addition to the right radicular pain she had reported since the industrial accident. Dr. Moore's chart note summarized his impressions:

⁴ Oddly, there are no medical records detailing office visits to Dr. Hajjar following Claimant's June 27, 2006 surgery until November 2006.

This is a 60-year-old woman who has a work injury claim and ongoing pain and lower limb pain, but without abnormal neurological findings or evidence of stenosis on her MRI. She feels that she is very disabled from work. She is not satisfied with her pain control. I am concerned about behavioral and psychological factors impeding her recovery.

Defendants' Ex. 21, p. 0061. Dr. Moore recommended a referral to the Elks Life Fit program, and a trial of OxyContin. Claimant reported several days later that she could not take the OxyContin, and asked what other options she had for dealing with her pain. Dr. Moore identified the Life Fit program, a morphine pump, or an SCS. He advised that she would need a psychological exam before being considered for a pump or a stimulator, and opined that she would not likely be found to be a good candidate for either modality.

22. When Claimant returned to Dr. Moore in early February, she expressed a desire to participate in the STAARS work-hardening program rather than Life Fit. Dr. Moore referred her to Life Fit, and Dr. Hajjar agreed that Claimant was a good candidate for the program.

23. Dr. Hajjar declared Claimant at MMI on February 15, 2007, and rated her at 21% PPI.

24. Claimant started the Life Fit program in early March 2007, and quit after three days. Both Dr. Moore and Dr. Hajjar opined that there was no medical reason that Claimant could not complete the program. In particular, Dr. Moore noted, "I do not feel that the patient gave reasonable effort during the program and that her perceived disability is not supported by objective findings. The findings are consistent with symptom magnification syndrome." *Id.*, at p. 069. Dr. Moore also noted that Claimant asked about an intrathecal pump, but he did not believe she was an appropriate candidate for such treatment. Dr. Moore declared Claimant at MMI from her work-related injury on April 4, 2007.

25. Claimant returned to Dr. Hajjar on March 20, 2007. During that visit, Claimant

asked Dr. Hajjar to refer her to Tyler Frizzell, a neurosurgeon, and Dr. Malleri, a pain specialist, for second opinions regarding further treatment. Dr. Hajjar concurred in Claimant's request and made the referrals.

26. Claimant saw Dr. Frizzell in early May. By this time, Claimant was complaining of pain in both legs. On exam, Dr. Frizzell did find some strength and sensory deficits in Claimant's left lower extremity. However, he concurred with Dr. Hajjar that Claimant had a solid fusion and was not a candidate for further surgery. He also concurred with Dr. Moore that Claimant was not a candidate for any other intervention, including SCS or pump, until she had been cleared by an appropriate psychologist.

27. Claimant first saw Dr. Malleri on May 3, 2007. She was seeking a consultation regarding her "chronic back and left leg pain." Claimant's Ex. 1, p. 014. She further advised that her pain had started on the right side and then it shifted to her left side. On exam, Dr. Malleri identified diminished reflexes in her left ankle and diminished sensation in the left L5-S1 dermatome, with slight weakness on left ankle flexion. Claimant was unable to bear full weight on her left leg. Dr. Malleri concluded that Claimant suffered from: 1) failed back syndrome; 2) epidural fibrosis; and 3) lumbar radiculitis involving several nerve roots. Dr. Malleri concluded that Claimant was not medically stable, and might benefit from epidural adhesiolysis procedure with a Racz catheter. If that procedure provided no relief, he suggested a SCS trial with an eye toward permanent implantation of an SCS.

28. In a letter dated May 4, the day following her first appointment with Dr. Malleri, Claimant's counsel wrote a letter to Dr. Malleri stating, in part, "[w]e received an email from [Claimant] this morning indicating that her mobility and pain is much improved since your

treatment yesterday.” *Id.*, at p. 017.⁵ The letter went on to note that Claimant wished to pursue the epidural adhesiolysis recommended by Dr. Malleri.

29. Claimant returned to Dr. Malleri on May 14 and 15, 2007. On May 15, the chart note states that Claimant was “having a lot of pain around both ankles and lower back pain. The left is worse than the right side.” *Id.*, at p. 022. Dr. Malleri gave Claimant an IMS (Intramuscular Stimulation) treatment, a modified form of acupuncture, and she reported significant reduction in her ankle pain. Dr. Malleri continued to pursue the issue of an SCS.

30. On May 17, Surety advised Dr. Malleri that it would not be paying for the care he was providing Claimant since she had been declared medically stable and had received an impairment rating from Dr. Hajjar.

31. Claimant returned to Dr. Malleri on May 30, reporting a significant amount of pain. Dr. Malleri reported that Claimant was frustrated and wanted to proceed with the epidural adhesiolysis procedure. Dr. Malleri opined that if Claimant did not get relief from the procedure, “she will mostly likely require a spinal cord stimulator placement.” *Id.*, at p. 024.

