

2. Whether, and to what extent, Defendants are liable for attorney fees under provisions of Idaho Code § 72-804 for unreasonably denying a claim for medical treatment which was thereafter accepted by Defendants.

CONTENTIONS OF THE PARTIES

Claimant argues that Defendants unreasonably denied her claim for medical treatment during a telephone conversation on May 30, 2008 when Claims Examiner, Janis Smith, stated that Claimant's file was closed. In the alternative, Claimant contends that Surety's failure to use due diligence in the investigation of Claimant's claim for continuing medical benefits constitutes a denial of Claimant's claim. Claimant requests attorney fees under Idaho Code § 72-804. Claimant argues that Idaho Code § 72-432 should be interpreted to require Surety to directly pay Claimant 100% of all denied medical benefits incurred in connection with Claimant's October 2, 2008 back surgery. Claimant contends that Defendants should not be able to directly pay providers. Claimant argues that the medical fee schedule established under Idaho Code § 72-803 violates the equal protection clause. Claimant requests that the Commission abandon the medical fee schedule. In addition, Claimant requests reimbursement for money she paid to her massage therapist, Michael Plyer, NCTMB,² whom she has been seeing since May 2006.

Defendants assert that they did not deny Claimant's claim for medical treatment during the May 30, 2008 phone conversation or during any subsequent correspondence between the parties. Defendants did not have all of Claimant's medical documents before Claimant's July 11, 2008 deadline for surgery authorization. Defendants contend that they explicitly authorized Claimant's requested surgical procedure on September 22, 2008, after conducting a reasonable investigation. Defendants have accepted responsibility for Claimant's reasonable medical

² Claimant refers to Michael Plyer as "Dr." Plyer. Mr. Plyer is a naturopathic physician and is "NCTMB" certified. The acronym "NCTMB" stands for "National Certification Board for Therapeutic Massage & Bodywork."

treatment and are processing the bills from Claimant's October 2, 2008 surgery as they are received. Defendants deny that they are responsible for Claimant's treatment with Mr. Plyer under Idaho Code § 72-432(5). Defendants contend that they requested this hearing for guidance on the payment of medical expenses, because Claimant threatened them with civil litigation if they paid medical providers directly for the surgery that they authorized.

EVIDENCE CONSIDERED

The Record in this instant case consists of the following:

1. Oral Testimony by Claimant and Janis Smith at hearing.
2. Claimant's Exhibits 1 through 23 admitted at hearing.
3. Defendants' Exhibits A through F admitted at hearing.
4. The Commission's legal file.

After having fully considered the above evidence and arguments of the parties, the Commission hereby issues its decision in this matter.

FINDINGS OF FACTS

1. Claimant was 30 years old at the time of the hearing. Claimant graduated from Borah High School in 1996, and began working for DirecTV in 1997. On May 1, 2006, Claimant had an industrial accident at DirecTV when she fell down six stairs at work on Employer's premises. Claimant reported her accident on May 2, 2006 to Employer. There was no dispute as to responsibility for Claimant's claim. Surety contacted Claimant on May 18, 2006 through Claims Examiner, Janis Smith. Surety assigned Ms. Susan Kinnon, a nurse case manager, to Claimant's file. Surety requested a medical history from Claimant on May 24, 2006. Claimant began visiting Mr. Michael Plyer in May 2006 for massage therapy and hydro-therapy upon the recommendation of family and friends. Claimant was not referred to Mr. Plyer by any

medical doctor or anybody in her treatment relating to the industrial accident. Claimant received treatment from St. Luke's Occupational Health Services related to her industrial accident, and Ms. Kinnon referred Claimant to Gregory Schweiger, M.D.

2. Dr. Schweiger diagnosed Claimant with a hip contusion, and gave her a zero percent impairment rating with no restrictions and released her to work on July 5, 2006. After her release, Claimant's physician did not recommended any further treatment beyond one additional visit to physical therapist, Jody Thatcher. Claimant's massage therapy with Mr. Plyer was not part of her physician recommended treatment plan. Surety paid for all of Claimant's recommended medical treatment. Claimant paid for her visits to Mr. Plyer. In July 2006, Surety submitted a summary of payments to the Commission and closed her file. The Commission approved Surety's summary of payments.