32. On June 7, Dr. Malleri performed the epidural adhesiolysis at left S1 and right L5 with a Racz catheter. Claimant returned for follow up on June 13 and reported “some improvement,” but still complaining of bilateral leg pain and low back pain. Once again, Dr. Malleri opined that an SCS was the definitive treatment for Claimant’s chronic pain complaints, but suggested a repeat of the epidural adhesiolysis procedure focusing on L4 bilaterally.

33. By letter dated June 22, 2007, Dr. Hajjar responded to a letter from Dr. Malleri regarding Claimant’s treatment. Dr. Hajjar stated:

⁵ Dr. Malleri’s chart note for May 3 does not indicate that Claimant received any treatment, merely that the recommended treatment was explained to her.

I believe your treatment plan to proceed with neural stimulation for [Claimant] is reasonable, and I will defer the modality of care and decision making to your expertise.

Id., at p. 030.

34. On June 25, 2007, Claimant underwent another procedure with Dr. Malleri. Although he had previously indicated that he intended to do another epidural adhesiolysis at L4 bilaterally, instead Dr. Malleri performed bilateral S1 and L5 dorsal ramus nerve injections and local steroid infiltration of the pedicle screws at L5 bilaterally.

35. Claimant returned to Dr. Malleri on July 2, and reported that she had five hours of relief after the local injection into the vicinity of her pedicle screws. Dr. Malleri continued to opine that an SCS was Claimant's best option for pain relief. Because Claimant had relief in the area of the pedicle screws, Dr. Malleri wanted to make sure that the hardware used for her fusion was not causing her problem.

36. On July 18, Claimant presented to Roger Olson, Psy.D., for a psychological evaluation preparatory to implantation of an SCS. Dr. Olson interviewed Claimant, observed her behavior, and administered the Millon Behavioral Medicine Diagnostic. He did not review any of her prior medical records. Based on his interaction with Claimant, Dr. Olson opined that she was "apt to be an easy and cooperative patient, especially with explicit directions and guidance." Claimant's Ex. 5, p. 002. He further opined that Claimant was comfortable with her social support system, and was likely to respond favorably to directives from friends and family regarding her health. Dr. Olson concluded:

[Claimant] did not indicate significant psychological distress at this time. She is likely to be compliant with medical treatment programs. She views her social support network as an asset in times of need. Mobilization of this network could be employed to enhance her adherence to the post-treatment regimen and to improve the maintenance of self-care behavior. She appears to be quite capable

of handling the psychological discomfort of various medical procedures. Smoking cessation assistance is strongly recommended.

Id.

37. On July 24, 2007, Dr. Malleri implanted a Medtronic single-lead spinal cord stimulator with eight electrodes for a one-week trial. The SCS was removed on July 31. Following the trial, Dr. Malleri advised Dr. Hajjar:

I would like to return [Claimant] to your care for a permanent Medtronic spinal cord stimulator placement. Rose recently completed a successful spinal cord stimulator trial at our facility. . . . [Claimant] has completed a psychological evaluation and is now ready for permanent stimulator placement.

Claimant's Ex. 1, p. 40.

38. While Claimant was undergoing the SCS trial, Dr. Hajjar was contacted by Surety regarding permanent placement of an SCS. By letter dated July 27, Dr. Hajjar acknowledged that Dr. Moore and Dr. Malleri were at odds over whether Claimant was a good candidate for permanent implantation, but intimated that he did not want to be in the middle of their clinical disagreement or side with either doctor against the other. Dr. Hajjar suggested that Claimant be evaluated by a neuropsychologist to resolve the impasse, and recommended Dr. Robert Calhoun.

39. Claimant returned to Dr. Mallari on August 22 concerned about her persistent back pain. She wanted Dr. Hajjar to address her fusion to see if the pedicle screws were causing her pain. Dr. Malleri offered to send Claimant to Howard King, M.D., for another opinion, but Claimant declined because the matter was being handled as a workers' compensation claim. Dr. Malleri continued to assert that she was a good candidate for an SCS, but deferred to Dr. Hajjar on the issue. In the meantime, he prescribed Cymbalta for her pain and Rozarem to help her sleep.

40. By letter dated August 24, Dr. Hajjar advised Claimant's counsel that while he

had recommended Dr. Calhoun for a neuropsych consult, any psych consult would do. He had reviewed Dr. Olson's report and concurred with his findings that Claimant was a good candidate, from a psychological standpoint, for a permanent implant.

41. Michael H. McClay, Ph.D., clinical psychologist, had done a psychological evaluation on Claimant as part of her brief participation in the Life Fit program. Surety contacted Dr. McClay in mid-August, and asked him to review medical records of Claimant's treatment, including Dr. Olson's evaluation, and to comment on Claimant's suitability for an SCS as well as the adequacy of Dr. Olson's evaluation. By letter dated August 31, Dr. McClay noted that Dr. Olson's "testing evaluation appears to lack specific components considered essentially [sic] to an evaluation of a chronic pain patient in a work related setting." Defendants' Ex. 32, p. 006. In particular, Dr. McClay noted that Dr. Olson had administered the Millon Behavioral Medicine Diagnostic rather than the MMPI, and had not administered the SF36, "a test that is rapidly gaining acceptance as the standard of evaluation and care for evaluation of the psychological readiness of medical patients to undergo invasive medical procedures." *Id.* Dr. McClay then turned to his own evaluation, which found Claimant had significant psychological overlay to her medical problems. In particular, he noted that he had found that she exhibited a conversion disorder that would make her a "very high risk candidate for any kind of surgical intervention." *Id.* Finally, Dr. McClay concluded that while SCS placement may provide some benefit to general medical patients, it "has been much less effective when dealing with patients when return to work is a primary issue." *Id.* Dr. McClay referenced the work of Michael Weiss, M.D., a Boise physician who had been following the use of SCS in cases involving return-to-work issues.

42. Claimant returned to Dr. Malleri on September 5. She advised that Dr. Hajjar was

awaiting authorization for permanent SCS placement. Dr. Malleri switched Claimant from Cymbalta to Lexapro, and restarted her on Lyrica. He scheduled her for lumbar facet/medial branch nerve blocks at L3, L4, and L5, bilaterally, as she had experienced some relief from the procedure in the past.

43. On September 14, at the behest of Defendants, Claimant was evaluated by Craig W. Beaver, Ph.D. The stated purpose of the evaluation was to determine whether Claimant was a psychologically suitable candidate for permanent SCS implantation. Dr. Beaver administered a series of twelve psychological tests, reviewed Claimant's medical records from October 1986 through August 24, 2007,⁶ conducted a clinical interview, and made behavioral observations. Dr. Beaver's "Impressions and Recommendations" takes up nearly four full single-spaced pages. His diagnoses included in pertinent part:

- Undifferentiated somatoform disorder;
- Pain disorder associated with both psychological and medical conditions;
- Maladaptive health behavior affecting medical condition (cigarette smoking);
- Nicotine addiction;
- Probable dysthymic disorder;
- Histrionic personality traits; and
- History of multiple surgeries, osteoarthritis, and fibromyalgia.

44. Dr. Beaver also addressed several factors that he believed were relevant to understanding Claimant's psychological diagnoses, all of which pre-existed her industrial injury:

[Claimant's] undifferentiated somatization disorder reflects the fact that she has multiple pain complaints, involving multiple systems, with additional neurological complaints over a number of years. While there have been medical

⁶ Dr. Beaver's thirteen-page review of Claimant's medical records is one of the most accurate and comprehensive digests of medical records ever encountered by this Referee.

conditions to explain some of her symptomatology, they have rarely explained the severity of her symptoms, nor has she been particularly responsive to treatment.

Pain disorder with both psychological factors and medical condition reflects the fact that [Claimant] shows a personality style in which her emotional duress affects her perception of her pain difficulties. This condition also existed before the industrial injury of 10/12/04, and is perhaps best illustrated by her appointments with Dr. Michaud . . . in which reviewing her multiple pain complaints he felt a trial of antidepressant medication would be indicated.

[Claimant], while minimizing the amount of depression she experiences, clearly evidences on psychological testing and displays in her behavior and some of her complaints, evidence of a low-level chronic depression, which is probably best described as dysthymia.

Defendants' Ex. 38, p. 023.

45. Dr. Beaver specifically addressed the evaluation of Claimant conducted by

Dr. Olson:

While doing a standard interview and administering a single psychological test, can with less complicated patients, be sufficient for ruling in or ruling out psychological issues, which would preclude a patient from certain medical procedures, this is not the case with [Claimant]. It is clear in reviewing Dr. Olson's reports, he was not aware of the extensiveness of [Claimant's] medical problems and the long entrenched history of multiple physical and particularly pain complaints with limited response to any treatment intervention. Additionally, it did not appear he had any type of realistic discussion with [Claimant] about what her response had been to the trial stimulator, which I believe also has bearing on these issues. Therefore, I do not consider the examination conducted by Dr. Olson as sufficient to answer the questions of concern regarding [Claimant] and the psychological appropriateness of the spinal cord stimulator.

Id., at p. 24. Dr. Beaver concluded his report:

From a psychological perspective, I have significant concerns about [Claimant] being considered for spinal cord stimulator. First of all, by her own report, she experienced only limited benefit from the spinal cord stimulator trial. Additionally, she has multiple pain complaints in multiple locations. She has not previously been responsive to other treatment interventions. Finally, there is evidence of both underlying depression, which has not yet being [sic] adequately treated, as well as evidence of a strong tendency towards increase of physiological complaints and difficulties in response to life stressors. All of which would be

contrary, from a psychological perspective, as to the effectiveness of utilizing a spinal cord stimulator for pain management with this particular patient.

Id.

46. Dr. Beaver's report was provided to both Dr. Hajjar and Dr. McClay for their review. Both indicated that they concurred in his findings.