3. On June 6, 2007, almost a year later, Claimant asked Surety to reopen her case. (HT at 34). Claimant testified that she told Ms. Smith that her pain had never gone away, and that her medical condition had progressively gotten worse. (HT at 35). Claimant requested that Surety authorize payment during the phone conversation for her upcoming appointment with Mr. Plyer on June 15, 2007. (HT at 35). Ms. Smith noted that there had not been a new injury, and told Claimant she would need to review her file before making a determination. Surety promptly assigned Ms. Kinnon to Claimant's file. Ms. Kinnon referred Claimant to Nancy Greenwald, M.D., a physiatrist.

4. Claimant visited Dr. Greenwald on July 25, 2007. Ms. Kinnon was present during the examination. Dr. Greenwald requested Claimant's medical history during that appointment, and ordered a lumbar-spine MRI and a right-hip MRI. Dr. Greenwald referred Claimant to Ms. Foucher, a physical therapist.

5. Claimant explains that she did not submit Mr. Plyer's bills to Surety based on her June 6, 2007 conversation with Ms. Smith, who told Claimant that she needed to review her file prior to submitting payment. However, Claimant discussed Mr. Plyer's treatment with her workers' compensation physician, Dr. Greenwald. Dr. Greenwald did not consider Claimant's massage therapy with Mr. Plyer as treatment related to her workers' compensation claim, and specifically noted that the treatment was "not Work Comp recommended." (C. Exh. 8 at 00809). On October 9, 2007, Claimant was found to be at MMI for the second time. Dr. Greenwald issued Claimant a 5% whole person PPI rating with 1% apportioned to pre-existing arthritic changes and 4% to Claimant's industrial accident on May 1, 2006. Claimant continued treating with Mr. Plyer, after Dr. Greenwald's release as MMI, and paid for Mr. Plyer's bills out of pocket.

6. After being released, Claimant and Ms. Smith had a few conversations regarding a missing check in January and February. (D. Exh. C at 00018-00019; HT at 99). There is no record that Claimant discussed pain or medical complications during those conversations. (D. Exh. C at 00018-00019; HT at 99-100).

7. In April 2008, Claimant took a long road trip to Las Vegas, Nevada. Claimant experienced severe low-back pain and right lower-extremity radiculopathy. When she returned from her trip, Claimant presented to the St. Luke's emergency room on April 22, 2008. Claimant requested that her group health carrier be billed for the services. On May 14, 2008, Claimant returned to the St. Luke's emergency room. Claimant reported that the emergency room physician told her that her medical problems were related to her previous industrial accident, and referred her to a primary care physician, Mark Michaud, M.D. Claimant requested that her group health carrier be billed for the services.

8. Claimant saw Dr. Michaud on May 27, 2008. Dr. Michaud ordered a lumbar spine MRI, which was performed on May 28, 2008. The MRI showed that Claimant had two herniated disks. Dr. Michaud referred Claimant to neurosurgeon, Douglas Smith, M.D.

9. Claimant contacted Ms. Smith on May 30, 2008, and informed her that she needed surgery and requested that Surety re-open her claim. (HT at 106). The parties disagree about the content of the conversation. Claimant argues that Ms. Smith told her that her case was closed by Dr. Greenwald, and that Claimant would need to prove her entitlement to additional medical benefits. Ms. Smith testified that closing a file refers to an internal process when someone has been released from care and needs no further treatment. When a file is closed, Surety submits a summary of payments to the Commission for approval. If the Commission approves the summary of payments, Surety closes the file and moves the physical file to storage. Claimant had previously re-opened her closed file, but believed that she could only re-open it once. Ms. Smith does not remember telling Claimant that she would need to prove her entitlement to additional medical benefits. Claimant believed that she told Ms. Smith she was referred to Dr. Smith, and that she would be visiting him shortly. Ms. Smith does not recall Claimant mentioning the name of a specific physician. Ms. Smith asked Claimant to send her the information that she had from her physician and stated that she would review Claimant's file. (HT at 107).

10. Claimant retained her attorney on June 4, 2008. After the May 30, 2008, phone conversation, Claimant left one message for Ms. Smith regarding her work release information. (HT at 69). However, Claimant testified that her direct conversation with Surety ended after June 13, 2008. Claimant gathered her medical records prior to meeting with Dr. Smith, but did not send the records to Surety or sign a medical records release form because she was "still

trying to determine causation.” (HT at 45). Claimant believed she needed to prove causation before releasing any medical records to Surety. (HT at 67).