47. On October 9, Dr. Beaver wrote to Surety to bring to its attention an article sponsored by Medtronic, Inc., the manufacturer of the SCS Dr. Malleri intended for Claimant's implant. The article, entitled Psychological Assessment and Intervention in Implantable Pain Therapies,⁷ specifically addressed psychological issues and factors relevant to the consideration of when an SCS was appropriate. Dr. Beaver found that his protocol for evaluating Claimant was consistent with the procedures recommended by the manufacturer, including a comprehensive patient history, medical record review, and substantial psychological testing. The article identified a number of circumstances and conditions that were more likely to result in negative outcomes, including: depression, somatization disorders, histrionic personality traits, inadequate social or family support systems, and unresolved litigation. Finally, the article stressed that permanent implantation of an SCS should not be considered unless the patient experienced "significant improvement" with a stimulator trial. After reviewing the article and Claimant's evaluation, Dr. Beaver determined that Claimant did not meet the manufacturer's recommendations for permanent implantation of an SCS.

48. Claimant returned to Dr. Malleri on October 18. They discussed his upcoming deposition, and her concerns with Dr. Beaver's report. Dr. Malleri opined that with regard to the SCS trial, "[t]he fact that she only got 50% coverage of her pain is actually quite good. We do not expect 100% coverage of a patients' [*sic*] pain problem during the spinal cord stimulator

⁷ Defendants' Ex. 39.

trial.” Claimant’s Ex. 1, p. 047.

DISCUSSION AND FURTHER FINDINGS

MEDICAL CAUSATION

49. The issue of medical causation, more specifically, whether Claimant’s asserted need for an SCS is attributable to her industrial injury, was identified as an issue in this proceeding. In part because this matter began as a denied claim, and in part because the causation issue was overlooked during the review of issues at the outset of the hearing, much of the evidence admitted on the causation issue related to the more general question of whether Claimant’s back injury and resulting surgery was the result of an October 12, 2004 industrial accident. Since the claim was ultimately accepted, the medical causation of Claimant’s need for back surgery was no longer at issue. There was, however, some evidence to be gleaned from the record on the more limited question of medical causation as it related to Claimant’s demand for a permanent SCS.

50. 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). Defendants assert that Claimant “never offered any evidence that her need for an SCS (if any) is related more probably than not to her October 12, 2004 claim, instead of her alleged September 14, 2004 claim, which was denied, or her other preexisting back problems.” Defendants’ Post-Hearing

Brief, p. 2.

51. While essentially correct, Defendants' assertion can be a bit misleading. It is true that Claimant did not ask Drs. Hajjar, Malleri, or Reedy to specifically opine whether it was more likely than not that the pain Claimant hoped to remedy with the SCS was the result of her October 12, 2004 industrial accident and its sequelae. However, Claimant's radicular complaints did not begin until after the industrial accident, and there does not seem to be any real dispute among Claimant's treating physicians that her radicular pain was the result of the industrial accident.

52. Claimant's radicular pain was described by both Drs. Malleri and Weiss as being consistent with the formation of scar tissue as a result of Claimant's multiple back surgeries. Dr. Malleri encountered resistance when attempting to maneuver a catheter through Claimant's epidural space during a procedure to try to block some of her pain. He testified that the existence of scar tissue, also known as epidural fibrosis, was associated with both back pain and radicular pain. During his testimony at hearing, Dr. Weiss acknowledged that scar tissue near the spine could impinge on nerve roots and cause pain. Dr. Moore did not believe that Claimant's pain complaints were related to her industrial accident, but was not asked whether he had found evidence of scar tissue, nor what effects scar tissue around and adjacent to exiting nerve roots might have. And while Dr. Beaver clearly stated that his review of the medical records showed that many of Claimant's pain complaints pre-existed her industrial injury, his evaluation focused only on Claimant's suitability for permanent SCS implantation and not on the narrow question of causation.

53. The issue of medical causation as it relates to Claimant's pain complaints and her industrial accident is an admittedly complex and thorny issue. Ultimately, however, there is at

least some credible evidence that Claimant's injury caused some of the pain she hopes to treat with an SCS. Dr. Moore's opinions were directed at Claimant's suitability for a permanent implant, and he made no attempt to address causation or tease out pre-existing versus post-accident pain complaints. Similarly, Dr. Beaver's evaluation focused on Claimant's suitability for the procedure, not causation. While the evidence in support of medical causation is slim, the evidence to the contrary is even slimmer. The Referee finds that Claimant has met her burden of establishing that at least some of the pain complaints that she seeks to treat with the stimulator were caused by her industrial accident.

MEDICAL CARE/SCS IMPLANTATION

Efficacy

54. At the heart of this proceeding is an issue concerning Defendants' obligation to provide Claimant medical care pursuant to Idaho Code § 72-432—in particular, whether Defendants are obligated to pay for the implantation of a permanent spinal cord stimulator together with the ongoing medical care that an implanted stimulator requires. The dispute is two-pronged. Defendants argue that permanent implantation of spinal cord stimulators is of questionable efficacy in general, is of even less effect in patients with Claimant's diagnoses, and is particularly ineffective in patients with Claimant's diagnoses who have return-to-work issues. The second prong of the dispute centers on the question of whether Claimant is a suitable candidate for permanent implantation, as she asserts.

55. The first question, regarding the efficacy of SCS implants in general and in patients like Claimant in particular, is beyond the purview of this Commission at this time. There is little agreement within the medical community on the use of spinal cord stimulators at the present time, and it is inappropriate for the Commission to usurp the role of the medical

professionals in reaching a consensus on the issue. In the future, should the medical community reach an accord on SCS implantation with generally accepted treatment protocols, it may be appropriate for the Commission to address the reasonableness of SCS as a form of treatment just as it has examined and made determinations regarding other medical protocols. *See, Brisson v. Terry B. Hale, DDS, 2000 IIC 0736 and Valerie McDaniel v. Smith's Food and Drug, 2007 IIC 0512.*

Suitability

56. The second question, whether Claimant is a suitable candidate for a stimulator implant, is within the Commission's purview because the question ultimately becomes whether the particular care recommended by Dr. Malleri is reasonable.

I.C. Section 72-432(1) obligates the employer to provide treatment, if the employee's physician requires the treatment *and if the treatment is reasonable*. It is for the physician, not the Commission, to decide whether the treatment is required. *The only review the Commission is entitled to make of the physician's decision is whether the treatment was reasonable.*

Sprague v. Caldwell Transp., Inc., 116 Idaho 720, 722, 779 P.2d 395, 397 (1989). Emphasis added.

57. Implantation of a permanent spinal cord stimulator brings with it certain risks, including infection, hematoma, spinal cord injury, meningitis, paralysis, migration of the unit, electric shock, granuloma, and additional surgeries in the event of unit failure or malfunction or battery failure. Given the risks inherent in the use of the device, it is in the best interest of all involved—patient, surgeon, treating physician, and manufacturer—to select patients who have the best chance of a good outcome. Measured at the most fundamental level, the question becomes whether the potential benefits of a stimulator outweigh the risks for a given patient.

58. For the reasons discussed herein, the Referee finds that Claimant is not a suitable

candidate for permanent implantation of a spinal cord stimulator; thus, the treatment recommended by Dr. Malleri is not reasonable for this Claimant.

59. There is no dispute that a psychological evaluation is a prerequisite to permanent implantation of an SCS. However, the type and extent of the psychological evaluation, and the weight given the evaluation by the physicians involved in Claimant's care, are in dispute.

Dr. Olson

60. Dr. Olson's psychological evaluation was facile at best. He did not review Claimant's medical records. He administered only one psychological test—a test not particularly well suited to a psychological evaluation of a chronic pain patient. He offered no opinion as to Claimant's cognitive abilities. Both Drs. McClay and Beaver discussed in detail what was lacking in Dr. Olson's evaluation. Particularly striking to Dr. Beaver and to the Referee was Dr. Olson's assertion that Claimant would likely be compliant with medical treatment regimes. A review of Claimant's medical records belies Dr. Olson's statement. Claimant refused most medication offered her, even though analgesics, including opioids, are considered by some pain specialists as the safest and most effective way to treat chronic pain. Claimant dismissed most treatment options offered to her by Drs. Moore, Gussner, and DuBose, while repeatedly returning to see them seeking additional pain relief alternatives. Claimant refused to quit smoking, even after her MI, her husband's death from lung cancer, and being advised that the best thing she could do to ease her pain was to quite smoking. Her attitude toward the oft-given advice was termed "defiant" and "adamant" by her treating physicians. Finally, regardless of the treatment modality utilized—physical therapy, epidural steroids, medications, or surgery—Claimant seldom reported a positive outcome.

61. Dr. Olson also stated in his evaluation that Claimant had a good support system of

family and friends and that she would be comfortable calling on them for help and heeding their advice. In fact, it is not clear that Claimant had even a minimal support system in Boise. Her only family, her son, lived in California, and they saw each other infrequently. The only evidence in the record of any kind of social network that Claimant had developed was one reference to a co-worker, Lois Malpass, who accompanied Claimant to one of her medical appointments. Claimant stated that she had only been to the co-worker's house once and that had been the previous year.

62. Dr. Olson's determination that Claimant evidenced no "significant psychological distress" at the time of his evaluation (Claimant's Ex. 5, p. 002) is at odds with the medical records, which document depression or dysthymia going back a number of years. Claimant asserted that her depression was situational—relating to her husband's illness and death and her own health problems. However, Claimant's history of depression/dysthymia significantly predates her husband's illness, and continued to be an issue up to the date of the hearing. Further, several of Claimant's physicians over the years noted that Claimant tended to minimize her dysthymic or depressive symptoms. Dr. Beaver testified that his testing confirmed that minimizing psychological distress was a consistent characteristic of Claimant's psychological makeup.