11. Dr. Smith examined Claimant on June 13, 2008 and found that Claimant had two disk herniations between L4 and L5 and also S1 with debris on her sciatic nerve. Dr. Smith reported on June 15, 2008 that three factors contributed to Claimant’s lumbar MRI changes—the fall of May 1, 2006 and secondary changes; the road trip to Nevada, and the wear and tear of every day life.

12. On June 19, 2008, Dr. Smith reported that Claimant needed a 2-level lumbar spine surgery and that the surgery was related to her industrial accident. On June 20, 2008, Claimant demanded that Surety authorize her 2-level lumbar spine surgery recommended by Dr. Smith within 21 days from the date of this letter, i.e. July 11, 2008. Claimant claimed that she submitted a portion of her medical records to Surety on June 20, 2006. At that point, Claimant had not submitted a medical release and Surety had not received Claimant’s recent medical records directly from the providers. On June 26, 2008, Surety requested a Medical Information Authorization and a 10-Year Medical Provider List from Claimant.

13. On July 10, 2008, one day before Claimant’s deadline for surgery authorization, Claimant submitted her Medical Information Authorization and 10-Year Medical Provider List. Claimant requested that Surety confirm “in writing” that Employer/Surety would authorize the 2-level lumbar fusion surgery recommended by Dr. Smith and the right hip consultation with Dr. Schwartzman, or confirm “in writing that Employer/Surety will not authorize the surgery or the consultation with Dr. Schwartzman.” (C. Exh. 15 at 015082). Claimant insisted that if she did not receive a written response from Employer/Surety on or before Friday, July 11, 2008, she would consider Surety’s behavior as a denial of her claim. (C. Exh. 15 at 015082). Claimant

explained that if she did not receive a response before her deadline, she would file a complaint and a motion for an emergency hearing on attorney's fees and the denied benefits. Claimant's response included a list of medical providers and a signed medical release form.

14. On July 11, 2008, Surety explained that it was unable to authorize the medical treatment until it obtained her recent medical records and completed the investigation of the matter. Claimant seemed to acknowledge that Surety could not make a determination on the surgery authorization, given that Surety did not have all of the pertinent medical records. (D. Exh. B at 00011). Claimant asked Surety to promptly obtain the records and offered to provide any other information that would be helpful in allowing Surety to complete its investigation and respond to the request for surgery authorization.

15. Claimant filed a complaint with the Commission on July 29, 2008. Claimant filed a motion for an emergency hearing on the issue of denied medical benefits. The emergency hearing was scheduled for September 25, 2008. Defendants deposed Claimant on September 17, 2008 and authorized Claimant's surgery on September 22, 2008.

16. Claimant had surgery on October 2, 2008 with Dr. Smith. Claimant demanded direct payment of the medical benefits on October 3, 2008, and the Defendants requested a hearing.

DISCUSSION AND CONCLUSION

Credibility

17. The Commission finds that Claimant was a credible witness.

18. Claims Examiner, Ms. Smith, was also a credible witness.

Surety's Treatment of Claimant's Claim

19. Claimant's arguments regarding the medical fee schedule, direct payment of

medical benefits, and attorney fees are premised on the assertion that Defendants unreasonably denied her claim for medical benefits during the brief May 30, 2008 phone conversation with Claims Examiner, Ms. Smith, or in the Defendants' subsequent failure to conduct a reasonable investigation of her claim. Although the wording of the issues in the notice of hearing was imprecise, the parties fully briefed the issue of whether Claimant's claim was denied.

20. In this case, Claimant argues that Surety denied her claim during a brief phone conversation on May 30, 2008, because she was told her claim was "closed," and that she would need to "prove" her entitlement to continuing medical benefits. Ms. Smith testified that she did not have Claimant's physical file and requested that Claimant ask her doctors to submit their records for her review. Understandably, it is frustrating for a claimant to wait for a response regarding financial responsibility for future medical care, but it is unrealistic to expect a surety to resolve a complex case like Claimant's in a brief conversation, and it is inaccurate to characterize a desire to review Claimant's medical information regarding the future medical care as a denial of her claim. See Idaho Code § 72-432; Troutner v. Traffic Control Co., 97 Idaho 525, 547 P.2d 1130 (1976) (Surety has a right and an obligation to investigate a claim for workers' compensation benefits to ensure reasonable medical care to an injured worker and to ensure that surety is, in fact, actually responsible for Claimant's medical care. Claimant has a duty to cooperate with this process). After months without any substantive communication between the parties, Claimant represented that she had some medical records that connected her current need for surgery with her industrial accident of 2006. Surety simply asked Claimant for that information and offered to review the file. There is nothing persuasive to indicate that Surety's request for more information was a subterfuge to delay Claimant's medical treatment or avoid responsibility for payment. Surety re-opened her claim once before in 2007 and cooperated with