Dr. Beaver

63. Unlike Dr. Olson, Dr. Beaver performed a comprehensive psychological evaluation of Claimant. He conducted an in-depth review of Claimant's medical history, he administered a battery of tests designed to evaluate both cognitive abilities and psychological makeup, he observed Claimant's behavior and demeanor, and he interviewed her at some length. His analysis of Claimant's psychological state is detailed, thorough, carefully analyzed, and well

documented.

64. Dr. Beaver expressed no doubt that Claimant has the cognitive ability to follow directions in managing her use of an SCS. Dr. Beaver spent the majority of his time and placed his emphasis on the analysis of Claimant's psychological makeup. Through testing, observation, discussion, and his review of her medical records, Dr. Beaver identified a number of particular psychological traits that, in his opinion, make the Claimant an unsuitable candidate for a permanent stimulator. Dr. Beaver subsequently reviewed materials published by the manufacturer of the stimulator detailing psychological factors that the manufacturer has found to be strongly predictive of success or failure. Dr. Beaver noted that the factors identified by the manufacturer were precisely the factors that he had identified in opining that Claimant was not a suitable candidate for permanent implantation. His analysis was so consistent with the manufacturer's published materials that Dr. Beaver felt compelled to bring the information to the attention of Surety *via* letter and to reiterate that the materials reinforced his earlier opinion regarding Claimant's psychological framework. In particular, Dr. Beaver noted that Claimant:

- Had a long history of chronic pain complaints that pre-dated her industrial injury;⁸
- Exhibited signs of a somatization disorder (also noted by Dr. McClay, suggested by Dr. Moore, and evident in Claimant's lengthy medical history);
- Was generally unresponsive to treatment; and
- Exhibited substantially elevated scores on the MMPI scales associated with individuals who have a history of depression/dysthymia and individuals who exhibit strong

⁸ Claimant attempts to deflect this argument by asserting that her complaints of upper left quadrant/thoracic pain resolved after her MI when stents were placed in two of her cardiac arteries. Claimant did have a long history of such complaints, and underwent a lengthy medical workup to try and identify the source of her long-standing upper quadrant/thoracic pain complaints. However, the medical records document a long history of chronic pain complaints in her back, neck, shoulders, and joints prior to her industrial accident.

emotional/psychological components to the intensity of their pain complaints and their ability to manage their pain.

These particular psychological factors were consistently present in all aspects of Claimant's psychological testing, and were corroborated by Dr. Beaver's observations and Claimant's voluminous medical records.

65. The Referee finds that Dr. Beaver's psychological evaluation was persuasive in discussing the importance of psychological factors in determining suitability for an invasive medical procedure, in identifying particular traits exhibited by Claimant, in discussing their significance, and in providing concrete examples from the medical records of how those factors manifested in Claimant's expectations and behaviors.

Dr. Malleri

66. Dr. Malleri's testimony was troubling in several respects. He stated in his deposition that an SCS trial was deemed "successful" if the patient had a 50% or greater reduction in their pain while using the stimulator. While the 50% reduction in pain may be the standard measure of success in SCS trials, it remains, as Dr. Malleri admits, an entirely subjective measurement. Dr. Malleri termed Claimant's SCS trial "successful," but nowhere in Dr. Malleri's medical records is there any indication that *Claimant* actually reported a 50% or greater reduction in pain during the stimulator trial. Claimant *did* report to Dr. Malleri that she had *some* reduction of her lower extremity pain, but *no* relief from her low back, spine, and hip pain—which Claimant repeatedly described as "excruciating" and "horrible." Dr. Malleri testified that during her trial, Claimant "had excellent coverage of her leg pain. Now, granted, we were not able to cover the lower back pain that was associated with her overall pain, but we felt like that was a technical issue." Dr. Malleri Depo., p. 14. Dr. Malleri went on to state that

when Claimant presented to his clinic, she was more concerned about her leg pain than her back pain. A careful review of Dr. Malleri's chart notes does not support this assertion, and when Dr. Beaver *specifically* asked Claimant to isolate her "most debilitating pain," she identified her back and hip pain. In contrast to Dr. Malleri's report, Claimant told Dr. Beaver that she had *limited* relief of her lower extremity pain. Thus, it appears by Claimant's own report that she had a modest reduction of her least-debilitating pain, and no reduction of her most debilitating pain.

67. In his deposition testimony, Dr. Malleri discussed the reasons that a psychological evaluation was generally required before a patient could be considered for a stimulator. Among the reasons he identified were to increase the likelihood of positive outcomes and to assure that the patient was psychologically able to manage the device. Dr. Malleri testified that as far as he was concerned, the main purpose of a psychological evaluation was to assure that the patient had the cognitive skills and mental wherewithal to follow instructions and operate the stimulator. As Dr. Malleri observed in his deposition, if he were to rely on the type of evaluation that Dr. Beaver performed, he would never do another implant.

As discussed by Drs. Weiss and Beaver during their testimonies, the purpose of a psychological exam prior to implantation of an SCS is much broader in scope than merely determining cognitive ability, and is inextricably tied with the likelihood that implantation of a stimulator will actually ameliorate a patient's pain. For this reason, Dr. Malleri's *pro forma* acceptance of Dr. Olson's psychological evaluation is troubling, unless Dr. Malleri had expected to get a positive report from Dr. Olson. Dr. Malleri had access to Claimant's prior medical records, and had treated Claimant without success for several months, yet he accepted without question Dr. Olson's opinion that Claimant was "apt to be an easy and cooperative patient, especially with explicit directions and guidance," and that she had no psychological stressors that

should be of concern. Claimant's Ex. 5, p. 002. Further, as pointed out by Dr. Beaver, Dr. Olson's assessment lacks the most basic testing, evaluation, or analysis of Claimant's cognitive abilities—Dr. Malleri's stated primary concern when considering a patient for a permanent stimulator.

68. In his deposition, Dr. Malleri presents as an enthusiastic champion of SCS technology as a panacea for refractory pain in general, and the Claimant in particular. Dr. Malleri testified that he treats three to four patients per month that he considers good candidates for SCS implantation, and asserts that he has a 90 to 95 percent "success" rate on the patients who undergo a stimulator trial. This means that 90 to 95 percent of the patients report 50% or greater reduction in their pain as a result of the trial. Dr. Malleri stated that in his experience, patients who have a "successful" trial are also psychologically good candidates for an implanted stimulator.

Given the uncertainty inherent in both reporting and measuring a patient's subjective improvement, Dr. Malleri's claim of a 90% to 95% success rate lacks reliability. Further, his assertion that patients who have a "successful" trial are also good candidates psychologically turns the entire purpose of the requirement for psychological evaluation on its head. The question is not, as Dr. Malleri's statement suggests, whether a patient experienced some relief from the trial, but whether the patient can tolerate, and still receive benefit from, a permanent implant in the long term.

69. Next, Dr. Malleri testified that he "usually" has 100% success rate with the permanent implantation in those patients who had successful trials. Dr. Malleri explained that the criteria for determining "success" in the case of a permanent implant is "(1) has the patient reduced his use of narcotic medications; (2) are they more functionally mobile, are they able to

do more things with their family and enjoy their avocation.” Dr. Malleri Depo., p. 10. Dr. Malleri admits that he does no systematic follow up on patients that he has referred for permanent implantation of spinal cord stimulators—many never return to him after their implantation, and of those who do, he cannot say how well they are doing with the stimulator after one or two years of use. Dr. Malleri’s claims of such success rates with permanent stimulators are unsubstantiated, untested, and unreliable. Since Dr. Malleri neither implants the stimulators, nor follows the implant recipients long-term, it is easy for him to hand off his patients to the surgeon, declare victory, and head for the locker room.

70. Not only are Dr. Malleri’s claims of success unsubstantiated, they deviate significantly from the general experience of the broader medical community. As discussed by Dr. Weiss during his testimony, the literature on SCS suggests that out of 100 individuals who are candidates for SCS, 50% will report a successful trial, but at the end of two years following permanent implantation, only 50% of those with permanent implants will still be reporting a 50% reduction in their pain. Further, the 25% of the initial group that is still reporting a reduction in pain have neither reduced their use of narcotics nor improved their ability to function. In short, Dr. Weiss suggests that while the studies do vary somewhat, generally the percentage of “successful” outcomes is about the same as would be expected from a placebo were one available. Dr. Weiss’ testimony was credible, and he is particularly well qualified to discuss and explicate the medical literature regarding SCS implantation.

Dr. Hajjar

71. As the surgeon who performed Claimant’s fusion, and the surgeon who would be implanting the permanent SCS, Dr. Hajjar’s opinions as to Claimant’s suitability for an SCS implant should carry some weight in deciding this case. However, as evidenced by Dr. Hajjar’s

medical records and his deposition testimony, his opinions are best described as “accommodating”: He declared Claimant to be medically stable, but then granted her request for referrals to Drs. Frizzell and Malleri; he agreed with Dr. Moore that there was no reason Claimant could not finish the Life Fit program, but then agreed with Dr. Malleri that Claimant needed additional pain management before she could complete a work-hardening program; he agreed with Drs. Moore and Beaver, both of whom opined that Claimant was not a good candidate for an SCS implant, and with Drs. Malleri and Olson, who opined that she was. Recognizing that as the surgeon implanting the stimulator he ultimately had the final say, he preferred to defer to the judgment of others when it came to determining suitability for the procedure. Given the facility with which Dr. Hajjar tacks into the ever-changing winds, his opinions as to Claimant’s suitability for an implant provide a tenuous mooring for a decision.