coordinating Claimant's medical treatment. Although the parties disagree as to the content of the phone conversation, Claimant's argument that Surety denied her claim for continuing medical benefits during this conversation is unpersuasive.

21. It is not clear that Claimant notified Surety of her upcoming June 13, 2008 medical appointment with Dr. Doug Smith or mentioned his name. Claimant testified that she did not contact Surety or send them any information after she retained her attorney on June 4, 2008, other than leaving a voicemail message regarding her work release information. (HT at 69). Claimant did not involve Surety until she believed that she had proven her case. Claimant received a favorable causation opinion from Dr. Smith on June 19, 2008. Claimant's June 20, 2008 letter informed Surety of this causal connection between Claimant's need for surgery her industrial accident of May 1, 2006 and demanded that Surety authorize the surgery within 21 days from the date of the letter, on or before Friday, July 11, 2008. The date of July 11, 2008 does not appear to be related to Claimant's medical treatment at all. At that point, Surety had not even received Claimant's medical records to review nor had Claimant submitted a medical release form. A claimant cannot reasonably expect to withhold medical information until she obtains a favorable causation opinion and cry foul that a surety wants to review the same medical information before authorizing a surgery. Such behavior lends itself to litigation, but not to the swift resolution of claims.

22. Claimant argues that Surety did not use appropriate procedures to investigate her claim. Of course, a surety must not unreasonably delay investigation of a claimant's claim for medical benefits. See Farrar v. Adecco, Inc., 2008 IIC 0556. (Defendants ended its investigation of claimant's injury based on a brief causation opinion, did not attempt to contact Claimant's medical provider, did not review the case when faced with a new causation opinion

or additional medical information). Nevertheless, it is unusual for a claimant to assert that a claim is denied, because the Defendants requested to review necessary medical information that Claimant delayed releasing. Claimant acknowledged that Surety did not have the medical information as late as July 11, 2008, Claimant's arbitrary deadline for Surety approval or denial. While not dispositive, Surety never sent a written statement issuing a denial; Surety asked for a medical release and time to review the necessary records. Claimant is entitled to pursue a causation opinion before she engages Defendants in a discussion over her medical treatment; however, that does not mean Defendants denied her claim.

23. Claimant insists that Surety acted unreasonably in asking for a medical release to obtain medical records from the providers, after Surety expressed willingness to receive information directly from Claimant for their review during the May 30, 2008 phone conversation. Claimant cannot be surprised that Defendants wanted to request a copy of the medical records directly from the providers as they are entitled to under Idaho Code § 72-432(11), given that she did not send the medical information after the May 30, 2008 phone call, and then sent incomplete records on June 20, 2008.

24. Further, it is unrealistic to expect Defendants to be aware of Claimant's emergency room visits on April 22, and May 14, 2008 without Claimant's notification. Those visits were billed to Claimant's group health insurance coverage, and the records were not timely submitted to Surety for processing of payment. Defendants have expressly accepted responsibility for these expenses.

25. The Commission is not persuaded that Defendants denied Claimant's claim for continuing medical benefits during the May 30, 2008 phone conversation or at any time thereafter. Defendants did take some time to review and approve Claimant's claim. The

Commission expects Surety to act promptly, but does not find that Surety's behavior was egregious or unreasonable in the circumstances of this case.

Claimant's Medical Treatment

26. Idaho Code § 72-432(1) obligates an employer to provide an injured employee reasonable medical care as may be required by his or her physician immediately following an injury and for a reasonable time thereafter. It is for the physician, not the Commission, to decide whether the treatment is required. The only review the Commission is entitled to make is whether the treatment was reasonable. See Sprague v. Caldwell Transportation, Inc., 116 Idaho 720, 779 P.2d 395 (1989). Idaho Code § 72-432(1) further permits an injured employee to obtain treatment on their own, at the expense of the employer, if the employer fails to provide reasonable medical treatment for the industrial injury.

27. Claimant argues that Surety acted unreasonably in providing medical care. In Overall v. Walgreen Company, IC 2004-008260 (April 24, 2007), the Commission found that a surety acted unreasonably in providing medical care under Idaho Code § 72-432.

Here, between the date of accident (July 2004) and January 2006 Defendants took no steps to fulfill their statutory obligations beyond instructing Claimant to go see an authorized provider. They did nothing to *provide* actual medical care to Claimant as required by Idaho Code § 72-432. Surety's nonpayment to Claimant's physician caused deterioration in the doctor-patient relationship, and Claimant stopped visiting her physician on March 14, 2005. In June 2005, Surety negotiated payment with the physician regarding Claimant's medical bills without contacting Claimant's counsel, because it believed paying for the bills would be cheaper than waiting for a hearing and "eventually have to pay for it in the long run anyway."

Overall, at 4.

28. The Commission found Overall's release as MMI to be premature and inconsistent with her physician's medical records made on or immediately prior to March 14,

2005. In all, “Defendants had an obligation and ample opportunity to provide reasonable medical care. Instead, they posted a notice, then sent one letter seven weeks later, and thereafter ignored or obstructed Claimant’s opportunity to obtain the care she needed for another year and one-half.” Overall, 2007 IIC 0380 at 11. Surety then made an “eleventh hour reversal” and decided to pay Claimant’s physician.

29. Claimant argues that Dr. Greenwald prematurely declared her MMI on October 9, 2007, and that the Surety’s “eleventh hour reversal” to accept responsibility for Claimant’s surgery on October 2, 2008 was unacceptable. However, the facts of this case distinguish it from Overall v. Walgreen Company. Unlike Overall, Claimant’s first injury on May 1, 2006 was accepted without dispute and Surety made payment to her providers. Claimant was released as MMI on July 5, 2006. After about a year, Claimant re-opened her claim for a second time on June 6, 2007, and Surety referred her to a nurse case manager and paid for her medical treatment. Again, Claimant was released as MMI on October 9, 2007. Several months later, Claimant made a brief phone call to Surety on May 30, 2008 and reported that her condition had not improved, and that a doctor believed it was related to her industrial accident. While Claimant reported she was in pain throughout her release as MMI, Claimant did not discuss any on-going pain with Surety for months nor did Claimant seek additional medical treatment until after her road trip to Las Vegas.

30. However, Defendants deny responsibility for Claimant’s visits to her massage therapist, Mr. Plyer. Claimant argues that she is entitled to reimbursement for all of the charges from Mr. Plyer, her massage therapist, whom she self-referred to and has been visiting with since May 2006. Claimant requests reimbursement for Mr. Plyer’s visits from June 15, 2007 to September 30, 2008. Claimant’s providers have not recommended that Claimant see Mr. Plyer

as part of the reasonable care that Claimant is entitled to under Idaho Code § 72-432. Claimant discussed coverage for these visits in 2007, and her workers' compensation physician, Dr. Greenwald, clearly stated in August 28, 2007, that her massage therapist was "not Work Comp recommended."

31. Further, Claimant's testimony regarding the visits suggests that the treatment does not provide any significant or even lasting benefits. (HT at 76; C. Exh. 22 at 02215). The Commission finds that Claimant is not entitled to reimbursement for her treatment with Mr. Plyer. The parties' poor cooperation, discussed above, contributed to a delayed determination on causation and approval. Surety did not have all of the necessary records or any of the bills before Claimant's arbitrary deadline of July 11, 2008.

32. Claimant also argues that equitable estoppel requires Surety to pay 100% of medical bills incurred after Surety explicitly authorized the medical treatment on September 22, 2008. The medical bills incurred after Surety's explicit acceptance include the October 2, 2008 back surgery; Boise Anesthesia, P.A., October 2, 2008; and several visits with Dr. Smith.