72. After a thorough review of the record, with special attention to the records and depositions of Drs. Malleri, Hajjar, Olson, and Beaver, the Referee finds:

A. That the conduct of a meaningful psychological evaluation prior to considering Claimant for permanent implantation of a spinal cord stimulator is a crucial and substantive step in making a responsible medical decision regarding the reasonableness of Claimant’s treatment;

B. That findings made as a result of a comprehensive psychological evaluation are an essential factor that must be weighed accordingly in making a determination whether Claimant is a suitable candidate for implantation of a permanent spinal cord stimulator;

C. That Dr. Beaver’s psychological evaluation was comprehensive, well documented, and persuasive.

D. That there is a lack of consistency between Dr. Malleri’s records and his testimony, particularly as to Claimant’s initial pain complaints and the results of her stimulator

trial. Such inconsistencies, taken together with Dr. Malleri's unverifiable claims of success for SCS use in his chronic pain patients, diminished his credibility;

E. That Claimant is not a suitable candidate for permanent implantation of an SCS, making such a procedure, *ipso facto*, unreasonable.

REMAINING ISSUES

MMI

73. As determined by Dr. Hajjar, Claimant was medically stable on and after February 15, 2007—in part because implantation of an SCS was the only remaining treatment that any physician had to offer her and she was not a suitable candidate for such surgery. Claimant's medical stability on and after February 15, 2007 is further supported by the fact that even though Claimant received various and sundry treatments after being declared medically stable, none of the treatments led to any improvement of her condition.

TTDs

74. Because the Referee finds that Claimant was medically stable as of February 15, 2007, she is not entitled to additional TTD benefits.

Payment for Drs. Malleri and Frizzell

75. Surety is not responsible for medical charges incurred by Claimant with Drs. Frizzell or Malleri following February 15, 2007, her date of medical stability.

Attorney Fees

76. Attorney fees are not granted to a claimant as a matter of right under the Idaho Workers' Compensation Law, but may be recovered only under the circumstances set forth in Idaho Code § 72-804. The decision that grounds exist for awarding a claimant attorney 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). Claimant has failed to establish an entitlement to attorney fees in this proceeding. Defendants were not unreasonable in their initial denial of Claimant's claim because of the number of confounding factors that surrounded her injury—walking the dog, loading boxes, moving furniture, and an MVA. Indeed, had not Defendants eventually accepted the claim, medical causation of Claimant's low back injury would have been a matter of some dispute in these proceedings. Neither was it unreasonable for Defendants to refuse to authorize an SCS for Claimant as requested by Dr. Malleri. The use of stimulators is a contentious one in the medical community with disputes about efficacy, the type of injuries most amenable to treatment with SCS, and which patients, in particular, should be considered for SCS implantation. Defendants acted reasonably in obtaining a thorough neuro-psych consult from Dr. Beaver and then relying upon his opinion to deny Dr. Malleri's proposed treatment as unreasonable.

CONCLUSIONS OF LAW

1. Claimant has met her burden of proving that at least some of the pain she hoped to treat with the use of a spinal cord stimulator was the result of her October 12, 2004 industrial accident.

2. Claimant was medically stable on and after February 15, 2007.

3. Claimant is not entitled to additional temporary total disability (TTD) benefits.

4. Defendants are not responsible for medical care that Claimant received from Drs. Malleri and Frizzell after she was medically stable.

5. Claimant is not entitled to a permanently implanted spinal cord stimulator at Defendants' expense.

6. Defendants' denial of a permanently implanted spinal cord stimulator was

reasonable and does not provide grounds for attorney fees pursuant to Idaho Code § 72-804.

RECOMMENDATION

Based upon the foregoing Findings of Fact, Conclusions of Law, and Recommendation, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this 4 day of September, 2008.

INDUSTRIAL COMMISSION

/s/ _____
Rinda Just, Referee

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

ROSE M. AULT,)
)
 Claimant,)
)
 v.)
)
 BOISE STATE UNIVERSITY,)
)
 Employer,)
)
 and)
)
 STATE INSURANCE FUND,)
)
 Surety,)
 Defendants.)
 _____)

IC 2005-501681

ORDER

Filed: September 22, 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 met her burden of proving that at least some of the pain she hoped to treat with the use of a spinal cord stimulator was the result of her October 12, 2004 industrial accident.
2. Claimant was medically stable on and after February 15, 2007.
3. Claimant is not entitled to additional temporary total disability (TTD) benefits.
4. Defendants are not responsible for medical care that Claimant received from Drs.

Malleri and Frizzell after she was medically stable.

5. Claimant is not entitled to a permanently implanted spinal cord stimulator at Defendants' expense.

6. Defendants' denial of a permanently implanted spinal cord stimulator was reasonable and does not provide grounds for attorney fees pursuant to Idaho Code § 72-804.

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

DATED this 22 day of September, 2008.

INDUSTRIAL COMMISSION

/s/ _____
James F. Kile, Chairman

Unavailable for signature _____
R.D. Maynard, Commissioner

/s/ _____
Thomas E. Limbaugh, Commissioner

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 22 day of September, 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:

DARIN G MONROE
PO BOX 50313
BOISE ID 83705

JON M BAUMAN
PO BOX 1539
BOISE ID 83701-1539

djb

/s/ _____

ORDER - 2