33. Surety authorized Claimant's surgery on September 22, 2008, after receiving the medical records and deposing Claimant. Thereafter, Claimant demanded that Surety pay 100% of the invoiced amount of the medical bills directly to the Claimant. Claimant's argument for 100% of the full invoiced amount of medical services is based on Edmondson and Sangster. See 130 Idaho 108; 2004 IIC 0851. Having found that Surety did not deny Claimant's claim, Claimant's situation is not analogous to Edmondson and Sangster. Id.

34. Defendants have accepted responsibility for the treatment related to Claimant's October 2, 2008 surgery and have stated that they will continue to pay the medical bills relating to the surgery through the workers' compensation system. Claimant's position that Defendants

must pay 100% of all medical benefits, even after Defendants gave Claimant an explicit acceptance of the medical treatment prior to Claimant's surgery, is contrary to the Supreme Court's holding in Neel v. Western Construction, Inc., (2009 Opinion No. 35). Defendants did not deny Claimant's claim. The Commission agrees that Defendants approach is appropriate.

Medical Fee System

35. Claimant asserts a constitutional challenge to Idaho Code § 72-803 and § 72-432. Claimant argues that the medical fee system violates her equal protection rights, because it provides greater rights to claimants who can afford medical care outside of the workers' compensation system. Claimant maintains that the medical fee classification system discriminates against claimants who are "stuck inside the workers' compensation system," because the claimants then lose the right to receive direct payment for medical benefits. Instead, the surety makes direct payments of a claimant's medical expenses to the medical providers.

The Idaho Supreme Court, not the Industrial Commission, addresses constitutional issues with statutes. See Rhodes v. Industrial Commission, 125 Idaho 139, 142, 868 P.2d 467, 470 (1993); Idaho State Ins. Fund v. Van Tine, 132 Idaho 902, 908 P.2d 566 (1999) (citing Tupper v. State Farm Ins., 131 Idaho at 970, 963 P.2d at 1167) (When a statute is constitutionally challenged, the Supreme Court will make every presumption in favor of constitutionality, and that the burden of establishing unconstitutionality rests upon the challengers). However, the Commission will comment that it disagrees with Claimant's arguments. The policy behind Workers' Compensation law is to provide sure and certain relief to the injured worker, not create financial windfalls for claimants. In a denied claim, claimant incurs medical bills without the regulation of the medical fee system, and is contractually responsible for those bills. Thus, the surety should pay the entire invoiced amount of those medical bills, if the Commission deems the

case compensable. Claimants, whose claims are accepted, are not forced to incur medical bills outside the workers' compensation regulatory scheme. As such, claimants should not receive direct payment of 100% of invoiced amounts on accepted claims.

Attorney Fees

36. Idaho Code § 72-804 provides for an award of attorney fees in the event an employer or its surety unreasonably denies a claim or neglected or refused to pay an injured employee compensation within a reasonable time. 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, which provides:

Attorney's fees - Punitive costs in certain cases. - If the commission or any court before whom any proceedings are brought under this law determines that the employer or his surety contested a claim for compensation made by an injured employee or dependent of a deceased employee without reasonable ground, or that an employer or his surety neglected or refused within a reasonable time after receipt of a written claim for compensation to pay to the injured employee or his dependents the compensation provided by law, or without reasonable grounds discontinued payment of compensation as provided by law justly due and owing to the employee or his dependents, the employer shall pay reasonable attorney fees in addition to the compensation provided by this law. In all such cases the fees of attorneys employed by injured employees or their dependents shall be fixed by the commission. (Emphasis added.)

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). In this case, the parties were unable to come to a swift resolution as to whether Claimant's October 2, 2008 surgery should be approved. It is reasonable for Surety to review a Claimant's information prior to authorizing surgery. To Surety's credit, they have re-opened her case on two occasions. The Commission finds that Claimant is not entitled to attorney fees.

ORDER

1. Because Surety did not deny Claimant's claim, Defendants are not obligated to pay Claimant directly for medical expenses incurred.

2. Defendants are not liable for attorney fees under the provisions of Idaho Code § 72-804.

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

IT IS SO ORDERED.

DATED this __13th____ day of April, 2009.

INDUSTRIAL COMMISSION

/s/
R.D. Maynard, Chairman

/s/
Thomas E. Limbaugh, Commissioner

_Com. Baskin recuses himself from participating
Thomas P. Baskin, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 13 day of April, 2009 a true and correct copy of **FINDINGS, CONCLUSIONS, AND ORDER** was served by regular United States Mail upon:

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